STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 08/08/2023

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BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE BARNEGAT, NJ 08005**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey Census: 97 Sample Size: 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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		9/5/23

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

Electronically Signed | 08/30/2023

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F 657	Continued From page 1 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to revise a care plan for a resident who transitioned from NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1. This deficient practice was identified for 1 of 25 sampled residents, (Resident # 69) and was evidenced by the following: A review of the Admission Record revealed Resident #69 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 [redacted] A review of the Admission Minimum Data Set, an assessment tool used to facilitate resident care dated 04/12/2023, revealed a Brief Interview for Mental Status of EX O[redacted]/15 indicating Resident #69 was EX Order 26 § 4b1. A review of section N revealed the resident received 7 days of EX Order 26 § 4b1 [redacted]. A review of the Order Summary Report (OSR) dated 05/01/2023 revealed a physician order for start date of EX Order 26 § 4b1 [redacted]	F 657	F657 Care Plan Timing and Revision The Care Plan of resident #69 has was reviewed and revised. The EX Order 26 § 4b1 [redacted] focus has been resolved since the completion of the order. Residents who have a Physician order change in the administration route of an EX Order 26 § 4b1 [redacted] have the potential to be affected. An audit was completed on residents who are currently receiving EX Order 26 § 4b1 and no other residents were affected. The facility educator provided education to the licensed nursing staff. Education included that if an item is care planned based on an order, then the item must be updated when the order is changed. The Director of Nursing or designee will audit up to five resident care plans who are receiving NJ Exec. Order 26:4.b.1 weekly x 4 weeks, then twice monthly for one month, then monthly for one month for review of the implementation and revisions if required.	

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F 657	Continued From page 2 Reconstituted with a start date of 04/22/2023 use EX Order 26 § 4b1 one time a day for EX Order 26 § until 05/07/2023. A review of the OSR dated 06/01/2023 revealed a physician order with a start date of 05/10/2023, EX Order 26 § 4b1 A review Resident #69's care plan did not include a Focus are for the use of an EX Order 26 § 4b1. During an interview with the surveyor on 07/31/2023 at 9:08 AM, Resident #69 said yes, I am on an EX Order 26 § 4b1 for a EX Order 26 § 4b1 in my EX Ord. Resident #61 went on to say the last day for the EX Order 26 § 4b1. During an interview with the surveyor on 07/31/2023 at 11:58 AM, the Infection Preventionist/Licensed Practical Nurse (IP/LPN) was asked who is responsible to initiate care plan for residents on EX Order 26 § 4b1. IP/LPN replied Usually the Unit Manager, or 3-11 nursing supervisor are responsible to initiate the care plan. Sometimes I am involved but usually the Unit Manager. During an interview with the surveyor on 08/02/2023 at 10:01 AM, Licensed Practical Nurse (LPN #1) said the baseline care plan is initiated upon admission. Then the care plan is developed within 7 days, and we have up to 21 days to complete the care plan. LPN #1 went on to say the care plans are reviewed quarterly, monthly, and annually and as need with changes. The surveyor asked LPN #1 what is expected to	F 657	Results of the above audit will be presented by the Director of Nursing to the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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F 657	Continued From page 3	F 657		

be on the care plan to direct care of residents, their strength, and weaknesses, like and dislikes and what we need to do for them.

During an interview with the surveyor on 08/02/2023 at 10:31 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) said that upon admission whatever nurse is here would initiate the baseline care plan when they are doing the assessments. When asked what would you expect to see on a baseline care plan LPN/UM #1 replied assist that is needed with adl's (activities of daily living) any special equipment such as oxygen, bipap cpap, if they are on isolation, use of DME (durable medical equipment) such as wheelchair, condition of skin, continent or not and if they wear briefs or pull ups, safety if have history of fall or fall related injuries, any special treatments such as dialysis, pacemaker, dentures, medications or treatments if receiving therapy. LPN/UM #1 went on to say that if resident is on anticoagulant would like to have that in care plan, psychotropic medications, allergies, oxygen, diabetes, isolation for infection it would go on there. If on antibiotic therapy should have a care plan for antibiotic. Also, anyone with Foley catheter suprapubic should have a care plan.

When asked when are care plans reviewed, LPN/UM #1 replied I generally start care plan within first couple days, quarterly with meetings, annually and when change in status care plan is updated. The nursing supervisor do update or initiate the care plan.

