STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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E 000	Initial Comments This facility is not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		10/27/23

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

Electronically Signed | 10/05/2023

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility Emergency Preparedness Plan and Program (EPP), it was revealed that the facility failed to ensure that the EPP was reviewed and undated at least annually, as evidence by the following: On 09/18/2023 at 02:11 PM, in the presence of the surveyor, the Licensed Nursing Home Administrator (LNHA) admitted that the Emergency Plan (EP) manual had not been updated since 2021 and the LNHA agreed that the EP manual is required to be updated annually. On 09/19/2023 at 11:03 AM, during an interview with the surveyor, the Director of Maintenance (DM) stated that he and the LNHA are responsible for the Emergency Preparedness manual and program and that he is aware that the program should be updated annually. The DM added that the program had not been update since 2021 and that is has now been placed on	E 004	E004 Specific Concern The Emergency Plan, which is required to be updated a minimum of every 2 years, has been reviewed and updated by the Administrator, the Director of Maintenance, and other members of the IDC Team. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. Systemic Changes The Director of Maintenance will be inserviced on the importance of ensuring the Emergency Plan is reviewed and updated a minimum of every 2 years. Monitoring The Administrator will submit a monthly report to the monthly QAPI Committee for	

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E 004	Continued From page 2 high priority to correct.	E 004	3 months.	
F 000	INITIAL COMMENTS Standard Survey C/O # NJ 151294, NJ 153876, NJ 155087, NJ 155712, NJ 156569, NJ 156805, NJ 157630, NJ 158743, NJ 163151 Census: 116 Sample Size: 27 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		10/27/23

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F 550	Continued From page 3 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the residents' dining experience was provided in a manner to promote the dignity and respect of the residents, who were not served their meal at the same time while seated at the same table as well as serving all residents who are seated in the dining room at the same time. This deficient practice was observed for 1 of 2 dining rooms, 2nd floor and was evidenced by the following: On 9/11/2023 at 12:18 PM, the surveyor observed the lunch meal in the [redacted] floor dining room. On the 2nd floor a meal cart indicated was DR (dining room) cart. However, in the dining room was 14 total residents and 1 resident was actively eating and the other 13 were not yet served. On 9/11/2023 at 12:23 PM, a 2nd meal cart	F 550	F550 Specific Residents The Nurses and the CNAs on the [redacted] floor were inserviced on ensuring residents at the same table are served at the same time, do not stand while feeding, and monitor residents to ensure they do not eat off each others tray or feed other residents. Other Residents With The Potential To Be Affected All other residents have the potential to be affected by these deficient practices. The facility will monitor residents who eat in the 1st floor dining room for similar issues.	

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F 550	Continued From page 4 arrived in the DR and 5 residents received their lunch meal but 9 residents still with no tray and cart was removed to the unit to finish passing. On 9/11/2023 12:30 PM, a 3rd meal cart arrived to the DR. Prior to that, 2 residents had received their trays. The remaining 7 resident received their trays. On 9/13/2023 at 7:58 AM, staff was observed standing next to a resident who was in bed feeding the resident breakfast. On 9/13/2023 at 11:50 AM, the surveyor performed a meal observation at lunch on [redacted] floor. 14 residents in DR. One resident sitting by him/herself at a table was actively eating and the remaining 13 had not received their meal. On 9/13/2023 at 11:58 AM, 16 residents were now in the DR. A table in the middle of the room had four residents seated. Three of the residents received their meals and were actively eating. The fourth did not receive their tray. The surveyor was sitting with a resident and the resident was asking where is my tray? He/she shrugged their shoulders. He/she called Unit Manager/Licensed Practical Nurse (UM/LPN #2) over and asked for his/her food and she looked on the cart and his/her tray was not on the cart. The resident said I don't always eat in the DR. On 9/13/2023 at 12:07 PM, the last resident at the middle table received his/her tray. On 9/15/2023 at 12:03 PM, the surveyor observed 2 residents seated at the same table eating off the same tray. Staff then removed the	F 550	Systemic Changes All in-house and newly hired Nurses and CNAs will be inserviced on ensuring residents at the same table are served at approximately the same time, do not stand while feeding, and monitor residents to ensure they do not eat off each others tray or feed other residents.. The Unit Manager, Director of Nursing and Administrator or designee will round on this issue on a daily basis. The facility will also evaluate it□s meal service system to better ensure residents are eating at approximately the same time. Monitoring The Unit Managers and Director of Nursing will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month and the Administrator will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	

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F 550	Continued From page 5	F 550		

tray from the residents and DR. At that time 14 residents were in the DR for the lunch meal.

During an interview with the surveyor on 9/15/2023 at 12:08 PM, Certified Nursing Assistant (CNA #1) said that the tray was for a resident, and he/she thinks the other resident is family. He/She always feeds him/her and confirmed he/she was eating off resident tray.

On 9/15/2023 at 12:12 PM, the surveyor observed the lunch cart arrive in DR. A table with three residents seated showed two of the three received their meal and the third resident was observed looking at the other two. The third resident was served at 12:18 PM, when the 3rd meal cart arrived.

A middle table that had 3 residents seated, showed that 1 resident received their tray, while the other 2 did not. Within 2 minutes a second resident received their tray. At 12:24 PM, the third resident received their tray.

During an interview with the surveyor on 9/15/2023 at 1:01 PM, Graduate Nurse (GN) was asked what the process is for assisting a resident to eat. GN said you feed them one thing at a time with drinks in between every couple of bites. I would position myself in front of them so they can see me. We are supposed to be sitting regardless of resident being in chair or bed. We don't want to hover over them.

During an interview with the surveyor on 9/18/2023 at 12:07 PM, UM/LPN #2 was asked what the process is for serving meals in the dining room. UM/LPN #2 said each table is to be individually served at the same time. Yes, we

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F 550	Continued From page 6 would like to have all resident in the dining room served at the same time in DR. UM/LPN #2 confirmed No, this was not happening that way last week. We are working on that. During an interview with the surveyor on 9/18/2023 at 12:10 PM, UM/LPN #2 was asked how staff feeds a resident who requires assistance with their meal. UM/LPN #2 said we pull up the resident, then we sit them up straight. We sometimes sit when we feed residents and depending on the resident when we are sitting it may be hard to calm them down because we don't want them throwing food. Mostly we are sitting down in chair across from them. It depends on the resident condition if it is high enough (the bed itself) we can stand to feed resident. NJAC 8:39-4.1(a)(12)	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		10/27/23

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F 582	Continued From page 7 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to inform the	F 582	F582 Specific Resident Resident #368 has been discharged	

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F 582	Continued From page 8 beneficiaries of potential financial liability and related standard claim appeal rights for 1 of 3 residents (Resident #368) reviewed for the Beneficiary Notification task. The deficient practice was evidenced by the following: On 09/15/2023 at 11:14 AM the surveyor randomly selected three residents that the facility identified on the Entrance Conference Worksheet, "Beneficiary Notice - Residents Discharged Within the Last Six Months" for the Beneficiary Notification task. A review of the facility-completed, "Skilled Nursing Facility Beneficiary Protection Notification Review" forms revealed that Resident #368 did not have the Notice of Medicare Non-Coverage (NOMNC). The Skilled Nursing Facility Beneficiary Protection Notification Review form for Resident #368 revealed a hand-written note that read, "Cannot be found [NOMNC]." On 09/15/2023 at 12:59 PM, during an interview with the surveyor, the Director of Nursing stated, "We don't have it [NOMNC]" when the surveyor asked for clarification of the hand-written note. On 09/19/2023 at 01:08 PM, during an interview with the surveyor, the Administrator replied, "It should be completed withing three days, I believe it is the regulation. Social Worker (SW) would take care of that, and the record of it should be kept by the SW" when asked about facility's expectation for beneficiary notices/NOMNC completion. The facility was unable to provide policy	F 582	All Other Residents With Potential To Be Affected All residents have the potential to be affected by this deficient practice. The facility conducted a retroactive review for 1 week to determine if any other residents needed to be issued a Notice of Medicare Non-Coverage Form (NOMNC) due to an oversight and no other issues were found. Systemic Change The Director of Social Services will be inserviced on this requirement. The Administrator and Director of Social Services will track the need to issue Notice of Medicare Non-Coverage Forms during the facility's weekly Utilization Review Meeting that reviews if resident's will have discontinued coverage. The Administrator will then ensure all Notice of Medicare Non-Coverage Forms are issued timely. Monitoring The Director of Social Services will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month and the Administrator will submit a monthly report to the facility's monthly Quality Assurance Performance Improvement Committee Meeting for 3 months.	

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F 582	Continued From page 9 addressing beneficiary notifications. N.J.A.C. § 8:39-5.1	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		10/27/23

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F 584	Continued From page 10 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a homelike atmosphere for 1 of 2 dining rooms, 2nd floor. This deficient practice was evidenced by the following.: On 9/11/2023 at 12:18 PM, the surveyor observed the lunch meal on the [redacted] floor dining room. 14 total residents were in the dining room. 14 of 14 residents were served their meal on the tray and the food remained on the tray throughout the meal. On 9/13/2023 at 11:50 AM, the surveyor observed the lunch meal on the [redacted] floor. 16 of 16 residents were served their meal on the tray and the food remained on the tray throughout the meal. On 9/15/2023 at 12:24 PM, the surveyor observed lunch meal on the [redacted] floor dining room. All residents were served their meal on the tray and the food remained on the tray throughout the meal. During an interview with the surveyor on 9/18/2023 at 1:01 PM, Licensed Practical Nurse #1 said everything should come off the tray in Dining Room. I don't think post covid people know to do that.	F 584	F584 Specific Residents The Nurses and the CNAs on the [redacted] floor were inserviced on ensuring residents food items are removed from their tray when being served to the residents in the dining area to provide them a more restaurant-style homelike dining experience. Other Residents With Potential To Be Affected All residents have the potential to be affected by this deficient practice. The facility will ensure residents who also eat in the 1st floor dining area have their food items removed from their tray when being served to provide the residents with a more restaurant-style homelike dining experience. Systemic Changes All in-house and newly hired Nurses and CNAs will be inserviced on ensuring residents food items are removed from their tray when being served to the residents in common dining areas to provide them a more restaurant-style homelike dining experience. The Unit	

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F 584	Continued From page 11 During an interview with the surveyor on 09/18/2023 at 2:01 PM, the Licensed Nursing Home Administrator (LNHA) said I saw how they deliver the meal carts. I like everybody to be served and carts to come one right after the other. Yes, all residents at one table should be served at same time. The Director of Nursing said the staff have to help open milk, set up food for the resident unless help is not needed, or the resident doesn't want staff to do that. The LNHA said I would like to move to restaurant style where we take the food off the tray. The facility was unable to provide a dining policy. NJAC 8:39-4.1(a)(12)	F 584	Manager, Director of Nursing and Administrator or designee will round on this issue on a daily basis. Monitoring The Unit Managers and Director of Nursing will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month and the Administrator will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604		10/27/23

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F 604	Continued From page 12 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to identify the use of a NJ EX Order. 264b1 (a NJ EX Order. 264b1 with a seat designed for use by individuals with NJ EX Order. 264b1) as a physical restraint for 2 of 5 residents (Resident #77 and Resident #79) reviewed for falls. This deficient practice was evidenced by the following: 1. On 09/11/2023 at 10:23 AM, during the initial tour of the facility, the surveyor observed Resident #77 in the NJ EX floor dining room positioned in a NJ EX Order. 264b1. Resident #77 was non-interview able and NJ EX Order. 264b1. Resident #77 was observed to be able to ambulate independently in the NJ EX Order. 264b1. The NJ EX Order. 264b1 was observed to be in the closed position. The surveyor was unable to determine if Resident #77 was able to get out of the NJ EX Order. NJ EX Order. independently on this observation. On 09/13/2023 at 10:02 AM, the surveyor observed Resident #77 seated in the NJ EX Order. NJ EX Order. the NJ EX floor dining/activity room. The NJ EX Or.	F 604	F604 Specific Residents Resident #77 and #79 were immediately evaluated by physical therapy for appropriateness of the merry walker and PT recommended wheelchairs for both residents when out of bed. The Director of Nursing discussed the Physical Therapy recommendations with resident # 77 and # 79 and the resident's will remain in their NJ EX Order. 264b1 per physican orders. Both resident's Care Plans and TARS have been updated accordingly. Other Residents With Potential To Be Affected All residents have the potential to be affected by this deficient practice. The Unit Managaers and Director of Nursing reviewed 100% of all residents on any devices that could be considered restraints to ensure the Restraint Policy is being followed. No other residents were found to be affected by this deficient practice.	

