STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. BUILDING _____ B. WING _____	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROY HILLS CENTER	200 REYNOLDS AVE PARSIPPANY, NJ 07054

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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: 2/27/23 Census:107 Sample: 23+24=47 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. The following Immediate Jeopardy Situations (IJ) were identified for F835, F880 and F886 during the survey conducted from 02/08/2023 through 02/27/2023. F835 S/S L The survey team identified and IJ situation that began on 02/08/23 and was identified on 02/10/23 at 4:07 PM after the survey team identified multiple breaches in infection practices for three consecutive days, on 02/08/23, 02/09/23 and 02/10/23 that affected [redacted] Resident Wings. The facility was in an active outbreak of [redacted] that began on [redacted]. The facility was notified in writing of the IJ situation on 02/10/23 at 4:08 PM.	F 000		

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

Electronically Signed | 03/23/2023

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F 000	Continued From page 1 The facility failed to: -Ensure the Administrator ensured policies, procedures and systems were developed and implemented to ensure appropriate infection control practices were followed to and residents were cared for and an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety, and welfare of staff and all residents who resided at the facility in compliance with federal, state and local requirements as outlined in the Center Executive Director Job Description,. -A removal plan was accepted on 02/13/23 at 10:17 AM. The survey team verified the removal plan on 02/13/23 at 12:33 PM. F 880 S/S L The facility failed to: -Ensure a system was in place and followed to prevent the spread of multidrug resistant infections (organisms resistant to multiple antibiotic treatments including EX. Order 26.(4) B1 [redacted] and EX. Order 26.(4) B1 (a EX. Order 26.(4) B1) -Facility policies and current infection control guidance was not followed to limit the spread of infection. The breaches in infection control practices were observed by the survey team on 02/08/23, 02/09/23, and 02/10/23, for 4 of 4 Resident Wings.	F 000		

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The Administrator was notified of the IJ on 02/10/23 at 4:08 PM

A removal plan was accepted on 02/13/23 at 10:17 AM. The survey team verified the removal plan on 02/13/23 at 12:33 PM.

F 886 S/S K

The facility failed to:

Take immediate action to prevent the spread of COVID-19 by failing to:

-Follow facility policy and pertinent guidance to conduct immediate EX. Order 26.(4) B1 testing for residents by either, a broad-based or contact tracing approach.

-Conduct immediate resident broad-based testing per facility policy on 02/08/23, 02/11/23 and 02/13/23, in response to a EX. Order 26.(4) B1 resident on EX. Order 26.(4 EX. Order 26.(4) B1 (Resident #84), who tested positive for EX. Order 26.(4) B1 on 02/07/23, and conduct resident broad based testing on 02/13/23 in response to Resident #86 who tested EX. Order 26.(4) B for EX. Order 26.(4) B1 on 02/12/23.

-Ensure a process was followed to ensure all close contacts of a dietary department employee who was symptomatic and tested EX. Order 26.(4) for EX. Order 26.(4) B1 on 02/16/23, were identified and tested immediately.

The failure to conduct immediate resident and staff testing upon utilizing either a broad- based approach or contact tracing approach, upon the identification of a single EX. Order 26.(4) B1 staff

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F 000	Continued From page 3 or resident result. The Immediate Jeopardy (IJ) situation which began on 02/03/23 when the facility failed to conduct either immediate broad based testing, or contact tracing testing in response to CNA #1, who was symptomatic and also tested EX. Order 26.(4) B1 EX. Order 26.(4) on 02/03/23 and worked on 02/01/23. The facility was notified of the IJ situation on 02/17/23 at 1:42 PM. The removal plan was received on 02/17/23 at 8:52 PM, and accepted on 02/21/23 at 9:07 AM. The removal plan was verified as implemented by the survey team on 02/21/23 at 1:08 PM. The noncompliance remained on 02/27/23 for "actual harm that is not immediate jeopardy based on the following."	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		4/11/23

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F 610	Continued From page 4 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 pertinent documents it was determined that the facility failed to complete and document a thorough investigation regarding bruises of unknown origin sustained on a EX. Order 26.(4) B1 [redacted]. This deficient practice occurred for 1 of 1 resident (Resident #92) reviewed for abuse and was evidenced by the following: On 02/14/23 at 8:46 AM, the surveyor observed Resident #92 seated in a chair next to the bed. Resident #92 was [redacted] but EX. Order 26.(4) B1 [redacted] asked by the surveyor. Resident #92 was [redacted] and unable to proceed with the interview. On 02/14/23 at 8:59 AM, the surveyor observed a Certified Nurse Aide (CNA) who was assigned to Resident #92, enter the resident's room with a meal tray. Plastic utensils were observed on the resident's meal tray and the surveyor inquired to the CNA about the plastic utensil use. The CNA stated that she did not know and "they don't want [him/her] to hurt [him/herself]." On 02/14/23 at 1:21 PM, the surveyor was in Resident #92's room and observed the Business Office Manager (BOM) enter the room with the lunch meal tray. The surveyor observed that plastic utensils were on Resident #92's meal tray and asked the BOM about the plastic utensils. The BOM stated she usually only passed trays to	F 610	1. The facility added an addendum to the initial reportable on resident #92 from [redacted] The skin was checked again on 3/14/23 with no skin injury noted. 2. All residents have the potential to be affected by the deficient practice. 3. The Administrator and the Director of Nursing were re-educated on 2/24/23 by the Regional Nurse Consultant. The Nurse Practice Educator or designee re-educated staff on the requirement to report allegations of abuse and neglect immediately to include injuries of unknown origins. The Director of Nursing or designee will audit all allegations of abuse and ensure timely reporting of occurrences weekly for four weeks then monthly for two months. 4. The results of the audit will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the course of the audit.	

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people that she knew. The BOM further stated that Resident #92 used plastic utensils and stated it was due to "behavior".

The surveyor reviewed the Admission Record for Resident #92 which revealed: the resident was admitted with diagnoses which included, but were not limited to: EX. Order 26.(4) B1 [redacted]

An annual Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident scored [redacted] on the Brief Interview for Mental Status which indicated the resident was EX. Order 26.(4) B1 [redacted].

A Progress Note signed by the former Director of Nursing, Registered Nurse, "Late Entry" Effective Date [redacted] 12:52 PM, revealed Note: on [redacted] approximately 8:30 AM, supervisor reported that during AM (morning) care, staff noted Resident #92 to have a EX. Order 26.(4) B1 near [his/her] [redacted]. Immediately following report this writer proceeded to assess resident's status. Upon assessment resident was noted to have a EX. Order 26.(4) B1 to [redacted], [redacted] in nature. Resident was able to open and close [redacted] without difficulty. No redness, bleeding and or signs of trauma noted to the EX. Order 26.(4) B1 slightly [redacted] no other visible injuries observed... Upon interview resident able to recall side rail use but unable to recollect correct timing, day of event... EX. Order 26.(4) B1 to [redacted] x [redacted]]...

A subsequent nursing progress note documented on [redacted] at 2:44, "Still noted with [redacted]

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EX. Order 26.(4) B1 ..."

A nursing progress note dated EX. Order 26.(4) B1 at 14:30, documented "This am, resident's been trying to hit staff while being cared...

A progress note dated EX. Order 26.(4) B1 at 4:00, entered by a Licensed Practical Nurse (LPN) revealed "recent noted EX. Order 26.(4) B1 area on EX. Order 26.(4) B1 and other areas...", "Can get EX. Order 26.(4) B1 with changes".

A progress note documented by an LPN on EX. Order 26.(4) B1 at 7:00, revealed "EX. Order 26.(4) B1 near EX. Order 26.(4) B1 to how it happened..."

A Nursing General/Health/History/Vitals documentation note dated EX. Order 26.(4) B1 at 21:06, and signed by an LPN, revealed "Describe other reason for admission/skilled care/CIC, "noted EX. Order 26.(4) B1 areas EX. Order 26.(4) B1 Resident on EX. Order 26.(4) B1 ", Additional details about the note revealed: "noted EX. Order 26.(4) B1 of EX. Order 26.(4) B1 on EX. Order 26.(4) B1. No complaints of pain when asked. Slept well entire shift. Noted EX. Order 26.(4) B1 with care".

An SBAR (Situation, Background, Assessment, Recommendation) summary for providers dated EX. Order 26.(4) B1 at 12:43, revealed a Registered Nurse documented that Resident #92 had EX. Order 26.(4) B1 on the EX. Order 26.(4) B1.

A nursing note, Signed by a Registered Nurse, Effective Date: EX. Order 26.(4) B1 at 15:48 , revealed, resident noted throwing things to other residents and hitting staff...lots of EX. Order 26.(4) B1 and EX. Order 26.(4) B1 episodes in the EX. Order 26.(4) B1 due to lots of stimulating factors that may be contributing to [his/her]

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behavior...

The Care Plan for Resident #92 revealed a Care Plan (CP) focus that resident was at risk for injury or complications from EX. Order 26.(4) B1 medication, initiated and revised on EX. Order 26.(4) B1. The goal was for Resident #92 not to exhibit sign/symptoms of EX. Order 26.(4) B1, with a target date of EX. Order 26.(4) B1. Interventions included, observed for EX. Order 26.(4) B1, i.e., EX. Order 26.(4) B1 ...created on EX. Order 26.(4) B1. The CP focus for EX. Order 26.(4) B1 with a goal of consuming 50-100% meals and 100% supplements daily, initiated on EX. Order 26.(4) B1, with a target date of EX. Order 26.(4) B1. The CP for nutritional risk, included an intervention of plastic utensils on meal trays due to behavioral issue, initiated EX. Order 26.(4) B1. The CP focus for the resident was at risk for EX. Order 26.(4) B1 due to advanced age, EX. Order 26.(4) B1, and decreased PO [by mouth] intake created on EX. Order 26.(4) B1 and revised on 1[illegible] EX. Order 26.(4) B1. The goal was that Resident #92 would remain free of EX. Order 26.(4) B1 and/or EX. Order 26.(4) B1 days with a target date of EX. Order 26.(4) B1. (The CP did not address the actual EX. Or EX. Order 26.(4) B1, or other documented EX. Or. Order 26.(4) B1 areas)

On 02/22/23 at 10:33 AM, the Director of Nursing (DON) was interviewed, in the presence of the survey team regarding what the process would be if a bruise was identified on a resident. The DON stated that an incident report would be completed, interviews would be conducted, and an investigation would be completed. The DON stated that she had been employed at the facility since EX. Order 26.(4) B1. The surveyor inquired regarding if an investigation would be completed for a reddened area that was found on a resident. The DON stated, "absolutely", it would be an

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investigation. The surveyor inquired regarding any incidents that had occurred with Resident #92 in EX. Order 26.(4) B1 The surveyor asked the DON if there would be any time that the DON would not be aware of any incidents, and the DON stated "there shouldn't be" any situations that she would not be made aware of. The surveyor asked what an SBAR form was completed for. The DON stated that was something that helped when the physician was called. The surveyor asked if the DON was aware of the documentation regarding the EX. Order 26.(4) B1 on EX. Order 26.(4) B1. The DON stated that she was not aware of that situation and when asked if she should have been, she responded "yes". The surveyor inquired to the DON why she should have been made aware of the red cheek documentation. The DON stated she would look into that because "we want to make sure there is no allegations of abuse" and if it was medical, we would look into that and she stated, "I don't have an incident report on it [red cheek]".

On 02/22/23 at 10:42 AM, the surveyors interviewed the DON regarding the purpose of a care plan. The DON stated the care plans were for the interventions needed to manage the care of the residents.

On 02/22/23 at 11:08 AM, the surveyor inquired to the DON regarding the purpose of having the injury of unknown origin policy. The DON stated the injury of unknown origin policy was for bruises of unknown origin, unless they were sure where an injury came from and were provided the example of how it could be explained or how it happened vs. an unwitnessed injury.

On 02/22/23 at 1:00 PM, the DON provided the surveyor with a copy of an incident report dated

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EX. Order 26.(4) B1 at 8:15 AM, and signed by an Registered Nurse (RN #1) for an incident that occurred with Resident #92. The document revealed: Incident Description: During AM [morning] a care staff member noted EX. Order 26.(to resident's EX. Order 26.(4) B1 skin intact, and no bleeding noted. Resident Description: "unable to state how [he/she] got it". Description of Immediate Action Taken: "placed EX. Order 26.(4) B1 ", Witnesses: "no witnesses found". Injury Type "no injuries observed at time of incident", The Injury Location and Injury Type sections on the form were left blank. Two statements were attached to the incident report which revealed Date of Event: EX. Order 26.(4) B1 Regarding: EX. Order 26.(4) B1, Statement: This morning around 8 AM, the CNA called me to show that the resident had a EX. Order 26.(4) EX. Order 26.(Noted EX. Order 26.(4) B1 in color, skin intact no bleeding. No complaint of pain and discomfort. Resident stated that didn't know what happened. Placed EX. Order 26.(4) B1 . Needs attended, will monitor, signed and undated by RN #1. A second statement revealed Date of Event: EX. Order 26.(4) B1, regarding EX. Order 26.(4) B1. Statement: Around 8:15 AM, I came to resident's room, before giving [him/her] care. I noticed that [his/her] EX. Order 26.(4) has a EX. Order 26. . I immediately called the nurse to see and assess. Signed and undated by a CNA.

On 02/23/23 at 11:59 AM, the surveyor asked the DON what the injury on 06/30/22 would be classified as and the DON confirmed it was a bruise of unknown origin. The surveyor inquired who would be interviewed regarding an investigation. The DON stated there should have been a look back period with the Nurse Aides for ruling out abuse and then stated "no", and

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confirmed that there was no look back period regarding any statements obtained, and "nothing else was found" by the DON regarding any other statements from the nurse aides regarding the EX. Order 26.(4) B1 of unknown origin.

On 02/23/23 at 12:09 PM, the surveyor requested, from the Licensed Nursing Home Administrator (LNHA), the facility investigation policy and any policies related to injuries of unknown origin. At 12:23 PM, the LHNA provided an accidents/incidents and care plan policy to the surveyor.

On 02/24/23 at 8:18 AM, the LNHA and in the presence of two surveyors provided an investigation file for Resident #92 which included a reportable event record dated EX. Order 26.(4) B1 for a date of event a[EX. Order 26.(4) B1 2 days later) regarding an unwitnessed injury that was reported. There were three completely different statements attached to the document then had been provided to the surveyor on 02/23/23 at 1:00 PM. The statements revealed: Date: EX. Order 26.(4) B1, Re: Resident moves frequently while in [his/her] bed, sleeping with [her/his] EX. Order near the bed rails and tends to lie with [his/her] hand on [his/her] EX. Order causing pressure has been noticed. Signature, undated and not titled. A second statement revealed Date: left blank, revealed received resident in bed, EX. Order 26.(4) B1... resident is active in bed and has poor EX. Order 26.(4) B1. Sleeps at intervals, moves around in bed. Received extensive care by CNA for EX. Order 26.(4) B1 of EX. Order 26.(CNA did not report to me of any marks on resident. Signed, undated by CNA. Third statement revealed Date of Event: EX. Order 26.(4) B1 resident moves a lot in bed. I have seen [him/her sleeping with [her/his] face near the side rails,

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signed, undated and untitled. The surveyor asked the LNHA what she would expect to see completed for an investigation. She stated the four what's, "what happened, when, why, and what are you doing about it". The LNHA stated the discoloration was found, all staff that cared for the resident were interviewed, the nurse and the CNA statements were provided to surveyor as original statements, and then the LNHA stated she "found additional statements" for the investigation that were from a Nurse and CNA that had taken care of the resident before. The surveyor asked the LNHA how the conclusion of the investigation was then determined. The LNHA stated that the resident moved around in bed, so it was concluded it was the side rail that caused the injury. The surveyor asked if abuse had been ruled out, and the LNHA stated it was ruled out because the resident moved in bed. The surveyor asked the LNHA if any residents had been interviewed to determine there was no potential abuse. The LNHA stated that no other residents were interviewed and "typically we interview other residents to see how care givers are and ensure there are no issues". The surveyor asked if there was a written assessment of the [redacted], and the LNHA stated would find and provide it, the surveyor also requested any interdisciplinary team review and documentation. The LNHA stated since the resident was seen sleeping "near" the siderail the night before, that was how the conclusion was determined and the LNHA again, confirmed that there had been no other interviews completed with any other residents regarding the care provided by the staff. The surveyor inquired if any documented physical assessments were completed for other residents who were not alert or confused and also cared for by the same staff and the LNHA stated there

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F 610	Continued From page 12	F 610		

were no body checks completed for any residents. The LNHA stated in this case we came to the conclusions because the resident was seen leaning up against a side rail and due to [redacted] use. The LNHA stated "typically we do" interview other residents, when asked about body assessments completed the LNHA stated staff would have been able to "see" other residents and did not further elaborate. The LNHA did not provided the surveyor with a documented assessment of the bruise or interdisciplinary documentation of the incident.

On 02/24/23 at 9:05 AM, the LNHA confirmed there was a nursing note completed on [redacted] regarding [redacted] areas on the [redacted], and there was no additional documentation provided regarding the investigation, or documented evidence regarding assessment of areas located on [redacted], or size of [redacted].

On 02/24/23 at 10:06 AM, the surveyor inquired about the purpose of care plans. The DON stated that the purpose was to identify a resident's needs and implement nursing interventions to keep a resident safe.

On 02/24/23 at 10:12 AM, the surveyor interviewed the DON regarding any assessments of the [redacted] or [redacted] areas on Resident #92. The DON stated typically with an assessment of a [redacted], measurements would be documented and there was no documentation regarding the [redacted] areas. The surveyor asked if that should be investigated and the DON stated, "yes", the pieces of the puzzle were not sticking together and typically a whole-body skin check would have been completed when [redacted] were identified.

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	315138	A. BUILDING _____ B. WING _____	02/27/2023

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F 610	Continued From page 13 A review of the Accident/Incidents Policy, Effective 06/01/96, Revised 10/24/22, revealed an incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the patient. An incident can involve a visitor or staff member, malfunctioning equipment ...4.4 When conducting an investigation, the Administrator, DON, or designee will make every effort to ascertain the cause of the accident/incident; Initiate of timeline chronology, Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident ... A review of the Abuse Prohibition Policy, Effective 06/01/96, and Reviewed 10/24/22, revealed the center will implement an abuse prohibition program through ...Identification of possible incidents or allegations which need investigation, Investigation of incidents and allegations ...Injuries of unknown source are defined as an injury with both of the following conditions: The source of the injury was not observed by an person or the source of the injury could not be explained by the patient; and 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.; 6.4 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. NJAC 8:39- 27.1(a)	F 610		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/11/23

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F 657	Continued From page 14 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to update comprehensive patient-centered care plans for: a.) a resident with EX. Order 26.(4) B1, b.) a resident on a EX. Order 26.(4) B1 medication, and c.) a resident with a diagnosis of EX. Order 26.(4) B1 requiring EX. Order 26.(4) B1 This deficient practice was identified for 3 of 23 residents (Resident #71, #95, and #26)	F 657	1.Resident #71 care plan was updated on EX. Order 26.(4) with EX. Order 26.(4) B1 behaviors. Resident #95 care plan was updated on EX. Order 26.(4) to reflect EX. Order 26.(4) B1 medications. Resident #26 care plan was active during the EX. Order 26.(4) B1 therapy and resolved on EX. Order 26. upon completion of the EX. Order 26.(4) B1	

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F 657	Continued From page 15 reviewed for Care Planning (CP) and was evidenced by the following: a.) On 02/09/23 at 8:21 AM, the surveyor observed Resident #71 sitting on the side of the bed reading the newspaper. The surveyor observed the resident's EX. Order 26.(4) B1 was not in a EX. Order 26.(4) B1. At that time, the Registered Nurse (RN) was outside the room in the hallway with the surveyor and stated the resident had behaviors including taking the EX. Order 26.(4) B1 out of the EX. Order 26.(4) B1. A review of the medical records for Resident #71's included an Admission Record which revealed the resident was recently readmitted with diagnoses which included, but were not limited to, EX. Order 26.(4) B1. A review of the "Order Summary Report", revealed the following orders: dated EX. Order 26.(4) B1 for EX. Order 26.(4) B1 (an EX. Order 26.(4) B1 milligram (mg) give one tablet by mouth one time a day for EX. Order 26.(4) B1; EX. Order 26.(4) B1) EX. Orde mg give one tablet by mouth two times a day for EX. Order 26.(4) B1; and EX. Order 26.(4) B1 e (an EX. Order 26.(4) B1 mg give EX. O mg by mouth at bedtime for EX. Order 26.(4) B1. A review of a, "Risk Assessment" note dated EX. Order 26.(4) B1 included, but was not limited to: Describe EX. Order 26.(4) B1: "Yesterday EX. Order 26.(4) B1 I had a moment where EX. Order 26.(4) B1 EX. Order 26.(4) " Risk Factor: HX (history) o EX. Order 26.(4) B behaviors, severity of EX. Order 26.(4) B1 symptoms. Identify who at facility was informed that patient is currently a EX. Order 26.(4) IX. Order 26 f: SW (Social Worker) [name redacted]. The Risk Assessment was completed by a SW therapist who worked for an	F 657	2. All residents have the potential to be affected by this deficient practice. 3. Licensed nurses and the interdisciplinary care planning team were re-educated to update resident behavior care plans to reflect a resident's current behavior on 2/24/23. Licensed nurses were re-educated to update resident medication related care plans to reflect EX. Order 26.(4) B1 medications. Licensed nurses were re-educated to update a resident care plan for residents on EX. Order 26.(4) B1. The Unit Manager or designee will conduct weekly audits for four weeks then monthly for two months to ensure that behavioral, EX. Order 26.(4) B1 medication and EX. Order 26.(4) B1 care plans are updated timely. 4. The results of the audits will be discussed in the Quality Assurance Performance Improvement meeting for three months with corrective needed or taken during the course of the audit.	

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outside facility.

A review of the on-going CP, including resolved focus areas, last care plan review completed [redacted] failed to include [redacted], or goals and interventions related to [redacted].

On 02/22/23 at 10:43 AM, the surveyor interviewed the Director of Nursing (DON) who stated the purpose of the CP was so the entire facility staff would be aware of the care a resident needed. She stated all staff should be aware of a resident's care plan and were able to read the CP on the electronic medical record.

On 02/23/23 at 8:50 AM, the DON stated, "No the care plan was not updated" to include Resident #71's [redacted]

A review of the facility provided, [redacted] Precautions", revision date 06/01/21, included, but was not limited to 5. Update care plan.

A review of the facility provided, "Behaviors: Management of Symptoms", revision date [redacted], included, but was not limited to 8. Document: 8.1 behavior goals, interventions, evaluation within the comprehensive patient-centered care plan.

b.) On 02/13/23 at 9:08 AM, the surveyor observed Resident #95 talking to the nurse in the [redacted] Wing hallway. At 9:49 AM, the surveyor observed Resident #95 sitting in a chair by the kitchen was out of the view of the nursing staff.

A review of Resident #95's Admission Record revealed the resident had been admitted with

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diagnoses including, but not limited EX. Order 26.(4) B1 [redacted] A review of the "Order Recap Report" revealed an order dated EX. Order 26.(4) B1, EX. Order 26.(4) B1 (medication to EX. Order 26.(4) B1 mg give one tablet by mouth three times a day for EX. Order 26.(4) B1. Hold if EX. Order (systolic blood pressure) EX. Order 26.(4) B1 mm hg (millimeters of Mercury). A review of the on-going CP revealed there was no documented focus area for EX. Order 26.(4) B1 or goals or interventions for EX. Order 26.(4) B1 including the use of EX. Order 26.(4) B1

On 02/24/23 at 9:59 AM, the surveyor and DON reviewed Resident #95's CP. The DON stated, "there should have been a care plan to address the EX. Order 26.(4) B1". She further stated she would "oversee" care plans and could not recall if she reviewed Resident #95's CP. The DON stated that the purpose of the care plan was to manage resident care and know what goals were needed to keep residents safe. The DON stated that if EX. Order 26.(4) B1 was administered outside the parameters ordered, Resident #95 could experience a EX. Order 26.(4) B1 (a EX. Order 26.(4) B1 in EX. Order 26.(4) B1, a medical emergency that could lead to EX. Order 26.(4) B1 [redacted].

c.) On 02/24/23 at 10:18 AM, the surveyor observed Resident #26 in bed with the head of the bed elevated. Resident #26 stated he/she had EX. Order 26.(4) B1) and had been on an EX. Order 26.(4) B1

On 02/24/23 at 10:21 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) caring for Resident #26, stated Resident #26 had EX. Order 26.(4) B1 and was on an EX. Order 26.(4) B1 She stated the staff would monitor side effects

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and vital signs. She further stated "we don't do care plans", but the supervisors would include the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 to the resident's care plan. If the resident had any problems, we would let the physician know and tell the next shift.

A review of the medical records for Resident #26's included an Admission Record which revealed the resident had diagnoses which included, but were not limited to, EX. Order 26.(4) EX. Order 26.(4) B1, and EX. Order 26.(4) B1. A review of the Physician Progress Note (PN) dated EX. Order 26.(4) B1, revealed a change in condition and noted EX. Order 26.(4) B1. A nursing PN dated EX. Order 26.(4) B1, which revealed infection EX. Order 26.(4) B1 EX. Order 26.(4) B1 for EX. Order. EX. Order 26.(4) B1 started for EX. Order. A review of the Medication Administration Record (MAR) dated EX. Order 26.(4) B1, revealed the resident had been started on EX. Order 26.(4) B1 on EX. Order 26.(4) B1 (an EX. Order 26.(4) B1) EX. Orde mg give one tablet by mouth two times a day for EX. Order 2 for 5 days. A review of the EX. Order 26.(4) B1 MAR revealed the resident completed the EX. Order 26.(4) B1 on EX. Order 26.(4) B1. A review of the on-gong comprehensive resident-centered Care Plan failed to document a focus area for EX. Order 26.(4) B1 or the EX. Order 26.(4) B1 use, a goal, or any interventions associated with EX. Order 26.(4) B1 and the physician ordered EX. Order 26.(4) B1.

A review of the facility provided, "Clinical Record: Charting and Documentation" policy and process, revised EX. Order 26.(4) B1, included, but was not limited to: Purpose: to provide a complete account of the patient's total stay from admission through discharge, provide information about the patient that will be used in developing a plan of care, and as a tool for measuring the quality of care provided.