During an interview with the surveyor on 08/04/2023 at 01:19 PM, the Director of Nursing (DON) said anyone can initiate the care plan, the

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F 657	Continued From page 4 nurse Social Worker, dietary and this is done on the day of admission. The surveyor asked when are care plans reviewed and the DON replied care plans are reviewed quarterly, annually, and as needed and for a significant change or change in medical status. When asked what is expected to be on a care plan, the DON said adl's, special diet, IV, infection control preferences. The DON confirmed yes, [redacted] should be on a care plan but will be resolved once it is done. A review of a facility policy titled Care Plans, Comprehensive Person-Centered with a revised date of March 2022, revealed under the Policy Interpretation and Implementation section 7. The comprehensive, person-centered care plan: ...b. describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well being, including: services that would otherwise be provided for the above. The policy also included 7. e. reflects currently recognized standards of practice for problem areas and conditions. NJAC 8:39-27.1(a)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined	F 658	F658 Services Provided Meet Professional Standards	9/5/23

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F 658	Continued From page 5 that the facility failed to ensure care and services were provided according to accepted standards of clinical practice specifically by A.) administering medication outside of blood-pressure parameters ordered by a physician, B.) failing to ensure the communication of abnormal laboratory results to the physician, and C.) administering medication tablets that dropped onto the top of a medication cart, and disposing medication tablets into a garbage receptacle. The deficient practices were observed for 2 of 5 residents (Resident #7, Resident #28) reviewed for Unnecessary Medications and for 2 of 2 nurses observed during the Medication Administration Task. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing, under 13:37-6.5 Non-Delegable Nursing Tasks, includes: "A registered professional nurse shall no delegate the physical, psychological, and social	F 658	The Physician of resident #7 was notified of the doses of [EX Order 26 § 4b1] administered outside of ordered parameters. The Physician of resident #28 was notified of the [NJ Exec. Order 26:4.b.1] of 5/15/23. LPN #1 and #2 received one-to-one education on disposing of medications that touch the surface of the med cart, glove use, and disposing of non-controlled medication that should not be administered to a patient. Any resident receiving medications at the facility and any resident having labs drawn at the facility have the potential to be effected. An audit has been completed on residents who receive Midodrine, with parameters of when to hold the [NJ Exec. Order 26:4.b.1]. The internal lab process was reviewed and revised to increase communication of the results between the facility and the Physicians. The facility educator and Pharmacy Consultant provided education to the licensed nursing staff on the process of the medication pass. There was emphasis regarding medications with parameters including [EX Order 26 § 4b1] of when and why to hold and notify the Physician. The facility educator and Unit Managers provided education to the licensed nursing staff on the laboratory process to increase communication between the medical staff. The facility educator and Pharmacy	

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F 658	Continued From page 6 assessment of the patient, which requires professional nursing judgement, intervention, referral, or modification of care." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Resident #7 On 07/26/2023 at 08:35 AM the surveyor observed Resident #7 in their room seated in a [redacted] doing a word search puzzle. Resident #7 was pleasant and cooperative and did not display any [redacted]. According to the Admission Record Resident #7 was admitted to the facility with the following but not limited to diagnoses: [redacted] Review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated May 12, 2023, revealed that Resident #7 had a Brief Interview for Mental Status score of [redacted]/15, indicating [redacted]. Section G revealed that Resident #7 required [redacted] with most	F 658	Consultant also provided education to the licensed nursing staff regarding the disposal of medications including The principles of what to do if a medication is dropped outside the cup. The Director of Nursing or designee will review up to five records daily for residents who receive [redacted] for a period of two weeks, then weekly for two weeks, then monthly for two months. The audit will focus on the [redacted] being administered within parameters ordered. The Director of Nursing or designee will audit ten medical records weekly for residents who have had labs drawn for a period of four weeks, then monthly for two months. The audit will focus on the lab order activated, completed, reviewed, communicated to the Physician and documentation the lab result was acknowledged. The Director of Nursing or designee such as the Pharmacy Consultant will complete two medication pass observations weekly for four weeks, then monthly for two months. The observations will capture the potential opportunity for destruction of a medication. The results of the above audits will be presented by the Director of Nursing to the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for three months. Any revisions to the audit plan will be reviewed and	