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F 604	Continued From page 13 NJ EX was observed to be in the closed position and Resident #77 was observed to be a passive activity participant. On 09/14/2023 at 09:08 AM, Resident #77 was observed in their NJ EX Order. 264b1 in the hallway. The NJ EX Order. 264b1) had completed his/her ADL (activities of daily living) care. Resident #77 was neat in appearance. Resident #77 was pleasant and answered surveyors' simple questions appropriately. Resident #77 was sitting in hallway in NJ EX Order. 264b1 in front of the nurse's station. The Surveyor asked Resident #77 if he/she could open the NJ EX Order. 264b on their NJ EX Order. 264b1. Resident #77 responded, "I don't think so." The surveyor attempted to open the NJ EX Order. 264b1 with their NJ EX Order. 264b but was unable to open it because the NJ EX Order. 264b was too tight for the surveyor's non-dominant hand. On 09/14/2023 at 11:17 AM, Resident #77 was observed in an activity group on the NJ EX floor dining/activity room. Resident #77 was seated in the NJ EX Order. 264b1 with the NJ EX Order. 26 closed and was placed in front of the activity table with 3 other residents. On 09/14/23 at 12:11 PM, Resident #77 was observed being pushed in his/her NJ EX Order. 264b1 from their room out to the nurse's station by their NJ EX. The surveyors were standing at nurses' station at. The NJ EX Order. 264b1 was observed to walk away, and Resident #77 stood up independently in their NJ EX Order. 264b1 and proceeded to ambulate to the dining room without assistance. The NJ EX Orde NJ EX was in the locked position. On 09/14/2023 12:20 PM, Resident #77 was observed at the lunch meal on the NJ EX floor	F 604	Systemic Changes All nurses will be re-inserviced by the Director of Staff Development or designee on the facility's Restraint Policy including the need to reassess the resident for continued need,the resident's ability to self-release and on the importance of ensuring these devices appear on the residents TAR and Care Plan. The Unit Managers will conduct a weekly audit on all residents with restraints to ensure the devices are in place and that the resident's TARS and Care Plans have been updated accordingly. The Director of Nursing and Unit Managers will reassess residents on a quarterly basis for continued need and ability to self-release from any restraints. Monitoring The Unit Managers will submit a report weekly to the Director of Nursing for 2 months, then bi-weekly for 1 month and the Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	

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dining room. Resident #77 was seated at a standard table in their [redacted]. Resident #77 was observed to ambulate to the dining room independently by the surveyor. Resident #77 was assisted to eat 1:1 by the [redacted] Resident #77 remained in the merry walker the entire meal with the [redacted] in the closed position.

According to the Admission Record Resident #77 was admitted to the facility with the following but not limited to [redacted].

According to the quarterly Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #77 had a Brief Interview for Mental Status score of [redacted] which indicated [redacted]. Section [redacted] of the MDS revealed that Resident #77 was a [redacted] According to Section [redacted] Resident #77 required [redacted] with most activities of daily living. Locomotion on the unit was described as requiring [redacted] of [redacted] physical assist. Section [redacted] revealed that Resident #77 had not had any [redacted] since the prior assessment. Section [redacted] revealed that Resident #77 received [redacted] services and Section [redacted] indicated that Resident #77 did not have a [redacted] or use an alarm.

A review of the Clinical Physician's Orders dated [redacted] did not reveal a physician's order for Resident #77 for the use of a [redacted].

A review of Resident #77's comprehensive care

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plan revealed a care plan Focus of "The resident is at risk/has NJ EX Order. 264b1 and incidents r/t (related to) NJ EX Order. 264b1." Date Initiated: NJ EX Order. 264b1 Interventions/Tasks included:

"PT Eval (physical therapy evaluation) for weakness"
NJ EX Order. 264b1 r safety eval (evaluation)"
"proper footwear-NJ EX Order. 264b1"
Date Initiated: NJ EX Order. 264b1

A review the physical medical record (MR) revealed that Resident #77 had no consent or recommendation via physical or occupational therapy for the use of a NJ EX Order. 264b1. Review of the electronic MR revealed the same.

On 09/15/2023 at 08:33 AM, the surveyor conducted an interview with the NJ EX Order. 264b1 NJ EX Ord assigned to Resident #77. The surveyor observed Resident #77 in their room. Resident #77 had a gown on and was seated in a NJ EX Order. NJ EX Order. 26 The surveyor asked the NJ EX when is the resident is placed in the NJ EX Order. 264b1. The NJ EX stated that Resident #77 is placed in the NJ EX Order. NJ EX Order. 2 in the AM when he/she gets out of bed and is out of the NJ EX Order. 26 when the resident is ready to return to bed, the surveyor asked if Resident #77 can be out of the NJ EX Order. 264b1 during meals or activities and the NJ EX responded, "No."

On 09/15/2023 at 10:16 AM, the surveyors met with the Director of Rehabilitation (DOR). The surveyor asked the DOR if they were responsible for issuing NJ EX Order. 264b1 to residents. The DOR stated that rehab did not issue NJ EX Order. 264b1 and that nursing staff was responsible for the NJ EX Order.

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F 604	Continued From page 16 NJ EX Order. 264b On 09/18/2023 at10:56 AM, the surveyor accompanied by the Unit Manager/Licensed Practical Nurse (UM/LPN #2) observed Resident #77 in their room seated in their NJ EX Order. 264b1 with the NJ EX Order. 264b closed. Resident #77 proceeded to stand up and ambulate out of the room and down the hallway independently in the presence of the surveyors and UM/LPN #2. UM/LPN #2 approached Resident #77 in the presence of the surveyors and asked Resident #77 if he/she could open the NJ EX Order. 264b to the NJ EX Order. 264b1. The resident stated, "Right there" repeatedly. After numerous verbal prompts by the UM/LPN #2 to determine if Resident #77 could independently open the NJ EX Order. 264b to his/her NJ EX Order. 264b1, Resident #77 then responded, "I can't." (Open the NJ EX Order. 264b2 On 09/19/2023 at 11:17 AM, the surveyor reviewed the MR. The following progress note documented by the facility Director of Nursing (DON) was revealed after the facility was made aware that Resident #77's NJ EX Order. 264b1 was considered a NJ EX Order. 264b1 on NJ EX Order. 264b2 during a meeting with the facility administrative staff: "Created Date : NJ EX Order. 264b3 10:01:27 Note Text: The resident was re-assessed this morning for the use of his/her NJ EX Order. 264b1 since there is a NJ EX Order. 264b1 by being unable to release the NJ EX Order. 264b1 anymore during an assessment. MD was made aware PT evaluation was ordered for the possibility of using NJ EX Or (NJ EX Order. 264b1). PT (physical therapy) notified. BIM (brief interview for mental status) score updated."	F 604		

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2. On 09/11/2023 at 10:18 AM Resident #79 was observed lying in bed. Resident #79 was NJ EX Order. 264b1 due to NJ EX Order. 264b1 but was NJ EX Order. 264b1. Resident #77 had a NJ EX Order on their NJ EX Order. 264b1, and it was wrapped with an NJ EX Order. 264b1. Resident #77 was unable to tell the surveyor what happened to their NJ EX Or when questioned by the surveyor.

On 09/12/2023 at 11:47 AM the surveyor observed Resident #79 in the NJ EX Or floor dining/recreation room. Resident #79 was seated in a NJ EX Order. 264b1, with staff seated beside him/her. Resident #79 made no attempts to get up. Resident #79 was observed to get up and ambulate with staff present at the end of a song being played by the activities staff. The gate to get in/out of NJ EX Order. 264b1 was closed and Resident #79 had a NJ EX Order. 264b1 between their NJ EX O that attached to the NJ EX Orde and the bottom of the NJ EX Order. 264b1 seat.

On 09/14/2023 at 11:01 AM Resident #79 was observed in the hallway seated in a NJ EX Order. 264b1 in front of the nurse's station. Resident #79 was seated in NJ EX Order. 264b1 with the NJ EX Order. 264b in the closed position and a NJ EX Order. 264b1 between their legs. The NJ EX Order. 264b is attached to the NJ EX Order. 264b and attached to the NJ EX Order. of the NJ EX Orde. The surveyor asked Resident #79 if he/she could open the NJ EX Or NJ EX r on the NJ EX Order. 264b1. Resident #79 responded to the surveyor with NJ EX Order. 264b1. The surveyor requested Resident #79 x 5 to independently open the NJ EX Order. 264b on the NJ EX Order. NJ EX Order r. Resident #79 made no attempt to open the NJ EX Order. 264b. Resident #79 did not comprehend what the surveyor was requesting of them.

On 09/14/2023 at 12:01 PM Resident #79 was

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observed in the dining room of the [redacted] floor at the lunch meal. Resident #79 was seated at a standard height table. Resident #79 was seated in a [redacted] with the [redacted] in the locked position and [redacted] between their [redacted]. Resident #79 was seated on the [redacted] and was approximately 3 feet away from the dining table. Staff assisted Resident #79 to eat at this meal as Resident #79 was not able to reach their food from the seated position in the [redacted]

According to the Admission Record Resident #79 was admitted to the facility with the following but not limited to diagnoses: [redacted].

A review of the quarterly Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #79 had [redacted] Section [redacted] revealed that Resident #79 required [redacted] with all activities of daily living except transfer and eating, which were assessed as being independent. Section [redacted] of the MDS indicated that Resident #79 had [redacted] since admission/entry or reentry or prior assessment. Review of Section [redacted] revealed that Resident #79 did not use a [redacted] or an [redacted].

Review of the Order Summary Report, active as of [redacted], did not include a physician order for a [redacted].

A review of the physical and electronic medical record (MR) did not include any consent for the use of the [redacted]

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F 604	Continued From page 19 Review of Resident #79's comprehensive care plan revealed a care plan Focus of "[resident name] is at risk/has potential [redacted], [redacted] and [redacted] r/t (related to) [redacted] date initiated: [redacted] The following was observed under the care planned Interventions/Tasks: "Education provided to staff for proper locking when device in use and not in use, date initiated: 07/17/2023" "Resident uses [redacted] for [redacted] while ambulating throughout unit. Able to [redacted] Date Initiated: [redacted] On 09/14/2023 at 01:19 PM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA #2). The surveyor asked CNA #2, who was assigned to Resident #79 that shift and was familiar with Resident #79, what was the purpose of the [redacted]. CNA #2 stated, "The purpose of the [redacted] is because he/she likes to walk. Sometimes he/she has [redacted] the [redacted] helps with that." The surveyor asked CNA #2 how often and when Resident #79 was released from the [redacted] CNA #2 replied, "I help him/her to get in the [redacted] and I will get him/her out of the walker if they want to go to bed or if they are tired." The surveyor questioned CNA #2 if Resident #79 was able to independently get in and out of the [redacted] without staff assistance. CNA #2 replied, "We have to help him/her get out of the chair because he/she cannot open the [redacted] by themselves." The surveyor questioned if the [redacted] was provided by rehabilitation services or by the nursing staff. CNA #2 stated, "I'm not sure who	F 604		

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provides the [NJ EX Order: 264] The surveyor then asked if Resident #79 was provided opportunities to be out of the [NJ EX Order: 264b1] other than to get into bed. CNA #2 stated, "I'm not sure if he/she gets out of the [NJ EX Order:] other than bed and bathroom." The surveyor asked CNA #2 what other interventions the facility has in place to keep the resident safe from [NJ EX Ord]. CNA #2 replied, "I am not sure what other things he/she has for [NJ EX] because I am not with him/her all the time."

On 09/18/2023 at 10:50 AM, the surveyor conducted an interview with UM/LPN #2. The surveyor asked UM/LPN #2 the purpose of Resident #2 using a [NJ EX Order: 264b1]. UM/LPN #2 told the surveyor, "The purpose of the [NJ EX Order: NJ EX Order:] is to walk and promote independence." The surveyor then asked UM/LPN #2 if she could demonstrate to the surveyor that Resident #79 can get out of the [NJ EX Order: 264b1] independently. UM/LPN #2 stated, "He/she cannot get out of it by her/himself. But it is a [NJ EX] prevention intervention." At 10:54 AM UM/LPN #2 asked resident #79 to open the [NJ EX Ord] on the [NJ EX Order: NJ EX Order: 26] Despite verbal directions and verbal prompts from UM/LPN #2, Resident #79 could not independently get out of the [NJ EX Order: 264b1]. UM/LPN #2 stated, "He/she can't get out."