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F 657	Continued From page 19 A review of the facility provided, "Person-Centered Care Plan" policy revised 10/24/22, included, but was not limited to: The interdisciplinary team ..... will establish the expected goals and outcomes of care, the type, amount frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. Documentation will show evidence of patient's goals and preferences. Purpose: to attain or maintain the patient's highest practicable physical, mental and psychosocial wellbeing. To promote positive communication between patient, patient representative, and team to obtain the patient's input into the plan of care, ensure effective communication, and optimize clinical outcomes. 4. A comprehensive person-centered care plan must be developed for each patient and must describe the following: 4.1 services that are to be furnished. 6.1. the care plan must be customized to each individual patient's preferences and needs. 6.2. if there is not a care plan available to meet a patient's needs, staff may develop one using the custom care plan in [redacted] (electronic medical record). 7. Care plans will be: 7.1. communicated to appropriate staff, patient, patient representative, family. 7.2. reviewed and revised by the interdisciplinary team after each assessment, and as needed to reflect the response to care and changing needs and goals. 7.3. documented on the Care Plan evaluation notes. The facility failed to follow their policies. NJAC 8:39-11.2 (i); 27.1 (a)(b)	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/11/23

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F 658	Continued From page 20 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to follow professional standards of clinical practice with respect to a.) medication administration and documentation, b.) follow the facility's policy/protocol on discarding controlled substances, and c.) follow standards of clinical practice and executing orders as prescribed by the physician. The deficient practice was identified for 4 of 8 residents during medication pass observation (4 unsampled residents); 1 of 6 residents (Resident #95) reviewed for medication parameters; and 3 of 3 sampled residents reviewed for care (Resident # 315, #88 and Resident #95). The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well being, and executing medical regimes as prescribed by	F 658	1. RN #1 was re-educated on signing medication administration and documentation on 2/21/23 and RN #1 received a new medication competency on 2/21/23. The licensed nurses who administered the Midodrine outside of the prescribed parameters were re-educated on 2/24/23. LPN #1 was re-educated on discarding controlled substances on 2/12/23. The dressing for resident #88 was changed on 2/10/23. 2. All residents have the potential to be affected by this deficient practice 3. The Nurse Practice Educator or designee re-educated licensed nurses on signing medications and documentation per policy and procedure. The Nurse Practice Educator or designee re-educated the licensed nurses on discarding controlled substances per policy and procedure. The Nurse Practice Educator or designee re-educated the licensed nurses on standards of clinical practice and following	

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F 658	Continued From page 21 a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." a.) On 02/10/23 between 7:43 AM through 8:36 AM, Surveyor #1 accompanied Registered Nurse (RN) #1 on the [redacted] Wing during medication administration pass and observed the following: At 7:43 AM, RN #1 began to prepare medications to administer to unsampled resident (UR) #1. RN #1 prepared two pills of one medication and put them into a medication cup. RN #1 and Surveyor #1 went to UR #1's room where we both observed that UR #1 was in the bathroom and unavailable to receive medications. RN #1 went back to the medication cart and placed the medication cup with two pills into the top drawer of the medication cart. There were no markings on the medication cup to identify the intended resident or the medication in the cup. At 7:47 AM, RN #1 proceeded to prepare medications to administer to UR #2. RN #1 poured three pills into a medication cup. RN #1 and Surveyor #1 proceeded to UR #2's room.	F 658	physician orders to include documenting treatments. The Director of Nursing or designee will audit timely administration of medication and documentation weekly for four weeks then monthly for two months. The Director of Nursing or designee will audit discarding of controlled substances weekly for four weeks then monthly for two months. The Director of Nursing or designee will audit treatments following physician orders weekly for four weeks then monthly for two months. 4. The results of the audit will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective action needed or taken during the course of the audit.	

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At 7:50 AM, UR #2 was observed swallowing his/her medications. At that time, RN #1 stated, "I know it's 10 minutes early." RN #1 also failed to immediately document administration of the three pills.

At 7:52 AM, RN #1 proceeded to prepare medications to administer to UR #3. RN #1 obtained one pill, crushed it per physician order, and administered the medication to UR #3 at 7:55 AM. RN #1 failed to immediately document administration of the medication.

On 02/10/23 at 8:22 AM, RN #1 stated that she was told to keep pills in the medication cart if the resident was not ready for them. RN #1 was unable to identify who instructed her to do that. Surveyor #1 asked RN #1 what the time frame process was to administer medication. RN #1 stated, "it was only 10 minutes". When asked about signing for medications administered to residents, RN #1 stated, "Oh I forgot to sign. I'll do that now".

On 02/10/23 at 9:40 AM, during an interview with Surveyor #1, the Director of Nursing (DON) stated that the process for medication was for the nurse to make sure the resident was available for medication administration before pouring the medication. If not, the nurse should have discarded the medications, the medications should not be kept in the drawer of the medication cart because of infection control and also the nurse could mix up the medications and administer them to the wrong resident. The DON further stated that medications may be administered up to one hour before or one hour after the prescribed medication time. The DON stated that nurses were required to sign the

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medication as administered as soon as the medication was taken by the resident.

On 02/13/23 at 10:32 AM, Surveyor #1 reviewed the medical record for Resident #95. A review of the Admission Record revealed Resident #95 was admitted with diagnoses which included, but were not limited to, EX. Order 26.(4) B1 and EX. Order 26.(4) B1. A review of the Admission Minimum Data Set (MDS), an assessment tool, dated EX. Order 26.(4) B1 revealed a Brief Mental Status (BIMS) score of EX. O out of EX. O indicative of intact cognition. A review of the on-going Care Plan (CP) failed to document a focus area of EX. Order 26.(4) B1 goals, or interventions. A review of the Order Recap Report revealed a physician's order dated EX. Order 26.(4) B1, for EX. Order 26.(4) B1 (medication to EX. Order 26.(4) B1 milligram (mg) 1 tablet by mouth three times a day for EX. Order 26.(4) B1. Hold if EX. Order 26.(4) B1 EX. Order 26.(4) B1 hg (millimeters of mercury).

A review of the Medication Administration Record (MAR) revealed the following:

EX. Order 26.(4) B1, date ranging from EX. Order 26.(4) through EX. Order 26.(4) B1 was administered to the resident outside of the prescribed parameters 4 out of 83 opportunities.
EX. Order 26.(4) B1, date ranging from EX. Order 26.(through EX. Order 26.(4) B1 was administered to the resident outside of the prescribed parameters 3 out of 93 opportunities.
EX. Order 26.(4) B1, date ranging from EX. Order 26.(through EX. Order 26.(4) B1 was administered to the resident outside of the prescribed parameters 5 out of 69 opportunities.

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On 02/22/23 at 10:08 AM, during an interview with Surveyor #1, a Licensed Practical Nurse (LPN) stated Resident #95 had an order for parameters to administer the EX. Order 26.(4) B1. She stated there if EX. Order 2 reading was over EX. Orde mm hg, do not give the medication. She stated giving the medication would cause EX. Order 26.(4) B1) and the resident could have a EX. Order 26.(4) B1. LPN stated some problems we have to monitor with having EX. Order 26.(4) B1 EX. Order 2EX. Orc would be EX. Order 26.(4) B1.

On 02/22/23 at 10:43 AM, during an interview with Surveyor #1, the DON stated a resident CP would be developed so the entire staff was aware of the care a resident needs.

On 02/24/23 at 9:59 AM, during an interview with Surveyor #1, the DON stated Resident #95 was on EX. Order 26.(4) B1 and there was a "hold" or if the EX. Order read over EX. Order 26.(4) B1. She stated that if given outside of the ordered parameters, the medication could cause the resident to have a EX. Order 26.(4) B1 emergency. Surveyor #1 and the DON reviewed Resident #95's MARs. The DON stated, "I see it (medication)" it's being given multiple times outside of the parameters."

b.) During a medication administration observation on 02/10/23 that began at 8:35 AM, Surveyor #2 observed the Licensed Practical Nurse (LPN #1), while she was preparing the following medications to administer to an unsampled resident.

EX. Order 26.(4) B1 mg a EX. Order 26.(4) B1
EX. Order 26.(4) B1 mg
EX. Order 26.(4) B1 mg EX. Order 26.(4) B1
medication

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EX. Order 26.(4) mg EX. Order 26.(4) B1
EX. Order 26.(4) B1 1 caps
EX. Order 26.(4) B1 gm used for EX. Order 26.(4) B1
EX. Order 26.(4) B1 tabs for EX. Order 26.(4) B1
EX. Order 26.(4) B1 1 tab (EX. Order 26.(4) B1) for
EX. Order

LPN #1 entered the room and informed the resident that all the medications, including the EX. Order 26.(4) were in the medication cup. The resident took some of the medications with water, then dropped some of the medications on the sheet. One of the medications observed on the sheet, was a EX. Order 26.(4) B1 EX. Order 26.(4) B1 milligrams). LPN #1 then informed the surveyor that she had to discard the medications and pour another set of medications. LPN #1 then reached for the drug buster (drug disposal system) that was located at the bottom of the medication cart and disposed of all of the medications, including the narcotic, into the drug buster. That same day at 9:30 AM, Surveyor #2 requested from the DON, the facility's policy for discarding controlled substances.

On 02/10/23 at 10:30 AM, Surveyor #2 interviewed LPN #1 regarding the protocol for discarding controlled substances. The LPN stated that all controlled substances EX. Order 26.(4) B1 were to be witnessed and discarded with two nurses present.

On 02/10/23 at 11:15 AM, the Assistant Director of Nursing/ Infection Control Preventionist (ADON/IP), approached Surveyor #2 and asked if Surveyor #2 would sign the controlled substance medication declining inventory sheet since the surveyor observed LPN #1 discard the EX. Order 26.(4) B1 in the drug buster. Surveyor #2

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informed the ADON/IP that surveyors could not sign the declining inventory sheet as they were not employed by the facility.

A review of the facility provided form titled, "Disposal/Destruction of Expired or Discontinued Medication" dated 12/01/07, last revised 01/01/22, indicated under Procedure #12, Controlled Substances: Facility should destroy Schedule II-IV controlled substances as detailed with the following exceptions:

12.1 Facility should destroyed controlled substances in the presence of a registered nurse and a licensed professional in accordance with Facility policy or applicable law.
12.2 Destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional who should record:
12.2.1 Quantity destroyed;
12.2.2 date of destruction; and
12.2.3 Signature of registered nurse and Licensed professional.

The policy was not being followed.

c.) On 02/10/23 at 12:25 PM, Surveyor #2 entered Resident #88's room, and observed 2 Certified Nursing Assistant (CNAs) at the bedside providing care. The resident was positioned on the right side. The surveyor observed a [redacted] dressing located on the resident and was dated "[redacted]".

Surveyor #2 reviewed Resident #88's Treatment Administration Record (TAR), with the nurse and noted that staff had signed on [redacted] and [redacted]

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that the EX. Order 26.(4) B1 dressing was changed. Resident #88 was admitted to the facility with diagnoses which included, but were not limited to, EX. Order 26.(4) B1 , EX. Order 26.(4) B1, EX. Order 26.(4) B1 and EX. Order 26.(4) B1 of EX. Order 26.(4) B1.

A review of the Quarterly MDS, an assessment tool, dated EX. Order 26.(4) B1 reflected that Resident #88 was totally dependent on staff for care. A review of Resident #88's, "Order Summary Report" (OS) dated EX. Order 26.(4) B1 timed 7:00 AM, showed that Resident #88 had an order to change bilateral EX. Order 26.(4) B1 site dressing every day shift, every other day for EX. Order 26.(4) B1 care. Cleansed EX. Order 26.(4) B1 site with EX. Order 26.(4) B1 solution cleanser), and cover with dry protective dressing every other day.

On 02/10/23 at 12:45 PM, during an interview with Surveyor #2, the nurse who signed the TAR on EX. Order 26.(4) B1 on the 7:00- 3:00 PM shift stated that she signed the TAR but forgot to change the dressing.

The nurse who signed the dressing on EX. Order 26.(4) B1 did not have any comment as to why she had signed for a dressing change that she had not performed.

On 02/14/23 at 11:15 AM, Surveyor #2 shared the above concerns with the DON.

A review of the facility provided, "Clinical Competency Validation Medication Administration", dated 03/25/22, revealed RN #1 was deemed competent in administering oral medications to residents. The Competency included, but was not limited to, introduces self to

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patient and verifies patient identification, and stays with patient until the drug has been swallowed.

A review of the facility provided, "Registered Nurse" Job Description, revised 06/16/17, included, but was not limited to, Position Summary: ...operates within the scope of practice defined by the State Nurse Practice Act. Implementing Care: 3.4. administers medications per physician orders. Job Skills: 2. Knowledge of medications, their proper dosage, and expected results.

A review of the facility provided, "Licensed Practical Nurse" Job Description, revised 06/16/17, included, but was not limited to, Position Summary: ...delivers efficient and effective nursing care; operates within the scope of practice defined by the State Nurse Practice Act. Provision of Direct Patient Care: 3.1. administers medications per physician orders. 4. Monitors patient care provided by unlicensed staff: 4.4. ensures that assigned tasks are performed in accordance with policies and procedures. Job Skills: 2. Knowledge of medications, their proper dosage, and expected results.

A review of the facility provided, "General Dose Preparation and Medication Administration" policy and procedure, revised 01/01/22, included but was not limited to Procedure: 3. Dose Preparation: 3.2. should only prepare medications for one resident at a time. 3.10. staff should not leave medications unattended. 4. Prior to administration of medication, 4.1 facility staff should: 4.1.1. verify each time a medication is administered that it is the correct medication,

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F 658	Continued From page 29 correct dose, correct route, correct rate, and at the correct time. 5.4 administer medications within timeframe specified. 6.1 document necessary medication administration (when medications are given). A review of the facility's policy titled, "Nursing Documentation", initiated 08/01/05 and last revised 06/01/21 revealed the following: Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's patient condition situation and complexity. Purpose:to communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Practice Standards Nurses will not document services that were not performed; Document services before they are performed; Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures. The policy was not being followed. NJAC 8:39-19.4; 27.1 (a); 29.2 (d)	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		4/11/23

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by:
Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide personal hygiene and provide timely assistance for 6 of 6 residents (Resident #1, #35, #45, #66, #88 and Resident #57) reviewed who required assistance with Activities of Daily Living (ADLs). The deficient practice was evidenced by the following:

On 02/08/2023 at 8:50 AM, the surveyor toured the EX. Order Wing of the with staff and observed the following:

1.The surveyor entered Resident #35's room with a Certified Nurse Aide (CNA). Resident #35 was observed in bed resting. The CNA informed the resident of the task and the CNA proceeded to turn the resident over. The surveyor, along with the CNA observed that Resident #35 was EX. Order 26.(4) B1 EX. Order 26.(4) B1 and was wearing EX. Order 26.(4) B1 briefs. The breakfast tray was noted on the bedside table that was untouched.

On 02/08/23 at 09:10 AM, during an interview with the CNA, she stated that the facility was shorthanded. She further added that she did not check the resident for EX. Order 26.(4) B1 during her first round or resident checks. The CNA stated she knew that most of the residents were wearing EX. Order 26.(4) B1 briefs. The CNA added, most of the time in the morning the residents would be EX. Order 26.(4) B1 and the bedding would also be EX. Order 26.(4) B1.

On 02/08/23 at 09:45 AM, the surveyor returned to the Resident #35's room and observed the breakfast tray was still on the table and was

1.Resident #35 EX. Order 26.(4) B1 was changed on 2/8/23. Resident was interviewed and stated that staff always assist with meals.

Resident #57 EX. Order 26.(4) B1 was changed and EX. O. C care was provided on 2/9/23. Therapy evaluated the resident on 2/20/23.

Resident #45 i EX. Order 26.(4) B1 brief was changed on 2/8/23 and EX. Orde care was provided on 2/13/23.

Resident #59 EX. Order 26.(4) B1 brief was changed on 2/8/23 and 2/13/23. EX. Orde care was provided on 2/16/23.

Resident #88 i EX. Order 26.(4) B1 brief was changed on 2/8/23 and EX. Orde care was provided on 2/24/23. OT evaluated resident on 3/22/23.

Resident #1 was interviewed on preferences regarding night time routine and the care plan was updated and added to the kardex on 3/15/23.

2. Residents needing assistance with incontinence care, nail care and feeding have been reviewed to ensure EX. Order 26.(4) B1 care is provided timely; EX. Order are clean and trimmed and meal assistance is provided as needed.

3. Director of Nursing or designee will

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F 677	Continued From page 31 untouched. Review of the medical record revealed according to the Admission Record, Resident #35 was admitted to the facility with diagnoses which included but was not limited to; EX. Order 26.(4) B1 and EX. Order 26.(4) B1 EX. Order 26.(4) B1 The Quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1, revealed that Resident #35 required extensive assistance from staff with ADLs (related to personal care activities including bathing, dressing, eating, using the toilet). 2. On 02/08/2023 at 9:15 AM, the surveyor entered Resident # 57's room. The surveyor observed the resident was in bed. The resident's arms were folded and rested on the chest area. The EX. Order 26.(4) B1 were EX. Order 26.(4) B1. The resident had his/her eyes open and was looking around. Resident #57 was being administered a EX. Order 26.(4) B1 at that time. The CNA was present and put the feeding tube on hold, informed the resident of the task and proceeded to turn the resident. The surveyor observed that the bedding was wet, and Resident #57 was wearing EX. Ord EX. Order 26.(4) B1 briefs. Resident #57's EX. Order 2 appeared EX. Order 26.(and were EX. Order 26 with debris underneath all EX. Order 26.(4) B1. The EX. Order 26.(4) B1 into the EX. Order 2 . There were nc EX. Order 26.(4) B1 in place. An interview with the CNA revealed that the facility had been shorthanded since the pandemic [2020]. The CNA stated when she first started back in EX. Order 2, she used to have 7 to 8 residents on her assignment. and gradually she was to care for 10 to 12 residents on the 7:00-3:00 PM shift. She stated lately she cared for 30.	F 677	re-educate direct care staff on double briefing. C.N.A.s were re-educated on conducting rounds at the start of the shift and assisting residents with eating. Director of Nursing or designee will re-educate direct care staff on ADL care policy and procedure to include EX. Orde care and following the level of care that is documented on the careplan. Director of Nursing or designee will re-educate direct care staff on providing meal assistance to residents requiring it. Director of Nursing or designee will re-educate direct care staff on following the resident preferences listed in the resident care plan. Director of Nursing or designee will conduct audit of five residents weekly for four weeks and monthly for two months for EX. Order 26.(briefing. Director of Nursing or designee will conduct audit of five residents weekly for four weeks and monthly for two months for EX. Orde care. Director of Activities or designee will conduct an audit of five residents weekly for four weeks and monthly for two months to ensure ADL care preferences are being followed.	

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F 677	Continued From page 32 She stated the CNAs were unable to provide the care that was required by the residents. Review of Resident #57's medical record revealed the resident was admitted to the facility with diagnoses which included but was not limited to; EX. Order 26.(4) B1 [redacted], and other EX. Order 26.(4) [redacted]. The Annual MDS dated EX. Order 26.(4) B1 [redacted], reflected that Resident #57 was totally dependent on staff for all ADL. A review of Resident #57's Care Plan for incontinence care initiated on EX. Order 26.(4) B1 [redacted] and revised on EX. Order 26.(4) B1 [redacted], revealed that Resident #57 was unable to participate in a cognitively or physically in a EX. Order 26.(4) B1 program due to EX. Order 26.(4) B1 [redacted]. Resident # 57 was EX. Order 26.(4) B1 [redacted] functions and was at risk for EX. Order 26.(4) B1 [redacted]. The goal was for Resident #57 to have EX. Order 26.(4) B1 [redacted] care needs met by staff to maintain dignity and comfort and to prevent EX. Order 26.(4) B1 [redacted] related complications. The interventions included: for staff to assist with EXEX. Order 26.([redacted] care as needed and monitor for skin redness/irritation and report as indicated. Utilize appropriate continent products. 3. At 9:30 AM the surveyor entered Resident #45's room with the CNA and observed the resident in bed. The resident was awake and EX. Order [redacted] and consented to be checked. The resident was EX. Ord [redacted] and was wearing EX. Order 26.(4) B1 [redacted] briefs. The resident's EX. Order [redacted] were EX. Order 26.(4) B1 [redacted]. The CNA stated that only one CNA worked the night shift and "could not provide EX. Order 26.(4) B1 [redacted] care to all residents every two hours". On 02/08/23 at 10:15 AM, the surveyor entered Resident #45's room a second time with the CNA. During the care tour, Resident #45 was observed	F 677	Dietician or designee will conduct an audit of five residents weekly for four weeks and monthly for two months to ensure residents are receiving assistance with meal trays as required. Director of Rehabilitation or designee will conduct an audit of five residents weekly for four weeks and monthly for two months to ensure splints/handrolls are in place as ordered. 4. Results of the audits will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the course of the audit.	

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to be EX. Order 26.(4) B1. Resident #45's EX. Order 26.(4) B1 were EX. Order and EX. Order 26.(4) with a EX. Order 26.(4) B1 noted EX. Order 26.(4) B1 the EX. Order 26.(4) B1.

On 02/13/22 at 10:28 AM, the surveyor again observed the resident in the Atrium waiting for the lunch meal. The surveyor inquired if Resident #45 would like their EXX. Order 26.(4) B1 to be cleaned and trimmed, he/she stated, "yes".

A review of the medical record revealed Resident #45 was admitted to the facility with diagnoses that included, but were not limited to major EX. Order 26.(4) B1

A review of the Quarterly MDS, dated EX. Order 26.(4) B1, revealed that Resident #45 was dependent on staff for care. The Care Plan for ADLs initiated EX. Order 26.(4) B1 revised EX. Order 26.(4) B1, revealed that Resident #45 required assistance with ADL care in bathing, grooming, and personal hygiene related to decline in EX. Order 26.(4) B1. Interventions included that Resident #45 would be provided with extensive assistance of 1 for personal EX. Order 26.(4) B1 (grooming). Resident #45 required extensive assistance of 1 for toileting and transfers.

The Care Plan for EX. Order 26.(4) B1 initiated on EX. Order 26.(4) B1, revised EX. Order 26.(4) B1, revealed that Resident #45 was unable to participate in a retraining program due to EX. Order 26.(4) B1. He/she will go the bathroom when he/she wanted to. The goal was for Resident #45 to have EX. Order 26.(4) B1 care needs met by staff to prevent EX. Order 26.(4) B1 related complications.
Interventions included: Assist with EX. Order 26.(4) B1 care

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as needed, use absorbent products as needed. Monitor for skin redness/irritation and report as indicated.

4. On 02/08/23 at 10:05 AM, the surveyor entered Resident # 59's room with the Licensed Practical Nurse (LPN). The surveyor observed the resident in bed, the head of the bed was elevated, the resident's eyes were closed. The LPN informed the resident of the task and proceeded to turn the resident. Resident #59 was EX. Order 26.(4) B1 and was wearing EX. Order 26.(4) B1 briefs.

On 02/08/23 at 10:31 AM, the surveyor left the room and interviewed the nurse regarding EX. Order 26.(4) B1 care. The nurse revealed that staff were to provide EX. Order 26.(4) B1 care every two hours, and as needed. When asked about the EX. Order 26.(4) briefs that were observed on multiple residents, she stated that the CNAs had been educated several times regarding putting EX. Order 26.(4) briefs on the residents. The LPN further stated that "for infection control purpose, residents should not have EX. Order 26.(4) briefs on."

Review of the medical record revealed Resident #59 was admitted to the facility with diagnoses which included but were not limited to: EX. Order 26.(4) and EX. Order 26.(4) EX. Order 26.(4) B1. Resident #59 received EX. Order 26.(4) B1 services.

The MDS, dated EX. Order 26.(4) B1, reflected that Resident #59 was EX. Order 26.(4) B1, and EX. Order 26.(4) EX. Order 26.(4) B1 on staff for care. The Care Plan for EX. Order 26.(4) B1 care initiated EX. Order 26.(4) 19 and revised EX. Order 26.(4) B1, revealed that Resident #59 was EX. Order 26.(4) B1 at night. Interventions

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included to check and changed every 3 hours when in bed. Offer/assist with EX. Order 26.(4) B1 as requested/ needed. Use absorbent products as needed.

On 02/13/23 at 10:57 AM, the surveyor checked Resident #59 with the EX. Order 26.(4) B1 CNA. The resident was observed to have only EX. Order 26.(4) B1 brief on which was EX. Order 26.(4) B1. An interview with the EX. Order 26.(4) B1 CNA at that time revealed that Resident #59 did not get out of the bed. She further stated that the facility staff would wait for her to provide care to the resident. The EX. Order 26.(4) B1 CNA stated that the resident would be EX. Order 26.(4) with EX. Order 26 and would have EX. Order 26.(4) B1 briefs on most days.

5. On 02/08/23 at 10:45 AM, the surveyor checked a random room on the EX. Order 26 Wing. The surveyor knocked on the door and with permission, entered the room, and observed 2 CNAs were at the bedside of Resident #88. The CNA's informed the surveyor that they were about to provide care to the resident. At that time, the surveyor observed that Resident #88 was wearing EX. Order 26.(4) B1 briefs, that was soiled with EX. Order 26.(4) B1, and the resident was also observed with a EX. Order 26.(4) B1. Both CNAs stated that they did not provide care yet to the resident and were not responsible for putting EX. Ord EX. Order 26.(4) B1 briefs on the resident. Resident #88's EX. Order 26.(4) B1, there was EX. Order 26.(4) B1 observed under all of the EX. Order, and the EX. Order 26.(4) of the EX. Or EX. Order 2 were curled into the EX. Order 26.(4) B1. There was no EX. Order 26.(4) B1 in place.

A review of the medical record of Resident # 88 revealed the resident was admitted to the facility with diagnoses which included but were not

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limited to: EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The quarterly MDS, dated EX. Order 26.(4) B1, reflected that Resident #88 was EX. Order 26.(4) B1 on staff for care. The Care Plan for ADL initiated EX. Order 26.(4) B1 with a revision date of EX. Order 26.(4) B1 revealed that Resident #88 required assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating and toileting. The interventions to be implemented included for staff to monitor decline in ADL function, refer to rehabilitation therapy if decline in ADLs is noted. Monitor for complications of immobility.

Resident #88's Comprehensive Care Plan had a focus for EX. Order 26.(4) B1 risk related to EX. Order 26.(4) B1. The interventions included but were not limited to, supervise/cue/assist as needed with meals. Resident to be assisted at mealtimes. Do not feed him/her if he/she holds the food in his/her mouth or if he/she is too lethargic.