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F 658	Continued From page 7 activities of daily living and Section I revealed EX Order 26 § 4b1 [redacted]. Review of the Order Summary Report, with active orders as of 08/01/2023 revealed the following physician orders for Resident #7: EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 [redacted] On 08/02/23 at10:43 AM the surveyor reviewed the consultant pharmacist (CP) monthly medication regimen review (MRR) for the period of February 2023 through July 2023. On 05/11/2023 the CP reported a medication error to the facility administration. The medication error was as follows: "EX Order 26 § 4b1 [redacted] has hold parameters that have not been followed correctly. EX Order 26 § 4b1 [redacted] was above threshold for medication to be held but was given [redacted]/6 and [redacted]/10. Please review. Please review, correct and report as per facility policy. A Medication Error Report was provided to the surveyor, dated 5/6/2023 by the facility Director of Nursing (DON) on 8/7/2023 On 08/04/2023 at 01:02 PM the surveyor reviewed the Medication Administration Record (MAR) for 5/1/2023-5/31/2023 for Resident #7. The MAR revealed that EX Order 26 § 4b1 [redacted] was administered outside of physician ordered	F 658	implemented with coordination of the interdisciplinary team at the QAPI Committee meeting.	

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parameters on the following dates and times:

EX Order 26 § 4b1 [redacted]

On 08/07/2023 at 09:14 AM the surveyor conducted an interview with Licensed Practical Nurse (LPN #3) assigned to the 2nd Floor of the facility where Resident #7 resided. The surveyor asked LPN#3 how NJ Exec. Order 26:4.b.1 was to be administered to a resident who had a physician order for the EX Order 26 § 4b1 [redacted] LPN #3 told the surveyor, "EX Order 26 § 4b1 has parameters. Generally, the drug should not be administered if the systolic blood pressure is greater than 120." The surveyor asked LPN #3 if she would administer EX Order 26 § 4b1 for a resident with a EX Order 26 § 4b [redacted] of EX Order and LPN #3 stated, "No. It is outside of the parameter for this medication."

On 08/07/2023 at 12:53 PM the surveyor conducted an interview with the facility DON. The surveyor asked the facility DON what the potential

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medical consequence could be by administering EX Order 26 § 4b1 medication outside of physician ordered parameters. The DON responded, "The potential consequence is that the resident could have EX Order 26 § 4b1 and EX Order 26 § 4b1 providing the medication outside of the prescribed parameters."

The surveyor reviewed the facility policy titled Administering Medications, revised April 2019. Under Policy Statement it was revealed that "Medications are administered in a safe and timely manner, and as prescribed." The following was revealed under the heading of Policy Interpretation and Implementation:

4. Medications are administered in accordance with prescriber orders, including any required time frame.

6. Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance Performance Improvement) committee to inform process changes and/or the need for additional staff training.

2. According to the Admission Record, Resident # 28 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 [redacted]

A review of the Consultant Pharmacist (CP)

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report dated 05/10/2023 revealed a note to the physician to Consider ordering [EX Order 2] - last noted 7/22 in medical record. A handwritten note indicated "[EX Order 2] ordered 5-15-22".

A review of the lab results for the [NJ Exec. Order] dated 05/15/2023 revealed Results [EX Order 2] with a Ref (reference range) [NJ Exec. Order 26]

A review of the progress notes dated 05/15/2023 through 05/31/2023 did not include documentation that the physician was notified of the [NJ Exec. Order 26:4.b.1] results.

A review of the Order Summary Report (OSR) with active orders as of 07/01/2023, revealed a physician order for EX Order 26 § 4b1 [redacted] one time only ordered on 06/06/2023 and scheduled for 07/10/2023.

A review of the lab results for the [EX Order 2] dated 07/10/2023 revealed results of [EX Order 2] with a Ref (reference range) [NJ Exec. Order 26]

A review of the progress notes date 07/10/2023 through 08/03/2023 did not include documentation that the physician was notified of the [EX Order 26 § 4b1] lab results.

During an interview with the surveyor on 08/03/2023 at 10:20 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) said the process for lab work to be ordered is that when the Nurse Practitioner (NP) comes in they put their own lab orders in the computer and then we (nursing) go into pending orders for confirmation. The nurse then goes into the lab system to print the slip and the slip goes into the lab book. When

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asked what the process is for when you receive the lab results, LPN/UM #1 replied, "If there is particular lab value we are looking at we go back in the lab system and look. The 3-11 nursing supervisor goes through the labs and will contact the physician for follow up. If all normal labs, then the physician and NP sign they reviewed the labs when they come in." Surveyor #2 asked where this would be documented when the physician or NP were notified of abnormal lab results. LPN/UM #1 replied, "We would document in the progress notes that we received abnormal labs and that we notified the physician or NP right away for orders and update the patient and responsible party."