On 09/19/2023 at 01:14 PM, after the surveyor had made the facility Director of Nursing (DON) aware that the surveyor had concerns that the use of the [NJ EX Order: 264b1] by Resident #79 was considered a [NJ EX Order: 264b1] on [NJ EX Order: 264b1] during a meeting with administrative staff, the DON told the surveyor, "I called the doctor today and we updated the BIMS (Brief Interview for Mental Status) score, and I also had them evaluated by therapy. Both residents have

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NJ EX Order. 264b1 right now." The DON was asked if the facility had monitored the residents use of the NJ EX Order. 264b1 and reassess them for continued use of the NJ EX Order. 264b1. The DON responded, "I did not monitor the resident's or reassess the residents for use of the NJ EX Order. 264b1 since they were provided to the residents." The DON agreed that the NJ EX Order. 264b1 was provided via the nursing department and was not provided by the therapy department.

The surveyor reviewed the facility policy titled Restraint Free Environment, undated. The following was revealed under the heading Policy:

"It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and NJ EX Order. 264b1 t use to circumstances in which the resident has medical symptoms that warrant the use of NJ EX Order. 264b1 "

The following was revealed under Definitions:

"NJ EX Order. 264b1" refers to any manual method or NJ EX Order. 264b1 or NJ EX Order. 264b1, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which NJ EX Order. 264b1 or NJ EX Order. 264b1 NJ EX Order. 264b1. NJ EX Order. 264b1 may include, but are not limited to:
"Placing a resident in an enclosed framed NJ EX Order. 264b1 r, in which the resident cannot open the NJ EX Order. 264b1, or if the device has been altered to prevent the resident from exiting the device."

N.J.A.C. 18:39-27.1 (c)(3)(i)

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to complete criminal background checks on employees prior to employment as well as to complete reference checks on employees before their start date. The	F 607	F607 Specific Concerns Criminal background checks have been completed for all 6 of the specific noted employees.	10/27/23

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F 607	Continued From page 23 deficient practice was identified for 6 of 10 employees reviewed for criminal background checks and 10 of 10 employees reference checks reviewed under Sufficient and Competent Nurse Staffing task. The deficient practice was evidenced by the following: A review of employee personnel files revealed that six of ten employees did not have a criminal background check completed prior to the start of the employment. A review of the same ten requested employee files revealed that all ten did not have reference checks done prior to start of the employment. On 09/18/2023 at 12:14 PM, during an interview with the surveyor, the Human Resources Director (HRD) replied, "Every employee who wants to work here needs to have one done" when the surveyor asked who was required to have a criminal background check completed. During the same interview, the HRD replied, "Criminal backgrounds are run prior to employee's orientation" when the surveyor asked what the expectation for the criminal background check completion was. Furthermore, the HRD replied, "To make sure that nobody has a criminal history ... and to make sure that nobody harms the residents" when asked why it was important to complete a criminal background check prior to employment. Lastly, the HRD confirmed that reference checks should be done prior to the first day of employment. On 09/19/2023 at 01:08 PM, during an interview	F 607	Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% audit of all employee files will be conducted to ensure criminal background checks exist. If not, they will be immediately completed. Systemic Changes The Director of Human Resources has been re-inserviced on the importance of conducting criminal background checks on all applicants upon hire to help protect residents from abuse. The Administrator will review all employee new hire packets to ensure background checks have occurred. Monitoring The Director of Human Resources will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month and the Administrator will submit a monthly report to the facility□s monthly QAPI Committee Meeting for 3 months.	

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F 607	Continued From page 24	F 607		

with the surveyor, the Administrator stated, "Every potential employee has to have criminal background and reference check" when the surveyor asked what the expectation for criminal background and reference check completion was.

During the same interview, the Administrator replied, "No, they are not able to initiate employment if criminal background and reference checks are not done" when the surveyor asked if an employee could start working in the facility before the criminal background and references checks were completed.

A review of undated facility policy titled "Abuse Policy" revealed under the section titled "Screening Components" that "It is the policy of this facility to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check..." Further, the policy revealed under section one, titled "Employee Screening and Training" that "a. Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background..." Lastly, the same section of the policy revealed that "d. Criminal background check will be conducted on all prospective employees as provided by the facility's policy in criminal background check..."

A review of facility policy revised November 2015 and titled "Background Screening Investigations" revealed under section "Policy Interpretation and Implementation" that "1. The Personnel/Human Resources Director, or other designee, will

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F 607	Continued From page 25 conduct background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential employees and contract personnel who meet the criteria for direct access employee as stated above. Such investigation will be initiated within two days of an offer of employment or contract agreement." N.J.A.C. § 8:39-9.3(b)	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		10/27/23

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F 656	Continued From page 26 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to implement a care plan for nail care as identified in the facility policy for 1 of 1 residents (Resident #101) investigated for Activities of Daily Living. On 09/11/2023 at 09:42 AM, during the initial tour, the surveyor observed Resident #101 in a wheelchair in his/her room. At that time, the surveyor observed Resident #101's NJ EX Order. 264b1 on his/her NJ EX Order. 264b1. The NJ EX Order. 264b1 were NJ EX Order. 264b1 NJ EX Order. 264b1. Resident #101 said to the surveyor that he/she needs them NJ EX O. On 09/12/2023 at 11:09 AM, during an interview with the surveyor, Resident #101 said that a doctor came to NJ EX his/her NJ EX Order. 264 Resident	F 656	F656 Specific Residents Resident #101 care plan was updated to reflect NJ EX Order. 264b1 should be provided by a licensed nurse due to their diagnosis of NJ EX Order. 264b1 per facility□s NJ EX Or Care Policy Other Residents With The Potential To Be Affected All other residents have the potential to be affected by these deficient practices. The facility will review 100% of residents with a diagnosis of NJ EX Order. 264b1 to ensure their care plan reflects NJ EX C care should only be provided by a licensed nurse per facility□s NJ EX O Care Policy.	

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F 656	Continued From page 27 #101 told the surveyor again that he/she wants their NJ EX Order. 264b1. Resident #101's NJ EX Order. 264b1 continued to appear NJ EX Order. 264b1, and NJ EX Order. 264b1 A review of Resident #101's Diagnoses located in the Electronic Medical Record (EMR) revealed diagnoses of but not limited to, NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 A review of Resident #101's Annual Minimum Data Set (MDS; an assessment tool) dated NJ EX Order. 264b1, revealed under section B0100 that Resident #101 had a Brief Interview for Mental Status score of NJ EX Order. 264b1 indicating he/she was NJ EX Order. 264b1. The MDS revealed under Section NJ EX Order. 264b1 that Resident #101 received NJ EX Order. 264b1 NJ EX Order. 264b1 with NJ EX Order. 264b1 physically assisting with personal hygiene. A review of Resident #101's Care Plan located in the revealed a focus of "NJ EX Order. 264b1 related to NJ EX Order. 264b1 " The Care Plan revealed an intervention initiated on NJ EX Order. 264b1 that Resident #101 required the assistance NJ EX Order. 264b1 NJ EX Order. 264b1 for personal hygiene. The Care Plan did not include focuses or interventions for NJ EX Order. 264b1 care. On 09/15/2023 at 10:15 AM, during an interview with the surveyor, Unit Manager /Licensed Practical Nurse (UM/LPN #1) replied. "I'm not sure." when the surveyor asked when the last time Resident #101 received NJ EX Order. 264b1 care. LPN/UM #1 replied, "CNA (Certified Nursing Assistant) is responsible" when the surveyor asked who is responsible to NJ EX Order. 264b1.	F 656	Systemic Changes All in-house and newly hired Nurses and CNAs will be educated on the facility's Nail Care Policy. The facility revised its Nail Care Policy to indicate that the resident's care plan only needs to include NJ EX Order. 264b1 care to be provided by a licensed nurse for residents with a diagnosis of NJ EX Order. 264b1 or other clinical condition warranting it. NJ EX Order. 264b1 care will not be indicated for all other resident's the CNA's provide care for. NJ EX Order. 264b1 care will also be provided to residents on their shower days. The Unit Managers and Director of Nursing will review the care plan of all new admissions with a diagnosis of NJ EX Order. 264b1 during daily Clinical Meeting to ensure it reflects NJ EX Order. 264b1 care should only be provided by a licensed nurse. Monitoring The Unit Managers will submit a report weekly to the Director of Nursing for 2 months, then bi-weekly for 1 month and the Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	

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F 656	Continued From page 28 On 09/18/2023 at 1:57 PM, during an interview with the surveyor, the Director of Nursing (DON) replied, "It can be the nurses, CNA, or the Nursing Assistant" when the surveyor asked who is responsible for performing [redacted] care on a resident. The DON replied, "Unless it's a [redacted] we don't put [redacted] care" when asked by the surveyor if there should be a care plan for [redacted] care. A review of the undated facility-provided policy titled, "Baseline Care Plan" revealed under, "Policy" that, "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." A review of the undated facility-provided policy titled, [redacted] Care" under, "Policy Explanation and Compliance Guidelines" revealed, "5. The resident's plan of care will identify: a. The frequency of [redacted] care to be provided. b. The type of [redacted] care to be provided. c. The person(s) responsible for providing [redacted] care (e.g., licensed nurse, nurse aide, podiatrist, activity professional)." 8:39-11.2 (e) 1	F 656		
F 677 SS=D	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;	F 677		10/27/23

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F 677	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for a resident specifically by not providing NJ EX Order. 264b1 care. The deficient practice was observed for 1 of 1 residents (Resident #101) investigated for Activities of Daily Living and was evidenced by the following: On 09/11/2023 at 09:42 AM, during the initial tour, the surveyor observed Resident #101 in a wheelchair in his/her room. At that time, the surveyor observed Resident #101's NJ EX Order. 264b1 on his/her NJ EX Order. 264b1. The NJ EX Order. 264b1 were NJ EX Order. 264b1 and NJ EX Order. 264b1. Resident #101 said to the surveyor that he/she needs them NJ EX O On 09/12/2023 at 11:09 AM, during an interview with the surveyor, Resident #101 said that a doctor came to NJ EX O his/her NJ EX Order. 264b1. Resident #101 told the surveyor again that he/she wants their NJ EX Order. 264b1. Resident #101's NJ EX Order. 264b1 continued to appear NJ EX Order. 264b1, and NJ EX Order. 264b1 A review of Resident #101's Diagnoses located in the Electronic Medical Record (EMR) revealed diagnoses of but not limited to, NJ EX Order. 264b1 [redacted] NJ EX Order. 264b1 A review of Resident #101's Annual Minimum Data Set (MDS; an assessment tool) dated NJ EX Order. 264b1 revealed under section NJ EX O. that	F 677	F677 Specific Residents Resident #101 was provided with NJ EX Order. 264b1 care by a licensed nurse due to their diagnosis of NJ EX Order. 264b1 per facility□s NJ EX Order. 264b1 Care Policy Other Residents With The Potential To Be Affected All other residents have the potential to be affected by these deficient practices. The facility will review 100% of residents with a diagnosis of NJ EX Order. 264b1 to ensure they have been provided with appropriate NJ EX Order. 264b1 care by a licensed nurse. Systemic Changes All Nurses and CNAs will be re-educated that NJ EX Order. 264b1 care is to be provided by a licensed nurse for residents with a diagnosis of NJ EX Order. 264b1 or other clinical condition warranting it. NJ EX Order. 264b1 care will also be provided to residents on their shower days. The Unit Managers will round on a weekly basis to ensure al NJ EX Order. 264b1 residents receive appropriate NJ EX Order. 264b1 care by the licensed nurse. Monitoring The Unit Managers will submit a report weekly to the Director of Nursing for 2 months, then bi-weekly for 1 month and the Director of Nursing will submit a	

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F 677	Continued From page 30 Resident #101 had a Brief Interview for Mental Status score of [redacted] indicating he/she was NJ EX Order. 264b1. The MDS revealed under Section [redacted]. that Resident #101 received [redacted] with [redacted] physically assisting with personal hygiene. A review of Resident #101's Care Plan located in the revealed a focus of 'NJ EX Order. 264b1 [redacted] " The Care Plan revealed an intervention initiated on [redacted] that Resident #101 required the assistance of [redacted] for personal hygiene. The Care Plan did not include focuses or interventions for [redacted] care. A review of the Progress Notes located in the EMR revealed a Physician's Progress Note from [redacted] that reflected , "NJ EX Order. 264b1 " On 09/15/2023 at 10:15 AM, during an interview with the surveyor, Unit Manager/Licensed Practical Nurse UM/LPN #1) replied. "I'm not sure" when the surveyor asked when the last time Resident #101 received [redacted] care. LPN/UM #1 replied, "CNA (Certified Nursing Assistant) is responsible" when the surveyor asked who is responsible to [redacted]. On 09/18/2023 at 1:57 PM, during an interview with the surveyor, the Director of Nursing (DON) replied, "They can [redacted] and they have to clean under the [redacted] and also hand washing" when asked by the surveyor what does [redacted] care include when being performed on a resident. The DON replied, "It can be the nurses, CNA, or the Nurses Assistant" when the surveyor asked who is responsible for performing [redacted] care on a resident. Lastly, the DON stated, "Unless its a	F 677	monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	