On 02/17/23 at 9:30 AM, the surveyor observed Resident #88 in bed positioned on their back, HOB slightly elevated. breakfast meal tray on the bedside table. Resident #88 attempted to feed self but could not. The surveyor escorted the Registered Nurse (RN) to the room where we both observed that the resident could not reached the food on the tray. The RN confirmed that the resident could not feed self.

On 02/21/23 at 9:45 AM, the surveyor observed Resident #88 in bed. The breakfast tray was setup for the resident to eat. The resident attempted to drink the juice and was falling asleep. The breakfast tray was untouched and

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there was no one supervising the resident at mealtime. The surveyor informed the LPN who was seated at the nursing station that the resident was not eating. The LPN stated that she set up the tray, ensured that Resident #88 could reach the spoon and left the room. At that time the surveyor reviewed the Care Plan with the nurse. The nurse asked the surveyor if the care plan stated supervise and assist with meals as needed, why he/she had to be assisted. The surveyor showed the nurse the documentation where the CP documented "Assist with all meals". The nurse stated that she was not aware that Resident #88 needed assistance with meals.

On 02/21/23 at 10:35 AM, the surveyor asked the DON how resident care needs were communicated to the staff. The DON stated that the supervisors were to inform staff of any changes in the resident condition. The surveyor then asked the DON how the needs identified on the care plan were communicated to staff. The DON stated that the staff should be aware of the needs identified on the care plan. The surveyor informed the DON that the staff on the unit were not aware that Resident #88 needed to be supervised during meals.

6. On 02/08/23 at 11:46 AM, the surveyor observed Resident #1 seated in a wheelchair in the room. The resident requested to speak to the surveyor. Resident #1 stated that he/she had been residing at the facility for [redacted] years and had noticed lots of changes. He/she requested to go to bed by 9:00 PM and requested that this information be communicated to the staff. Resident #1 informed the surveyor that the above information was on the care plan and discussed during the quarterly meeting. The resident also

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stated that he/she needed assistance with transfer and using the bathroom. Staff would say they cannot accommodate his/her request because they were shorthanded. The resident stated that [redacted] fell and activate the call light. Resident #1 stated that he/she was on the floor for [redacted] minutes before staff answered the call light.

A review of the medical record for Resident #1 revealed the resident was admitted to the facility with diagnoses which included but were not limited to: EX. Order 26.(4) B1 [redacted]

The Quarterly MDS dated [redacted] revealed that Resident #1 was [redacted] and able to make his/her needs known and scored 15/15 on the Brief Interview for Mental Status (BIMS) which was indicative of intact cognition. The Comprehensive Care Plan initiated [redacted] with a revision date of [redacted], included a focus for falls. The interventions were to have two staff assistance while transferring from bed to the wheelchair and from wheelchair to bed. Minimize risk for [redacted]. Educate staff to ask for help when assisting Resident #1 during transfers since Resident #1, was a two person assist.

On 02/24/23 at 9:10 AM, the surveyor escorted the Director of Nursing (DON) to Resident #45's room where we both observed the [redacted] were [redacted] and needed to be cleaned. The DON stated that she asked the CNAs to provide [redacted] care on [redacted] and was unable to explain why it had not been done.

The above concerns with incontinence care, [redacted]

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care, and assistance with meals were discussed with the facility management during the survey and again on [redacted]. The DON responded that the staff were in-serviced and no additional information had been provided.

According to the Facility Policy titled "Activities of Daily Living (ADLs)" dated 06/01/96 and last revised 06/01/21, provided by the facility on 02/23/23, the following were documented:

Policy:

Based on the comprehensive assessment of a resident/patient (hereinafter "patient") and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living abilities are maintained or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable.

Purpose: To ensure ADLs are provided in accordance with accepted standards of practice, the care plan and the patient's choices and preferences.

Practice Standards: 4.2 A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal hygiene.

The policy was not being followed. Staff indicated that they were short-handed almost every day. Staff was not aware of level of care documented on the care plan.

NJAC 8:39-27.2 (b)(f)(g)(h)

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F 689 SS=G	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, record review, and review of pertinent documentation, it was determined that the facility failed to: a.) ensure the facility policy for [redacted] Management and Accidents/Incidents policy was followed to determine the causal factor and interventions were updated to prevent recurrent [redacted], for a EX. Order 26.(4) B1 resident (Resident #45), who was identified as high [redacted] risk, had a history of EX. Order 26.(4) B1 which included a [redacted] on [redacted] that resulted in a EX. Order 26.(4) B1 that required hospitalization, a subsequent EX. Order 26.(4) B1 on [redacted], and a [redacted] requiring hospitalization on [redacted] after sustaining a EX. Order 26.(4) B1 to the [redacted] b.) supervision was provided to prevent recurrent [redacted] c.) implement care plan interventions for a resident (Resident #1) identified as requiring two-persons for transfer, was transferred by one staff on [redacted], and sustained a [redacted] during transfer which necessitated transfer to the hospital for evaluation, and d.) immediately implement [redacted] preventions precautions per facility policy and immediately notify the attending physician in response to a resident (Resident #71) who expressed EX. Order 26.(4) B1. This deficient practice occurred for 3 of 5 residents reviewed for	F 689	1. The interdisciplinary team met on 3/23/23 and reviewed the past [redacted] for resident #45 to ensure the causal factor was identified and an intervention was care planned. Resident #1 was re-evaluated by therapy on 2/16/23 which included the level of assistance needed for safe transfers. Resident #71 was evaluated by [redacted] service for EX. Order 26.(4) B1 on [redacted]. Resident #71 care plan was update on 2/23/23. 2. Residents with a [redacted] in the last 30 days will have their [redacted] reviewed to ensure causal factors were identified, supervision needed is accurate and care plan interventions were implemented. 3.The Director of Nursing and Social Worker were re-educated regarding the policy on management of behavior symptoms and [redacted] precaution procedures on 2/23/23.	4/11/23

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F 689	Continued From page 41 accidents and was evidenced by the following: a) During the initial tour of the facility on 02/08/23 at 9:00 AM, Surveyor #1 entered Resident #45's room and observed the resident in bed. At 10:15 AM, surveyor #1 performed a care tour with the Certified Nursing Assistant (CNA). Surveyor #1 observed the resident in bed. The CNA informed the surveyor that Resident #45 was EX. Order 26.(4) B1 and required staff assistance with care. On 02/09/23 at 12:30 PM, surveyor #1 reviewed the medical record for Resident #45. According to the Admission Face sheet, Resident #45 was admitted to the facility with diagnoses that included but were not limited to: EX. Order 26.(4) B1 , and EX. Order 26.(4) B1 A review of the Quarterly Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care dated EX. Order 26.(4) B1, revealed Resident #45 was EX. Order 26.(4) B1. Resident #45 received a score of EX. Order 26.(4) B1 on the Brief Interview for Mental Status (BIMS), indicative of a EX. Order 26.(4) B1. Resident #45 was totally dependent on staff for care and required extensive assistance of 1 person assist with bed mobility, transfers, and tilting. A review of the Comprehensive Care Plan, initiated EX. Order 26.(4) B1, and last revised EX. Order 26.(4) B1 revealed a "Focus" for falls related to: EX. Order 26.(4) B1 , preference to be independent. The Care Plan (CP) revealed that Resident #45 sustained EX. Order at the facility on the following dates: EX. Order 26.(4) B1EX. Order 26.(4) B1 and EX. Order 26.(4) B1 The Goal was to minimize the risk for EX. Order.	F 689	The Administrator re-educated the interdisciplinary team on accidents/incidents and investigation on 2/23/23. The Nurse Practice Educator or designee re-educated staff on care plans and the use of kardex to include EX. O interventions on 2/23/23. The Nurse Practice Educator or designee re-educated licensed staff on management of behavior symptoms and suicidal precautions on 2/23/23. The Administrator or designee will audit accidents/incidents weekly for four weeks then monthly for two months. The audit will include updating care plans. The Director of Nursing or designee will audit five resident kardexs weekly for four weeks then monthly for two months. 4. The results of the audits will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective action needed or taken during the course of the audit.	

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Interventions to minimize [redacted], included:
Provide verbal cues for safety and sequencing when needed. Initiated [redacted]
Utilize night light in room/ bathroom. Initiated [redacted]
Place call light within reach while in bed or close proximity to the bed. Initiated [redacted];
Remind Resident #45 to use call light when attempting to ambulate or transfer to get in and out of bed. Initiated [redacted]
Closely monitoring Resident #45, if he/she tired, offer him/her to return to the room for a nap. initiated [redacted];
Assist out of bed with 1 assist with walker. [redacted];
[redacted] and [redacted] Initiated [redacted]
Encourage to participate in activities that he/she likes. Initiated [redacted]
Observe for signs and symptoms of [redacted] including [redacted] and promote self-management strategies. Initiated [redacted]
PT/OT (Physical Therapy / Occupational Therapy) evaluation and treat as needed. Initiated [redacted];

On 02/15/23 at 8:56 AM, upon entry to the [redacted] wing, surveyor #1 observed Resident #45 in the resident's room holding onto the wheelchair and was attempting to transfer self to the bed. Resident #45 could not complete the transfer and was very unsteady. The surveyor alerted a staff member who went to the room and assisted Resident #45 into the bed.

On 02/16/23, Surveyor #1 requested the [redacted] investigations and a timeline of the [redacted] which included the day, time and location of the [redacted],

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and any interventions implemented after each [redacted]

On 02/17/23, the Director of Nursing (DON) provided [redacted] investigations dated [redacted] and [redacted]. On 02/24/23, the DON provided the [redacted] investigation dated [redacted].

A summary of the fall incident of [redacted] which was dated [redacted], revealed that Resident #45 sustained an unwitnessed [redacted] at 1:15 PM in the Atrium. Another resident yelled out that Resident #45 was on the floor. Resident #45 was unable to move their [redacted]. Resident #45 was transferred to the hospital and admitted with a EX. Order 26.(4) B1. Resident #45 was readmitted to the facility on [redacted], with [redacted] EX. Order 26.(4) B1 .

A statement from a staff who was assigned to the [redacted] wing revealed that she was on the [redacted] wing getting ready for medication administration and heard another resident calling out that Resident #45 was on the floor.

A statement from the nurse assigned to the [redacted] wing documented, "I was in a resident's room and was notified that Resident # 45 was on the floor."

A statement from the the CNA assigned to the [redacted] wing documented, "I was inside assisted with feeding. The nurse called and informed of the [redacted] Other residents (including Resident #45) were in the Atrium eating lunch, and there was no staff around to monitor the residents."

An un-witnessed Incident report (a report the facility fills out to investigate an incident) dated [redacted] timed 12:55 PM, included the following: Incident Description: Nursing Description: "This

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writer finds Resident #45 sitting up on his/her EX. Order 26.(4) B1 in the hallway between room EX. Orde and EX. Orde. This writer asks what happened. Resident #45 stated, "I don't know". ...Assisted to chair with 2 staff using EX. Order 26.(4) B1
Injury Type: No injuries observed at time of incident. There was no witness to the EX. O. There were no staff statements that would indicate when Resident #45 was last seen/checked. The causal factor was not identified.

According to documentation provided by the DON on 02/27/23 the Interdisciplinary Team met and discussed the EX. O on EX. Order 26.(4) B1. The following was documented, "Met and discussed the resident's EX. O. The resident's plan of care updated to reflect, environmental rounds in resident area for safety, to provide education and redirection within limits. Staff will continue to encourage Resident #45 to use call bell to ask for assistance prior to ambulating. Will refer to PT/OT post incident."

An Incident report dated EX. Order 26.(4) B1 timed 7:15 PM, included the following information: "Incident Description. Nursing Description: Resident #45 was seen at 6:30 PM lying on his/her bed. At 7:15 PM, I was notified by CNA that resident was sitting on the floor by his/her room door. Resident #45 is EX. Order 26.(4) B1, denies any pain at this time, ROM [Range of Motion] to EX. Order 26 and EX. Order 26.(4) B1. Assisted back to bed via EX. Order 26.(4) B1 with 2 assist. Once in bed, EX. Order 26.(4) B1 (EX. Order 26.(4) B1), noted on the EX. Order 26.(4) B1 Resident Description: Resident unable to give description".

Immediate action: Physician notified of incident and reminded that Resident #45 is on EX. Order 26.(4) B1 medication). Order received to

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send Resident #45 to the hospital for evaluation. An attached note dated [redacted] timed 19:15 [7:15 PM] revealed that the resident was admitted to the hospital and was diagnosed with [redacted].

On 02/13/23 at 9:55 AM, surveyor #1 interviewed the DON regarding the [redacted]. She stated that she could not locate any [redacted] investigation related to the [redacted] of [redacted]. The DON stated that she was not working at the facility at that time and could not locate the investigations. When asked about how residents needs were communicated to the staff, she stated that the supervisors were responsible to communicate to direct care staff any change in condition and then update the care plan with any changes.

On 02/13/23 at 1:25 PM, the surveyor interviewed a CNA regarding using the residents care plans. The CNA stated that the CNAs did not have access to resident care plans and received report from the nurses and other CNAs. When asked about a CNA care card, the direct care staff was not aware of the care card.

On 02/23/23 at 10:30 AM, Surveyor #1 reviewed the electronic progress notes and could not locate any documentation regarding the [redacted] that occurred on [redacted]

On 02/24/23 at 11:30 AM, the DON provided the reportable (a report required to be sent to the state department of health) dated [redacted], that the fall had been reported to the state, and she could not locate the incident report. The DON indicated she called some staff and was able to get some statements. Statements from residents who could have possibly witnessed the [redacted] were

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collected on 02/25/23.

b) On 02/08/23 at 11:46 AM, Surveyor #1 observed Resident #1 seated in a wheelchair inside the room. The resident requested to speak to the surveyor. Resident #1 stated that he/she had been residing at the facility for [redacted] years and had noticed a lot of changes. He/she requested to go to bed by 9:00 PM and requested that this information be communicated to staff. Resident #1 informed the surveyor that the above information was on the care plan and had been discussed during the quarterly meeting. The resident also stated that he/she needed assistance with transfer for using the bathroom, and that staff would say they cannot accommodate his/her request because they were shorthanded. The resident stated that he/she [redacted] and was on the floor for [redacted] minutes before staff answered the call light.

On 02/10/23 at 1:19 PM, the surveyor reviewed Resident #1's medical record which revealed: Resident #1 was admitted to the facility with diagnoses which included but were not limited to; [redacted] and need for [redacted].

The Quarterly MDS dated [redacted], revealed that Resident #1 was awake and alert and able to make his/her needs know. Resident #1 scored [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident was [redacted].

The Comprehensive Care Plan initiated [redacted] with a revision date of [redacted], had a focus for [redacted] related to [redacted]

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to the EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The interventions were:

Assist Resident #1 with 2 staff assistance while transferring from bed to Wheelchair and from wheelchair to bed. Date Initiated: EX. Order 26.(4) B1, and revised EX. O. Order 26.(4), Educate staff to ask for help when assisting Resident #1 during transfers since he/she is a two person assist wheelchair to bed.

On 02/23/23 the surveyor requested the investigation report for review. The DON provided 2 incidents reports dated EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The investigation report dated EX. Order 26.(4) B1 contained the following information:

Incident Description: Nursing Description. This writer informed by CNA of resident slipped and EX. O during transfer from bed to the electric chair. Slip was witnessed by CNA. Resident #1 slipped and EX. O to floor landing on his/her EX. Order. No loss of consciousness reported. No complaint of pain. Resident #1 assisted to wheelchair using EX. Order 26.(4) B1 with 3 staff. Resident Description: I slipped and EX. O when transferring. Immediate action: Taken to hospital.

The CNA who was present in the room during the transfer, documented the following: "While doing a routine care with the resident. While transferring the resident from the bed to the chair, suddenly the resident lost balance landed on the floor. Immediately I called the nurse. My coworker used the [brand name EX. Order 26.(4) B1], to lift the resident assisted to the wheelchair". (The causal factor for the EX. O was not identified and the EX. Order Management policy was not followed post EX. O. The CNA executed the transfer alone and the care plan interventions for Resident #1, who

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required a 2 person assist for transfer from the bed to the chair and from the chair to the bed, had not been implemented when the [redacted] occurred.)

On 02/24/23 at 1:35 PM, the surveyor conducted an interview with the CNA who cared for Resident #1 on [redacted]. The CNA stated, in the presence of the nurse, that she had not been made aware that Resident #1 required 2 persons assist for transfer from the bed to the chair when she had cared for the resident on [redacted] and transferred him/her alone.

On 02/24/23 at 12:17 PM, the surveyor discussed the [redacted] incident with the DON and requested any additional information.

On 02/27/23 at 9:30 AM, the DON provided a typed incident summary with the following statements:
The CNA documented that she "did not see anything, I just help the nurse to pick the resident up."
Another CNA documented: "I was working on wing [redacted] and the other CNA was wing [redacted]."
The nurse assigned to the Wing documented: "I assisted the staff with moving the resident from Room [redacted] to Room [redacted]. The resident was able to get into the room. I walked away from my cart for less than 10-minutes, and I was walking back I heard [him/her] start to yell."

On 02/27/23 at 10:30 AM, after surveyor inquiry, the DON provide an updated care plan which indicated that Resident #1 was now a one-person transfer. The Surveyor showed the care plan documentation indicating the resident required a two-person transfer to the DON, the DON did not

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have any comment. No additional information was provided.

Another [EX. O] incident dated [EX. Order 26.(4) B1], documented the following: Incident Description: Nursing Description: Resident was noted on the floor in the room in front of the wheelchair. Resident is [EX. Order 26.(4) B1] and denied hitting his/her [EX. Order 26]. Resident Description: Resident stated he slipped out of the wheelchair. A statement from the nurse assigned to the [EX. Or] wing, revealed that she found the resident on the floor. There was no investigation included with the incident.

On 02/08/23 at 11:46 AM, the resident told the surveyor that he/she slipped from the wheelchair and was on the floor for [EX. O] minutes before he/she could get assistance.
The resident had a BINS of [EX. Order 26] which indicated the resident was [EX. Order 26.(4) B1]. The facility failed to obtain a statement from the resident to identify the causal factor for the [EX. Or] and implement interventions to prevent further [EX. Order]
An interview with the resident, revealed that the facility was shorthanded and could not get staff to assist with transfer when needed.

A review of the facility provided form titled, [EX. Order 26] Management", dated 09/15/01, and last revised 06/15/22, indicated the following:
Policy:
Patients will be assessed for risk of [EX. Order 26] as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate.
Patient experiencing a [EX. O], will receive appropriate care and post [EX. Or] interventions will be implemented.
Purpose:

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F 689	Continued From page 50 To identify risk for [EX. Orde] and minimize the risk of recurrence of [EX. Orde]. To evaluate the patient for injury post [EX. Or] and provide appropriate and timely care. To ensure the patient-centered care plan is reviewed and revised according to the patient's [EX. Or] risk status. Practice Standards: All patients will be assessed for risk of [EX. Orc] upon admission, with reassessment routinely, post fall to determine ongoing need for [EX. Or] prevention. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Post [EX. Orde] management: Document circumstances of the [EX. Or], post [EX. Or] assessment, and patient outcome. A review of the Accidents/Incidents Policy, Effective Date: 06/01/96, Revision Date: 10/24/22 revealed: The Center staff will report, review, and investigate all accidents/incidents which occurred, or allegedly occurred, on or off Center property involving, allegedly involving, a patient who is receiving services. Incident: defined as any occurrence not consistent with the routine operation of the Center or normal care of a patient. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or security. Purpose: To determine root cause and contributing factors, identify measures to reduce further occurrences and adverse outcomes as part of the Quality Assurance Performance Improvement process. 2.1.4. The physician/APP will be notified of any fall resulting in head injury, suspected head injury, and/or has an unwitnessed fall...2.1.6.2. Document the accident/incident in the patient's chart;	F 689		

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Documentation will include all pertinent information, date, time, place, notifications, post-accident/incident evaluation, ongoing evaluations. Reporting: 3.1 All accidents/incidents, witnessed or unwitnessed, will be reported to the supervisor. 3.1.1. Employees witnessing an accident involving a patient will communicate a factual description of his/her findings to the supervisor or the nurse responsible on the unit. 4.
Follow-up/Investigation: 4.1. The Administrator or designee will coordinate all investigations. 4.2. The Administrator, DON, or designee will review all accidents/incidents to determine if: 4.2.2. Required documentation has been completed; 4.2.3. Accident/incident has been investigated; 4.2.4. Interventions to eliminate if possible and, if not, reduce the risk of the accident/incident have been identified and implemented. 4.4. When conducting an investigation, the Administrator, DON, or designee will: 4.4.1. Make every effort to ascertain the cause of the accident/incident; 4.4.2. Initiate a timeline chronology; 4.4.4. Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident; 4.4.5. Document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident...

c) On 02/09/23 at 8:21 AM, Surveyor #2 observed Resident #71 sitting on the side of the bed reading a newspaper. The Registered Nurse (RN) who was caring for the resident, was standing with the surveyor in the hall. At that time, the RN stated Resident #71 had behaviors.

A review of the medical record revealed Resident #71 was admitted to the facility with diagnoses which included but were not limited to; [redacted]

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EX. Order 26.(4) B1 .

A review of the on-going Care Plan (CP), revealed a focus area initiated EX. Order 26.(4) B1, and revised on EX. Order 26.(4) B1, at risk for complications related to; the use of EX. Order 26.(4) B1 drugs, EX. Order 26.(4) B1, gets excited and EX. Order 26.(4) B1 easily, and cries easily. Interventions included but were not limited to; monitor for changes in mental status and functional level and report to MD (physician). A focus area EX. Order 26.(4) B1 in EX. Order 26.(4) B1 function or EX. Order 26.(4) B1 related to a condition other than EX. Order 26.(4) B1 EX. Order 26.(4) B1 l disability. Interventions included but were not limited to observe and evaluate types of changes .....decision making ability, ability to EX. Order 26.(4) B1 EX. Order 26.(4) B1 and notify physician as needed.

A review of the, "Therapy Note", dated EX. Order 26.(4) B1 documented by a Social Worker (SW) therapist who was not on staff at the facility, included but was not limited to: Diagnosis EX. Order 26.(4) B1 . Past history included EX. Order 26.(4) B1 hospital admission. Patient disclosed EX. Order 26.(4) B1.

A review of a "Risk Assessment" form dated EX. Order 26.(4) B1, included but was not limited to: "EX. Order 26.(4) B1 " Risk Factor: Hx (history) of EX. Order 26.(4) B1 symptoms. "Pt (patient) verbally agrees to notifying staff immediately if EX. Order 26.(4) B1 EX. Order 26.(4) B1 or EX. Order 26.(4) B1 should arise again." Identify who at the facility was informed that patient is currently a EX. Order 26.(4) B1: SW (Social Worker) [name redacted]. The form was completed by a SW

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therapist who was not on staff at the facility.

A review of the facility provided Progress Notes (PN) ranging from EX. Order 26.(4) B1 through EX. Order 26.(4) B1, revealed all staff disciplines failed to document Resident #71's EX. Order 26.(4) B1 on EX. Order 26.(4) B1 that was reported to the facility on EX. Order 26.(4) B1. The PN failed to document the resident's physician being contacted, any interventions implemented to ensure the residents safety, and any aspect of the facility, EX. Order 26.(4) B1 Precautions" policy being implemented. A PN dated EXEX. Order 26.(4) B1 documented by the facility SW, failed to address the resident's EX. Order 26.(4) B1 that had been reported to her on EX. Order 26.(4) B1, per the SW therapist's documentation. However, the note revealed Resident #71 had been missing his/her roommate.

The quarterly Minimum Data Set dated EX. Order 26.(4) B1, revealed a Brief Interview for Mental Status score of EX. Order 26 indicating the resident was EX. Order 26.(4) B1 EX. Order 2.

A review of the facility provided, "Behavior Monitoring and Interventions Report", ranging from EX. Order 26.(4) B1 through EX. Order 26.(4) B1, revealed an entry dated EX. Order 26.(4) B1, "no behaviors observed". The next entry was dated EX. Order 26.(4) B1 "no behaviors observed". The facility failed to document if any behaviors were present on EX. Order 26.(4) B1 when the resident had his/her EX. Order 26.(4) B1.

A review of Resident #71's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated EX. Order 26.(4) B1 through EX. Order 26.(4) B1, revealed the facility failed to document any interventions or monitoring of Resident #71 regarding the EX. Order 26.(4) B1.

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On 02/22/23 at 9:49 AM, during an interview with Surveyor #2, a CNA who was familiar with Resident #71, stated that the resident has not had any behaviors lately that she had been aware of.

On 02/22/23 at 10:00 AM, during an interview with Surveyor #2, a second CNA who was familiar with Resident #71, stated that the resident could be EX. Order 26.(4) B and that she would report any behaviors to the nurses. She further stated she was not aware of any concerns in EX. Order 26.(4) B1 EX. Order .

On 02/22/23 at 10:08 AM, during an interview with Surveyor #2, the LPN caring for the resident stated the resident could be nasty and wants things done immediately. The LPN showed the surveyor where behaviors would be documented in the electronic medical record. The LPN further stated she was not aware of any concerns regarding Resident #71 in EX. Order 26.(4) B1

On 02/22/23 at 10:43 AM, during an interview with Surveyor #2, the DON stated a resident's care plan would be so the entire staff would be aware of the resident's care needs.

On 02/22/23 at 11:02 AM, the facility Social Worker (SW) and DON were interviewed by the survey team. Surveyor #2 requested the SW show the documentation from where she had been contacted by the therapist SW. The SW was unable to locate any documentation and stated maybe the therapist SW did not inform her. Surveyor #2 showed the SW the note from the therapist SW the documentation that she had been made aware of the notation "identify who at facility was informed that patient is currently a

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danger to self: SW [name redacted] which indicated the facility SW. The DON stated that the EX. Order 26.(4) B1 should have been documented to ensure the nurses were monitoring the resident. The DON stated the resident would have been on EX. Order 26.(4) B1. The DON further stated the CP should have been updated, even if the resident stated he/she was not going to do anything, they would still need to be "on watch" until seen by the EX. Order 26.(4) B1 and that the physician should have been notified.