On 08/03/2023 at 10:26 AM, Surveyor #2 reviewed the labs of 05/15/2023 and 07/10/2023 with LPN/UM #1 and asked where the documentation is that the physician or NP were notified of the NJ Exec. Order 26:4.b.1. LPN/UM #1 confirmed she did not see anything in the progress notes that the physician or NP were notified of the EX Order 26:4.b.1 labs results.

On 08/03/2023 at 11:35 AM, LPN/UM #1 provided Surveyor #2 a progress note dated 06/06/2023 that the NP indicated reviewed NJ Exec. Order 26:4.b.1 repeat in 1 month. LPN/UM #1 said I don't see a note for the 7/10/23 NJ Exec. Orde

On 08/03/2023 at 12:45 PM, LPN/UM #1 came to Surveyor #2 and said she had spoken to the NP and the NP wasn't aware of the lab results. LPN/UM #1 went on to say the NP gave new orders for medication NJ Exec. Order 26:4.b.1 confirmed that the NP was not made aware of the lab results of 07/10/2023 until 08/03/2023.

During an interview with Surveyor #2 on

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08/04/2023 at 1:24 PM, the Director of Nursing said it is the nurse who is responsible to notify the physician or NP of [redacted] labs.

3.) On 7/26/2023 at 8:20 AM during the observation of medication administration, Surveyor #3 observed Licensed Practical Nurse (LPN) #1 begin adding medication tablets to a medicine cup to give to a resident. At this time, the surveyor observed LPN #1 drop a [redacted] tablet (medication used to treat [redacted]) onto the surface of the medication cart. LPN #1 then picked up the tablet with her bare hands and place it back into the medication cup and proceeded to administer the medication to a resident.

On the same date at 8:33 AM during the observation of medication administration, Surveyor #3 observed LPN #1 begin adding medication tablets to a medicine cup to give to a resident. At this time, Surveyor #3 observed LPN #1 drop an [redacted] onto the surface of the medication cart. LPN #1 then picked up the tablet with her bare hands and placed it back into the medication cup and proceeded to administer the medication to a resident.

On the same date at 8:39 AM during an interview with Surveyor #3, LPN #1 said that in each medication cart there is a, "Drug-Buster" (solution mixture used to disintegrate medications) in the bottom of the cart. She stated that medications should be disposed of in the Drug-Buster and the nurse should get a new medication. Surveyor #3 asked if she did that when she dropped the tablets onto the medication cart. She replied, "No."

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On the same date at 9:14 AM during the observation of medication administration, Surveyor #3 observed LPN #2 begin adding medication tablets to a medicine cup to give to a resident. At this time, Surveyor #3 observed LPN #2 drop a Comtan oral tablet (medication used to treat Parkinson's disease) onto the surface of the medication cart. LPN #2 then picked up the tablet with her bare hands and placed it back into the medication cup followed by administering the medication to a resident.

On the same date at 9:25 AM during the observation of medication administration, Surveyor #3 observed LPN #2 begin adding medication tablets to a medicine cup to give to a resident. At this time, Surveyor #3 observed LPN #2 drop a Furosemide oral tablet (medication used to treat fluid retention) onto the surface of the medication cart. LPN #2 tossed the medication into the garbage receptacle attached to the medication cart.

On the same date at 9:30 AM during an interview with Surveyor #3, LPN #2 replied, "If it (medication tablet) drops, I throw it away." when Surveyor #3 asked what the facility policy on disposing medications is. LPN #2 replied, "They (staff nurses) do it if it's narcotics. I use the trash or sharps box." when asked if staff use the Drug-Buster.