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F 677	Continued From page 31 NJ EX Order. 264, we don't put NJ EX Or care" when the surveyor asked should there be a care plan for NJ EX care. A review of the undated facility-provided policy titled, NJ EX Orde Care" under, "Policy Explanation and Compliance Guidelines" revealed, "3. Routine cleaning and inspection of NJ EX Orde will be provided during ADL care on an ongoing basis". The policy also revealed, "4. Routine NJ EX O care, to include NJ EX Order. 264b1, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). NJ EX Orde care will be provided between scheduled occasions as the need arises." Lastly, under "6. Principles of NJ EX O care:" the policy revealed, "b. Only licensed nurses shall NJ EX Order. NJ EX Order. 264b1 of residents with NJ Ex Order 264b..."	F 677		
F 688 SS=D	8:39-27.1 (a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		10/27/23

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F 688	Continued From page 32 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, and review of other facility documentation, it was determined that the facility failed to consistently provide services to treat and prevent a decline in NJ EX Order. 264b1) for a resident with a NJ EX Order. 264b1 of the NJ EX Order. 264b1. This deficient practice was identified for 1 of 2 residents reviewed for NJ EX Order. 264b1 (Resident #2) and was evidenced by the following: On 09/12/2023 at 08:54 AM, Resident #2 was observed in bed and being assisted with the breakfast meal by staff. Resident #2's NJ EX Order. 2 were covered with bedding on this observation and the surveyor was unable to observed for NJ EX O NJ EX Order. 264b1. On 09/13/23 09:55 AM, Resident #2 was observed lying in bed and the NJ EX Order. 264b1 was observed to be on top of the bedside nightstand. On 09/13/20233 at 11:54 AM, the surveyors visited the room of Resident #2. Resident was not present on this observation, however, the surveyors did observe Resident #2's NJ EX Order. 264b1 NJ EX Order. 264b1 on the bedside nightstand. Resident #2 was then observed in the NJ EX O floor dining room at 11:59 AM. Resident #2 was observed to be seated in their wheelchair at a table. Resident #2 did not have the NJ EX Order. 264b1 t on his/her NJ EX Order. 264b1 as ordered when out of bed. On 09/15/2023 at 12:08 PM, Resident #2 was observed seated in his/her wheel chair in the NJ EX O	F 688	F688 Specific Resident Resident #2 NJ EX Orde was applied immediately by the nurse and the physicians order with instructions on when to apply and remove the NJ EX Orde been added to their TAR enabling the nurse to followup on proper application. All Other Residents With Potential To Be Affected All residents have the potential to be affected by this deficient practice. The Unit Managers reviewed 100% of all residents who have NJ EX Order. 2 and/or other NJ EX Order. 264 devices to ensure it is indicated on their TAR and CNA data record so nursing staff is aware. The results of the review revealed that no physician orders for NJ EX Order. 2 existed on the TARS indicating proper application and removal of NJ EX Order. 26 Proper application and removal of NJ EX Order. 264b1 devices have been added to these residents TARS by the Unit Managers. Systemic Change All in-house and newly hired nurses will be inserviced by the Dir of Staff Development or designee on the need to include all residents NJ EX Order. 264b1 devices on their TAR and CNA data record so staff is aware and applies them in accordance	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 33 floor dining room. Resident #2 did not have a NJ EX Order. 264b1 on their NJ EX Order. 264b1 on this observation, as ordered on NJ EX Order. 264b1. The surveyor observed the NJ EX Order. 264b1 in Resident #2's room after the surveyor left the dining room and went to Resident #2's room. The NJ EX Order. 264b1 was on top of the bedside table. The surveyor asked the Certified Nursing Assistant (CNA #1) assigned to Resident #2 if Resident #2 was supposed to wear the NJ EX Order. 264b1 NJ EX Order. 264b1 when out of bed. CNA #1 stated, "Yes, I have to be honest, I forgot to put it on." According to the Admission Record Resident #2 was admitted to the facility with the following but not limited to diagnoses: NJ EX Order. 264b1 [redacted]. A review of the quarterly Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1, revealed that Resident #2 had a Brief Interview for Mental Status score of NJ EX D indicating moderate cognitive impairment. Section NJ E revealed that Resident #2 required NJ EX Order. 264b1 for most activities of daily living. Section NJ EX revealed that Resident #2 had received approximately NJ EX D minutes of NJ EX Order. 264b1 therapy during the NJ day observation period. Section NJ D also indicated that Resident #2 received NJ EX Order. 264b1 nursing services NJ days a week for NJ EX Order. 264b1 assistance. A review of the Order Summary Sheet, active orders as of NJ EX Order. 264b1, revealed that Resident #2 had the following physician's order: "Pt (patient) to wear NJ EX Order. 264b1	F 688	with physician orders. The Unit Managers will round weekly to ensure residents are wearing them in accordance with physician orders. The Unit Managers will conduct audits weekly to ensure all residents who have NJ EX Order. 26 and/or other NJ EX Order. 26 devices have it indicated on their TAR and CNA data record so nursing staff is aware. Monitoring The Unit Managers will submit a report weekly to the Director of Nursing for 2 months, then bi-weekly for 1 month and the Director of Nursing will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	

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NJ EX Order. 264b1 during NJ EX Order. 264b1 /out of bed. Remove at night and during bath/exercise. Check for NJ EX Order. 264b1 every shift. order date NJ EX Order. 264b1

A review of the 9 NJ EX Order. 264b1 Treatment Administration Record did not reveal an order for the NJ EX Order. 264b1 for Resident #2.

A review of Resident #2's comprehensive care plan did not reveal a care plan for the use of the NJ EX Order. 264b1 NJ EX Order. 264b1.

On 09/15/2023 at 01:12 PM the surveyor conducted an interview with Unit Manager/Licensed Practical Nurse (UM/LPN #2). The surveyor asked UM/LPN #2 if Resident #2 had a physician's order for a NJ EX Order. 264b1 to the NJ EX Order. 264b1. UM/LPN #2 responded, "Let me check this is only my second week, I'm not aware of everything yet. UM/LPN #2 stated that Resident #2 did indeed have a physician's order for a NJ EX Order. 264b1 when out of bed and during NJ EX Order. 264b1 activities. The surveyor questioned UM/LPN #2 if Resident #2 should have the NJ EX Order. 264b1 when out of bed. UM/LPN #2 responded, "Yes, the resident should have the NJ EX Order. 264b when out of bed. Yes, he/she should."

On 09/19/2023 at 09:58 AM, the surveyor reviewed the NJ EX Order. 264b1 management" form provided to the surveyor via the facility rehabilitation director. The form revealed that the facility was to "NJ EX Order. 264b1 Pt. (patient) to wear daily when NJ EX Order. 264b1. Remove at night and during bathing/exer. (exercise) Check for

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NJ EX Order. 264b1." Staff signed in-service on NJ EX Order. 264b1. In addition, The Occupational Therapist (OT) documented the following on the Occupational Therapy Treatment Encounter Note, dated NJ EX Order. 264b1: "In-service training given to nursing unit manager and CNA's on proper use, NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order. 264b1. Staff verbalized and demonstrated understanding. Provided visual handout of instructions with pictures of NJ EX Order. 2 NJ EX Order. 26 facilitate carry over." In addition, OT documented the following on the NJ EX Order. 264b1 Occupational Therapy Discharge Summary: "NJ EX Order. 264b1 Recommendations: It is recommended the patient wear a NJ EX Order. 264b1 for (sic) during daily tasks in order to NJ EX Order. 264b1 and improve NJ EX Order. 2) for adequate hygiene." The following was revealed under RNP (NJ EX Order. 264b1 nursing program): "RNP/FMP: To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNP's has been completed with the IDT NJ EX Order. 264 NJ EX Order. 264b1

On 09/19/2023 at 01:23 PM, during an interview with the facility administration, the surveyor asked the purpose of the NJ EX Order. 264b1 ordered for Resident #2. The facility Director of Nursing (DON) replied, "The purpose of the NJ EX Order is too prevent NJ EX Order. 264b1." The surveyor asked the DON if the NJ EX Order should have been listed on the TAR. The DON stated, " It should be listed on the TAR." The surveyor asked if the NJ EX Order should be applied to Resident #2's NJ EX Order. 264b1 when out of bed. The DON responded, Yes, I agree. When the resident is out of bed t NJ EX Ex Order should be

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F 688	Continued From page 36 applied as ordered." The facility was unable to provide a policy/procedure for splint management. N.J.A.C. 18:39-27.2(m)	F 688		
F 689 SS=E	. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and facility documents, it was determined that the facility failed to 1.) follow [redacted] prevention interventions as written on the resident's plan of care and ordered by the physician and 2.) ensure a resident who sustained [redacted] and cause determined to be [redacted], was followed by a [redacted] This deficient practice was identified for 2 of 5	F 689	F689 Specific Residents The [redacted] have been put in place as well as additional [redacted] interventions for resident #79. Resident # 167 no longer resides in the facility. All nurses were educated to follow up with	10/27/23

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F 689	Continued From page 37 residents (Resident #79, and Resident #167) reviewed for [redacted] and accidents and was evidenced by the following: 1. On 09/11/2023 at 10:18 AM, Surveyor #1 observed Resident #79 lying in bed. Resident #79 was unable to be interviewed at the time but was [redacted]. Resident #79 had a [redacted] their [redacted] and was w[redacted]. Resident #79 was [redacted] the surveyors what happened to his/her [redacted] when asked. The bed was observed in a low position and the call bell was accessible. According to the Admission Record Resident #79 was admitted to the facility with the following but not limited to diagnoses: [redacted] A review of the [redacted] Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, revealed that Resident #79 had a Brief Interview for Mental Status score of not being [redacted] and Resident #79 had [redacted]. Section [redacted] revealed Resident #79 required [redacted] with most activities of daily living. According to Section [redacted] of the MDS Resident #79 had [redacted] since admission/entry or reentry or prior assessment. A review of the Order Summary Report, dated [redacted] revealed Resident #79 had the following physician's order with an order date of [redacted]	F 689	the resident's physician on every resident with dx of [redacted] after a [redacted] for meds review, possible [redacted] consultation if [redacted] is unwitnessed. Other Residents With The Potential To Be Affected All other residents have the potential to be affected by these deficient practices. The Unit Managers or designee will do a 100% audit of all resident's care planned for fall mats to ensure they are in place. Systemic Changes All Nurses and CNA□s will be re-educated to ensure resident□s [redacted] are in place per resident□s care plan. Additionally, licensed nurses will be re-educated to ensure [redacted] and follow-up with a [redacted] occur according to facility [redacted] Prevention policies and recommendations of others. Unit Managers will conduct weekly rounds regarding placement of [redacted]. The Director of Nursing and Unit Managers will review for the need to follow-up with a [redacted] when reviewing [redacted] at the daily Clinical Meeting. Monitoring The Unit Managers will submit a report weekly to the Director of Nursing for 2 months, then bi-weekly for 1 month and the Director of Nursing will submit a monthly report to the facility's monthly	

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F 689	Continued From page 38 "NJ EX Order. 264b1 prevention when in bed." A review of Resident #79's comprehensive care plan revealed that Resident #79 had a care plan Focus of "[resident name] is at NJ EX Order. 264b1 NJ EX Order. 264b1, initiated NJ Ex Ex Order. 264b1. The Focus section also revealed that Resident #79 had a NJ EX O on NJ EX Order. 264b1 with NJ EX Order. 264b1 and NJ EX Order. 264b1. Care planned Interventions/Tasks included NJ EX Order. 264b1 date initiated: NJ EX Order. 264b1. On 09/13/2023 at 09:42 AM the surveyor observed Resident #79 lying in bed. The bed was in the low position and the call bell was within reach. No NJ EX Ord were in place, as ordered, to NJ EX Order. 264b1. On 09/14/2023 at 09:04 AM Resident #79 was observed lying in bed and asleep. The bed was in low position and Resident #79 was centered in the middle of the bed. NJ EX Order. 264b were observed on NJ EX Order. 264b1 as ordered by physician. On 09/15/2023 at 08:40 AM Resident #79 was observed lying in bed. The bed was in the low position and Resident #79 was centered in the middle of the bed with the head of bed elevated. Call bell was within reach. There were no NJ EX Orde NJ EX Order. 264b1 as ordered, on this observation. The surveyor asked the Certified Nursing Assistant (CNA #1) if she was familiar with Resident #79. CNA #1 replied that she was and had worked with Resident #79 previously. CNA #1 identified Resident #79 as a NJ EX Order. 264 and stated that Resident #79 had NJ EX Order. 264b as a care planned intervention, but she had not seen them	F 689	QAPI Committee Meeting for 3 months.	