On 02/22/23 at 12:26 PM, during an interview with Surveyor #2, the Nurse Practitioner for the resident's EX. Order 26.(4) B1 medical group, stated she could not remember what happened in EX. Order 26.(4) B1 EX. Order 2 and was unable to continue to speak to the surveyor.

On 02/23/23 at 8:50 AM, during an interview with the survey team, the DON stated that the staff were able to locate a handwritten piece in a drawer at the nurse's station, of paper with EX. Order 26.(4) B1 for the resident. A review of the provided paper revealed the resident's name, room number, EX. Order 26.(4) B1" (no year), and staff initials. The paper did not reveal what the resident was being monitored for any behaviors. The DON stated that the EX. Order 26.(4) B1 should have been documented in the resident's medical record. The DON further stated, "I can't see a note that attending physician was notified." The DON stated that the physicians had remote access to medical records.

The survey team reviewed the facility provided, EX. Order 26.(4) B1 Precautions" procedure revision date 06/01/21, which included but was not limited to: 2. Immediately report behavior/wishes to supervisor

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and attending physician. 3.1. initiate suicide precautions which included but were not limited to: EX. Order 26.(4) B1 ; limit/restrict mobility throughout center; remove hazardous items.

The DON stated there was no 24-hour supervision initiated; no limited or restricted mobility through the center; and she could not say if any hazardous items were removed. The DON stated that the facility policy should have been followed and that there should have been documentation to ensure the resident was kept safe and what the staff should have been doing. The DON acknowledged the EX. Order 26.(4) B1 was not on the 24-hour report to inform the next shift staff. The DON further stated there were no directives or orders provided by the physician because he was not notified.

The DON stated there was no investigation completed, but that the SW therapist stated the resident was, "ok". When asked if the SW therapist was a practitioner and able to make the decision to order interventions, the DON stated, "I don't know".

On 02/23/22 at 10:05 AM, during a telephone interview with Surveyor #2, Resident #71's attending physician (MD) stated he was not made aware of the resident's EX. Order 26.(4) B1 in EX. Order 26.(4) B1. The MD stated that he would have ordered the nurses to do either EXEX. Order 26.(4) B1 EX. Order 26.(4 or as needed for the resident who was very independent. The MD stated he would have ordered a EX. Order 26.(4) B1 evaluation and possibly may have sent the resident out for a EX. Order 26.(4) B1 evaluation as he has had to do before.

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F 689	Continued From page 57 On 02/23/23 at 10:22 AM, during an interview with the surveyor, the DON stated that the SW therapists note dated [redacted], revealed "[redacted]. The DON acknowledged that any risk of [redacted] should be taken seriously and does not negate that the procedure was not followed. A review of the facility provided, "Behaviors: Management of Symptoms", revision date 10/24/22, included but was not limited to: 7. if behavior escalates to the point of being dangerous to self or others, take immediate measures to protect the safety of all patients and staff. 8. Document: 8.1. behavior goals, interventions, evaluation within the comprehensive patient-centered care plan; 8.2. behavior monitoring and interventions in electronic Medication Administration Record. 8.4. notification of physician. NJAC 8:39-27.1 (a)	F 689		
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, interviews, record review, and review of pertinent facility documents, it was	F 695	1. Resident #59 had [redacted] supplies transferred to the room on	4/11/23

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F 695	Continued From page 58 determined that the facility failed to ensure the facility policy was followed to ensure appropriate care was provided for a resident who required EX. Order 26.(4) B1 for a EX. Order 26.(4) B1 (a EX. Order 26.(4) B1 into the EX. Order 26.(4) B1 EX. Order 26.(4) B1). The deficient practice occurred for 1 of 1 resident reviewed (Resident #57) for EX. Order 26.(4) B1 and was evidenced by the following: On 02/13/23 at 10:56 AM, the surveyor attempted to complete an observation of Resident #57. The resident was not in the room, and the staff informed the surveyor that the resident had been transferred to the hospital and was admitted with EX. Order 26.(4) B1 On 02/23/23 at 9:00 AM, the surveyor reviewed Resident #57's medical record. Record review revealed Resident #57 was readmitted from the hospital on EX. Order 26.(4) B1. The diagnoses from the readmission included, but was not limited to; EX. Order 26.(4) B1 . The Annual Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1, revealed Resident #57 was EX. Order 26.(4) B1 and required extensive to total assistance with all activities of daily living. Review of the hospital discharge Physician Orders dated EX. Order 26.(4) B1 for Resident #57, revealed an order for EX. Order 26.(4) B1 as needed for EX. Order 26.(4) B1. Pre/Post Treatment: Evaluate EX. Order 26.(4) B1 EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The admission intake revealed that upon hospital admission, Resident #57 had to be EX. Order 26.(4) B1 for EX. Order 26.(4) B1	F 695	2/23/23. The nurse for resident #59 received EX. Order 26.(4) B1 care education and competency that included hand hygiene, donning appropriate PPE, assessment and documentation on 2/23/23. 2. All residents who have a EX. Order 26.(4) B1 have the potential to be affected by this deficient practice. 3. Licensed nurses were re-educated on the EX. Order 26.(4) B1 care policy and procedure that include hand hygiene, supplies requirement, required PPE and assessment on 2/23/23. The Unit Manager or designee will conduct EX. Order 26.(4) B1 care audits weekly for four weeks then monthly for two months. The Unit Manager or designee will conduct room audits for EX. Order 26.(4) B1 supplies weekly for four weeks then monthly for two months. 4. The results of the audits will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective action needed or taken during the course of the audit.	

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	315138	A. BUILDING _____ B. WING _____	02/27/2023

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amount of EX. Order 26.(4) B1 from the EX. Order 26.(4) B1.

The New Jersey Universal Transfer Form (NJUTF) (a form that communicates pertinent accurate clinical patient information at the time of a transfer between health care facilities/programs), dated EX. Order 26.(4) B1, only indicated that Resident #57 was transferred to the hospital for EX. Order 26.(4) B1 .

On 02/23/23 at 9:50 AM, an interview was conducted with the nurse who completed the NJUTF. She revealed she was just covering the unit until the 3:00 PM-11:00 PM nurse reported to work. She went to Resident #57's room to check the resident's EX. Order 26.(4) B1 and observed that the resident's clothing was covered with large amount of EX. Order 26.(4) B1 and the resident had EX. Order 26.(4) B1. She alerted the staff and the physician and Resident #57 was sent out to the hospital for evaluation. The nurse admitted that she did not properly completed the NJUTF. The nurse assigned to the EX. Or Wing that day failed to enter any notes in the medical record regarding the resident's condition.

On 02/23/23 at 11:00 AM, the surveyor observed Resident #57 lying in bed with EX. Order 26.(4) B1 being administered at EX. Order 26.(4) B1 per EX. Order 26.(4) B1 EX. Order 26.(4) B1.

Resident #57 was EX. Order 26.(4) B1 of EX. Order 26.(4) B1 were observed dripping into the EX. Order 26.(4) B1). The surveyor alerted a staff who was in the hallway who then in

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turn alerted the nurse. The nurse entered the room and informed the surveyor that Resident #57 was always EX. Order 26.(4) B1 and did not need to be EX. Order 26.(4) B1. The nurse then left the room and returned with the EX. Order 26.(4) B1 and checked Resident #57 EX. Order 26.(4) B1. The nurse reported that the EX. Order 26.(4) B1 was EX. Order. The nurse was about to leave the room when the resident started again began EX. Order 26.(4) B1. The nurse then stated, "now I can hear the EX. Order 26.(4) B1".

The nurse looked inside the resident room, the EX. Order 26.(4) B1 was turned on with the EX. Order 26.(4) B1 attached. The nurse then could not locate the supplies needed to EX. Order 26.(4) the resident. The nurse then left the room and returned with two EX. Order 26.(4) B1, a EX. Order 26.(4) B1. The nurse then informed the surveyor that Resident #57 had been transferred from the EX. Or Wing that morning and the staff failed to transfer the supplies.

On 02/23/23 at 11:15 AM, the surveyor observed EX. Order 26.(4) B1 care for Resident #57 and the following was observed: the nurse donned (put on) gloves and did not put on a PPE gown (she was wearing an N95 respirator and a face shield), without first setting up a sterile field, she opened the EX. Order 26.(water and the EX. Order 26.(4) B1 kit and next removed the EX. Order 26.(4) B1. She removed the soiled gloves, applied the sterile gloves from the EX. Order 26.(4) B1, without first performing hand hygiene, and proceeded to EX. Order 26.(4) B1. Large amounts of EX. Order 26.(4) B1 were observed inside of the EX. Order 26.(4) B1 EX. Order 26(as she continued to EX. Order 26.(4). She then removed the EX. Order 26.(4) B1 and replaced it with a EX. Order 26.(4) B1. The Nurse then reapplied the

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EX. Order 26.(4) B1, rinsed the EX. Order 26.(4) B1 and discarded it in the receptacle bin at the bedside. The nurse then went to the bathroom, washed her hands and left the room. The nurse failed to perform hand hygiene after removing the soiled gloves and prior to EX. C. Order 26.(4) B1 the resident, she did not check the EX. Order 26.(4) B1 and she did not change the EX. Order 26.(4) B1 dressing that was observed soiled with EX. Order 26.(4) B1. The nurse did not clean the EX. Order 26.(4) B1 and she did not reevaluate the resident after the procedure was completed, or inspect the EX. Order 26.(4) B1) site. The dressing that was soiled with EX. Order 26.(4) was not replaced.

On 02/23/23 at 11:40 AM, an interview was conducted with the nurse regarding the observed EX. Order 26.(4) B1 care. She stated that she had received in-service training and education on EX. Order 26.(4) B1 care in the past and the facility had a EX. Order 26.(4) B1 therapist on board that could be reached if needed.

On 02/23/23 at 11:50 AM, an interview was conducted with the Director of Nursing (DON) regarding the observed EX. Order 26.(4) B1 care. The DON stated that the facility had a policy and her expectation was that the nurse would follow the policy.

A review of the facility provided procedure for EX. Order 26.(4) B1 dated 01/01/04, last revised 07/15/21, revealed that the following steps were to be followed:

Turn on suction machine.
Remove gloves and perform hand hygiene.
Place EX. Order 26.(4) B1 on the bedside table. Open wrapper and use as EX. Order 26 field.

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F 695	Continued From page 62 Fill rinse cup with EX. Order 26.(4) B1 or EX. Order 26.(Establish one sterile and one non-sterile hand. Designate your dominant hand as the sterile hand. Put on sterile gloves. When EX. Order 26.(4) B1 is complete, remove gloves and cleanse hands. Put on gloves. Remove soiled dressing and EX. Order 26.(4) B1 and discard in waste bag. Loosen EX. Order2 holder enough so that you are able to maneuver under the EX. Order 26.(4) B1) but not much that you can risk EX. Order 26.(4) B1 . Evaluate the condition of the EX. Order 26.(4 Cleanse under EX. Order 26.(4) B1) holder and secure. Place EX. Order 26.(4) B1 under EX. Order 26.(4) B1) EX. Order 26.(4) B1 , pulling the ends up under the EX. Order and the EX. Order 26.(4) B1) holder. Evaluate patient's EX. Order 26.(4) B1 , and EX. Order 26.(4) B1 . Assist patient to a comfortable position. Remove PPE (Personal Protective Equipment) and perform hand hygiene. During a second interview with the nurse in the presence of another surveyor on 12/23/23 at 12:15 PM, she confirmed that after receiving the resident from the other wing, she did not fully assess the room to ensure all the supplies needed to perform EX. Order 26.(4) B1 care were in place. When inquired regarding the EX. Order 26.(4) B1 site she stated that could visualize the EX. Order 26.(without removing the dressing. On 02/27/23 at 9:50 AM, the DON informed the surveyor that the nurse had been re-educated on EX. Order 26.(4) B1 care. NJAC 8:39-27.1(a)	F 695		

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F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and document review, it was determined that the facility failed to ensure sufficient nursing staff was in place to ensure resident's highest practicable well-being was maintained by failing to ensure: a.) appropriate incontinence care was provided for 6 of 6 residents reviewed (Resident #35, #57, #88, #45, #59, #88) on 2 of 4 resident Wings (Wing [redacted]	F 725	1.Resident #35 [redacted] brief was changed on 2/8/23. Resident was interviewed and stated that staff always assist with meals. Resident #57 [redacted] brief was changed and [redacted] care was provided on 2/9/23. Therapy evaluated the resident on	4/11/23

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F 725	Continued From page 64 and Wing [redacted], b.) residents were provided with nail care and hygiene services for 3 of 5 residents (Resident #57, #45, #88) reviewed on 2 of 4 resident Wings (Wing [redacted] and Wing [redacted]), and c.) appropriate nursing and related services required for a resident who required assistance with meals for 2 of 5 residents reviewed (Resident #35 and #88), on 2 of 4 resident Wings (Wing [redacted] and Wing [redacted]) to meet the residents individual needs. This deficient practice has the potential to affect all residents and was evidenced by the following: Refer to: F677 and F689 On 02/08/2023 at 8:50 AM, the surveyor toured the [redacted] Wing of the with staff and observed the following: 1. The surveyor entered Resident #35's room with a Certified Nurse Aide (CNA). Resident #35 was observed in bed resting. The CNA informed the resident of the task and the CNA proceeded to turn the resident over. The surveyor, along with the CNA observed that Resident #35 was [redacted] with [redacted] and was wearing EX. Order 26.(4) B1 briefs. The breakfast tray was noted on the bedside table that was untouched. On 02/08/23 at 9:10 AM, during an interview with the CNA, she stated that the facility was shorthanded. She further added that she did not check the resident for EX. Order 26.(4) B1 during her first round or resident checks. The CNA stated she knew that most of the residents were wearing EX. Order 26.(4) B1 briefs. The CNA added, most of the time in the morning the residents would be EX. Order 26.(4) B1 and the bedding would also be EX. Order 26.(4) B1. On 02/08/23 at 09:45 AM, the surveyor returned	F 725	2/20/23. Resident #45 EX. Order 26.(4) B1 brief was changed on 2/8/23 and [redacted] care was provided on 2/13/23. Resident #59 i EX. Order 26.(4) B1 brief was changed on 2/8/23 and 2/13/23. [redacted] care was provided on 2/16/23. Resident #88 EX. Order 26.(4) B1 e brief was changed on 2/8/23 and [redacted] care was provided on 2/24/23. OT evaluated resident on 3/22/23. Resident #1 was interviewed on preferences regarding night time routine and the care plan was updated and added to the kardex on 3/15/23. 2. All residents have the potential to be affected by this deficient practice. 3. Director of nursing or designee re-educated direct care staff on double briefing. The Administrator, Interim Director of Nursing and Scheduling Manager were re-educated on the position control analysis report and daily staffing sheets which outline staffing patterns, unit assignments and open positions. New agency requisitions were opened and current position postings were boosted.	

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F 725	Continued From page 65 to the Resident #35's room and observed the breakfast tray was still on the table and was untouched. 2. On 02/08/2023 at 9:15 AM, the surveyor entered Resident # 57's room. The surveyor observed the resident was in bed. The resident's arms were folded and rested on the chest area. The EX. Order 26.(4) B1 were EX. Order 26.(4) B1. The resident had his/her eyes open and was looking around. Resident #57 was being administered a EX. Order 26.(4) B1 at that time. The CNA was present and put the EX. Order 26.(4) B1 on hold, informed the resident of the task and proceeded to turn the resident. The surveyor observed that the EX. Order 26.(4) B1 EX. Order 26.(4) B1, and Resident #57 was wearing EX. Order 26.(4) B1 briefs. Resident #57's EX. Order 26.(4) B1 appeared EX. Order 26.(4) B1 and were EX. Order 26.(4) B1 with EX. Order 26.(4) B1 all EX. Order 26.(4) B1. The EX. Order 26.(4) B1 were curled into the EX. Order 26.(4) B1 of EX. Order 26.(4) B1. There were no EX. Order 26.(4) B1 in place. An interview with the CNA revealed that the facility had been shorthanded since the pandemic. The CNA stated when she first started back in EX. Order 26.(4) B1, she used to have EX. Order 26.(4) B1 residents on her assignment. Gradually she was to care for 10 to 12 residents on the 7:00 AM- 3:00 PM shift. She stated lately she cared for 30 residents and only two CNA's were assigned. She stated the CNAs were unable to provide the care required by the residents. 3. At 9:30 AM the surveyor entered Resident #45's room with the CNA and observed the resident in bed. The resident was EX. Order 26.(4) B1 and EX. Order 26.(4) B1 and consented to be checked. The resident was EX. Order 26.(4) B1 and was wearing EX. Order 26.(4) B1 briefs. The resident's EX. Order 26.(4) B1 were EX. Order 26.(4) B1. The CNA stated that only one CNA worked the night shift and "could not provide EX. Order 26.(4) B1 care to all	F 725	The facility position control analysis report was updated on 4/2/23. Director of nursing or designee re-educated direct care staff on ADL care policy and procedure to include EX. Order 26.(4) B1 care and following the level of care that is documented on the careplan. Director of Nursing or designee will conduct random audit of five residents weekly for four weeks and then monthly for two months for EX. Order 26.(4) B1 briefing. Director of Nursing or designee will conduct random audit of five residents weekly for four weeks and monthly for two months for nail care. Director of Activities or designee will conduct an audit of five residents weekly for four weeks and monthly for two months for preferences. Dietician or designee will conduct an audit of five residents weekly for four weeks and monthly for two months for meal trays. Director of Rehabilitation or designee will conduct an audit of 5 residents weekly for four weeks and monthly for two months for EX. Order 26.(4) B1 The Administrator or designee will audit daily staffing schedules weekly for four weeks and then weekly for two months to ensure sufficient nursing staff to meet the	

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F 725	Continued From page 66 residents every two hours". The current Wing census was [redacted] 4. On 02/08/23 at 10:05 AM, the surveyor entered Resident # 59's room with the Licensed Practical Nurse (LPN). The surveyor observed the resident in bed, the head of the bed was elevated, the resident's eyes were closed. The LPN informed the resident of the task and proceeded to turn the resident. Resident #59 was [redacted] and was wearing EX. Order 26.(4) B1 briefs. On 02/08/23 at 10:31 AM, the surveyor left the room and interviewed the nurse regarding [redacted] care. The nurse revealed that staff were to provide [redacted] care every two hours, and as needed. When asked about the [redacted] briefs that were observed on residents during the surveyor observations, she stated that the CNAs had been educated several times regarding having [redacted] briefs on the residents. The LPN further stated that "for infection control purpose, residents should not have [redacted] briefs on." 5. On 02/08/23 at 10:45 AM, the surveyor checked a random room on the [redacted] Wing. The surveyor knocked at the door and with permission, entered the room and observed two CNAs at the bedside of Resident #88. The CNA's informed the surveyor that they were about to provide care to the resident. At that time, the surveyor observed that Resident #88 was wearing EX. Order 26.(4) B1 briefs, was soiled with [redacted], and was also observed with a pressure sore. Both CNAs stated that they did not provide care yet to the resident and were not responsible for putting EX. Order 26.(4) B1 briefs on the resident. Resident #88's [redacted] were [redacted], the	F 725	daily care required for the residents. 4.Results of audits will be presented monthly by the Director of Nursing or designee at the Monthly Quality Assurance Meeting for three months with corrective actions needed or taken during the course of the audit.	

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EXX. Order 26. of the EX. Order 26.(4) B1 were EX. Order 26.(4) B1 of the EX. Order 26.(4) B1 and a EX. Order 26.(4) B1 was EX. Order 26.(4) B1 all of the EX. Order. There was EX. Order 26.(4) B1 in place.

6. On 02/08/23 at 11:46 AM, the surveyor observed Resident #1 seated in a wheelchair inside the room. The resident requested to speak with the surveyor. The resident stated that he/she had been at the facility for EX. years. Resident #1 stated that currently the facility was "poorly managed", and the CNAs had "attitudes". When asked to elaborate, he/she stated that he requested to get to bed by 9:00 PM daily. He/she met with the administrative staff and requested that this information be entered on the care plan to facilitate communication amongst staff. Resident #1 stated that this information was again discussed during the quarterly Interdisciplinary Team meeting. Almost daily he/she could not get to bed as requested. Staff would say they cannot accommodate his/her request due to the facility being shorthanded. The resident stated that he/she needed assistance with transfer and to use the bathroom. He/she followed a routine and needed assistance around 3:00 PM to use the bathroom daily. Resident #1 stated that some days he/she could not find any staff to assist. EX. Or could take between 45 minutes to 1 hour for staff to answer the call light. The resident stated that he fell and was on the floor for twenty minutes before someone answered the call light. The surveyor reviewed the resident's care plan and verified that the information regarding his/her preference for bedtime was entered on the care plan, and staff were to honor his/her preference or explain if the request would be delayed.

On 02/10/23 at 9:28 AM, the surveyor interviewed

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F 725	Continued From page 68	F 725		

the registered nurse (RN) on the [redacted] Wing. The staffing board at the nursing station indicated a census of [redacted] with 1 RN, and 2 CNAs. The RN explained that the staffing levels were split between the four wings and usually two CNAs were assigned on each wing. The RN stated they were short one CNA that day, and when asked about usual staffing she stated, "they were short CNAs at all times".

On 02/10/23 at 11:45 AM, the surveyor observed Resident #88 in bed with the head of the bed elevated. The lunch tray was placed in front of him/her and was set up with utensils to eat. Resident #88 was then [redacted] herself/himself [redacted] with no assistance offered. Resident #88 was observed as being unable to reach the meal tray. The surveyor left the room and escorted the RN, Unit Manager (RN/UM) to the room. The RN/UM confirmed that Resident #88 was not set up properly to eat. The UM repositioned the resident and exited the room. The surveyor observed when the meal tray had been removed, nothing had been touched. There was no staff to assist/ supervise Resident #88's [redacted] himself/herself independently. A review of the Care Plan revealed that Resident #88 must be supervised at all meals.

On 02/21/23 at 9:45 AM, the surveyor observed Resident #88 in bed. The breakfast tray was setup for the resident to eat. The resident attempted to drink the juice and was falling asleep. The breakfast tray was untouched and there was no one supervising the resident at mealtime. The surveyor informed the LPN who was seated at the nursing station that the resident was not eating. The LPN stated that she set up

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the tray, ensured that Resident #88 could reach the spoon and left the room. The LPN was not aware that Resident #88 required assistance and supervision with all meals per Resident #88's Care Plan.

On 02/21/23 at 11:05 PM, the surveyor reviewed Resident #88's care plan which revealed Resident #88 was at nutritional risk due to dysphagia but still wants to eat by mouth. Staff were directed to "Supervise/cue/assist as needed with meal. Resident #88 was to be assisted at mealtimes".

On 02/21/23 at 11:53 AM, the surveyor interviewed the staffing Coordinator who stated that staffing was based on HPPD (hours per patient per day). The calculation was done by adding nurses and CNA hours and divided by the census. She was aware of the State regulation sets forth for the ratio of CNA to residents. She stated that since the pandemic[2020], staffing had been a challenge and the facility had not been able to meet the requirement.

On 02/22/23 at 10:16 AM, surveyor #2, interviewed the Administrator (LNHA) regarding the staffing. The LNHA stated she was aware of staffing requirements. The LNHA stated that staffing was important to the facility and she had been made aware of the days that the facility did not meet the staffing minimums and would utilize other staff where she was able to.

On 02/22/23 at 1:30 PM, the surveyor discussed the above concerns with the Director of Nursing (DON). The DON stated that she was aware of staff using EX. Order 26.(4) B1 briefs on the residents and she had previously in serviced the staff. The

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F 725	Continued From page 70 DON acknowledged that staffing was a challenge. The Staffing/Center Plan, Effective 06/01/96, revealed the facility will provide qualified and appropriate staffing levels to meet the needs of the patient population. The staffing plan will include all shifts, seven days per week. Purpose: To assure that appropriate staffing levels are scheduled and maintained. Process: 1. The Center meets or exceeds the staffing levels mandated by state and federal staffing requirements., 2. Staffing levels are reviewed on an ongoing basis by center staff to evaluate compliance and provide appropriate levels of care by qualified employees., 4. The Center maintains appropriate staffing levels, with qualified personnel, 25 hours/day, seven days/ week on each shift to assure that patients are safe, and their needs are met. Inquiries concerning staffing should be referred to the Director of Nursing. Staffing inquiries for all other departments should be directed to the Center's Administrator... The Facility Assessment Tool, Updated 03/22/22 revealed Individual Staff Assignment, 3.3. Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments. Staff members have assignments that offer continuity of care throughout all disciplines. Staffing patterns are reviewed daily and adjusted to meet the needs of the patient population. This conversation is revisited throughout the day to ensure adjustments are made based on planned admissions. We strive for consistent staff- patient assignments by staff members regularly caring for residents on the same unit each day.	F 725		

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F 725	Continued From page 71 NJAC 8:39-5.1(a); 27.1 (a)	F 725		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to evaluate the performance of all Certified Nursing Assistants (CNAs) on an annual basis. This deficient practice occurred with 5 of the 5 CNAs whose personnel records were reviewed and was evidenced by the following: On 02/22/2023 at 12:40 PM, the surveyor reviewed the employee files of 5 randomly selected CNAs which were provided by the facility. The surveyor identified the following: CNA #1 had a hire date of EX. Order 26.(4) B1. According to the CNA #1's personnel record, the last documented performance appraisal was EX. Order 26.(4) B1. There were no annual performance reviews conducted within the past year. CNA #2 had a hire date of EX. Order 26.(4) B1. According to the CNA #2's personnel record, the last documented performance appraisal was EX. Order 26.(4) B1. There were no annual performance reviews conducted within the past year.	F 730	1. The five certified nursing assistants received their annual performance review on 3/2/23. 2. All current certified nursing assistants have the potential to be affected by the deficient practice. 3. Human Resources or designee will provide a monthly list of certified nursing assistants who are due for annual performance reviews. The Director of Nursing or designee will be responsible to ensure that the current certified nursing assistants receive their annual performance reviews. Human Resources or designee will audit the completion of the performance reviews weekly for four weeks then monthly for two months. 4. The results of the performance review audit will be discussed in the monthly	4/11/23

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F 730	Continued From page 72 CNA #3 had a hire date of EX. Order 26.(4) B1. According to the CNA #3's personnel record, the last documented performance appraisal was EX. Order 26.(4) B1. There were no annual performance reviews conducted within the past year. CNA #4 had a hire date of EX. Order 26.(4) B1. According to the CNA #4's personnel record, the last documented performance appraisal was EX. Order 26.(4) B1. There were no annual performance reviews conducted within the past year. CNA #5 had a hire date of EX. Order 26.(4) B1. According to the CNA #5's personnel record, the last documented performance appraisal was EX. Order 26.(4) B1. There were no annual performance reviews conducted within the past year. During an interview with the surveyor on 02/23/23 at 10:57 AM, the Licensed Nursing Home Administrator (LNHA) stated she had been employed at the facility since EX. Order 26.(4) B1. The LNHA stated that the purpose of a performance appraisal was to provide feedback for someone over a period of time, by reviewing an employee's strengths, their goals, and ways to improve. The LNHA stated that performance appraisals should be done annually. The surveyor then showed the LNHA the personnel records of CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5, and confirmed that their performance appraisals were not completed annually. The LNHA further stated that the prior Director of Nursing (DON) and the current Assistant Director of Nursing Infection Preventionist (ADON IP) were responsible for performance appraisals. During an interview with the surveyor on 02/23/2023 at 12:16 PM, the ADON IP stated that	F 730	Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the course of the audit.	