On 8/07/2023 at 12:47 PM during an interview with Surveyor #3, the Director of Nursing (DON) replied, "No" when asked by Surveyor #3 if medication tablets be placed back into a medicine cup if they are dropped onto the medication cart surface. The DON further stated,

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F 658	Continued From page 14 "It could be contaiminated on top of the cart" when Surveyor #3 asked why the medication tablets should not be placed back into the medication cup. Lastly, the DON stated, "No. Never." when Surveyor #3 asked if medications should be disposed of in the medication cart garbage receptacle. A review of the facility provided policy titled, "Discarding and Destroying Medications" revised April 2019 revealed under "Policy Interpretation and Implementation" that, "2. Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications." § 8:39-27.1 (a) § 8:39-29.4 (i)	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: NJ # 164925 Based on interview, record review, and review of pertinent facility documentation it was determined that the facility failed to ensure a resident (Resident #299) received EX Order 26 § 4b1 to	F 689	F689 Free of Accident Hazards/Supervision/Devices Resident #299 has been discharged from this facility. The employee received clinical counseling and coaching the same	9/5/23

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F 689	Continued From page 15 prevent an EX Order 26 § 4b1, specifically by a staff member EX Order 26 § 4b1 without another staff member as required resulting in the resident EX Order 26 § from the EX Order 26 § 4b1 concluding in a EX Order 26 § 4b1, EX Order 26 § 4b1, and a EX Order 26 § 4b1. The deficient practice was evident for 1 of 4 residents reviewed for Accidents. The deficient practice was evidenced by the following: A review of Resident #299's Minimum Data Set (MDS; an assessment tool) dated 5/31/2023 revealed under section "C" that he/she had a Brief Interview for Mental Status score of EX O/15 indicating that he/she had EX Order 26 § 4b1. The MDS also revealed under section "G", that he/she required NJ Exec. Order 26:4.b.1 providing support to physically assist. A review of Resident #299's Diagnoses located in the Electronic Medical Record (EMR) revealed but not limited to; EX Order 26 § 4b1 A review of Resident #299's Care Plan located in the EMR with revision date of 12/27/2022 revealed a readmission continuation Care Plan focus that read, EX Order 26 § 4b1	F 689	day. The employee was able to verbalize the procedure for a NJ Exec. Order 26:4.b.1 transfer and demonstrated correct mechanical lift transfers via observation. Residents who use a NJ Exec. Order 26:4.b.1 to transfer have the potential to be affected. A review of the NJ Exec. Order 26:4.b.1, slings and function of the lifts that are in use was audited as well as other residents who require the use of the equipment. No other residents were affected. The facility educator coordinated a lifting competency with a return demonstration for the nursing staff that use NJ Exec. Order 26:4.b.1 Maintenance reviewed the log in place and the process of updating when new lifts are entered into inventory. Random observations of up to five transfers per week will be completed for a period of four weeks, then twice monthly for two months. The observation audit will capture the effective steps of transferring from either a bed to a chair, a chair to a bed, and opportunities of a mechanical transfer to a shower chair. Results of the above observation audits will be presented by the Director of Nursing to the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for three months. Any revisions to the observation plan will be reviewed and implemented with coordination of the interdisciplinary team at the meeting	

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transfer..." Further, the Care Plan revealed an intervention for a EX Order 26 § 4b1 [redacted]

A review of Resident #299's Care Plan located in the EMR with an initiated date of 0[redacted] EX Order 26 § 4b1 revealed another readmission continuation Care Plan focus that read, EX Order 26 § 4b1 [redacted]

A review of Resident #299's Nursing Progress Notes located in the [redacted] EX Order 26 dated [redacted] EX Order 26 § 4b1 revealed that a Certified Nurses Aide (CNA) was heard calling for help. The Nursing Progress Note revealed that Resident #299 was observed [redacted] EX Order 26 §

A review of the facility's "Reportable Event Record/Report" document revealed that on 6/03/2023 at 11:50 AM, Resident #299 sustained a EX Order 26 § 4b1 [redacted]
The document further revealed that Resident #299 sustained an NJ Exec. Order 26:4.b.1 to the [redacted] NJ Exec. Orde and complained of [redacted] NJ Exec. Or EX Order 26 § 4b1. Resident #299 was transferred to the NJ Exec. Order 26:4.b.1 for evaluation. The document revealed that Resident #299 was admitted to the [redacted] NJ Exec. Order 26:4 for a [redacted] EX Order 26 EX Order 26 § 4b1 [redacted]

On 8/02/2023 at 12:00 PM during an interview

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with the surveyor, CNA #1 stated, "I asked for help. As I was waiting for help, I took it upon myself to ([redacted]." CNA #1 replied, "I might have thought she (another staff member) was outside the door coming." when asked by the surveyor if there was a reason she did not wait for help to transfer Resident #299 with the [redacted]. CNA #1 replied, "No" when asked if Resident #299 could sit up. CNA #1 replied, "Not at all" when asked if Resident #299 could move on his/her own. Further, CNA #1 confirmed Resident #299 required [redacted] and that he/she is [redacted]. CNA #1 said that Resident #299 fell forward. Lastly, CNA #1 stated, "Two people" when asked by the surveyor if the facility policy required one person or two people to operate a [redacted].