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in a while. The surveyor asked if the [redacted] disappeared and CNA #1 stated, "Yeah, I guess." The surveyor asked CNA #1 how long the [redacted] had been missing and CNA #1 responded, "It's been a long time. It's been longer than a month."

On 09/15/2023 at 12:17 PM, Surveyor #1 was approached by CNA #1 in the hallway. CNA #1 proceeded to show the surveyor that Resident #79 had [redacted] in place on [redacted]. The surveyor asked CNA #1 who did she advise that Resident #79 had no[redacted] as ordered by the physician. CNA #1 responded, "Nobody, they just showed up."

On 09/15/2023 at 01:10 PM, Surveyor #1 interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN #2) assigned to the [redacted] floor of the facility. The surveyor asked what interventions were in place to [redacted] or [redacted] for Resident #79. UM/LKPN #2 stated, "There are supposed to be [redacted] of Resident #79's [redacted]." The surveyor asked the UM/LPN #2 what the purpose of the [redacted] was to [redacted] for Resident #79. UM/LPN #2 responded, "They are there to prevent [redacted] if the resident happens to [redacted]

On 09/19/2023 at 01:20 PM, Surveyor #1 conducted an interview with the facility administration. The surveyor asked the facility Director of Nursing (DON) if she considered Resident #79 to be a [redacted] The DON responded, "Yes, he/she is considered a [redacted] The surveyor then asked the DON if Resident #79 had a physician's order for [redacted] placed on [redacted] when Resident #79 is in bed. The DON replied, "Yes, he/she had

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an order for NJ EX Order. 264b1 and it is care planned as well." The surveyor asked Resident #79 what purpose the NJ EX Order. 264b1. The DON told the surveyor, "The purpose of the NJ EX Order is to be some NJ EX Order. 264b1 in case they NJ EX Order. 264b1 to reduce the chance of injury." The surveyor then asked the DON if the facility consistently followed the physicians order for NJ EX NJ EX Order with Resident #79. The DON stated, "I agree we failed to carry out that order."

Surveyor #1 reviewed the facility policy titled NJ EX Prevention Program, undated. The following was revealed under Policy: "Each resident will be assessed for NJ EX Order. 2 and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of NJ EX Order The following was revealed under the heading Policy Explanation and Compliance Guidelines:

6. High Risk Protocols:
d. Provide additional interventions as directed by the resident's assessment, including but not limited to:
i. Assistive devices

Surveyor #1 reviewed the facility policy titled NJ EX Risk Assessment, undated. The following was revealed under the heading Policy:

"It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents."

According to the Face Sheet Resident # 167 was admitted to the facility with diagnoses including but not limited to: NJ EX Order. 264b1.

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A review of the Physician Order form dated [redacted] revealed physician orders for [redacted] (medication used NJ EX Order. 264b1 mg (milligrams) [redacted] daily for [redacted] D/O (disorder) with a start date of [redacted]. A further review of the Physician Order form revealed a physician order for [redacted] (a medication used [redacted] mg po (by mouth) every [redacted] hours for [redacted] disorder with a start date of [redacted] There was no physician order for [redacted].

A review of the care plan with date of [redacted], revealed a "Problem" section 'NJ EX Order. 264b1 [redacted]"
Under the "Goal" section "Resident will remain [redacted] related to [redacted] through next review."
Interventions included but were not limited to:
-medicate with medications as ordered.
-Monitor Lab work. Notify MD (physician) of any abnormal lab values.
-Keep Resident safe during [redacted]

A review of a second care plan indicated under the "Problem" Potential for Falls R/T (related to) [redacted] secondary to [redacted] NJ EX Order. 264b1 [redacted]."
Under the Goal section decrease potential [redacted] R/T [redacted] through next review.
Interventions included but were not limited to:
Assess [redacted] admission, quarterly and PRN (as needed).
Encourage resident [redacted] appropriate [redacted]
Encourage resident to NJ EX Order. 264b1 [redacted] at all times.
Frequent visual rounds to increase compliance.

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F 689	Continued From page 42 Labs for NJ EX Order. 264b1 . A review of a facility "Incident Report" (IR) dated NJ EX Order. 26 timed at 7:30 PM revealed "saw resident NJ EX Order. 264b1 , upon approaching resident noted NJ EX Order. 264b1 , cleaned area with NJ EX Ord noted NJ EX Order. 264b1 A review of the NJ EX investigation dated NJ EX Order. 26 revealed resident unable to explain how he/she NJ EX Order. 264b0 EX Order . A review of a "Interdisciplinary NJ EX Or /Incident Committee Report" dated NJ EX Order. 26 , revealed under the Brief Summary of Incident section: "Residen NJ EX Order. 264b1 Went to ER [emergency room] for evaluation. Under the Interventions section: "Sent to ER Upon return NJ EX Order. 264b1 initiated PT (physical therapy) screening done Resident returned NJ EX Order to be removed on NJ EX Order. 264b Added to care plan was checked. A review of a care plan dated NJ EX Order. 26 indicated resident fell while ambulating. Under the intervention section revealed Sent to ER for evaluation and PT evaluation. A review of a facility Incident Report dated NJ EX Order. 26 and timed at 11:15 AM, revealed "resident observed in dining room NJ EX Order. 264b1 Off balance and NJ EX Order. 264b1 his/her NJ EX Orde on the floor. Pt (patient) noted with NJ EX Order. 26 ." Resident transferred to hospital. A review of a "Interdisciplinary NJ EX l/Incident Committee Report" dated NJ EX Order. 264b revealed	F 689		

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under the Brief Summary of Incident: section Resident walking NJ EX Order. 264b1 .
Under the Interventions: section Transfer to hospital for evaluation, PT/OT (occupational therapy) evaluation, NJ EX Order. 264b1 follow-up, encourage to NJ EX Order. 264b1 .

A review of a care plan dated NJ EX Order. 264b1 revealed Pt observed with NJ EX Order. 264b1 resulting in NJ EX Order.
ER evaluation and returned NJ EX Order. 264b1 .
under interventions: NJ EX Order. 264b1) checks, ER eval (evaluation with NJ EX Order. 264b1 screen, MD and family aware, NJ EX Order. 264b1 follow-up) encourage compliance NJ EX Order. 264b1 .

A review of a facility IR dated NJ EX Order. 26 timed at 845PM revealed resident was standing at the desk, next thing NJ EX was NJ EX Order. 264b1 , he/she NJ EX NJ EX Order. 264b1 his/her NJ EX Order. 264b1 the floor. 911 was called resident taken to hospital.

A review of a care plan dated NJ EX Order. 264 revealed under the "Evaluation" section resident was standing at the nurse's station when NJ EX Order. 264b1 observed NJ EX Order. 264b1 landing onto the NJ EX Order. NJ EX Order. his/her NJ EX Order. causing it to NJ EX Order. 264b1 NJ EX Order. 264b1 "
Under the Interventions section sent to hospital rec'd (received) NJ EX Order. 264b1 of his/her NJ EX Order. and returned @ NJ EX Order. 264b1 @8am. Therapy eval staff to enc (encourage) resident to have frequent NJ EX Order. 264b1 .

A review of a facility IR dated NJNJ EX Order. 264b1 timed at 745PM, revealed notified by CNA (Certified Nursing Assistant) that resident was on the NJ EX Order. in his/her room. Found on NJ EX Order. 264b1 and awake NJ EX Order. 264b1 , usually NJ EX Order. 264b1 that may occur

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F 689	Continued From page 44 because of an NJ EX Order. 264b1 allowing NJ EX Order. 264b1 where it does not belong.) on NJ EX Order. 264b1. NJ EX Order. 264b1 NJ EX Order. 264b1. Currently taking NJ EX Order. 264b1 Q (every) NJ EX hours. A review of a Progress Note revealed resident was sent to the hospital and subsequently transferred to a different hospital. During an interview with Surveyor #2 on 09/14/2023 at 10:25 AM, Unit Manager/Licensed Practical Nurse (UM/LPN #1) said she recalled Resident #167. I am pretty sure he/she had a NJ EX Order. 264b1. UM/LPN #1 went on to say that I know NJ EX would NJ EX Order. 264b1. Resident #167 did NJ EX Order. 264b1, and he/she would be standing in one spot and just NJ EX Order. 264b1 He/she walked around a lot. When asked what care a resident with a NJ EX Order. 264b1 would receive, UM/LPN #1 responded "If a resident had a NJ EX Order. 264b1, I would NJ EX Order. 264b1 of their medications and then go from there. I would discuss with the MD and if NJ EX Order. 264b1 and still having NJ EX Order. 264b1 have NJ EX Order. 264b1 consult as maybe something else was going on." On 09/14/2023 at 1:15 PM, Surveyor #2 requested form the DON all of Resident #167's NJ EX Order. 264b1 consults. On 09/15/2023 at 08:11 AM, the DON provided Surveyor #2 with NJ EX Order. 264b1 consult dated NJ EX Order. The DON said, "We can't find any more." During an interview with Surveyor #2 on 09/18/2023 at 09:36 AM, the DON said when we have a NJ EX we assess resident on the floor, NJ EX M NJ EX Orde are taken and ask if they NJ EX Order. 264b1. If	F 689		

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resident has NJ EX Orde don't move the resident and call 911. If no NJ EX Ord, we assist resident off the floor. We do an incident report, call family and DR (doctor). We assess them post incident for 3 days and if they (resident) have an injury we send them to the hospital. If they NJ EX Order. 264b1, any injury send resident to hospital.

A further interview with Surveyor #2 on 09/18/2023 at 09:46 AM, the DON reviewed each incident for Resident #167 as follows:
-NJ EX Order. 264b1, Resident #167 had a NJ EX Order. 264b1 after a fall. He/she sent to the hospital, and he came back with NJ EX Order. 264b1 of his/her NJ EX Order. The cause was he/she was NJ EX Order. 264b1, NJ EX Order. 264b1. When asked what intervention was put into place NJ EX Order. 264b1 The DON said since it was NJ EX Order. 264b1 had PT to get his/her strength back. I called the prior MD office to see if he types his notes in the office and was told they have nothing but what we have here.
NJ EX Order. 264b1 had a NJ EX Order. 264b1 Resident #167 was NJ EX Order. 264b1, and he/she NJ EX Order. 264b1 NJ EX Order. 2. Also had a NJ EX Order. 264b1 of his/her NJ EX Order. 264b1. Transferred to hospital. Did a NJ EX Order. 264b of NJ EX Orde with NJ EX Order. 264b1 No NJ EX Order. 264b1. NJ EX Order. XX to NJ EX Order. 264b1 I believe and came back with a NJ EX Order We sent him/her to NJ EX Order. 264b1 f/u. The DON went on to say that NJ EX Order. 264 was f/u with NJ EX Orde I guess PT evaluation and encourage resident to wear NJ EX Order. 264b1. Yes, that is what I see. I don't see it here, but I remember we had the Dr. evaluate NJ EX meds due NJ EX Order. 264b1. The DON said" there is no documentation that the MD saw pt due to his/her NJ EX Order. 264 and we have to have meds reviewed and will order labs."
NJ EX Order. 264b1 reviewed on 09/18/2023 at 10:01

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AM, the DON said Resident #167 NJ EX Order. 264b1. He/she was standing at the NJ EX Order. 264b1 NJ EX Order. 264b1 his/her NJ EX Order. 264b1 the NJ EX Or. The DON said Yes, according to the notes that is what happened. Yes, he/she just NJ EX Order. 264 and was not NJ EX Order. 264b1. Yes, this is different for this resident. The resident went to the hospital again. Interventions should have been to be seen by his/her medical physician here upon return. The DON went on to say NJ EX Order. 264 beside PT/OT, should have NJ EX Order. 264b1NJ evaluation, Labs should have had been done but I don't see any. Resident #167 has NJ EX Order. 264b1 and yes, he/she should have had a NJ EX Order. 264b1 consult but I don't see it. We ask MD if wants NJ EX Order. 264b1 consult. I think I saw an order but couldn't find any more consults.