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F 730	Continued From page 73 the prior DON kept information on all facility staff. The IP added that she was not sure where the information was kept. The ADON IP was unable to provide documented evidence of performance appraisals for the 5 CNA staff reviewed annually A review of the facility policy titled, "Performance Appraisal", with a revision date of 03/29/2021, indicated that managers will meet with their regular full-time, regular part-time, and regular casual employees at least annually to conduct a performance appraisal or have a performance-based conversation. In-service education will be provided based on the outcome of these reviews.	F 730		
F 804 SS=E	NJAC 8:39-43.17(b) 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; §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 and document review it was determine that the facility failed to provided meals at acceptable temperatures for 2 of 4 residents interviewed during a resident council meeting and for 4 of 4 items sampled during a test tray observation. The deficient practice was evidenced by the following:	F 804	1. Meal temperatures are monitored daily on the service line to ensure temperature recording procedures are properly followed. Staff were re-educated on the system for passing meal trays on 2/24/23.	4/11/23

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F 804	Continued From page 74 On 02/14/23 10:33 AM, a surveyor conducted a resident meeting with four residents, and 2 of 4 residents stated that the food served would sit on the meal trays too long and would then be cold because there were not enough Certified Nurse Aides to give out the meal trays. On 02/15/23 at 11:37 AM to 12:08 PM, the surveyor entered the kitchen and observed the tray line in progress for the lunch meal. The surveyor observed the tray line while next to a Dietary Staff worker (DS #1) who was opposite the Cook. The surveyor selected a hot dog, cheese pizza, puree hot dog and four ounces of milk from the tray line and posted menu. The food temperatures had been recorded by the Cook and reviewed by the surveyor which revealed: hot dog 194 degrees Fahrenheit (F), puree hot dog 187 degrees F, cheese pizza 189 degrees F. On 02/15/23 at 12:08 PM, the test tray was plated by the DS #1 and an insulated base that was stacked next to the trays was used to hold the plate and an insulate lid was place on top of the food. The test tray left the kitchen and arrived on unit three at 12:09 PM. The surveyor, along with the Food Service Director (FSD) awaited the trays to be passed. On 02/15/23 at 12:12 PM, the first meal tray was passed. On 02/15/23 at 12:16 PM, the surveyor inquired to the FSD what the standard for the cold and hot food should be when it reached the resident. The FSD stated the cold food should be between 41-45 degrees F, and the hot food should be between 150-160 F.	F 804	2. All residents have the potential to be affected by the deficient practice. 3. Cooks were re-educate on 2/8/23 to ensure that temperatures of food items are recorded prior to meal service and are within the appropriate ranges. Food Service Director or designee will conduct five test tray audits on different units weekly for four weeks then monthly for two months. 4. Results of the audits will be discussed in the monthly Quality Assurance Performance Improvement for three months with corrective action needed or taken during the course of the audit.	

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F 804	Continued From page 75 On 02/15/23 at 12:30 PM, the last meal tray had been passed (18 minutes between the first and last tray passed) and the FSD and surveyor immediately tested the food temperatures which revealed: 1. Hot dog- surveyor: 121.2 F, FSD: 120, the FSD stated "it should be higher"; 2. Puree hot dog- surveyor: 117.8 F, FSD: 118 F; 3. Pizza- surveyor: 114 F, FSD: 112.2 F; 4. Four ounces milk- surveyor: 50.6 F, FSD: 49.5 F; On 02/15/23 at 12:34 PM, the surveyor asked if the amount of time it took to pass the meal trays was typical and the FSD stated "usually doesn't take this long". The surveyor requested the policy for food temperatures. On 02/16/23 at 8:55 AM, the FSD provided the surveyor with a copy of a blank test tray log. The log revealed the Temperature Standard for Hot Foods was 150 F, and for Cold foods 45 F. NJAC 8:39-17.4(a)	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		4/11/23

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F 812	Continued From page 76 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 document review, it was determined that the facility failed to ensure a.) that the kitchen environment, equipment and resident meal service items were maintained in a clean and sanitary manner, b.) a walk in refrigeration unit maintained appropriate food temperatures, c.) a commercial dishwashing machine was operated within manufactures specifications, d.) food temperatures were consistently monitored, e.) hair restraints were consistently worn, and e.)food items were consistently labeled and dated with a use by date to limit the spread of infection and potential food borne illness. The deficient practice was evidenced by the following: On 02/08/23 at 8:51 AM through 9:25 AM, the surveyor conducted an initial tour of the kitchen. The surveyor observed the Cook wearing a surgical mask under his nose and facial hair was protruding out the side of his mask. The Cook was not wearing a facial restraint. There were two additional dietary workers in the kitchen who informed the surveyor that the Food Service Director (FSD) was on the way. The surveyor went to the large walk-in refrigerator unit with the Cook and asked the cook what the temperature of the unit was. The Cook proceeded to look at	F 812	1.All products affected by the can opener were discarded on 2/8/23. Can opener and base were cleaned on 2/8/23. Employees were provided with beard guards on 2/8/23. The unlabeled products were discarded on 2/8/23. The milk was discarded on 2/8/23 and maintenance repaired the walk in unit on 2/8/23. Fan was removed on 2/15/23. Dishmachine was immediately shut down on 2/16/23 and disposable products were used for the lunch meal. The machine was repaired on 2/16/23. Regular service resumed for dinner. Racks were cleaned on 2/16/23. 2.All residents have the potential to be	

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F 812	Continued From page 77 the external temperature gauge and the surveyor observed that the needle appeared broken. The thin indicator side of the temperature needle was not registering any temperature, was in the white area of the gauge, and below the temperature reading. The larger opposite side of the temperature needle appeared to be facing the green colored area between 35 to 40 degrees Fahrenheit (F). The cook then retrieved an internal thermometer and stated the temperature of the refrigerator was 37-38 (degrees F), the surveyor observed the thermometer reading at 42 degrees F and the Cook then asked the surveyor what the temperature was. The Cook then looked at the external thermometer, that appeared broken and stated the temperature was 37-38 (degrees F). At that time, the surveyor requested that the Cook take the internal temperature of a food item inside the refrigeration unit. The Cook stated, "I don't have access to a thermometer", it's "locked in office". At that time the cook was trying to find a key for the office. The surveyor asked the Cook if he had taken food temperatures for the breakfast meal that he cooked and he stated, "today, no", because the thermometer was in the office and again stated, "no", he did not take food temperatures. The surveyor then observed a refrigerator temperature log affixed on the outside of the refrigeration unit. The log was for February 2023, and the AM temperature on 02/08/23 was handwritten in, as 37, and was also initialed. On 02/08/23 at 9:01 AM, the FSD entered the kitchen, with a surgical mask over his face and facial hair was protruding out of the sides. At that time, the FSD and surveyor entered the walk-in refrigerator unit, and the surveyor observed a ¼ sized metal pan on a shelf. The pan contained	F 812	affected by the deficient practice. 3.The employees were re-educated on proper cleaning procedures on 2/16/23. Employees were re-educated on proper restraint of facial hair with use of beard guards on 2/16/23. Employees were re-educated on proper labeling and dating guidelines on 2/16/23. Employees were re-educated on the proper usage of the low temperature PPM test strip on 2/16/23. Food Service Director or designee will audit hair restraint usage five times per week for four weeks and monthly for two months. Food Service Director or designee will audit labeling and dating five times per week for four weeks and then monthly for two months. Food Service Director or designee will audit cleaning five times per week for four weeks and then monthly for two months. Food Service Director or designee will audit the dish machine temperature and parts per million testing strips five times per week and then monthly for two months. 4. Results of the audit will be discussed in the monthly Quality Assurance	

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F 812	Continued From page 78 pieces of ham, identified by the FSD, and there was no label or use by date on the ham. At that time the surveyor asked the FSD what was worn to cover facial hair, and the FSD stated they wore beard guards. The surveyor asked the FSD if his facial hair was covered, and he confirmed it was not covered. The FSD and surveyor exited the refrigerator unit, and the surveyor observed a can opener affixed to a metal table, and the black can opener insert had visible debris affixed to it. The FSD stated it needed to be cleaned, and the surveyor asked if it was cleaned and the FSD stated "technically no". On 02/08/23 at 9:07 AM the surveyor inquired to the FSD regarding if food temperatures should be taken when the food is cooked. The FSD stated "yes" that food temperatures should be done and stated "yes" the cook has to take them and use thermometers. The FSD stated there should have been a thermometer available there and supposed to be thermometers at the cooking station. The FSD stated he has been in the FSD position for four to five months and that he was employed by a management company, not the facility. 02/08/23 at 9:11 AM, the surveyor asked the FSD to take the temperature of an item that was inside the refrigerated walk-in unit. The FSD took a 4-ounce container of milk, that he removed from a crate, inserted his thermometer and the temperature was 41.2 degrees F. The FSD stated that the temperature should be below 41 degrees F. The FSD stated the milk was delivered yesterday, and then proceeded to take a 2nd 4-ounce milk from a different milk crate. The FSD inserted his thermometer, and the temperature was 47.8 degrees F. At that time, the surveyor	F 812	Performance Improvement meeting for three months with corrective action needed or taken during the course of the audit.	

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F 812	Continued From page 79	F 812		

asked the FSD what the temperature was for the refrigerated walk-in unit, and stated, he called the unit the "produce box" and looked at an internal thermometer which read 45 degrees F. The surveyor asked the FSD to check another food item, and the FSD removed a 6-ounce juice container and inserted his thermometer. The surveyor asked the FSD if the thermometer was calibrated, and he stated it was. The surveyor asked the FSD if the temperature was okay, after the FSD was looking at the thermometer inside of the juice. The FSD stated, "no", not okay, and showed the surveyor that the thermometer was at 52 degrees F. At that time, the FSD stated to the surveyor that the food temperatures were not good, and both the FSD and surveyor observed that two logs were affixed next to both walk in refrigerator units and both were documented as 37 degrees F on 02/08/23. The surveyor asked the FSD if there had been any concerns regarding the walk-in refrigeration unit and the FSD stated he was not aware and he will follow-up.

On 02/08/23 at 9:42 AM, the surveyor re-entered the kitchen and inquired to the FSD about the walk-in refrigeration unit temperature. The FSD stated that the maintenance person from the facility came and moved the temperature control for the walk-in refrigeration unit to a colder setting. The surveyor asked the FSD to check the temperature of an item. The FSD removed a 4-ounce milk container from a lower crate in the back of the walk-in refrigeration unit. The surveyor and FSD proceeded to take the temperature of the milk which was 43 degrees F. The FSD stated that the maintenance person was contacting the vendor to come look at the unit, and it was the "first time" that he had heard about

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the unit having an issue with temperature maintenance, and that both he and the maintenance person were unaware of any issues with the walk-in refrigeration unit until the surveyor brought it to his attention.

On 02/08/23 at 9:49 AM, the surveyor observed a bread rack. There were five loaves of undated raisin bread on the rack. The FSD stated, "they forgot to put dates on it".

On 02/08/23 the LNHA provided the surveyor with a copy of an email dated 02/09/23 at 10:36 AM subject: "walking repairs", which revealed: Called by building maintenance director at 10:00 AM on 02/08/23 stating walking refrigerator running warm, arrived 11:00 AM 02/08/23 and checked walkins. Walking #1 found at 50 degrees. Cleaned evaporator and condenser coils. Replaced the thermometer on walking box front panel. Door warped, added gasket material and will get pricing on new door and order. Walking #2 found at 42 degrees. Cleaned condenser coil. Replaced the thermometer on walking box front panel. Adjusted temperature setting.

On 02/08/23 at 12:58 PM, the surveyor interviewed the facility maintenance person, who stated he was not the maintenance director, along with a representative from the facility's corporate maintenance department (CMD). The CMD stated that the walk-in refrigeration unit needed to have the coils cleaned on the condenser and evaporator, and that usually the maintenance director would have been responsible to keep that clean because it would affect the temperature of the unit. The CMD also stated that the door to the walk-in refrigeration unit was warped, and that could also affect the

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temperature and that both external thermometers were broken, and he was going to replace both.

On 02/08/23 at 1:40 PM, the surveyor entered the kitchen to inquire about the walk-in refrigeration unit. A District Manager (DM) from the food service management company was in the kitchen. The surveyor asked about the temperature of the unit and the DM went to the unit and the surveyor asked the DM to take the temperature of a food item. The DM removed a 4-ounce container of milk, took the temperature of the item which was 41.9 degrees F. The surveyor asked if the DM had checked the temperature of the food prior to surveyor inquiry and the DM stated, the maintenance people are still working on the unit, and the surveyor observed multiple stacked crates of milk, and other food items inside the unit as in the prior observations. The DM stated that he checked a food item one hour ago at 12:30 PM, and the item (undisclosed) was 42 degrees F. The DM stated that food should be below 41 degrees. At that time the surveyor asked the DM to accompany the surveyor to the facility Administrator's office (LNHA) and the surveyor advised the LNHA, in the presence of the Corporate Nurse (CN), of the temperature concerns and issues conveyed by the CMD. Both the LNHA and CN were unaware of the temperature concerns regarding the walk-in refrigeration unit.

On 02/15/23 at 11:38 AM to 128 PM, the surveyor entered the kitchen and observed the tray line in progress for the lunch meal. The surveyor observed a differed food service management company district manager in the kitchen. The surveyor observed the tray line while next to a Dietary Staff worker (DS #1) who was opposite

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the Cook and was at the tray line start position and prepared the [redacted] Wing trays.

On 02/15/23 at 11:46 AM, the DS was observed removing meal trays that were stacked on the tray line and that were visibly wet. The DS then used a napkin to dry the trays as she set them up with resident meal tickets and food items. At that time, the FSD was also in the kitchen and the surveyor inquired as to the drying process for the meal trays. The surveyor pointed to the wet trays and the FSD stated that the facility had a low temperature dish machine, so they used a fan to dry the trays. At that time, the surveyor observed a large box type fan suspended from the ceiling and was aimed toward the exit area of the dish machine.

On 02/15/23 at 11:54 AM, the surveyor observed the DS take a napkin with her gloved hand and wipe the wet trays, the DS then reused the napkin which was visibly wet and continued to wipe the trays and set them up with resident's meals. The surveyor asked the FSD about the DS process of wiping the trays with a napkin and the FSD stated, "no, she is not supposed to be doing that, trays should be dry", then took a different type of towel and proceeded to wipe the trays. The surveyor observed 24 wet trays in total that were wiped with a napkin by the DS.

On 02/16/23 at 9:37 AM, the surveyor entered the kitchen and observed the commercial dish machine (machine) was being set up to clean the breakfast dishes. The surveyor observed that the large box fan that was suspended above the exit area of the machine was turned on. There were fourteen clean meal trays in a rack, placed in front of the blowing fan. The fan was visibly

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covered with dark dust like particles throughout the grate of the fan. At that time the surveyor inquired to the FSD what the fan was doing. The FSD stated "we don't have a rack for the trays, the "fan is to help air dry the trays". The surveyor asked the FSD if the fan was clean, and the FSD stated "it is dusty". The surveyor requested an equipment policy at that time.

On 02/16/23 at 9:47 AM, the surveyor observed a four-tier metal rack base with four metal racks, that had embedded dark greasy areas throughout the rack edges, and crumb like food particles. The four racks were removable and were used to hold insulated tray items as confirmed by the FSD. The surveyor showed the FSD the crumb like and greasy areas and asked the FSD if the rack was cleaned. The FSD stated monthly or as needed. A rack of clean pots, adjacent to the four-tiered rack had copious types of food type crumbs and debris underneath on the floor, and the surveyor asked the FSD if the floor is cleaned. The FSD stated "maybe they missed it".

02/16/23 at 9:51 AM, the surveyor observed DS #2 placing dishes and other items through the dish machine for cleaning. The surveyor asked the DS #2 what the temperature of the machine was. The DS #2 stated the hot was 160 degrees F and the rinse was 170 degrees F. The FSD interjected and stated that the wash was 140 degrees F, and the rinse was 150 degrees F, and stated the machine was a "low temperature machine, not a high temperature".

On 02/16/23 at 9:55 AM, the surveyor, in the presence of the FSD, observed that the DS #2 was running items through the dish machine and observed the wash gauge was 150 degrees F

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and the rinse gauge was 135. At that time, the FSD stated there was an "issue" with the dish machine and told the surveyor that the thermostat for the dish machine was broken and needed to be replaced. The surveyor asked the FSD how the dish machine would then be checked to ensure it was effectively sanitizing the dishes if the thermostat was broken.

On 02/16/23 at 9:56 AM, the FSD stated there was an issue with the dish machine and that the repair company came to look at it and determined there was an issue with the rinse thermometer. The FSD stated there was an email that documented the concern, and the surveyor requested the email.

On 02/16/23 at 9:57 AM, the surveyor asked the FSD how the dish machine would be checked and the FSD showed the surveyor the sanitation test strips (strip) to measure the amount of chemical sanitizer in the dish machine. The FSD took a test strip and placed it between two cups and ran the cups through the dish machine. At that time the FSD stated the strip should read 50 parts per million (PPM) which was a dark charcoal color per the test strip bottle. Once the strip exited the machine, the FSD showed the surveyor the strip next to the indicator color on the strip bottle. The strip was a very light gray color which matched the 10 PPM color on the bottle and the FSD confirmed it was not the proper concentration at 50 PPM. The FSD then attempted a second placement of a strip and ran the strip through the dish machine. The FSD then removed the strip and placed it next to the test strip bottle. The strip appeared the same light color as the previous strip and matched the 10 PPM color. The surveyor asked the FSD if the

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strip matched the 10 PPM light gray and he stated, "I believe so".

On 02/16/23 at 10:04 AM, the FSD run another strip through the dish machine and showed surveyor color of strip which matched the light gray color at 10 PPM. The FSD then stated, "at this point I am going to not use the machine until I figure what is going on" and he instructed his staff that they are going to use the three compartment sink to finish the dishes. He was unable to confirm that the machine worked appropriately after multiple attempts to check the sanitation concentration which did not meet the required 50 PPM. During the dish machine observations, the surveyor observed the ceiling tiles above the dish machine area were visibly soiled with dark colored debris and fuzz like matter and were also over the area where the clean dishes were stored. The surveyor asked if the ceiling tiles were cleaned, and he stated they had been cleaned once by maintenance since he had worked there.

On 02/16/23 at 10:59 AM, the surveyor reviewed the dish machine sanitation log for that day. The surveyor observed the log was dated for February 16, 2023, and the Breakfast Wash temperature was 140 degrees, the Rinse temperature was 156 degrees, and the PPM was 50 and it was illegibly initialed. The surveyor interviewed DS #1 and DS#2 who denied documenting the temperatures and PPM. DS #3 stated she took the temperatures and stated she read them from the machine at 8:00 AM. The surveyor asked DS #3 about the PPM 50 number and showed her the bottle of the test strips and asked her if she had used the test strips to get the number. The DS #3 stated she didn't know anything about the bottle

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of the test strips that the surveyor was holding and stated that she had copied the 50 number from the previous number. The surveyor asked DS #3 if she had been trained on uses the test strips and she stated "no". The surveyor asked the FSD regarding if he had trained the DS #3 and he confirmed that he had not trained her to use the strips. The surveyor asked DS #3 if she had been aware of a broken temperature gauge on the dish machine and she stated "no".

On 02/16/23 at 11:57 AM, the surveyor interviewed the dish machine repair company representative (RPR) who stated he was called in today to check the dish machine. The RPR stated the thermostat for the machine needed to be replaced and he was called in the day before by the FSD. The RPR stated he came last night, and the sanitizer was working on the dish machine, and he checked the temperature with his thermometer and the machine had been okay. The RPR stated that he was contacted today and informed that the dish machine was reading 10 PPM on the sanitizer. The RPR stated he came today and increased the amount of sanitizing chemical the machine was dispensing. He then showed the surveyor a dark charcoal colored test strip that matched the 50 PPM and stated he also calibrated the dish machine chemical sanitizer and stated the bottle of chemical sanitizer for the dish machine was not connected to the dish machine appropriately and was very low when he had come today. The RPR stated that because chemical was not appropriately connected to the dish machine it was not drawing up the proper amount of chemical that was required and stated that when he had left last night it was working appropriately. He stated that the dish machine was being operated as a low temperature

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machine because the heat booster had not been functioning and needed to be replaced. The RPR stated it was important to have the proper chemical concentration and stated you needed that for "safety" purposes.

The surveyor reviewed the following policies which revealed:

Warewashing Policy, Revised 09/2017 revealed that all cookware, dishware, and serviceware will be cleaned and sanitized after each use., Procedures: 1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. 2. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. 3. Temperature and/or sanitizer concentration logs will be completed, as appropriate. 4. All dishware will be air dried and properly stored.

Staff Attire, Revised 09/2017, All employees were approved attire for the performance of their duties., Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.

Receiving, Revised 09/2017, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items., 5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. A Food Storage and Retention Guide, Refrigerator less than or equal to 41 degrees F for dairy items.

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Food Preparation, Revised 09/2017, All foods are prepared in accordance with the FDA Food Code., 1. Staff will practice proper hand washing and glove use., 3. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitize after every use., 10. Time/Temperature Control for Safety (TCS) hot food items will be cooked to a minimum internal temperature for 15 seconds, as follows: Poultry and stuffed foods 165 degrees F, Ground meat 155 degrees F, Fish, pork, other meats, 145 degrees F, Unpasteurized eggs 145 degrees F., 13. Temperature for TCS foods will be recorded at time of service, and monitored periodically during meal service periods.

Food Storage: Cold Foods, Revised 4/2018, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. Procedures: 2. All perishable foods will be maintained at a temperature meeting safe food handling standards., 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. If corrective action is necessary, designated staff members will monitor temperatures until food storage environment is acceptable., 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

Facility provided dish machine specifications revealed: Chemical Sanitizer Rinse, Minimum chlorine PPM (low temp), 50 PPM

Environment: Revised 09/2017, All food

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F 812	Continued From page 89 preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition., 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces., 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. NJAC 8:39-17.2(g)	F 812		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interview, review of medical records and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a.) that policies and procedures were developed and implemented to mitigate the spread of infections, and b.) documented on-going staff education and in-services were completed to combat breaks in infection control practices. The multiple observed breaches in infection control practices by multiple facility disciplines, were identified on 02/08/23, 02/09/23,	F 835	1. F880, F886 and F835 removal plans were submitted, accepted, and implemented. The F835 removal plan was accepted and verified as implemented during an onsite visit by the New Jersey Department of Health (NJDOH) surveyors on 2/13/23. 2.All residents have the potential to be affected by this deficient practice. 3.The Administrator was re-educated on	4/11/23

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F 835	Continued From page 90 and 02/10/23 on 4 of 4 resident care Wings. This posed a serious and immediate threat to the health, safety and well-being of all residents who resided at the facility due to the lack of infection control oversight provided by the LNHA, which resulted in an Immediate Jeopardy (IJ) that began on 02/08/23 and was identified on 02/10/23 at 4:07 PM. The LNHA was notified of the IJ situation on 02/10/23 at 4:08 PM. The failure of the LNHA to ensure the facility operated in a manner that ensured residents were cared for and an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety, and welfare of staff and all residents who resided at the facility in compliance with federal, state and local requirements as outlined in the Center Executive Director Job Description,. A removal plan was accepted on 02/13/23 at 10:17 AM. The survey team verified the removal plan on 02/13/23 at 12:33 PM. A review of the facility's Center Executive Director Job Description provided on 02/10/23, included but was not limited to the following; Position Summary: The Center Executive Director is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Center Executive Director administers, directs, and coordinates all	F 835	2/10/23 by the Regional Nurse Consultant on the following policies- IC102 Infection Control Surveillance and Reporting IC103 Outbreak Investigation/Management IC104 Reportable Diseases- Nationally Notifiable Infectious Diseases and Conditions IC203 Hand Hygiene IC300 Airborne Infection Isolation Precautions IC301 Contact Precautions IC302 Discontinuing Transmission Based Precautions IC303 Droplet Precautions IC304 Infectious Disease and Transmission Based Precautions IC309 Modified Enhanced Barrier Precautions IC306 Patient Placement in Transmission Based Precautions IC310 Special Droplet and Contact Precautions IC307 Standard Precautions The Administrator has been re-educated on 2/10/23 by the Regional Nurse Consultant on staff education expectations. All staff present in the facility have been re-educated on the proper use and donning and doffing of PPE, and the hand hygiene process on 2/10/23. Meal trays have been removed from outside resident rooms and common areas on 2/10/23.	