On 8/07/2023 at 12:47 PM during an interview with the surveyor, the Director of Nursing (DON) replied, "Two staff members. Always explain what you are going to do and have the right sized sling." when the surveyor asked what was the expectation of care from staff members who use the [redacted] to transfer a resident from the bed to a wheelchair. Secondly, the DON replied, "No" when the surveyor asked if it is ever reasonable for a staff member to operate a [redacted] to transfer a resident between a bed and a wheelchair without another staff member. Lastly, the DON replied, "Safety, guidance. Something could happen" when the surveyor asked why it was not reasonable.

A review of the facility-provided document titled, "Initial Education and Competency Checklist - Invacare Lift" dated 4/14/21, revealed that CNA #1 identified that two staff are involved while

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using the [NJ Exec. O] The document revealed that CNA #1 met criteria for identifying components of the [NJ Exec] sling use and operation, and [NJ Exec. Order 26:4.b.1] operation. The document was signed by the Infection Prevention Licensed Practical Nurse as the trainer and CNA #1 as the employee.

A review of the facility-provided document titled "Individual In-Service Sheets" for CNA #1, year 2022 revealed that on 7/13/2022, CNA #1 attended "0.5 Hrs (hours)" of "Safe Resident Handling"

A review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" revised March 2018 revealed under "Policy Interpretation and Implementation" that, "2.) Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: b. Mobility (transfer and ambulation, including walking)..."

A review of the facility policy titled, "Lifting Machine, Using a Mechanical" with a revised date of July 2017 revealed under "General Guidelines" that, "1. At least two (2) nursing assistants are needed to safely move a resident with a [NJ Exec. Order 26:4.b.1]

A follow-up review of Resident #299's imaging orders and results from the [NJ Exec. Order 26:4] he/she was transferred to after the [NJ Exec.] revealed an [NJ Exec. Order 2] result that concluded Resident #299 [NJ Exec. Order 26:4.b.1] [EX Order 26 § 4b1] .

A further review of Resident #299's [EX Order 26 § 4b] record revealed an assessment for [EX Order] on

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F 689	Continued From page 19 6/03/2023 at 18:46 (06:46 PM) that showed he/she verbalized his/her [redacted] was "[redacted]" based on a 0-10 [redacted] scale [redacted] indicates the highest level of [redacted]. The hospital record further revealed that Resident #299 was prescribed a [redacted], Resident #299 was last administered the [redacted] on 06/04/2023 at 5:15 AM.	F 689		
F 690 SS=E	§ 8:39-27.1 (a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		9/15/23

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F 690	Continued From page 20 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and review of other facility documentation, it was determined that the facility failed to maintain an EX Order 26 § 4b1 in a manner that would limit the potential to cause a EX Order 26 § 4b1 for 3 of 3 residents reviewed for EX Order 26 § 4b1 (Resident #199, #79, and #20). This deficient practice was evidenced by the following: On 07/25/2023 at 10:23 AM, during the initial tour of the facility, the Surveyor #1 observed Resident #199 lying in bed. Surveyor #1 observed Resident #199's NJ Exec. Order 26:4.b.1 suspended from bed frame and EX Order 26 § 4b1 was in place. EX Order 26 was visible, however Resident #199's EX Order 26 § 4b1 was obscured from view on this observation due to their privacy curtain preventing observation from the common hallway outside the room. On 07/27/2023 at 8:38 AM, Surveyor #1 observed Resident #199 lying in bed eating breakfast.	F 690	Residents #199, #20 and #79 had their EX Order 26 § 4b1 changed and a EX Order 26 § 4b1 was applied. Residents with an NJ Exec. Order 26:4.b.1 have the potential to be affected. The facility educator and designee have completed education related to the EX Order 26 § 4b1. Elements of the education included application of the EX Order 26 § 4b1 along with position of the EX Order 2. The Director of Nursing or designee will observe up to five random residents with EX Order 26 § 4b1 weekly for four weeks, then twice monthly for two months. The observations will include EX Order 26 § 4b1 positioning as well as EX Order 26 § 4b1. Results of the above audits will be presented by the Director of Nursing to	