NJ EX Order. 264b1 reviewed on 09/18/2023 at 10:09 AM, with the DON. The DON said I remember this one. We called the police because the patient NJ EX and was NJ EX Order. 264b1 and the story the nurses gave us didn't match. We checked camera and the resident was coming out of the room and Temporary Nurse Aide (TNA #1) said she hadn't given care to the resident yet. TNA #1 found Resident #167 on NJ EX Order. 264b1 and we asked what happened. TNA #1 said he/she (resident) was walked from dining room to his/her room and sat him/her on the chair. TNA #1 said she went to get supplies to do care and when she came back, he/she refused care and she left Resident #167 sitting on the chair in his/her room. The DON said Yes, NJ EX Order. 264b1 chair when asked what type of chair. The DON went on to say he/she was able to sit in his/her room without supervision. TNA #1 went back to Resident #167's room to give care and resident was on the NJ EX Order. 264b1 and the chair was next to the bed according to TNA #1. Resident #167 went to the hospital and did not

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F 689	Continued From page 47 return to facility. During an interview with Surveyor #2 on 09/18/2023 at 10:23 AM, when asked if Resident #167 should have had a follow-up with a NJ EX Order. 264b1 the DON said "Absolutely he/she should have been seen by a NJ EX Order. 264b1 for his/her NJ Ex Order 264b1 The DON went on to say "No, I didn't find any more NJ Ex Order. 264b1 consults since the NJ Ex Order one." On 09/18/2023 at 12:49 PM, the DON came to Surveyor #2 and said I can't find any consult or orders NJ EX Order. 264b1 follow up. When asked should the resident have been seen by NJ Ex Order. 264b1, the DON replied "Absolutely, should have been seen 100% he/she should have been seen." A review of a facility policy titled NJ EX Prevention Program, undated revealed under Policy section Each Resident will be assessed for NJ EX risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of NJ EX Order Under the Definition section "A NJ EX is an event in which an individual unintentionally comes to rest on the ground, floor or other level but not as a result of an overwhelming force. The event may be witnessed, reported or presumed when a resident is found on the floor or ground and can occur anywhere. Under policy Explanation and Compliance Guidelines: 1. the facility utilizes a standard risk assessment for determining a resident NJ EX risk. a. The risk assessment categorizes residents according to NJ EX Order. 264b1 risk. 2. Upon admission the nurse will complete a NJ EX risk assessment along with the admission	F 689		

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assessment to determine the resident's level of fall risk.
3. The nurse will refer to the NJ EX Order. 264b1 of NJ EX Order. 264b1 protocols when determining primary interventions.
4. The nurse will refer to the facility's NJ EX Order. 264b1 or NJ EX Order. 264b1 risk protocols when determining primary interventions.
A further review revealed
6. NJ EX Order. 264b1 Protocols:
a. The resident will be placed on the facility's NJ EX O Prevention Program.
i. Indicate NJ EX l risk on care plan.
ii. Place NJ EX prevention Indicator (such as star, color coded sticker) on the name plate to residents rooms.
iii. place fall prevention indicator on residents wheelchair.
b. Implement interventions from NJ EX Order. 264b1 NJ EX Order. 264b1
c. Provide interventions that address unique NJ EX F factors measured by the NJ EX F assessment tool: medications, psychological, cognitive status, or recent change in functional status.
d. Provide additional interventions as directed by the resident's assessment, including but not limited to:
i. assistive devices
ii. increased frequency of rounds
iii. Sitter, if needed.
iv. medication regime review
v low bed
vi alternate call system access.
vii. scheduled ambulating or toileting assistance
viii Family/caregiver or resident education
ix. Therapy services referral
8. Each resident risk factors and environmental hazards will be evaluated when developing the resident comprehensive plan of care.

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F 689	Continued From page 49 a. interventions will be monitored for effectiveness. b. care plan will be revised as needed. 9. When any resident experiences a fall, the facility will: a. assess resident b. complete a post fall assessment. c. complete an incident report. d. notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. obtain witness statements in the case of injury. A review of a facility titled [redacted] Risk Assessment policy undated, revealed under the Policy section It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. Under the Policy Explanation and Compliance Guidelines: 1. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified. 3. An "At [redacted] care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly. 4. The "At [redacted] care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident. 5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice.	F 689		

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F 689	Continued From page 50 NJAC 8:39-27.1(a)	F 689		
F 730 SS=D	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, record review and review of pertinent facility documents, it was determined that the facility failed to complete a performance review of a Certified Nurse Aide (CNA) at least every 12 months. The deficient practice was identified for 1 of 5 Certified Nurse Aides reviewed under Sufficient and Competent Nurse Staffing task. The deficient practice was evidenced by the following: A review of the facility-provided CNA annual performance evaluations revealed that 1 of the 5 CNAs did not have an annual performance evaluation. On 09/15/2023 at 12:01 PM, during an interview with the surveyor, the Human Resources Director confirmed one performance evaluation was not completed for one of the five CNAs. On 09/19/2023 at 01:08 PM, during an interview with the surveyor, the Director of Nursing (DON)	F 730	F730 Specific Concern The evaluation for the specific noted employee wass completed. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% audit of all employee files will be conducted to ensure an evaluation exists in the last 12 months. If not, they will be immediately completed. Systemic Changes The Director of Human Resources has been re-inserviced on the importance of ensuring annual evaluations are completed for all employees. The Director of Human Resources will generate a monthly list, by employee hire date, indicating who is due for their annual evaluation in the upcoming month and distribute to the appropriate department heads and Administrator. The	10/27/23

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F 730	Continued From page 51 replied, "It should be done yearly" when asked what the process for reviewing the performance evaluation for nurse aides was. The DON confirmed that the annual performance evaluation was not completed for one of the CNAs by replying, "Yes" when the surveyor stated that the CNA should have had at least one annual performance evaluation since his/her hire date. A review of facility-provided policy titled, "Annual Employee Evaluations" with a date implemented of May 2, 2023, revealed under section titled, "Purpose" that "To comply with federal regulations, all employees will receive an annual evaluation of their work performance." N.J.A.C. § 8:39-43.17(b)	F 730	Administrator will ensure all evaluations are completed timely. Monitoring The Director of Human Resources will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month regarding status of all employee evaluations and the Administrator will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		10/27/23

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F 803	Continued From page 52 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined that the facility 1.) failed to follow the planned, written menu and ensure residents were notified in advance of menu changes for 2 of 2 meals observed and 2.) failed to post the menu in area that was accessible to residents. This deficient practice was evidenced by the following: 1. On 09/13/2023 at 12:03 PM the surveyor observed the lunch meal in the [redacted] floor dining/recreation room. The surveyor observed Resident #77. Resident #77 received an 8oz skim milk, coffee, lemonade 4oz, mechanical pork tenderloin with gravy, mashed potato with onions, wax beans, and applesauce. On 09/13/23 at 12:13 PM the surveyor reviewed the facility menu for the lunch meal on Wednesday 9/13/2023. The Food Service Director (FSD) stated to the surveyor on the initial tour of the kitchen that the facility was currently on week 2 of the cycle menu. The menu indicated that on week 2 on Wednesday 9/13/2023 the lunch meal was to consist of the following: Cheeseburger with bacon, macaroni & cheese, baby carrots, Bun, Brownie, beverage of choice, and margarine. On 09/13/2023 at 12:18 PM the surveyor went to the kitchen to conduct an interview with the FSD.	F 803	F803 Specific Residents The Director of Food Service has been re-inserviced on the facility□s Menu Change Policy, specifically on the importance of contacting the Dietitian and keeping a record of all menu changes. The menu is now being posted. Other Residents With Potential To Be Affected All residents have the potential to be affected by this deficient practice. Systemic Changes The Director of Food Service will notify the Administrator and Dietitian regarding all menu changes and keep a record accordingly. The Director of Food Service is now responsible to post the menu daily. The Administrator will audit that the menu has been posted weekly. Monitoring The Director of Food Services will submit a report weekly to the Administrator for 2 months, then bi-weekly for 1 month. and the Administrator will submit a monthly	

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F 803	Continued From page 53 The surveyor asked the FSD what he served for the lunch meal on 9/13/2023. The FSD responded, "I served pork loin, potatoes with peppers and onions and wax beans." The surveyor pointed out to the FSD that the week 2 cycle menu indicated that the lunch meal to be served was a cheeseburger with bacon, macaroni & cheese, baby carrots, bun, brownie, beverage of choice, and margarine. The surveyor asked the FSD why the menu was not served for the lunch meal today. The FSD stated, "The simple answer is that I ran out of hamburgers. I ran out of hamburgers yesterday. They (dietary staff) used up the second box of hamburgers yesterday. It was the alternate yesterday. It's my fault, I'll take it." The surveyor asked the FSD to get the food substitution approval log for the surveyor to observe. The FSD responded, "I have to print one up. I don't have one right now and the dietitian will not be here until Friday." The surveyor asked the FSD if he had a menu substitution book available for the surveyor to review. The FSD, "I do not have a menu substitution book. I will have one." The FSD agreed that he did not follow the facility policy for menu substitutions. According to documentation provided by the FSD the census for this meal was 114. According to the lunch for 9/15/2023: Week 2 on Friday the facility was to serve the following meal: Chicken BBQ sandwich, steak fries, coleslaw, dinner roll, lemon bar, beverage of choice, margarine, mayo/ketchup. During the lunch meal observation on the 2nd floor dining/recreation room the surveyors observed the following at the lunch meal: spaghetti with tomato sauce, chicken parmesan, carrot slices, garlic bread, and orange sherbet.	F 803	report to the facility's monthly QAPI Committee Meeting for 3 months.	

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On 09/15/2023 at 12:33 PM the surveyor conducted an interview with the facility Registered Dietitian (RD). The surveyor asked the RD if she had been contacted by the facility FSD to approve a menu change for the lunch meal served on 9/15/2023. The RD responded, "I was not contacted by the FSD for a menu change/substitution." The surveyor asked the facility RD what the policy was for menu changes in the facility. The RD explained, "Our policy is that the food service director is to contact me to approve of any menu substitutions. He (FSD) contacted me on the 13th (September) concerning the menu substitution for the pork and cheeseburger, but I was not contacted today."

On 09/15/2023 at 12:56 PM the surveyor conducted an interview with the facility FSD concerning the menu substitution for the lunch meal on 9/15/2023. The surveyor asked the FSD if he approved the menu substitution for the lunch meal with the facility RD prior to the lunch meal. The FSD replied, "Actually, I did not, but I will do it now." According to the FSD provided documentation the census for the lunch meal on this date was 118.

2. On 09/15/2023 at 08:57 AM the surveyors toured the [redacted] floors of the facility, including dining rooms and nurses' stations. The surveyors did not see or observe a menu posted in the facility for lunch or dinner meals.

On 09/15/2023 at 09:03 AM the surveyor conducted an interview with Resident #74m who was seated at a table in the [redacted] floor dining/recreation room at the time. The surveyor asked Resident #74 if he/she knew what was for lunch on this day. The resident responded, "No."

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The surveyor then asked Resident #74 how do you know what they are serving? Resident #74 responded, "I don't know. When the food arrives that's when I know what's to eat." The surveyor asked Resident #74 if the facility posts menus so that residents are aware what is being served at mealtimes. Resident #74 stated, "No."

On 09/18/2023 at 12:52 PM the surveyor observed the [redacted] floor dining room. The surveyor did not observe any menus posted in or around the inside/outside of the dining room so that residents could be informed of what was to eat for the week and make informed menu choices.

On 09/18/2023 at 12:55 PM the surveyor observed the [redacted] floor dining/recreation room. The surveyor did not observe any posted menu to inform residents of meals to be served.

On 09/19/20233 at 01:27 PM during an interview with the facility administration the surveyor informed the Licensed Nursing Home Administrator (LNHA) that the survey team did not observe the menu posted in the facility throughout the survey process. The surveyor asked the LNHA who in the facility was responsible for posting menus in the facility where they are readily available to residents. The LNHA responded, "I will make sure the menu gets posted. I want to get to the point where residents can select their menu, so we know exactly how much food to produce for that meal. I'm not sure at this moment who would be responsible to post the menus. I'm probably going to make it dietary."