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F 835	Continued From page 91 activities of the Center to assure that the highest degree of quality of care is consistently provided to residents. Works in close collaboration with the Center Nurse Executive....to assure high quality clinical outcomes. Ensures staff participate in orientation and training programs.....relative policies and procedures, and that such training is properly documented. Refer to: F880, F886 Findings include: On 02/08/23 at 11:12 AM during entrance conference, the LNHA stated the facility was currently in a EX. Order 26.(4) B1 outbreak. The outbreak began EX. Order 26.(4) B1, and the facility currently had EX. Order 26.(4) B1 residents on four of the four resident care Wings. The survey team requested multiple documents, one of which was the facility staff in-service and education information. On 02/08/23, during tour of the facility, the survey team observed isolation transmission-based precaution (TBP) resident rooms on 4 of the 4 resident care Wings. The surveyor observed Resident #31's room on the EX. Order wing. Resident #31's room did not have any TBP signage affixed to the resident's door, or Personal Protective Equipment (PPE) containers outside the room and readily available. The surveyor observed Resident #88's room on the EX. Or wing. Resident #88's room did not have any TBP signage affixed to the resident's door, or PPE containers outside the room and readily available. The surveyor conducted medical record reviews which included, but were not limited to, Resident #31 had a physician's order dated EX. Order 26.(4) B1 to be	F 835	Precaution signage has been hung on the doors of residents who require precautions and dedicated equipment has been placed in the room on 2/10/23. Blood glucose meters have been disinfected per manufacturer's guidelines and staff present in the building have been educated on the process of disinfection of multi- use equipment on 2/10/23. Education and competencies were conducted on donning and doffing PPE, Hand Hygiene process for all current staff, new hires and new agency staff on 2/10/23. Education and competencies were conducted on disinfecting blood glucose meters, and proper signage to place outside residents□ doors who are on precautions for all current licensed staff, new hires and agency staff on 2/10/23. The in room meal tray removal system has been revised to include bagging trays before exiting the room and place on meal cart. Education was conducted on the in room meal tray removal system with all current staff, new hires and agency staff on 2/10/23. Infection Preventionist or designee will audit donning and doffing of PPE including hand hygiene weekly for four weeks then monthly for two months.	

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F 835	Continued From page 92 placed on contact precautions (procedures that reduce the risk of the spread of infections through direct or indirect contact) for EX. Order 26.(4) B1 [redacted] - an organism which is among those responsible for EX. Order 26.(4) B1 [redacted]) of the EX. Order 2[redacted] every shift. Resident #88 had a physician's order dated EX. Order 26.(4) B1 to be placed on contact precautions for EX. Order 26.(4) B1 [redacted] EX. Order 26.([redacted] every shift. On 02/08/23 at 10:58 AM on the 1st wing, Surveyor #1 and #2 observed a laundry aide walking down the hall wearing a PPE gown which was not secured in the back, an N95 mask and eye protection. The laundry aide entered a EX. Order 26.(4) B1 resident room and through an open door, the surveyors observed her touched multiple environmental surfaces, including the furniture. The laundry aide exited the room without first removing her gloves and perform hand hygiene. On 02/10/23 at 9:28 AM in the presence of three surveyors, the LNHA, Director of Nursing (DON), and Assistant Director of Nursing Infection Preventionist (ADON IP) were interviewed and made aware of the situation concerning the two residents who had not been placed on TBP as per physician's orders. The LNHA, DON, and ADON IP acknowledged they were not aware of the two residents being on TBP and that there was no signage affixed to the resident's room doors to alert staff of the required PPE to wear to protect themselves and other residents. The ADON IP stated the facility kept an	F 835	Infection Preventionist or designee will audit residents who require precautions proper signage is hung on the door weekly for four weeks and monthly for two months. Unit Manager or designee will audit nurses disinfecting blood glucose meters weekly for four weeks then monthly for two months. Infection Preventionist or designee will audit meal tray removal process for residents on transmission based precautions weekly for four weeks then monthly for two months. 4. Results of audits will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the course of the audit.	

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	315138	A. BUILDING _____ B. WING _____	02/27/2023

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antibiotic listing but, "infections were not tracked for every patient unless an antibiotic was ordered." The LNHA was not aware of no documented tracking of residents on TBP despite an ordered antibiotic.

On 02/10/23 at 12:58 PM, the survey team asked the LNHA a second time for the staff education book. The LNHA stated, "I thought I told you I gave you all the education I had to give". When asked if the few in-services she gave encompassed the entire staff, the LNHA stated she was not sure and "I guess I can have nursing give you the book to see."

On 02/10/23 at 1:23 PM, the ADON IP and Registered Nurse (RN) in training for IP, were being interviewed.

The ADON IP stated in-services and education for the staff on Infection Control was done, "on and off" and "whenever I get a chance". She further stated that there were not always sign in sheets kept to document who attended or the content of education or in-services. The LNHA was not aware of the lack of completed, documented education, in-services, and competencies for the facility staff.

On 02/10/2023 at 10:49 AM on Wing [redacted] of the facility, a surveyor observed a housekeeper wearing an N95 mask and a face shield. The housekeeper was observed in the doorway of a EX. Order 26.(4) B1 resident room which had signage on the door to indicate what the TBP was and what PPE was required. The housekeeper had not donned a PPE gown or gloves. The housekeeper was using his bare hands to tie a plastic bag that contained used, soiled PPE

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gowns. The housekeeper then brought the plastic bag filled with soiled PPE gowns out into the hallway and placed the bag on top of the housekeeping cart. The surveyor asked the housekeeper what the process was for collecting soiled gowns in resident rooms that were on droplet precautions or any transmission-based precautions (TBP)? The housekeeper stated that he followed directions from his "administrator (LNHA)".

On 02/10/23 at 2:27 PM, the LNHA and DON were being interviewed. The surveyor asked who was responsible for overseeing the Infection Control program? The DON stated she and the LNHA were responsible. The LNHA was present and agreed.

On 02/22/23 at 10:00 AM the LNHA was interviewed in the presence of the survey team. regarding her job decription. The surveyor asked if the LNHA was responsible for everyong in the facility and she stated, "ultimately yes" and the surveyor inquried if that included infection control and the LNHA stated "yes". The surveyor asked what her role in infection control was, the LNHA stated "to make sure we have an infection preventionist".

On 02/22/23 at 10:04 AM, the surveyor asked if the LNHA was aware that there was no one assuming the ADON IP's role when she had been out. The LNHA sated it would have then deferred to the DON. When asked if the LNHA was aware that all [redacted] testing was not completed as indicated. The LNHA stated "honestly, not". The surveyor asked the LNHA if she should have been made aware and she staetd "absolutely", things should have been communicated to me so

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F 835	Continued From page 95 I could have strategized. A review of the facility provided, "Outbreak Investigation / Management" policy and process revised 02/01/23, included, but was not limited to 6. Notify: 6.1. Administrator .... 7. Implement control measures based on signs, symptoms, diagnosis, mode of transmission, and location in the Center. 8. Conduct staff education/competencies as needed regarding disease outbreak and mode of transmission. 10. Monitor for effectiveness of investigation and control measures until cases cease to occur or return to usual levels. The LNHA failed to ensure these directives were being followed. A review of the facility provided, "Infection Control Policies and Procedures for [redacted]", effective 03/27/20 and revised 12/07/22. The Policy revealed: General Standard Precautions: 9. Follow CDC published guidance related to the use of facemasks, respirators, gowns, gloves, and eye protection. Education: 31. Provide [redacted] education as indicated to employees, patients, and visitors. The LNHA failed to ensure these directives were being followed. NJAC 8:39- 19.1(a); 19.2(a)(c)	F 835		
F 880 SS=L	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.	F 880		4/11/23

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F 880	Continued From page 96 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 97 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Part A Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility, who has been in an active EX. Order 26.(4) B1 outbreak status since EX. Order 26.(4) B1, failed to ensure: a.) a system was in place and followed to prevent the spread of multidrug resistant infections (organisms resistant to multiple antibiotic treatments including EX. Order 26.(4) B1 [redacted]) and EX. Order 26.(4) B1 (a EXEX. Order 2 virus), and b.) facility policies and current infection control guidance was followed to limit the spread of infection. The breaches in infection control practices were observed by the survey team on 02/08/23, 02/09/23, and 02/10/23, for 4 of 4 Resident Wings and was evidenced by the	F 880	1.Immediate Jeopardy removal plan was submitted, accepted, and implemented. The F880 removal plan was accepted and verified as implemented during an onsite visit by the New Jersey Department of Health (NJDOH) surveyors on 2/10/23. All staff present in the facility have been educated on the proper use and donning and doffing of PPE, and hand hygiene process on 2/10/23. Meal trays have been removed from outside resident rooms and common areas on 2/10/23 . Precaution signage has been hung on the doors of residents who require precautions and dedicated equipment has	

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F 880	Continued From page 98 following: Reference: Centers for Medicare and Medicaid Services Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the [redacted] Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH DATE: August 26, 2020 REVISED 09/23/2022. Centers for Disease Control and Prevention, [redacted], Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the [redacted] Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022. The facility's system wide failure to ensure that infection control practices were implemented to mitigate the spread of [redacted] E, and [redacted] posed a serious and immediate risk to the health, safety and well-being of all residents who resided at the facility. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that began on 02/08/23 and was identified by the survey team on 02/10/23 at 4:07 PM. The Administrator was notified of the IJ on 02/10/23 at 4:08 PM A removal plan was accepted on 02/13/23 at 10:17 AM. The survey team verified the removal plan on 02/13/23 at 12:33 PM. On 02/08/23 at 9:08 AM during tour of the facility, surveyor #1 observed Resident #31's room on the	F 880	been placed in the room on 2/10/23. Blood glucose meters have been disinfected per manufacturer's guidelines and staff present in the building have been educated on the process of disinfection of multi- use equipment on 2/10/23. [redacted] surveillance was re-initiated on 2/8/23. 2. All residents have the potential of being affected by this deficient practice . 3. Infection Preventionist or designee will re-educate and competency staff on donning and doffing PPE, Hand Hygiene process for current staff, new hires and new agency staff. Infection Preventionist or designee will re-educate and competency on disinfecting blood glucose meters, and proper signage to place outside residents□ doors who are on precautions for current licensed staff, new hires and agency staff. Education was conducted on the in room meal tray removal system with current staff, new hires and agency staff by the Infection Preventionist or designee. Unit Manager or designee will re-educated licensed nurses on resident [redacted] surveillance during an outbreak.	

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F 880	Continued From page 99 EX. Orde Wing. Resident #31's room did not have any transmission-based precaution (TBP) signage, or PPE (personal protective equipment, including gowns, gloves, etc.) containers outside of the room and readily available. Surveyor #1, entered the room and attempted to interview Resident #31 at that time and the resident was EX. Order 26.(4) B1 and unable to be interviewed. On 02/02/23 at 10:00 AM, surveyor #1 returned to Resident #31's with a Certified Nursing Assistant (CNA) to perform an EX. Order 26.(4) B1 check. There was no PPE signage, or PPE available at the resident's room at that time. The surveyor entered the room with the CNA. The CNA was wearing an N95 respirator mask (filters out 95% of airborne particles), eye protection and gloves, and proceeded to re-position the resident, who was awake, and then check the resident's incontinence brief (disposable brief designed to collect urine and feces). The CNA completed the entire task without wearing a PPE gown. Surveyor #1 reviewed the medical record for Resident #31. Resident #31 was admitted to the facility with diagnoses which included but were not limited; EX. Order 26.(4) B1 . A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1, revealed Resident #31 required extensive assistance of at least one staff for toileting; was always EX. Order 26.(4) B1 and EX. Order 2 l and did not have any EX. Order 26.(4) B1 appliances. A review of a physician's order dated EX. Order 26.(4) B1, revealed the resident was ordered to be placed on contact precautions (procedures that reduce the risk of spread of infections through direct or indirect contact) for EX. Order 26.(4) B1 every shift. A review of the facility provided	F 880	Infection Preventionist or designee will re-educate and competency staff on hand hygiene. Infection Preventionist or designee will audit Donning and Doffing of PPE including hand hygiene weekly for four weeks then monthly for two months. Infection Preventionist or designee will audit residents who require precautions proper signage is hung on the door weekly for four weeks and monthly for two months. Unit Manager or designee will audit nurses disinfecting blood glucose meters weekly for four weeks then monthly for two months. Dietician or designee will audit meal tray removal process for residents on transmission based precautions weekly for four weeks then monthly for two months. Infection Preventionist or designee will audit COVID 19 resident symptom surveillance during an outbreak weekly for four weeks and monthly for two months. Infection Preventionist or designee will conduct staff hand hygiene audits weekly for four weeks and monthly for two months .	

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F 880	Continued From page 100 EX. Order 26.(4) B1 with a EX. Order 26.(4) B1 test, "Lab Results" reported EX. Order 26.(4) B1 revealed organism identification to include EX. Order 26.(4) B1. A review of the Medication Administration Report (MAR) for EX. Order 26.(4) B1 revealed Contact Precaution due to EX. Order 26.(4) B1, with a start date of EX. Order 26.(4) B1. There was no end date documented for the order, and staff were signing off as administered / completed from EX. Order 26.(4) B1 through EX. Order 26.(4) B1. A review of the MAR for EX. Order 26.(4) EX. CEX. O revealed Contact Precaution due to EX. Order 26.(4) B1, with a start date of EX. Order 26.(4) B1. There was no end date documented for the order, and staff were signing off as administered/completed from 01/01/23 through 01/31/23. A review of the MAR for EX. Order 26.(4) B1 revealed Contact Precaution due to EX. Order 26.(4) B1, with a start date of EX. Order 26.(4) B1. There was no end date documented for the order, and staff were signing off as administered/completed from 02/01/23 through 02/10/23, when the MAR was printed. A review of the on-going resident Care Plan (CP) including resolved areas, revealed no focus area, goal or interventions for or related to contact precautions and/or EX. Order 26.(4) B1. On 02/08/23 during tour of the facility, Surveyor #1, #2, and #3 observed Resident #88's room which was located on the EX. C Wing. Resident #88 did not have TBP signage or PPE readily available outside the resident's room. A review of Resident #88's medical record revealed a physician's order dated EX. Order 26.(4) B1 to be placed on contact precautions for EX. Order 26.(4) B1 every shift.	F 880	4.Results of audits will be discussed at the monthly Quality Assurance Performance Improvement meeting for three month with corrective actions needed or taken during the course of the audit.	

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F 880	Continued From page 101 On 02/08/23 at 8:40 AM on the [redacted] Wing, Surveyor #3 observed a Registered Nurse (RN) entering a [redacted] resident room. The RN was wearing only an N95 (a respirator mask that filters 95% of airborne particles) mask and eye protection. The [redacted] room had signage posted on the door which indicated what the TBP were and what PPE was required to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included, but was not limited to, performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The RN failed to follow the posted guidance and don (put on) a PPE gown or gloves. On 02/08/23 at 9:15 AM on the [redacted] Wing, Surveyor #1 observed CNA #1 who was wearing an N95 mask and eye protection. CNA #1 donned a PPE gown, but failed to secure the back of the gown, and failed to don gloves. CNA #1 proceeded to pick up a meal tray and then entered a [redacted] resident room. The [redacted] room had signage on the door to indicate what the TBP was and what PPE needed to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to; performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. Surveyor #1 also observed CNA #2 wearing an N95 mask and eye protection. CNA #2 picked up a PPE gown and	F 880		

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F 880	Continued From page 102 entered the same EX. Order 26.(4) B1 resident positive room without first donning the PPE gown as indicated by signage. On 02/08/23 at 9:20 AM, Surveyor #1 observed the Director of Nursing (DON) on the EX. Orde Wing. During an interview at the time, the DON stated the staff should put all the required PPE on before entering a room. She stated the PPE gown needed to be secured in the back to keep the person protected, and that once someone entered a TBP room, they would be considered "dirty". The DON stated she would send the Assistant Director of Nursing Infection Preventionist (ADON IP) over. On 02/08/23 at 9:28 AM, the ADON IP and the RN in training for IP arrived on the EX. Orde Wing. Both were made aware of the surveyor's observations. The surveyor observed both were wearing N95 masks and eye protection. The ADON IP stated staff must put the required PPE on outside of the TBP room and then tie the PPE gown in the back for protection. At that time, Surveyor #1 observed the ADON IP enter the same EX. Order 26.(4) B1 EX. Order 26.(4) resident room without wearing a PPE gown or gloves. The EX. Order 26.(4) B1 room had signage affixed to the door which indicated what the TBP was and what PPE was required to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room.	F 880		

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On 02/08/23 at 9:37 AM, CNA #2 exited the EX. Order Wing EX. Order 26.(4) B1 resident room and was interviewed by Surveyor #1 at that time. CNA #2 stated she had worked at the facility for EX. O years and had been educated on PPE. CNA #2 stated she thought she was in the way, so she stepped inside the room to don her PPE gown. CNA #2 stated should not have entered the room without first putting on the PPE in order to protect herself and the residents.

On 02/08/23 at 9:39 AM, CNA #1 exited the EX. Orde Wing EX. Order 26.(4) B1 resident room and was interviewed by Surveyor #1. CNA #1 stated she had worked at the facility for EX. O years and had received training on PPE. CNA #1 stated she should have been wearing gloves, and that the PPE gown should have been tied in the back, but sometimes the ties become loose. Surveyor #1 asked what the process would be in the PPE gown became loose while in a TBP room. CNA #1 stated she should put her PPE gown in the hamper and then get a new one.

On 02/08/23 at 9:50 AM on the EX. Or Wing, Surveyor #3 observed the RN training for IP in the hallway. The RN donned gloves to pick up trash from the floor and then disposed of the trash. She then removed the gloves and touched a resident meal tray and had not performed hand hygiene or changed gloves. Surveyor #3 approached the RN training for IP and interviewed her. The RN stated, "I probably should not have touched his/her tray". The RN then used the ABHR located in the hallway to sanitize her hands.

On 02/08/23 at 10:28 AM on the EX. Or Wing, Surveyor #2 observed CNA #3 exit a EX. Order 26.(4) B1

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EX. Order 26.(4) room wearing gloves and an N95 mask which had been positioned down on her face not and was not fully covering her nose. The EX. Order 26.(4) B1 resident room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. CNA #3 was carrying a meal tray that was not bagged and proceeded to place the meal tray directly on top of the shredder bin that was located in front of the nurse's station in the common area accessible to all nursing wings, and where residents were gathered. CNA #3 was observed moving the N95 mask up on her face multiple times.

During an interview at that time, CNA #3 stated to the surveyor that normally she would have taken off her gloves, and that she had been fit tested for her N95 mask, but that it kept sliding down on her face. CNA #3 further stated there were no meal tray trucks, so she placed the meal tray on the shredder box.

At 10:33 AM, Surveyor #2 observed CNA #3 enter the staff bathroom to wash her hands. CNA #3 turned on the water, applied soap and lathered her hands for 10 seconds with her hands under the running water.

During an interview at that time, CNA #3 stated to the surveyor that the process was to lather her hands for 20 seconds.

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On 02/08/23 at 10:58 AM on the 1st wing, Surveyor #1 and #2 observed a laundry aide while she was walking down the hall and wearing a PPE gown which was not secured in the back, an N95 mask and eye protection. The laundry aide then entered a EX. Order 26.(4) B1 resident room and through an open door, the surveyors observed her touch multiple environmental surfaces including a dresser, and folded clothes, and proceeded to go to the other side of the room and touch other surfaces, including the furniture. She exited the room without first removing gloves, and performing hand hygiene. The EX. Order 26.(4) B1 room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to; performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The laundry aide did not perform hand hygiene upon exiting the room and proceeded to continue to wear the same gloves as she walked to the hallway of Wing #1.

During an interview at that time, the laundry aide stated she had worked at the facility for 25 years and had been educated on PPE. The laundry aide confirmed it was her practice to wear the PPE gown through the hallway and stated the PPE gown should be tied in the back for protection. The laundry aide stated, "Sorry I forgot" when asked about if she should have been wearing gloves through the hallway.

On 02/08/23 at 11:12 AM, during the entrance conference conducted with the Licensed Nursing

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Home Administrator (LNHA) and Director of Nursing (DON) the survey team was informed that the facility was currently experiencing a EX. Order 26.(4) B1 outbreak and there were EX. Order 26.(4) B1 positive residents. The facility provided line list verified the COVID-19 outbreak began on EX. Order 26.(4) B1.

On 02/08/23 at 12:25 PM on the EX. Order wing, Surveyor #1 observed a recreation aide wearing an N95 mask, eye protection and a PPE gown. The recreation aide entered a EX. Order 26.(4) B1 resident room (Resident #95) without wearing gloves and was carrying a lunch meal tray. The EX. Order 26.(4) B1 room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The recreation aide placed the meal tray on the resident's over bed table and then moved the over bed table towards the resident with her bare hands.

At 1:08 PM, the recreation aide exited the room and was interviewed by Surveyor #1. She stated she had worked at the facility for EX. O years and had been educated on PPE and EX. Order 26.(4) B1. She further stated, "I didn't see gloves. It was my mistake, sorry".

On 02/09/23 at 9:08 AM, Surveyor #1 observed Resident #31's room and there was no TBP signage or PPE readily available. At that time the surveyor reviewed the medical record for

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F 880	Continued From page 107 Resident #31 which revealed an order dated EX. Order 26.(4) B1 for contact precaution for EX. Order 26.(4) B1 EX. Order 26. On 02/09/23 at 9:13 AM on the EX. Order Wing, Surveyor #3 observed RN #2 wearing an N95 mask and eye protection. RN #2 donned a PPE gown and gloves and entered a EX. Order 26.(4) B1 positive resident room. The EX. Order 26.(4) B1 room had signage on the door to indicate what the TBP was and what PPE was required to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. RN #2 then exited the EX. Order 26.(4) B1 resident room wearing the same PPE gown which was not removed prior to exiting the room. On 02/09/23 at 11:39 AM, during an interview with Surveyor #1 and #2, the DON, in the presence of the LNHA, stated the facility had completed infection control audits and staff was educated to mitigate the spread of infection. The surveyors inquired to the DON for any documentation regarding the audits and education. The DON was unable to provide documentation and stated that the facility recently implemented a form that was used for audits, and the DON stated "I don't know if they are always using it [form]". On 02/09/23 at 11:43 AM, the ADON IP stated she had been in contact with the Local Health Department (LHD) either, "today, yesterday or the other day". She stated that the LHD had provided	F 880		

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her with the Communicable Disease Services (CDS), "EX. Order 26.(4) B1 Patient/Resident Management in Post-acute Care Settings" guidance dated 01/23/23.

On 02/09/23 at 12:30 PM, Surveyor #3 observed a resident who had tested positive for EX. Order 26.(4) B1 and was seated in the facility Atrium at a table. The surveyor went to the 3rd Wing to verify that resident was the EX. Order 26.(4) B1 resident who was on TBP. The resident's room door was observed open. Staff were not aware that the resident had left the room and was seated in the Atrium waiting for the lunch tray. The RN in training for IP observed the resident in the Atrium and then escorted the resident back to the unit. While being escorted to his/her room, Surveyor #3 heard the resident EX. Order 26.(4) B1 The staff confirmed that the resident was symptomatic and had been complaining of a headache also. During a subsequent surveyor interview, the RN in training for IP did not know or was not aware that the table the EX. Order 26.(4) B1 resident was sitting at, needed to be disinfected.

On 02/10/23 at 7:43 A.M. to through 8:22 A.M. on the EX. Ord Wing, Surveyor #1 observed a Registered Nurse (RN) #1 during a medication administration and observed the following:

RN #1 walked up and down the EX. Ord Wing, administered medications to five residents and was within arm's length of the residents. The RN wore her eye protection on the top of her head offering no eye or face coverage or protection during her medication administration. At 8:22 AM, during an interview with Surveyor #1, RN #1 stated eye protection should be worn down over the eyes for protection.

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On 02/10/23 at 8:36 AM, RN #1 entered Resident #31's room. RN #1 was wearing an N95 mask and eye protection. RN #1 then picked up a pillow from floor with gloves on, helped the resident take a sip of their protein drink by touching the resident's head and environment, and then administered medications. RN #1 was not wearing a PPE gown and there was no TBP signage on the door. Surveyor #1 had conducted a medical record review on 02/09/23, for Resident #31 and there was a physician's order for contact precautions to be observed.

On 02/10/23 at 9:28 AM in the presence of three surveyors, the LNHA, DON, and ADON IP were interviewed in the conference room. The DON stated there were no TBP residents other than EX. Order 26.(4) B1 on the [redacted] wing, [redacted] wing, or [redacted] wing. The DON stated there were only two residents located on the [redacted] wing with TBP other than [redacted]. The DON further stated that "someone" would let her know if there was an abnormal test result requiring TBP that she was not aware of. The DON stated that the staff would talk in clinical meeting and the physician would decide what TBP to order. After that, it would be the ADON IP's responsibility to put the signage up or have the nurse on the unit place the signage on the door. The DON stated the information would be communicated in the shift to shift report. The ADON IP stated nurses give report to other nurses and CNAs and that would be how the staff would know about TBP. The DON stated that contact precaution would require a PPE gown, gloves, N95 mask and eye protection; and that enhanced barrier and droplet precautions required "everything" PPE. The ADON IP stated the facility kept an antibiotic listing but, "infections

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were not tracked for every patient unless an antibiotic was ordered."

A review of the facility provided list, "Resident's on precaution other than EX. Order 26.(4) B1" undated, but provided on 02/10/23, revealed two residents and their room numbers. The surveyor team identified that the first resident noted was on contact precautions for EX. Order 26.(4) B1 and the second resident noted was on contact precautions for EX. Order 26 and EX. Order. Resident #31 and Resident #88 were not included on the facility provided list as the DON, ADON IIP, and LNHA were not aware of the physician ordered contact precautions for EX. Order 26.(and EX. Order 26.(

On 02/10/23 at 9:58 AM, Surveyor #1 interviewed RN #1 who stated there were no residents that required contact precautions on the EX. Order Wing. RN #1 stated she would know that information because there would be signs posted on the door and the ADON IP would have put up the signs.

On 02/10/23 at 9:59 AM, CNA #5 stated to the surveyor that there were no other residents on TBP besides EX. Order 26.(4) B1 on the EX. Orde wing. She further stated that if there were any other residents requiring TBP, the nurse would let the CNAs know during report and there would be a sign on the door also.

On 02/10/2023 at 10:49 AM on Wing EX of the facility, Surveyor #4 observed a housekeeper wearing an N95 mask and a face shield. The housekeeper was observed to don a PPE gown and gloves, enter a resident room, picking up soiled gowns and collecting soiled gowns in a see-through plastic bag. The housekeeper doffed

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(removed) his PPE gown and gloves inside the resident room, brought the bag with soiled PPE out into a cart in the hall and next sanitized his hands. The housekeeper was next observed in the doorway of a EX. Order 26.(4) B1 resident room wearing an N95 mask and face shield. The EX. Order 26.(4) B1 room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to; performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The housekeeper had not donned a PPE gown or gloves. The housekeeper was using his bare hands to tie a plastic bag that contained used, soiled PPE gowns. The housekeeper then brought the plastic bag filled with soiled PPE gowns out into the hallway and placed the bag on top of the housekeeping cart. Surveyor #4 asked the housekeeper what the process was for collecting soiled gowns in resident rooms for residents were on droplet precautions or any transmission-based precautions (TBP)? The housekeeper stated that he followed directions from his administrator. The housekeeper was unwilling to answer any additional questions from the surveyor and stated, "please let me get back to work and do my job."