The surveyor reviewed the facility policy titled Standardized Menus, undated. The following was revealed under the heading Compliance

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F 803	Continued From page 56 Guidelines: "Menus are revised by the Registered Dietitian and Dietary Manager based on resident food preferences. Reasons for change should be noted and kept on file." "The menu should be posted in a designated area(s) where it will be readily available to residents, facility staff, and visitors." The surveyor reviewed the facility policy titled Menus and Adequate Nutrition, undated. The policy revealed the following under the heading Policy Explanation and Compliance Guidelines: "Menus shall be prepared at least two weeks in advance for timely approval and ordering of food. Menus will be posted in the kitchen and in areas accessible by residents at least one week in advance." "Menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable. Substitutions shall comprise of foods with comparable nutritive value." N.J.A.C. 18-39-17.4(a)(c)(e) N.J.A.C. 18: 39-18.4(e)	F 803		
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.	F 812		10/27/23

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F 812	Continued From page 57 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/11/2023 from 9:15 to 9:58 AM, the surveyors, accompanied by the facility Food Service Director (FSD), observed the following in the kitchen: 1. Upon entry to the kitchen the surveyors observed a staff member at the ice machine inside of the kitchen door. The staff was actively filling a cooler on top of a wheeled cart with ice obtained from the ice machine. The staff member identified him/herself as a Recreation Assistant (RA). The female RA had lengthy hair and no hair net. The RA's hair was exposed while in the kitchen. The FSD agreed that all staff should don a hair net while in the kitchen. 2. On an upper shelf in the dry storage room a	F 812	F812 Specific Concerns The Activity employee was re-inserviced on the importance of wearing a hair net when entering the kitchen. The undated pasta, omelets, waffles, croissants ,hot dogs, and baby carrots were immediately discarded. The thickener, biscuit mix, french toast slices , and frozen egg omelets were covered. The paper towels were filled. The chef salad, hard boiled eggs, jelly, diced pears and sliced tomatoes were immediately dated. The meat slicer was covered. Resident #52 refrigerator now has a thermometer, daily temperature log and dated food inside. Identification of Similar Concerns All residents have the potential to be affected by these deficient practices. All other food items were observed to identify if anything else needed to be covered or dated. A 100% audit of all resident refrigerators will be conducted to	

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F 812	Continued From page 58 previously opened bag of uncooked pasta noodles had no dates. On interview the FSD stated that once opened the pasta required a use by date. 3. On a lower shelf, an opened box contained food thickener used to thicken foods and beverages for residents with swallowing issues. The food thickener was in an opened plastic bag within the cardboard box and the food thickener was exposed. Additionally, on a lower shelf a large bag of buttermilk biscuit mix was opened, and the biscuit mix used for resident meals was exposed. 4. In the walk-in freezer on an upper shelf an opened plastic bag within a cardboard box contained frozen omelets. The bag had no dates, and the omelets were exposed. A previously opened plastic bag within a cardboard box contained frozen waffles. The bag had no dates, and the bag had a hole in it, exposing the waffles to the air. In addition, a previously opened bag of what appeared to be croissants had no dates. 5. On a middle shelf next to the freezer door, a previously opened bag contained hot dogs. The bag had no dates, and the hot dogs were exposed. The FSD removed the items to the trash. 6. Upon exiting the walk-in freezer the surveyor went to the designated hand washing sink to get a paper towel. The dispenser was empty, and no hand towels were available. The FSD stated that he would have somebody fill it, when made aware by the surveyor. 7. In the walk-in refrigerator on a middle shelf	F 812	ensure they all have a thermometer, daily temperature log and dated food inside. Systemic Changes All other food items were observed to identify if anything else needed to be covered or dated. A 100% audit of all resident refrigerators will be conducted to ensure they all have a thermometer, daily temperature log and dated food inside. All Activity and Dietary employees will be re-inserviced on the importance of wearing a hair net while in the kitchen. All Dietary employees will be re-inserviced on ensuring paper towels and soap are available, that all food items are dated/covered, and that the meat slicer is covered when not in use. Housekeeping will be inserviced on their responsibility to ensure resident personal refrigerators contain a thermometer, daily temperature log and dated food inside. Monitoring The Director of Food Service will submit a daily report to the Administrator regarding food dating, proper food storage, covering the slicer and staff compliance with wearing hair nets. The Administrator will also monitor compliance to all of these items weekly. The Administrator will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months.	

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were (6) chef salads on white plates covered with clear plastic wrap. The salads had no dates. Next to the salads, a 1/2 pan contained hard boiled eggs. The pan was covered with clear plastic wrap. The pan had no dates. In addition, a plastic container with a plastic lid on an upper shelf contained jelly. The container had no dates.

8. A cleaned and sanitized meat slicer was observed on a metal counter in the prep area. The meat slicer was not in use, per the FSD when asked by the surveyor. The meat slicer was uncovered and exposed to contamination. The FSD agreed that the slicer should be covered when not in use.

On 09/13/2023 from 11:18 to 11:24 AM, the surveyor entered room 149 after being made aware that a personal refrigerator was observed in that room. Resident #52 stated that the refrigerator was in his/her room for approximately 3 months and was brought in to the facility by his/her brother. The surveyor asked Resident #52 if anybody in the facility monitored the temperature of the refrigerator or monitored the dates of the foods stored within the refrigerator. Resident #52 told the surveyor, "Nobody monitors my refrigerator. Nobody checks the temperature." The surveyor did not observe a temperature log or an internal thermometer within the personal refrigerator once they received permission from the resident to look inside. The surveyor asked the Unit Manager/Licensed Practical Nurse (UM/LPN #1) if she was aware that Room 149 had a personal refrigerator. UM/LPN #1 responded that she was not aware that there was a personal refrigerator in the room. The surveyor asked UM/LPN #1 if the refrigerator should be monitored for temperatures and use by dates for

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food and beverages. UM/LPN #1 responded, "Yes, the refrigerator should be monitored for temperature and checked to ensure that foods are not expired." The surveyor informed UM/LPN #1 that there was no temperature log or internal thermometer observed in room 149 for the personal refrigerator.

On 09/20/23 at 09:09 AM, the surveyor gained permission to enter room 149 from Resident #52. Upon entering the room, the surveyor observed a temperature log sheet on the front of Resident #52's personal refrigerator. The temperature log had a recorded temperature of 37 degrees in the AM on 9/13. The temperature log was labeled September. No other temperatures had been recorded since 9/13 in the AM. The surveyor had made the facility Director of Nursing and Licensed Nursing Home Administrator aware of the issue on 9/19/2023.

On 09/18/2023 from 10:20 to 10:36 AM, the surveyor, accompanied by the FSD, observed the following in the kitchen:

1. Upon entry to the walk-in freezer the surveyor observed a previously opened box of frozen French Toast Slices. The French toast slices were in a clear plastic bag within the box. The bag was opened, and the French toast slices were exposed. Adjacent to the opened and exposed French toast slices, a previously opened box contained frozen egg omelets with cheese. The clear plastic bag inside the box was opened and the cheese omelets were exposed. On an upper shelf, a previously opened bag of baby carrots was removed from its original container. The carrots had no dates.

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2. On a middle shelf in the walk-in refrigerator a plastic milk-style crate contained individual portions of diced pears in plastic covered portion control cups. The cups and the crate did not contain any dates. A deep, clear, plastic container contained sliced tomatoes and was covered with plastic wrap. The tomatoes were undated. The FSD stated on interview that the tomatoes were sliced this morning for today's lunch and the pears were for today's lunch meal. The FSD told the surveyor that he would in-service my staff on labeling and dating.

The surveyor reviewed the facility policy titled Date Marking for Food Safety, undated. According to the Policy, "The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety (sic) food." The following was reveled under the heading Policy Implementation and Compliance Guidelines for Staffing:

"Refrigerated, ready-to-eat, time/temperature control for safety food (i.e., perishable food) shall be held at a temperature of 41 F (Fahrenheit) or less for a maximum of 7 days."

"The food shall clearly be marked to indicate the date or day by which the food shall be consumed or discarded."

"The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared."

"The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded."

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F 812	Continued From page 62 "The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed." The surveyor reviewed the facility policy titled Maintaining a Sanitary Tray Line, undated. The following was revealed under the heading Compliance Guidelines: During tray assembly, staff shall: "Wear hair restraints (bonnets, caps, nets, to cover hair) when preparing or handling food." N.J.A.C. 18:39-17.2(g)	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective	F 865		10/27/23

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actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique

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care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

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F 865	Continued From page 65 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents, it was determined that the facility failed to ensure that their Quality Assurance and Performance Improvement (QAPI) Program was being implemented, and failed to provide sources of qualitative data that showed the facility had analyzed or identified quality deficiencies and evaluated program effectiveness. This deficient practice was evidenced by the following: On 09/15/2023 at 10:17 AM, the Administrator and the Director of Nursing (DON) advised the surveyor that they were unable to provide any sign-in sheets or documentation of a comprehensive QAPI program. During an interview with the surveyor on 09/15/2023, at 11:55 AM, the Administrator stated that the facility prior to his arrival in September 2023, was not conducting QAPI committee meetings. He added that the previous administration did not maintain any documentation that a QAPI program was implemented or maintained as required by the regulation. On 09/15/2023 at 01:13 PM during an interview with the DON, she stated that there has not been a QAPI program in place since she started at the facility October 2021. The DON added that she is	F 865	F865 Specific Concern The Administrator identified this concern and conducted a QAPI meeting in September which included several studies. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. Systemic Changes The Administrator conducted a training session during the September QAPI Meeting. QAPI meetings will be held monthly rather than the quarterly mandate. Monitoring The Administrator and the Director will co-chair the monthly QAPI meeting and the Administrator will ensure the Medical Director attends quarterly as required. The Administrator will submit a monthly report to the facility's monthly QAPI Committee Meeting for 3 months regarding overall compliance to the various provisions of this QAPI regulation.	

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F 865	Continued From page 66 aware of the requirements of QAPI to meet at least quarterly with all department heads; the administrator and the medical director must all be present. She added that the QAPI program must be ongoing, comprehensive and address all care areas and services provided by the facility. A review of the facility's "Quality Assurance and Performance Improvement (QAPI) Plan dated August 2017, policy statement reflected, "This facility shall develop, implement, and maintain an ongoing, facility wide QAPI Plan designated to monitor and evaluate the quality of resident car, pursue methods to improve care quality, and resolve identified problems." NJAC 8:39-33.1(a)(c)(e); 33.2(a)(b)(c)(d)	F 865		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services	F 947		10/27/23

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F 947	Continued From page 67 to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that all Certified Nursing Assistants (CNAs) received 12 hours of mandatory in-service training and Dementia training as required. This was identified for 5 of 5 CNA files reviewed for in-service training under Sufficient and Competent Nurse Staffing task. The deficient practice was evidenced by the following: A review of five randomly selected CNA education files did not reveal the mandatory 12 hours in-service training and Dementia training. A review of "Mandatory In-service" sheets for year 2022 revealed that CNA #1 was hired on 11/11/2021 and completed 5.5 hours of the training. CNA #2 was hired on 06/16/2022 and completed 5.5 hours of the training. CNA #3 was hired on 07/26/2021 and completed 5.0 hours of the training. CNA #4 was hired on 05/18/2021 and completed 6.0 hours of the training. CNA #5 was hired on 08/12/2021 and completed 5.5 hours of the training. On 09/19/2023 at 12:10 PM, during an interview with the surveyor, the Staff Development Nurse (SDN) provided an additional document titled "Mandatory In-service" for one of the five selected CNAs. At that time, the SDN stated, "That's all I	F 947	F947 Specific Concern The 5 noted Certified Nursing Assistant's (CNA's) will be provided with a minimum of 12 hours of training annually including Dementia training. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The Infection Preventionist/Staff Development or designee will conduct a 100% audit of all Certified Nursing Assistannt inservice records to determine if any other of them need additional training, including Dementia training, to meet the 12 hour annual training minimum requirement. Systemic Changes The Infection Preventionist and Director of Nursing has been re-inserviced on 10/23/23 by the Administrator on on the requirement that all Certified Nursing Assistants need a minimum of 12 hours of training, including Dementia training on an annual basis. All employees now have an annual Individual Employee Training Profile which reflects all inservices the Certified Nursing Assistants have received. Monitoring The Infection Preventionist or designee	

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F 947	Continued From page 68 have for 2022." A review of the "Mandatory In-service" sheet provided by the SDN revealed an initial training provided upon hire, and not the annual 12 hours training required for CNAs. A review of facility undated policy titled "Required Training, Certification and Continuing Education of Nurse Aides" revealed under section "Policy Explanation and Compliance Guidelines" that "5. The facility will provide at least 12 hours of in-service training annually ..." and "6. ... Minimum training will include ... b. Dementia management and care of cognitively impaired." N.J.A.C. § 8:39-43.17(b)	F 947	will submit a weekly report to the Director of Nursing and the Administrator on the status of all newly hired and in-house Certified Nursing Assistant 12 hours of annual training , including Dementia training. The Administrator will submit a monthly report to the facility's monthly Quality Assurance Performance Improvement Committee for the next 3 months.	

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S 000	Initial Comments C/O # NJ163151, NJ158743, NJ157630 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C/O # NJ163151, NJ158743, NJ157630 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 as mandated by the state of New Jersey. This was evident for A.) 14 of 14 day shifts for the period of 08/21/2022 to 09/03/2022 and 13 of 14 day shifts for the period of 10/02/2022 to 10/15/2022, and 14 of 14 day shifts for the period of 08/27/2023 to 09/09/2023 and B.) ensure that all general training for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a	S 560	S560 Specific Concerns The facility can not correct the specific days/shifts it did not meet the state minimum requirements for CNA staffing as the dates have already passed. Regarding mandated LGBTQ+ training, the facility is in the process of certifying additional employees representing management and staff who will conduct the mandatory training for all staff. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. The	10/27/23

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

Electronically Signed | 10/05/23

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S 560	Continued From page 1 combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program for the administrators and staff members employed at a facility as of August 30, 2021, shall complete the general training on or before August 29, 2022. Individuals hired after August 30, 2021, are required to complete the training within one year after the date of hire. Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. 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. 1.) The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows for the period 08/21/2022 to 09/03/2022: -08/21/22 had 13 CNAs for 113 residents on the	S 560	Administrator will review all Daily Nursing Staffing Sheets for the month of September 2023 to determine additional days/shifts the CNA minimums were not met. The Administrator will review all 2023 Inservice records for all employees to determine if any staff received the required LGBTQ+ training. Systemic Changes The facility has implemented a weekly staffing committee consisting of the Administrator, DON, Staffing Coordinator, and HR as well as the corporate HR team. The Committee will discuss and implement recruitment and retention strategies geared towards consistently meeting the required CNA minimum staffing patterns. Strategies include wage analysis, job fairs, referral bonuses and more. All employees will receive the required LGBTQ+ at a minimum of upon hire and annually by a certified Instructor. The Director of Staff Development or designee will prepare a monthly report on the status of the mandatory inservice training on LGBTQ+. Monitoring The Administrator will review the Nursing Staffing Sheets on a daily basis and submit a monthly report to the facility's monthly QAPI Committee on the status of the facility's progress on meeting state mandated CNA minimum staffing patterns for the next 3 months. The ADON or designee will submit a weekly report on the progress of the LGBTQ+ training to the Director of Nursing and Administrator. The Director of Nursing will submit a	

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S 560	Continued From page 2 day shift, required at least 14 CNAs. -08/22/22 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/23/22 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/24/22 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/25/22 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/26/22 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/27/22 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -08/28/22 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -08/29/22 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/30/22 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/31/22 had 10 CNAs for 108 residents on the day shift, required at least 14 CNAs. -09/01/22 had 11 CNAs for 108 residents on the day shift, required at least 14 CNAs. -09/02/22 had 11 CNAs for 110 residents on the day shift, required at least14 CNAs. -09/03/22 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. 2.) The facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows for the period of 10/02/2022 to 10/15/2022: -10/02/22 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -10/03/22 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/04/22 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -10/05/22 had 10 CNAs for 108 residents on the	S 560	monthly report on the status of all employees mandatory inservice training on LGBTQ+ to the facility's monthly QAPI Committee for the next 3 months.	

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day shift, required at least 13 CNAs.
-10/06/22 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-10/07/22 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-10/08/22 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs.

-10/09/22 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-10/10/22 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-10/11/22 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-10/12/22 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs.
-10/13/22 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-10/14/22 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs.

3. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows for the period of 08/27/2023 to 09/09/2023:

-08/27/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs.
-08/28/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs.
-08/29/23 had 7 CNAs for 115 residents on the day shift, required at least 14 CNAs.
-08/30/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs.
-08/31/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs.
-09/01/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs.
-09/02/23 had 8 CNAs for 116 residents on the day shift, required at least 14 CNAs.

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S 560	Continued From page 4 -09/03/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -09/04/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -09/05/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -09/06/23 had 5 CNAs for 114 residents on the day shift, required at least 14 CNAs. -09/07/23 had 9 CNAs for 114 residents on the day shift, required at least 14 CNAs. -09/08/23 had 9 CNAs for 114 residents on the day shift, required at least 14 CNAs. -09/09/23 had 10 CNAs for 114 residents on the day shift, required at least14 CNAs. On 09/18/2023 at 1:57 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) replied, "Yes" when asked by the surveyor if he was aware of the state CNA staffing ratios. The LNHA replied, "No" when the surveyor asked if they are meeting those ratios. A review of the undated, facility-provided policy titled; "Nurse Staffing Posting Information" did not address Certified Nurse Aide staffing ratios. B.) Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C. 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes	S 560		

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

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called, despite being clearly informed of the resident's choice;
6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices;
7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;
8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and
9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6).

Resident Records
Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality
The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.

Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or

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accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.

Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.

Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling.

Violations
A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action.

Training
Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated

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S 560	Continued From page 8 expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. 09/20/23 08:51 AM, requested policy for LGBTQI from the DON she provided the training information. Other than the designated employees identified above, the administrators and staff members employed at a facility as of August 30, 2021, shall complete the general training plan ... , on or	S 560		

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S 560	Continued From page 9 before August29, 2022. Individuals hired after August 30, 2021, are required to complete the training within one year after the date of hire. During Entrance conference on 09/11/2023 at 9:49 AM, Surveyor #2 requested documentation of the facility staff training for the LGBTQI+, and what approved agency provided staff education and the training agenda. During an interview with Surveyor #2 on 9/11/2023 at 1:36 PM, the Director of Nursing (DON) who provided her certification for the training of LGBTQI. The DON said the prior Administrator and Social Worker who are no longer here, were also trained. The DON said, "I'm not going lie to you, the rest of our staff has not been trained." The facility was unable to provide a policy regarding training for the staff on LGBTQI+.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENT	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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
S1405	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. The deficient practice was evident for 2 of 10 employees reviewed under the Sufficient and Competent Nurse Staffing task and was evidenced by the following: On 09/15/2023 at 12:15 PM, the surveyor reviewed the employee files of ten random and recently hired employees. Employee # 1 was hired on 07/19/2023. Employee # 1's "Employee's Health Questionnaire" document dated 07/19/2023 was not complete. The document was blank including the history of disease, employee signature, and the "Employee Health Examination" that was to be filled out by the employee's physician. The bottom section requiring a date, physician's signature and address were blank. Employee # 2 was hired 07/29/2023. Employee # 2's "Employee's Health Questionnaire" document dated 07/27/2023 was not complete. The	S1405	S1405 Specific Concerns Both employees will have a health history and examination completed by the facility□s consulting Nurse Practitioner. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% audit of all employees health files will be conducted by the Infection Preventionist or designee to determine if any additional employees need a health history and/or examination done and they will be completed accordingly. Systemic Changes The Infection Preventionist has been inserviced on the requirement that all employees must receive a health history and examination in accordance with this provision. The facility□s consultant Nurse Practitioner will now be conducting them upon hire. Monitoring The Infection Preventionist or designee will submit a weekly report to the Director of Nursing and the Administrator on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENT	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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
S1405	Continued From page 11 questionnaire did not include a section requiring a date, Physician's signature, and address. No further documentation was provided by the facility showing that Employee # 2 was screened by Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. On 09/18/2023 at 1:57 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) said, "It's on hire or slightly before hire. We should be doing it as part of our onboarding, orientation process upon hire" when the surveyor asked when new employees should receive an employment physical. Lastly, the LNHA replied, "Physicals got to be done" when asked by the surveyor should new employees be allowed to work without being assessed by a Physician. A review of the facility-provided policy titled, "Employee Health Program" with a revised date of January 2012 revealed under the section titled, "Policy Interpretation and Implementation" that, "1. The major components of the employee health program consist of the following: a. Providing pre-employment physical examinations and testing ..."	S1405	health history and examination compliance status of all in-house and newly hired employees. The Administrator will submit a monthly report to the facility's monthly QAPI Committee for the next 3 months.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative	S1410		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENT	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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
S1410	Continued From page 12 two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that a new employee received the Mantoux tuberculin skin test (a test to determine the presence of tuberculin bacteria) as required. This deficient practice was identified for 2 of 10 new employee files reviewed under the Sufficient and Competent Nurse Staffing task. The deficient practice was evidenced by the following: A review of new employee files revealed that 2 of 10 newly hired employees had not received the second step of the 2-step Mantoux test. A review of Employee # 2's facility-provided	S1410	S1410 Specific Concerns Both employees will have a 2-step Mantoux test completed. Identification of Similar Concerns All residents have the potential to be affected by this deficient practice. A 100% audit of all employees health files will be conducted by the Infection Preventionist or designee to determine if any additional employees need a 2-step Mantoux test and they will be completed accordingly. Systemic Changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENT	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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
S1410	Continued From page 13 medical file revealed a document titled, "CARING Tuberculin Skin Testing" that included a subsection titled, "Step #1" with an administered date of "1/15/23" and a date read of "1/17/23". The document included a subsection titled; "Step #2" that was left blank. A review of Employee # 3's facility-provided medical file revealed an untitled document that included a section titled, "Initial Mantoux Record (Two Step)". The subsection titled, "Initial Skin test" revealed a date given of "8/15/22" and a date read as, "8/17/22." The subsection titled, "Second Skin test" was left blank. On 09/18/2023 at 1:57 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) replied, "Same thing, on hire and before resident contact. It's part of the onboarding process" when the surveyor asked when should new employees receive a two-step tuberculin test. During the same interview, the Director of Nursing replied, "Yes, two weeks after" when the surveyor asked if the second step in the test is required. Lastly, the LNHA replied, "yes" when the surveyor asked should the second step be completed before an employee beings work. A review of the facility-provided policy titled, "Tuberculosis, Employee Screening for" with a revised date of July 2010 revealed under subsection "New Employee Screening" that, "1. Each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to the employee's duty assignment." The policy also revealed under subsection "Tuberculin Skin Testing" number "2" that, "a. If the reaction to the first skin test is negative, the facility will administer a second skin test 1 to 2 weeks after the first test ..."	S1410	The facility□s Infection Preventionist, who is responsible for Employee Health, has been inserviced on the requirement that all employees must receive a 2-step Mantoux test in accordance with this provision and they will be completed upon hire. Monitoring The Infection Preventionist or designee will submit a weekly report to the Director of Nursing and the Administrator on the 2-step Mantoux compliance status of all in-house and newly hired employees. The Administrator will submit a monthly report to the facility's monthly QAPI Committee for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061520	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENT	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061520 Y1	A. Building B. Wing Y2	11/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/27/2023	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 10/27/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 10/27/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 9/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061520		11/13/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/27/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315206 Y1	A. Building B. Wing Y2	11/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	10/27/2023	LSC	10/27/2023	LSC	10/27/2023
ID Prefix F0604	Correction	ID Prefix F0607	Correction	ID Prefix F0656	Correction
Reg. # 483.10(e)(1), 483.12(a)(2)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	10/27/2023	LSC	10/27/2023	LSC	10/27/2023
ID Prefix F0677	Correction	ID Prefix F0688	Correction	ID Prefix F0689	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	10/27/2023	LSC	10/27/2023	LSC	10/27/2023
ID Prefix F0730	Correction	ID Prefix F0803	Correction	ID Prefix F0812	Correction
Reg. # 483.35(d)(7)	Completed	Reg. # 483.60(c)(1)-(7)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	10/27/2023	LSC	10/27/2023	LSC	10/27/2023
ID Prefix F0865	Correction	ID Prefix F0947	Correction	ID Prefix	Correction
Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed
LSC	10/27/2023	LSC	10/27/2023	LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/20/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315206	A. Building B. Wing	11/13/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 10/27/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315206		11/13/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN HEALTH AND REHABILITATION CENTER	1211 RT 72 WEST MANAHAWKIN, NJ 08050

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004 Reg. # 483.73(a) LSC	Correction Completed 10/27/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			