On 02/10/23 at 11:30 AM, Surveyor #3 observed CNA #4 in the EX. Order Wing hallway. CNA #4 reached inside a TBP room and picked up the breakfast meal tray without donning gloves.

On 02/10/23 at 11:35 AM, Surveyor #3 observed

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a breakfast meal tray bagged and placed on the EX. Or Wing hallway shredder. Surveyor #3 read the name and verified the tray came from an isolation TBP resident room.

On 02/10/23 at 12:02 PM, Surveyor #4 asked the LNHA what the process was for collecting used or soiled gowns from EX. Order 26.(4) B1 resident rooms and other TBP resident rooms. The LNHA stated that she would have to check what the process was and would provide the surveyor with the policy.

On 02/10/23 at 2:00 PM, the LNHA provided the surveyor with a policy on the laundry process for collecting biohazard laundry. A review of the policy titled, "The Laundry Process" dated 01/01/2000, indicated that the Laundry Department was responsible for the safe and proper collection, cleaning, and distribution of linens within the nursing home. At designated times, laundry workers using a large bin with lid, marked "For Soiled Linen Use Only" will go to each Soiled Linen Room to pick up the soiled linen. The policy did not indicate for housekeeping to collect soiled gowns from EX. Order 26.(4) B1 resident rooms or other TBP resident rooms.

On 02/10/23 at 12:58 PM, the survey team again requested from the LNHA staff education on infection control. The LNHA stated, "I thought I told you I gave you all the education I had to give." Surveyor #1 asked if the few in services she provided encompassed the entire facility staff. The LNHA stated she was not sure and, "I guess I can have nursing give you the book to see.".

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At 1:23 PM, the ADON IP and RN in training for IP were in the conference room with three surveyors. The ADON IP stated in services and education for staff regarding infection control was "on and off" and "whenever I get a chance." The ADON IP stated there was not always a sign in sheets to identify who received education or what the education was provided.

At 1:25 PM, Surveyor #3 inquired if a resident tested EX. Order 26.(4) B1 and had a room mate, what would the process be. The ADON IP stated the facility would remove the roommate without EX. Order 26.(4) B1 and place them into another room. She stated if the roommate was unvaccinated, they would, "test them, move them, monitor them, and place them on empiric TBP which means if they become symptomatic, they would be put on isolation until the facility could be sure they were not EX. Order 26.(4) B1." The ADON IP stated the staff were educated to care for the "well" resident first unless, "something comes up". She stated that trying to have dedicated EX. Order 26.(4) B1 staff was, "challenging, which means very difficult. We (facility) don't have enough staff sometimes".

The RN in training for IP stated that as long as the staff followed the TBP, they "should be ok".

At 1:38 PM, the ADON IP stated the EX. Order 26.(4) B1 outbreak started the end of EX. Order 26.(4) B1 and, "we are not in the big numbers of EX. Order 26.(4)". When asked what she had implemented since the start of the outbreak, the ADON IP stated, "we have a form of auditing". She stated supervisors also do education and, "I think there are in services on the nursing units."

On 02/10/23 at 2:12 PM in the presence of three

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surveyors, the DON stated that since the facility outbreak, the facility had tried to have dedicated EX. Order 26.(4) B1 staff but were unable to. The DON acknowledged that all four wings had both well and ill residents. The LNHA was also present and stated that the facility did not have enough equipment to provide dedicated equipment to residents on TBP.

On 02/14/2023 at 11:03 AM during an interview with Surveyor #4, the Director of Housekeeping stated that housekeeping was responsible for picking up soiled gowns from EX. Order 26.(4) B1 resident rooms. He stated the process was to don a PPE gown, gloves, N95 mask, and face shield to enter the room. The resident's bin for disposal of soiled PPE gowns had a plastic bag. The housekeeper would tie the dirty bag and hand the bag to a second person outside the room. The second staff would be holding a clean plastic bag for the housekeeper to drop the tied bag of soiled gowns into so it would be double bagged. The second person standing outside the room would then dispose of the double bagged linen into the linen bin in the hallway. The Director of Housekeeping demonstrated the process and showed the surveyor the different bins in the hallway of Wing [redacted]. One bin for trash, two bins for soiled gowns and/or linen, and a third bin for resident's personal clothes.

A review of the facility provided, "Outbreak Response Plan", undated, included but was not limited to 1.b. Control Measures.....frequent COVID-19 in-services and handwashing as well as PPE education and competencies.

A review of the facility provided, "Outbreak Investigation/Management" policy and procedure

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revised 02/01/23, included but was not limited to Purpose to manage and contain disease/condition outbreak when identified. Case definitions included [redacted] and [redacted] 7. Implement control measures based on signs, mode of transmission. Measures may include standard and transmission-based precautions. 8. Conduct station education/competencies..... include hand hygiene, donning and doffing PPE, transmission precautions, MDRO.

A review of the facility provided, "Modified Enhanced Barrier Precautions" revised 11/15/21, included but was not limited to Policy: In addition to standard precautions, modified enhanced barrier precautions and contact precautions will be used for MDROs. 5. post the appropriate enhanced barrier precautions or contact precautions sign on the patient's room door. Contact Precautions: required PPE: gloves and gown (don before room entry, doff before room exit; change before caring for another patient) face protection may also be needed if performing activity with risk of splash or spray. 9. Before exiting room, remove and place PPE in trash and perform hand hygiene upon exiting room. 16. Document: type of precautions in care plan. Specific MDRO identification in special instructions section of [redacted] (electronic medical record).

Review of the CDS, "COVID-19 Patient/Resident Management in Post-acute Care Settings" guidance dated 01/23/23, provided to the ADON IP by the LHD, included but was not limited to, "When resources permit, facilities should dedicate equipment to individual cohorts. Equipment should not be shared between individuals on TBP and those cared for with

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F 880	Continued From page 116 standard precautions. If this is not possible, equipment should be used by rounding in a "well to ill" flow to minimize the risk of cross-contamination." A review of the facility provided, EX. Order 26.(4) B1 policy and procedure revised 12/07/22, included but was not limited to Policy: in addition to standard precautions, special droplet and contact precautions will be implemented for patients suspected or confirmed with EX. Order 26.(4) B1. Special droplet and contact precautions requires wearing a N95 respirator upon entry.....in addition to the recommended PPE. Definition: all recommended PPE (gown, gloves, eye protection, respirator) while present in the room. Infection Surveillance: 6.2 during an outbreak, the EX. Order 26.(4) B1 screen will be completed each shift. Part B The non-compliance remained on 02/27/23 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Based on observation, interview, record review and document review it was determined that the facility failed to ensure the faciliy policy for infection surveillance during an outbreak was followed by completing a EX. Order 26.(4) B1 resident screening each shift (for 4 of 4 Wings), and ensure staff performed hand hygiene as indicated on 1 of 4 Wings. The deficient practice was evidenced by the following: Reference:	F 880		

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Centers for Medicare and Medicaid Services Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the EX. Order 26.(4) B1 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH DATE: August 26, 2020 REVISED 09/23/2022.

Centers for Disease Control and Prevention, EX. Order 26.(4) B1, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the EX. Order 26.(4) B1 Disease 2019 (EX. Order 26.(4) B1) Pandemic, Updated Sept. 23, 2022.

On 02/08/23 at 11:22 AM, during the entrance conference held with the facility Administrator (LNHA) and Director of Nursing (DON), the LNHA informed Surveyor #2 that the facility was currently experiencing an outbreak that began on EX. Order 26.(4) B1. The DON informed the surveyor that there were currently twenty-seven EX. Order 26.(4) B1 residents. Surveyor #2 inquired about any EX. Order 26.(4) B1 testing in progress and the DON stated that per facility policy employees and residents were tested twice per week on Tuesday and Thursday, and "only" employees would be tested for a EX. Order 26.(4) B1.

On 02/09/23 at 11:33 AM, the LNHA provided the survey team with a copy of the current Infection Control Policies and Procedures for EX. Order 26.(4) B1 Effective 03/27/20 and Revised 12/07/22. The Policy revealed: the facility follows the CDC published guidance for patient and/or healthcare personnel (HCP) with suspected EX. Order 26.(4) B1 Infection Surveillance: 6. Complete the EX. Order 26.(4) B1 Screen UDA in the electronic medical record to monitor patients each shift (or twice daily if permitted by state) for fever and signs/symptoms

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of EX. Order 26.(4) B1. 6.2. During an outbreak, the EX. Order 26.(4) B1 screen will be completed each shift.

On 02/14/23 at 10:40 AM, Surveyor #2 interviewed the facility Assistant Director of Nursing, Infection Preventionist (ADON IP) and DON, who stated there were four new EX. Order 26.(4) B1 cases, that were discovered during routine, not outbreak testing, that was held on Tuesday and Thursday. The surveyor asked if the residents were monitored for EX. Order 26.(4) B1 symptoms. The DON stated that EX. Order 26.(4) B1 monitoring was completed once daily on the 11-7 shift. The surveyor asked where that documentation would be located, and the DON stated "maybe" in the medication administration record or assessment, it would not be in the progress note. She stated it would include the oxygen saturation, temperature, and any new signs of cough or congestion.

At that time, Surveyor #2 reviewed an electronic medical record for an unsampled resident from Wing B who was symptomatic with a cough and tested EX. Order 26.(4) B1 on EX. Order 26.(4) B1 There was no EX. Order 26.(4) B1 9 symptom monitoring documented each shift and a progress note completed by a Registered Nurse (RN) revealed a Daily EX. Order 26.(4) B1 screen, Effective 02/10/2023 at :52 (12:52 AM), Daily EX. Order 26.(4) B1 Screen every night shift if symptoms present, place screen order on hold, Complete E-Interact (electronic form) change in condition and contact provider. Resume Screen when transmission-based precautions are discontinues, no symptoms noted.

On 02/14/23 at 11:01 AM, the DON stated the resident EX. Order 26.(4) B1 screening was "put on hold

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today", and if someone was (were [redacted]) positive it would pop up on a dashboard.

On 02/14/23 at 11:36 AM, Surveyor #2 requested from the DON, with the LNHA present, a copy of the policy for monitoring residents' symptoms. The DON stated she was still looking for a policy for symptom monitoring.

On 02/15/23 at 9:05 AM, while interviewing a CNA in the [redacted] Wing hallway, Surveyor #3 observed the RN picked up a medication cup from the floor and place it on the medication cart. The RN did not wash her hands and left the soiled medication cup on the medication cart in use. The RN then moved the medication cart to the next resident room and started touching other medication cups located on the medication cart.

On 02/15/23 at 10:00 AM, Surveyor #3 reviewed with the IP in training the audits she had completed on 02/06/23 and 02/07/23. A review of the audits revealed that the facility identified concerns with respiratory hygiene, cough etiquette, hand hygiene, donning and doffing, staff not changing gloves after each resident, PPE not readily accessible, staff not consistently wearing the appropriate PPE. The IP in training stated that concerns she could address, she took immediate actions, which included replenishing the PPE bins. She stated she did not initiate any in-service education following the audits dated 02/06/23 and 02/07/23. She further stated that the infection control audits were forwarded to the LNHA at that time.

A review of the facility's policy titled, " Hand Hygiene dated 02/05/01 and last revised 11/15/22 revealed:

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F 880	Continued From page 120 Policy : Adherence to hand hygiene practices is maintained by all Center Personnel. This includes hand washing with soap and water when visibly soiled and after exposure to known or suspected Clostridium difficile or infectious diarrhea (e.g., Norovirus) and the use of alcohol based hand rubs for routine decontamination in clinical situations. Per the Centers for Disease Control and Prevention (CDC) when hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for hand hygiene. Alcohol based hand rubs will be placed near entrances and in common area. Purpose: To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. Process 1. Perform hand hygiene : 1.1 Before patient care; 1.2 Before an aseptic procedure; 1.3 After any contact with blood or other body fluid, even if gloves are worn; 1.4 After patient care; 1.5 After contact with the environment. 2. Hand hygiene techniques: 2.1 To wash hands with soap and water: Wet hands (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds. covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use towel to turn off faucet. 2.2 To decontaminate hands with alcohol based rub: Apply products to palm of one hands and rub hands together, covering all surfaces of the hands and fingers until the hands are dry. Follow manufacturer's instructions for amount and application of product.	F 880		

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F 880	Continued From page 121 A review of the facility provided, "Infection Control Outcome and Process Surveillance and Reporting" revised 11/18/17, included but was not limited to: Process surveillance include monitoring of compliance with transmission-based precautions, proper hand hygiene, the use and disposal of gloves, and observation of the environment On 02/14/23 at 2:06 PM, the DON provided the survey team with an updated Infection Control Policies and Procedures for [redacted], Effective 03/27/20 and Revised, 02/14/23. This new policy revealed 6. Complete the [redacted] Screen in the electronic medical record to monitor patients for fever and signs/symptoms of [redacted]. The policy did not indicate how often this process should be conducted. On 02/17/23 at 9:35 AM, Surveyor #2 interviewed the ADON IP and DON and asked them if the facility was still in a [redacted] outbreak. The DON stated "yes". NJAC 8:39-19.4, 27.1	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	F 881		4/11/23

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F 881	Continued From page 122 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent documentation, it was determined that the facility failed to follow facility policy and ensure the implementation of a comprehensive antibiotic stewardship program (ASP). This deficient practice was identified during a review for 3 of 3 months of the facility Infection Control Monthly Line Listing tracking forms (December 2022, January 2023, and February 2023). The deficient practice was evidenced by the following: On 02/08/23 at 11:12 AM during entrance conference, the Licensed Nursing Home Administrator (LNHA) stated that the facility was in a current outbreak of [redacted] A review of the facility provided line list revealed the outbreak began 10/23/22. On 02/10/23 at 2:48 PM, the ADON IP provided Surveyor #1 with Infection Control Monthly Line Listing forms for December 2022, January 2023, and February 2023 up to 02/10/23. A review of the Infection Control Monthly Line Listing form revealed the following information to be documented: Name; Room #; Admit date; Date onset; HAI (healthcare acquired)/C (community acquired); type of symptoms/diagnosis; Culture/Chest x-ray: date taken, site, results; Treatments: abt (antibiotic) type, start date; precaution type; and infection resolved. A review of the December 2022 Line Listing revealed 18 resident entries documented. The facility failed to document the following:	F 881	1. The monthly infection control line listings were updated and completed for December 2022, January 2023 and February 2023. 2. All residents have the potential to be affected by the deficient practice. 3. The Regional Nurse Consultant re-educated the Medical Director, Administrator, Director of Nursing and the Infection Preventionist on the antibiotic stewardship program on 3/23/23. The Infection Preventionist or designee will audit the line listing weekly for four weeks then monthly for two months. 4. The results of the audit will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the course of the audit.	

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Nine of 18 admit dates. Eleven of 18 date onset. Ten of 18 HAI/C. Three of 18 type of symptoms/diagnosis. Seven of 18 abt start date. Eighteen of 18 infection resolve date.

A review of the January 2023 Line Listing revealed 20 resident entries documented. The facility failed to document the following:

Eighteen of 20 admit dates. Fifteen of 20 date onset. Five of 20 HAI/C. Five of 20 start date. Twenty of 20 infection resolve date.

A review of the February 2023 Line Listing revealed four resident entries documented. The facility failed to document the following:

Three of 4 admit dates. Two of 4 date onset. Two of 4 HAI/C. One of 4 without the resident's full name.

The January 2023 Infection Control Monthly Line List revealed Resident #26 had a date onset of EX. Order 26.(4) B1, a diagnosis of EX. Order 26.(4) B1, no EX. Order 26.(4) B1 documented, the EX. Order 26.(4) B1", a start date of EX. Order 26.(4) B1, and "contact" precaution type. The form failed to document if the infection had resolved.

A review of the medical record revealed that Resident #26 had been admitted with diagnoses which included, but were not limited to EX. Order 26.(4) B1. A review of the, "Order Summary Report" dated EX. Order 26.(4) B1, failed to list EX. Order 26.(4) B1 or any EX. Order 26.(4) B1 order. A review of the Medication Administration Record (MAR) dated EX. Order 26.(4) B1, revealed an order for

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EX. Order 26.(4) B1 milligram (mg) give 1 capsule by mouth two times a day for EX. Order 26.(4) B1 for 5 days. Start date EX. Order 26.(4) B1. A review of the EX. Order 26.(4) B1 MAR revealed an order for EX. Order EX. Order 26.(4) B1 milligram (mg) give 1 capsule by mouth two times a day for EX. Order 26.(4) B1 for [redacted] days. Start date EX. Order 26.(4) B1 with no end date documented. The medication was signed off as administered until EX. Order 26.(4) B1. A review of the Progress Notes (PN) revealed a PN dated EX. Order 26.(4) B1 for EX. Order (EX. Order 26.(4) B1)". "EX. Order 26.(4) B1) started for EX. Order. A PN dated EX. Order 26.(4) B1 revealed "EX. Order 26.(4) B1 for EX. Order 26.(4) B1. A PN dated EX. Order 26.(4) B1, EX. Order 26.(4) B1 for EX. Order 26.(4) B1. The EX. Order 26.(4) B1 was documented [redacted] days post EX. Order 26.(4) B1 and did not address if the EX. Order 26.(4) B1 had been resolved.

On 02/24/23 at 9:27 AM, the DON stated to the survey team that the ADON IP was responsible for the ASP. The ADON IP was not available to be interviewed. The DON and the surveyor reviewed the Infection Control Monthly Line Listing forms the ADON IP had provided. The DON stated that the forms were not complete. When asked about specific residents on the Line Listing forms with incomplete information, the DON stated to the surveyors that she was unaware of where the ADON IP kept all the antibiotic stewardship Line Listing forms.

The DON further stated she was responsible for the ASP the week of 01/29/23 through 02/08/23, "but I did not fill out any forms". Surveyor #1 asked the DON about Resident #26 who was added to the Line Listing on EX. Order 26.(4) B1 while the DON was responsible for the ASP. The DON stated that she did not fill out any form to address if the infection was resolved. The DON stated, "I

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don't have anything in the book" and that "we talk about it as a clinical team". The surveyor asked the DON how an antibiotic would be tracked and monitored if it was not documented. The DON stated to the survey team that the facility would not want to put residents on antibiotics if they were not needed. The surveyor asked the DON about the Line Listing form from February 2023 which failed to document a resident's first name. The DON stated that a resident's complete name should be on the form. The DON stated to the survey team, that the facility would track and document responses to antibiotics such as any side effects, symptoms being resolved, and results from the hospital. The surveyor asked to be provided with the documentation for the resident listed with no first name. The DON stated, "I'm looking to see what the nurses documented" and "I don't see where they (nurses) documented anything". The DON stated that the facility should have observed and assessed how the resident was responding to the antibiotic. The surveyor reviewed the facility ASP with the DON.

A review of the facility provided, "Antibiotic Stewardship Program revised 11/07/17, included but was not limited to the ASP was based upon the CDC's Core Elements of Antibiotic Stewardship for Nursing Homes. The Core Elements listed were leadership, accountability, drug expertise, action, tracking, reporting, and education. Infection Preventionist monitors and supports through rounds, review of provider orders, documentation and available [redacted] (electronic medical records)/pharmacy/lab reports. Monitors HAI MDROs on Monthly Line Listing. Tracking: monitor both antibiotic use practices and outcomes related to antibiotics in

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F 881	Continued From page 126 order to guide practice and changes and track the impact of new interventions. Clinical evaluation documentation (i.e., signs/symptoms, vital signs, physical exam findings). Monitoring outcomes of antibiotic use. Education: educational programs will be provided to both nursing staff and clinical providers on the goals of the antibiotic stewardship program. The surveyor asked the DON where the accountability of the ASP would be. The DON stated the accountability would be in the education of the staff and the follow up, "but I don't have that". Surveyor #1 asked the DON about the resident clinical response documentation. The DON stated, "I don't know if we have that. I have not done it". The DON stated that it was important to perform a time out (stopping an antibiotic) to see if the antibiotic was appropriate. The DON stated that someone could build up a resistance to antibiotics if the antibiotic was not appropriate for the diagnosis. She further stated that she would look for trends like the same bacteria in the same Wing to determine if hand hygiene was a concern. NJAC 8:39-19.4, 27.1	F 881		
F 886 SS=K	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886		4/11/23

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F 886	Continued From page 127 §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the	F 886		

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F 886	Continued From page 128 transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility, who was experiencing an outbreak of COVID-19 (a potentially deadly virus) failed to take immediate action to prevent the spread of COVID-19 by failing to: a.) follow facility policy and pertinent guidance to conduct immediate COVID-19 testing for residents by either, a broad-based or contact tracing approach when two Certified Nurse Aide's (CNA #1) who was symptomatic with a [redacted] and [redacted] worked on Wing [redacted] tested EX. Order 26.(4) B1 on [redacted] and worked on [redacted] and [redacted], and CNA #2, who was symptomatic with a [redacted] and [redacted] tested EX. Order 26.(4) B1 on [redacted] and worked on Wing [redacted] on [redacted], b.) conduct immediate resident broad-based testing per facility policy on EX. Order 26.(4) B1 and [redacted], in response to a EX. Order 26.(4) B1 resident on Wing [redacted] (Resident #84), who tested [redacted] for [redacted] on [redacted], and conduct resident broad based testing on [redacted] in response to Resident #86 who EX. Order 26.(4) B1 for [redacted] on [redacted], and c.) ensure a process was followed to ensure all close contacts of a	F 886	1. Immediate Jeopardy removal plan was submitted, accepted, and implemented. The F886 removal plan was accepted and verified as implemented during an onsite visit by the New Jersey Department of Health (NJDOH) surveyors on 2/21/23. All residents and staff present in the facility were tested on 2/17/23. 2/17/23 results of resident testing revealed 1 additional positive case. Resident was placed on Transmission Based Precautions, contact tracing initiated, and cases were reported to the Department of Health on 2/17/23. Residents who had a high risk exposure have been placed on precautions and are tested on day 1, day 3 and day 5 and as needed. Contact tracing was conducted for the employees who tested positive on	

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F 886	Continued From page 129 dietary department employee (Employee #3), who was symptomatic and tested EX. Order 26.(4) B1 for EX. Order 26.(4) B1 on EX. Order 26.(4) B1, were identified and tested immediately (a Cook worked on EX. Order 26.(4) B1 and failed to receive a EX. Order 26.(4) B1 test on EX. Order 26.(4) B1 during routine facility testing and then proceeded to work on EX. Order 26.(4) B1, without first being tested for EX. OrdOrder 26.(4) B1). This deficient practice occurred for 3 of 3 employees (CNA #1, CNA #2 and Employee #3) and 2 of 5 residents reviewed for EX. Order 26.(4) B1 (Resident #84 & #86) and was evidence by the following: Reference: Centers for Medicare and Medicaid Services Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the EX. Order 26.(4) B1 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH DATE: August 26, 2020 REVISED 09/23/2022. Centers for Disease Control and Prevention, EX. Order 26.(4) B1 Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the EX. Order 26.(4) B1 Disease 2019 (EX. Order 26.(4) B1) Pandemic, Updated Sept. 23, 2022. Refer to F880 The failure to conduct immediate resident and staff testing upon utilizing either a broad- based approach or contact tracing approach, upon the identification of a single EX. Order 26.(4) B1 staff or resident result resulted in an Immediate Jeopardy (IJ) situation which began on 02/03/23 when the facility failed to conduct either immediate broad based testing, or contact tracing testing in response to CNA #1, who was	F 886	2/16/23. Administrator, Director of Nursing and Infection Preventionist were re-educated by Regional Nurse consultant regarding Federal, State and CDC guidelines regarding testing cadence and contact tracing requirements for Covid-19 on 2/17/23. 2.All residents and staff have the potential to be affected by this deficient practice. 3. Nurse educator or designee re-educated staff on Federal, State and CDC guidelines regarding testing cadence and contact tracing requirements. The Infection Preventionist or designee will audit testing cadence and contact tracing for COVID 19 for 4 weeks then monthly for two months. 4. Results of the audit will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the course of the audit.	

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symptomatic and also tested EX. Order 26.(4) B1 positive on EX. Order 26.(4) B1 and worked on EX. Order 26.(4) B1

The facility was notified of the IJ situation on 02/17/23 at 1:42 PM.

The removal plan was received on 02/17/23 at 8:52 PM, and accepted on 02/21/23 at 9:07 AM.

The removal plan was verified as implemented by the survey team on 02/21/23 at 1:08 PM.

On 02/08/23 at 11:22 AM, during the entrance conference held with the facility Administrator (LNHA) and Director of Nursing (DON), the LNHA informed the surveyor that the facility was currently experiencing an outbreak that began on EX. Order 26.(4) B1. The DON informed the surveyor that there were currently EX. Order 26.(4) B1 EX. Order 26.(4) B1 residents. The surveyor inquired about any EX. Order 26.(4) B1 testing in progress and the DON stated that employees and residents were tested twice per week on Tuesday and Thursday, and "only" employees would be tested for a EX. Order 26.(4) B1 exposure.

On 02/09/23 at 11:43 AM, the Assistant Director of Nursing, Infection Preventionist (ADON IP) stated she had been in contact with the Local Health Department (LHD) either, "today, yesterday, or the other day". She stated that the LHD had provided her with the Communicable Disease Services (CDS), "EX. Order 26.(4) B1 Patient/Resident Management in Post-acute Care Settings" guidance dated 01/23/23.

On 02/13/23 at 1:15 PM, the LNHA provided the survey team with a copy of the Centers for Disease Control and Prevention, EX. Order 26.(4) B1

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Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (EX. Order 26.(4) B1) Pandemic, Updated Sept. 23, 2022, which she stated was their reference for EX. Order 26.(4) B1 policies. The document revealed Perform SARS-CoV-2 Viral Testing; Anyone with even mild symptoms of EX. Order 26.(4) B1, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.; Asymptomatic patients with close contact with someone with SARS-CoV-2 should have a series of three viral tests for SARS-CoV-2 infection. Testing recommended immediately (but not earlier than 24 hours after the exposure), and if negative, again 48 hours after the first negative test and, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0, day 3, and day 5. Create a Process to Respond to SARS-CoV-2 Exposures Among HCP (Health Care Personnel) and Others; Healthcare Facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed.

On 02/14/23 at 12:56 PM, the surveyor asked the facility Assistant Director of Nursing Infection Preventionist (ADON IP) what the purpose was for identifying a close contact. The ADON IP stated, "to make sure the close contact will be aware and make sure they do not get sick" and we test the close contacts for EX. Order 26.(4) B1

On 02/14/23 at 1:56 PM, a surveyor conducted a telephone interview with the Registered Nurse from the Local Health Department (LHDRN). The LHDRN stated that she informed the facility to follow all Communicable Disease Services of the

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Department of Health guidance regarding the outbreak. The LHDRN stated she informed the facility ADON IP to follow contact tracing guidance and recommended if the facility was unable to perform contact tracing, they should have tested the whole floor or unit and/or the whole facility. She stated she informed the facility that EX. Order 26.(4) B1 testing should be completed on day 1, 5, and day 7.

On 02/14/23 at 2:06 PM, the DON provided the surveyor with the facility undated Performing Contact Tracing document. The document revealed contact tracing slows the spread of EX. Order 26.(4) B1 by: Letting people know they may have been exposed to EX. Order 26.(4) B1 and should monitor their health for signs and symptoms of EX. Order 26.(4) B1 Helping people who may have been exposed to EX. Order 26.(4) B1 get tested...A close contact is defined as. 1) someone who was within 6 feet of an infected person for a total of 15 minutes or more, and 2) laboratory confirmed or probable EX. Order 26.(4) B1 patients. This is regardless of wearing cloth face coverings and PPE. Testing is recommended for all close contacts of confirmed or probable EX. Order 26.(4) B1 patients...Contact Tracing Workflow for EX. Order 26.(4) B1, 1. Infected/suspected person interviewed; a. Include status 48 hours prior to exposure; b. Questions to ask regarding exposure: 1. Was the individual tested, 4. When eating (on breaks, etc.) were employees socially distanced, on per table (if appropriate) and facing the same direction...For more detailed information, see Key Information to Collect During a Case Interview from the CDC; 4. Fill out contact tracing log; a. Update information as soon as possible,; b. Infection Preventionist/Center leadership to maintain on Center Share Drive.

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On 02/15/23 at 9:54 AM, a surveyor interviewed the DON and ADON IP in the presence of the survey team. The surveyor inquired what the contact tracing process entailed. The ADON IP stated if a resident tested EX. Order 26.(4) B1 for EX. Order 26.(4) B1 that they would find out who the contacts were, who took care of the resident, and if there had been visitors. The ADON IP stated that they would go back and look for a forty-eight-hour period to determine the contacts. The ADON IP stated that when they determined the contacts, they would be tested for EX. Order 26.(4) B1 the day after the exposure, and then the third and fifth day after exposure.

On 02/17/23 at 8:56 AM, the DON provided the facility line listing (LL) to the survey team. The surveyor reviewed the LL which revealed that the initial Onset Date for the first listed Resident on the LL was EX. Order 26.(4) B1, not EX. Order 26.(4) B1 as indicated by the LNHA during the entrance conference, and listed four additional COVID positive staff which included a dietary staff (Employee #3) who was symptomatic with myalgia (EX. Order 26.(4) B1) and a EX. Order 26.(4) B1, and tested EX. Order 26.(4) B1 on EX. Order 26.(4) B1. The surveyor asked who was completing the contact tracing (a process to determine who came into contact with someone who had an infectious illness) and the DON stated the ADON IP was responsible for all the contact tracing.

On 02/17/23 at 9:18 AM, the surveyor interviewed the Food Service Director (FSD), regarding when he had been tested for EX. Order 26.(4) B1. The FSD stated yesterday (02/16/23) he was tested since it was Tuesday and was the routine testing day. The surveyor asked if he had been aware that Employee #3 was symptomatic, and stated he

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was not aware. The surveyor asked the FSD if the DON or ADON IP had asked any questions regarding Employee #3 which may have included who Employee #3 had come into contact with, and what her job functions consisted of. The FSD stated "no", that he had been informed that the Employee #3 tested EX. Order 26.(4) B1 for EX. Order 26.(4) B1, and that she needed to go home to quarantine. The surveyor asked what jobs Employee #3 was responsible for, in addition to the observations made by the surveyor on 02/15/23 from 11:37 AM to 12:08 PM when the surveyor observed Employee #3 who had been preparing resident meal trays on the tray-line and was also observed positioned opposite of the cook. The FSD stated that Employee #3 had also been responsible for serving meals to residents in the dining room and when asked what type of mask Employee #3 had worn, he stated a surgical mask.

On 02/17/23 at 9:23 AM, in the kitchen, the surveyor observed the cook, prepping food and was wearing a surgical mask that was not fully covering his nose. The surveyor asked the cook if he had been tested on 02/16/23 for EX. Order 26.(4) B1 The cook confirmed he had worked on 02/16/23 and stated, "no, not yesterday". The cook stated then he was supposed to come in today to get tested, and he went to the testing area and there was no one there to do his test and he started working.

On 02/17/23 at 9:25 AM, the surveyor, again, interviewed the FSD. The surveyor asked the FSD if he had been aware that the Cook was not tested for EX. Order 26.(4) B1 on 02/16/23. The FSD stated, "no, I was not aware" and "I was not told". The FSD stated that no one had told him that the Cook was not tested for EX. Order 26.(4) B1 during the

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routine testing conducted on 02/16/23.

On 02/17/23 at 9:35 AM, the surveyor, in the presence of the survey team, interviewed the IP and DON. The surveyor asked the DON if the facility was still in an outbreak, and she stated "yes". The surveyor asked what the process was for staff to be tested routinely. The ADON IP stated routine testing doesn't have to be done prior to the employees shift, only if the staff is symptomatic, they will be tested first. If a staff member was exposed, they should be tested the next day. The DON stated if staff were here on the routine testing days, they must be tested. The ADON IP then stated before the employee starts their shift, they must be tested, which was confirmed by the DON. The surveyor asked how they know everyone is tested; the DON stated they use a staffing sheet. The surveyor asked what the testing policy was for an outbreak. The ADON IP stated, "I don't know if there is a policy", there is no specific guidance other than if the person was exposed. The surveyor asked if the cook should have been tested on 02/16/23. The ADON IP stated that she didn't have the cook on the schedule and was unaware that he had worked with the DS forty-eight hours back from when she had tested positive for [redacted] on 02/16/23. The ADON IP stated the cook should have been tested yesterday and today (02/17/23) and stated, "I didn't know he wasn't tested".

On 02/17/23 at 9:50 AM, the surveyor asked the ADON IP, in the presence of the DON, what was process used to gather information regarding the contact tracing for the close contacts of Employee #3. The ADON IP stated she went to Employee #3 to ask who Employee #3 worked with and stated, "I don't really ask many questions

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to the supervisor, only to the person". The surveyor then asked the ADON IP if Employee #3 had direct contact with any residents, and the ADON IP stated she was unaware and that she had not asked the FSD that question. The surveyor asked if the supervisors should be questioned regarding staff responsibilities during contact tracing. The DON stated "yes", absolutely and supervisors should be included in the contact tracing process, and at that time the DON confirmed there was no documented process for completing contact tracing.

On 02/17/23 at 10:04 AM, the surveyor interviewed the FSD regarding what time Employee #3 was tested on 02/16/23. The FSD stated around 2:30 PM, and then Employee #3 left at 3:00 PM after working her full shift. The FSD stated he "tried" to get the staff to test earlier and sometimes there would be an overhead intercom announcement.

On 02/17/23 at 10:29 AM, the surveyor reviewed the LL which revealed Resident #84, who resided on Wing [redacted] was [redacted] tested [redacted] on [redacted]. The surveyor asked the DON what testing was completed in response to Resident #84 testing [redacted] The DON stated all residents were tested, and stated [redacted] was day zero, then day one was the next day. The surveyor asked the DON if a contact tracing or broad-based (testing individuals within a particular location, including facility wide, when all contacts who may have been exposed cannot be identified), and all the staff and residents were included. The surveyor asked the DON to confirm the date of testing completed for Resident #84. The DON stated [redacted] was the

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date that all of the EX. Order 26.(4) B1 testing was completed for Resident #84, and the surveyor asked to see all of the testing information. The DON looked on her computer, and stated, "I don't have anything for that date for that unit [Wing EX.], I don't see it there, no it was not done". The DON stated she had EX. Order 26.(4) B1 testing for EX. Order 26.(4) B1 (Thursday, a routine testing date), and stated EX. Order 26.(4) B1 (Saturday) would be day three of the required outbreak testing for Resident #84. The DON stated, "I don't have anything EX. Order 26.(4) B1 testing) listed there". The DON confirmed that the next broad-based EX. Order 26.(4) B1 testing day in response to Resident #84 would be for day five and that would be on EX. Order 26.(4) B1 (Monday). The DON stated, "I don't have anything listed for the EX. Order 2 no, I don't have it, if it was done it should be there, and everything should be entered in here (computer)".

The surveyor continued to review the LL which revealed, Resident #86, who resided on Wing 3, was asymptomatic and EX. Order 26.(4) B1 for EX. Order 26.(4) B1 on EX. Order 26.(4) B1. On 02/17/23 at 10:47 AM, the surveyor requested all testing that was completed regarding Resident #86 testing EX. Order 26.(4) B1 on EXEX. Order 26.(4). The DON stated that the broad-based testing should have been completed on EX. Order 26.(4) B1, which would have been the required day 1 testing. The DON stated, "it should have been done", and confirmed it was not completed and the DON stated she does not know why it was not completed, and she will look for it.

On 02/17/23 at 10:41 AM, a further review of the LL by the surveyor revealed two Certified Nurse Aide's, (CNA #1) who was EXEX. Order 26.(4) B1 with EX. Order 26.(4) B1, and who worked on Wing EX.

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tested EX. Order 26.(4) B1 on EX. Order 26.(4) and worked on EX. Order 26.(4) B1 and CNA #2, who was EX. Order 26.(4) B1 with EX. Order 2 and EX. Order 26.(4) B1, tested EX. Order 26.(4) B1 on EX. Order 26.(4) B1 and worked on Wing EX. on EX. Order 26.(4) B1. The surveyor requested any contact tracing and any EX. Order 26.(4) B1 testing related to either CNA. The DON stated that there was no contact tracing completed for either CNA. The surveyor asked if there was a file, or anything in writing regarding the contact tracing. The DON stated nothing was written down, there was no file and confirmed that CNA #2 worked on EX. Order 26.(4) B1, caring for residents, and on EX. Order 26.(4) B1 tested EX. Order 26.(4) B1. The DON confirmed that contact tracing should have been completed and that there was no contact tracing completed on or testing completed, on EX. Order 26.(4) B1. She stated there was "nothing, and unfortunately no one was doing it when she (IP) was out". The DON provided CNA #1's time punch logs which confirmed CNA #1 worked on EX. Order 26.(4) EX. Order 26.(4) B1, on EX. Order 26.(4) B1 and CNA #2 worked on EX. Order 26.(4) B1.

On 02/17/23 at 11:31 AM, the DON confirmed the day 1, 3, 5 broad- based testing was not completed in response to Resident #84 who tested EX. Order 26.(4) B1 on EX. Order 26.(4) B1 and she did not have documented evidence to support that it was completed. In addition, the DON confirmed that the day 1 testing that should have been completed in response to the EX. Order 26.(4) B1 EX. Order 26.(4) B1 test result for Resident #86 had also not been completed, and she was unable to provide documented evidence for completion.

On 02/17/23 at 11:43 AM, the DON provided testing documentation to the surveyor for:

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EX. Order 26.(4) B1, "Wing EX., and 02/12/23, "Unit EX. [Wing EX.] Residents and staff secondary to exposure". The DON again, confirmed there was no testing that had been completed on EX. Order 26.(4) B1 in response to Resident #86, who resided on Wing EX.. At that time, the DON again stated there had been no testing completed on Wing EX., in response to Resident #84's EX. Order 26.(4) B1 test result on EX. Order 26.(4) B1

On 02/17/23 at 11:46 AM, LNHA provided time stamp log for the Cook which revealed the Cook worked on 02/15/23 from 6:07 AM to 6:51 PM; 02/16/23 from 11:11 AM to 7:15 PM; 02/17/23 he punched in at 8:56 AM. The Employee #3 time stamp log revealed that Employee #3 worked on 02/14/23 from 7:03 AM to 1:30 PM; 02/15/23 (three separate time punches) from 6:51 AM to 1:00 PM, from 1:30 PM to 3:04 PM, and from 4:00 PM to 7:30 PM; 02/16/23, 7:02 AM to 12:57 PM, and a second punch log from 1:30 PM to 3:17 PM.

Review of the facility COVID-19 Policy, Effective 03/27/20, Revision Date 02/14/23, revealed Definitions: Broad Based Testing requires testing of all individuals within a particular location (unit, wing, floor, facility-wide). Used most often due to the difficulty of ascertaining ALL contacts who may have been exposed to a COVID positive person.; Contact tracing is testing process that requires identifying all of the potential contacts within a patient/person who tests positive for COVID-19 testing.; Contact Tracing is a testing process that requires identifying all of the potential contacts with a patient/person who tests positive for COVID-19 for testing.; Purpose: To prevent the development and transmission of COVID-19.; Practice Standards: 4. Outbreak

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F 886	Continued From page 140 testing is completed utilizing broad based or contact tracing approach.; 5. Centers will conduct testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests...; 5.2. Completed tests and results will be properly documented and reported as required.; 18. Follow CDC published guidance for patient or HCP with suspected COVID-19.; 20. Perform contact tracing for both suspected and confirmed cases and document on Contact Tracing Log.; 10.1 A broad based approach is utilized to investigate a possible COVID-19 outbreak.: 21. Centers will have a plan based on CDC/CMS/state/local recommendations to prevent transmission, such as having a dedicated space in the facility for cohorting and managing care for patients with COVID-19. Testing for COVID-19: 35. Patients, facility staff, and visitors will be tested according to CMS and state Department of Health requirements and [corporate] guidance.; 35.1 COVID-19 testing results will be documented. NJAC 8:39-5.1(a)	F 886		
F 940 SS=F	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced	F 940		4/11/23

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F 940	Continued From page 141 by: Based on observation, interview and document review, it was determined that that facility failed to ensure that contracted facility departments received training and competencies in accordance with the Facility Assessment, and to ensure facility policies and procedures for infection control standards were met. This deficient practice affected 4 of 4 Resident Wings and was evidenced by the following: On 02/08/23 at 11:12 AM, during the facility entrance conference the Licensed Nursing Home Administrator (LNHA) provided a copy of the Facility Assessment Tool (Tool), dated 03/22/22. The Tool revealed staff training/education and competencies, 3.4. Describe the staff training/education and the competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies. At facility staff members are provided with training and education beginning with the new hire orientation and regular on-going training. All staff members are provided with annual education and competencies that are necessary to their job responsibilities. On 02/08/23 at 10:58 AM, on the [redacted] Wing, Surveyor #1 and #2 observed a laundry aide walking down the hallway and was wearing a Personal Protective Equipment (PPE) gown which was not secured in the back, an N95 mask and eye protection. The laundry aide then entered a COVID-19 positive resident room, and through an open door, the surveyors observed her touch	F 940	1. The laundry aide was re-educated on proper donning and doffing of PPE, entering/exiting a COVID 19 positive room, glove usage and hand hygiene on 2/13/23. The housekeeper was re-educated on proper donning and doffing of PPE and usage and the process for removal of soiled items from COVID 19 positive rooms on 2/13/23. The facility re-educated the staff on COVID 19 positive meal tray process on 2/10/23. The housekeeping staff were re-educated and received competencies on proper donning and doffing of PPE and hand hygiene on 2/10/23. 2. All residents have the potential to be affected by the deficient practice. 3. Staff members were re-educated on annual education and competencies that are necessary for their job responsibilities. The Administrator or designee will audit the education and competencies in all departments for four weeks for one month then monthly for two months. 4. The results of the audit will be discussed in the monthly Quality Assurance Performance Improvement meeting for three months with corrective actions	

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F 940	Continued From page 142 multiple environmental surfaces including a dresser, and folded clothes, and proceeded to go to the other side of the room and touch other surfaces, including the furniture. She exited the room without first removing gloves and performing hand hygiene. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The laundry aide did not perform hand hygiene upon exiting the room and proceeded to continue to wear the same gloves. On 02/10/2023 at 10:49 AM on Wing [redacted] of the facility, Surveyor #4 observed a housekeeper wearing an N95 mask and a face shield. The housekeeper was observed to don (put on) a PPE gown and gloves, enter a resident room, picking up soiled gowns and collecting soiled gowns in a see-through plastic bag. The housekeeper doffed (removed) his PPE gown and gloves inside the resident room, brought the bag with soiled PPE out into a cart in the hall and next sanitized his hands. The housekeeper was next observed in the doorway of a COVID-19 positive resident room wearing an N95 mask and face shield. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated "Special Contact and Droplet Precautions for special respiratory circumstances" and included but was not limited to performing hand hygiene before and after	F 940	needed or taken during the audit.	

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patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The housekeeper had not donned a PPE gown or gloves. The housekeeper was using his bare hands to tie a plastic bag that contained used, soiled PPE gowns. The housekeeper then brought the plastic bag filled with soiled PPE gowns out into the hallway and placed the bag on top of the housekeeping cart. Surveyor #4 asked the housekeeper what the process was for collecting soiled gowns in resident rooms for residents were on droplet precautions or any transmission-based precautions (TBP). The housekeeper stated that he followed directions from his administrator. The housekeeper was unwilling to answer any additional questions from the surveyor and stated, "please let me get back to work and do my job".

On 02/10/23 at 12:58 PM, a surveyor asked the LNHA again for a staff education book, or documented education. The LNHA stated "I thought I told you I gave you all the education I had to give", and the surveyor asked if the in services shehad provided encompassed the entire staff. The LNHA stated she was not sure and "I guess I can have nursing give you the book to see."

On 02/10/23 at 2:02 PM, the facility Assistant Director of Nursing Infection Preventionist (ADON/IP) stated to the survey team that she and the Director of Nursing (DON) were responsible for the staff education.

On 02/10/23 at 2:38 PM, the surveyor interviewed the DON and LNHA in the presence of the survey

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team. The LNHA stated the nurse managers and department heads complete infection control rounds. The DON stated that when rounds were completed, there was no sign in sheet to show who had been provided with the education or the topic of the education.

On 02/14/23 at 11:03 AM, the surveyor interviewed the Director of Housekeeping (DOH) who stated that housekeeping was responsible for picking up soiled gown from Covid-19 positive resident rooms. The process was to don PPE including a gown, gloves, N95 mask, and face shield prior to entering. The DOH stated the bin for gowns had a plastic bag inside and the housekeeper would pick up soiled gowns in the bag then tie the bag, then a second person would be outside of the room and holding a plastic bag. The housekeeper would then drop the tied bag of soiled gowns into the second plastic bag outside the room. The DOH stated it was double bagged and then the person standing outside the room would then tie the bag and place inside the linen bin in the hallway. The DOH demonstrated the process and showed the surveyor the different bins in the hallway of Unit 1. One bin for trash and two bins for soiled gowns/linens and a third bin for personal clothes.

On 02/13/23 at 12:22 PM, the surveyor interviewed the LNHA who stated that she had been at the facility since EX. Order 26.(4) B1

On 02/13/23 at 12:24 PM, the surveyor requested all education and staff competencies regarding hand washing, putting on and removing personal protective equipment (donning and doffing PPE and infection control education and competencies for all staff). The LNHA stated she had been

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responsible for overseeing the staff education process and auditing the inservice education and competencies. The LNHA stated the Infection Preventionist and department heads received infection control training and have been doing infection control rounds with on-the-spot training. The surveyor asked the LNHA if the education was documented, and the LNHA stated, "we didn't have the documentation."

On 02/13/23 at 1:03 PM, the LNHA confirmed to the survey team that all the education that had been provided to the surveyors was what the facility had. The LNHA stated the facility utilizes an online education system, and there is not necessarily competencies. The LNHA stated there has been anyone fulfilling a staff educator role at the facility for a few months. The LNHA stated that if there was a need for specific education for a new procedure, and the LNHA used the example of providing intravenous nutrition, the facility would do a refresher education as needed. however, "nothing formally documented." The surveyor inquired as to who would be providing any specialized education, including education on infection control, and the LNHA it would be a combination of different managers. The surveyor asked if there was any documented evidence of the education, and the LNHA stated, "no."

On 02/13/23 at 1:12 PM, the surveyor inquired regarding what the policy was for removing COVID-19 positive resident meal trays. The LNHA stated "we don't have a policy, we have a process and we do well to ill and we would collect all the non-precaution trays and take care of those residents first, then we take care of the isolation trays, and we bag them". The LNHA

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stated "we were supposed to have the process in place". The LNHA stated "we don't have anything documented" regarding training the staff on picking up the covid positive resident trays.

On 02/22/23 at 10:08 AM, the surveyor asked to LNHA to review facility assessment regarding infection control. The surveyor asked the LNHA what the purpose of the facility assessment was. The LNHA stated to look and see that we can meet the resident's needs, and if we had a certain type of population, we would make sure the staff had the resources and training, including regarding any religions. The surveyor asked if any resources were identified for infection control, the LNHA stated "it doesn't specifically lay it out", and the surveyor asked were there any trainings, or competencies identified in the facility assessment. The LNHA stated there was "nothing specific to infection control" in the facility assessment, "it should be more specific."

On 02/24/23 at 11:39 AM, the surveyor interviewed the LNHA regarding any education and competencies that had been provided by the contracted departments which included housekeeping and dietary. The LNHA stated she spoke to housekeeping, and they informed her that they did not complete educational competencies with their staff. The LNHA stated there was specific education related to each department and then the departments all participated in the facility education. The surveyor asked the LNHA to review the facility education book to locate any educational competencies for housekeeping since the housekeeping director confirmed that he did not complete them. The LNHA stated she "was not aware that housekeeping director did not do competencies."

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F 940	Continued From page 147 The surveyor specifically asked about donning and doffing related to the observations made during the survey. The LNHA stated the donning and doffing competencies should have been completed by the facility and stated, "I am not finding the housekeeping department in the competency book, clearly there is no process." The LNHA stated she looked through the education book and stated that there is no list for what educational competencies should have been provided by each department. NJAC 8:39-13.4 (b)	F 940		

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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 maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in CNA staffing for 14 of 14-day shifts reviewed. 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	S 560	1. No residents were affected by the practice. 2. All residents have the potential to be affected by the deficient practice. 3. The Administrator, Human Resource Representative, Director of Nursing and Staffing Coordinator have developed a written recruitment plan along with the regional support team that includes to continue with all recruitment functions through various forums to increase the number of nursing applicants. The facility staff will continue with staffing calls five times per week with the regional	4/11/23

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

Electronically Signed | 03/23/23

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. On 02/16/2023 at 11:21 AM, a review of the "Nurse Staffing Report" completed by the facility for the weeks of 01/22/2023 through 01/28/2023 and 01/29/2023 through 02/04/2023, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/22/23 had 9 CNAs for 116 residents on the day shift, required 14 CNAs. -01/23/23 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. -01/24/23 had 10 CNAs for 111 residents on the day shift, required 14 CNAs. -01/25/23 had 10 CNAs for 111 residents on the day shift, required 14 CNAs. -01/26/23 had 10 CNAs for 111 residents	S 560	support team to recruit nursing staff for open nursing positions. The Human Resource representative or staffing coordinator will maintain a listing of current recruiting efforts and outcomes. This will be documented at least three times per week. 4. The results of the audit will be discussed in the Quality Assurance Performance Improvement meeting for three months with corrective actions needed or taken during the audit.	

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on the day shift, required 14 CNAs.
-01/27/23 had 11 CNAs for 109 residents on the day shift, required 14 CNAs.
-01/28/23 had 5 CNAs for 108 residents on the day shift, required 13 CNAs. (21.60 residents per CNA)
-01/29/23 had 7 CNAs for 108 residents on the day shift, required 13 CNAs. (15.42 residents per CNA)
-01/30/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs.
-01/31/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs.
-02/01/23 had 8 CNAs for 107 residents on the day shift, required 13 CNAs.
-02/02/23 had 9 CNAs for 107 residents on the day shift, required 13 CNAs.
-02/03/23 had 10 CNAs for 106 residents on the day shift, required 13 CNAs.
-02/04/23 had 10 CNAs for 103 residents on the day shift, required 13 CNAs.

During an interview with the surveyor on 02/21/23 at 11:53 AM, the Staffing Coordinator (SC) stated that staffing in the facility was based on hours per patient per day (HPPD). The SC stated that the nurses work 8-hour days and the CNAs work 7.5 hour days. The hours are counted then divided by the resident census. The SC added that the facility staffing was based on the state regulation for CNA to resident ratio, such as on the 7:00 AM to 3:00 PM shift should be 1 CNA to 8 residents, on the 3:00 PM to 11:00 PM shift 1 CNA to 12 residents, and on the 11:00 PM to 7:00 AM shift 1 CNA to 15 residents. The SC acknowledged that the staffing requirements were not being met. The SC stated that there had been a staffing shortage since Covid-19. The facility allowed people not to work and to stay home during that time. The SC also added that once staff

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TROY HILLS CENTER	200 REYNOLDS AVE PARSIPPANY, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 completed the facility's orientation, the staff opted out and would not show up for additional interviews. The SC stated that interventions had been implemented to combat the staffing shortage such as, recruiting from a nearby CNA school and an increase in facility staff pay. On 02/22/23 at 09:15 AM, the SC approached the surveyor and stated that the facility also had a contract with a CNA school and offered a $3,500.00 dollars sign on bonus. The SC stated that the outcome of a staffing shortage was resident care not being done, residents who required assistance with meals not being assisted, and call lights not being answered in a timely manner. During an interview with the surveyor on 02/22/23 at 10:40 AM, an LPN (Licensed Practical Nurse) on Wing 4 stated that he/she would sometimes work doubles or be asked to come in to work on his/her day off. The LPN added that no bonuses or incentives were offered to work overtime. On 02/24/2 at 12:46 PM, in the presence of the survey team, the LNHA (Licensed Nursing Home Administrator) stated that the facility had staffing issues. The LNHA stated that the facility recently hired 2 nurses and 1 CNA for weekends. The LNHA added, "It is a work in progress." The LNHA and the DON (Director of Nursing) both acknowledged the required minimum direct care staff to resident ratios as mandated by the state. NJAC 8:39-5.1(a)	S 560		