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F 690	Continued From page 21 Surveyor #1 observed Resident #199's EX Order 26 § 4b1 EX Orde lying on floor. The EX Order 26 § 4b1 was in direct contact with the floor and there was no NJ Exec. Order 26 in place. 1.) According to the Admission Record, Resident #199 was admitted to the facility with the diagnoses including but not limited to EX Order 26 § 4b1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated June 4, 2023, revealed that Resident #199 had a Brief Interview for Mental Status score of EX Or /15, indicating he/she was EX Order 26 § 4b1. Section H revealed that Resident #199 was not rated for EX Order 26 § 4 [redacted] secondary to the presence of a EX Order 26 § 4b1. Section I revealed that Resident #199 had active diagnoses of EX Order 26 § 4b1 [redacted] The MDS also indicated that Resident #199 had received an EX Order 26 § 4b1 daily during the 7 day look back period. A review of the Order Summary Sheet on 7/26/2023 at 10:57 AM revealed the following physician orders for Resident #199: "R-L (right/left) EX Order 26 § 4b1 monitor site clean and dry every shift. Monitor related to other mechanical complication of EX Order 26 § 4b1 [redacted] every shift, order	F 690	the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for a period of three months. Any revision to the observation plan will be revised and implemented with coordination of the interdisciplinary team at the QAPI Committee meeting.	

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F 690	Continued From page 22 date: 06/16/2023." "EX Order 26 § 4b1 , R-L EX Order 26 § 4b1 every shift. Order Date: 06/16/2023." According to Resident #199's comprehensive care plan, revised on: 07/25/2023, Resident #199 had the following care plan Focus: "I have EX Order 26 § 4b1 Resident #199 had a care plan goal as follows: EX Order 26 § 4b1 According to the 07/1/2023-07/31/2023 Medication Administration Record (MAR for Resident #199, he/she was prescribed the following EX Order 26 § 4b1 order on 7/30/2023: EX Order 26 § 4b1 Start Date: 07/30/2023 1700. On 08/04/2023 at 11:20 AM, during an interview with Surveyor #1, the Certified Nursing Aide (CNA #2) Surveyor #1 asked what responsibility she	F 690		

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had for residents with [redacted]. CNA #2 told Surveyor #1, "Yes, I have worked with residents with [redacted]. We are responsible to empty the [redacted]. If the resident is in bed the [redacted] should be suspended below the [redacted] and in a [redacted]." Surveyor #1 then asked CNA #2 if it was facility practice to allow [redacted] to be on the floor. CNA #2 stated, "The [redacted] should not be on the floor. If the resident puts it on the floor, I make sure nothing is wrong with it and report any problems to the nurse. I would get the [redacted] off the floor."

On 08/04/2023 at 11:28 AM, during an interview with Surveyor #1, Licensed Practical Nurse (LPN #2 was asked what the standard of practice was for the care of [redacted] in the facility. LPN #2 responded, "Residents with [redacted] should have the [redacted] in a [redacted]. The [redacted] should be below the [redacted] level, suspended from the bed at the lowest point without touching or in contact with the ground or floor." Surveyor #1 then asked LPN #2 what they should do if a [redacted] was observed in contact with the floor. LPN #2 stated, "If I see the [redacted] on the floor, I will remove it from the ground and sanitize the [redacted] because the [redacted] might be contaminated from contact with the floor."

On 08/07/2023 at 01:01 PM during an interview with the facility administration the facility Director of Nursing (DON) told the survey team, "A [redacted] should never be on the floor. It's a source of contamination."

2.) On 7/25/2023 at 9:42 AM during the initial tour of the facility, Surveyor #2 observed Resident #79 in bed. At this time, Surveyor #2 observed

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that the EX Order 26 § 4b1 was in contact with the floor as it hung from the bed frame. The EX Order 26 § 4b1 did not have a NJ Exec. Order 26 [redacted]

A review of Resident #79's diagnoses located in the Electronic Medical Record (EMR) revealed diagnoses of but not limited to EX Order 26 § 4b1 [redacted]

A review of Resident #79's Quarterly Minimum Data Set dated 07/10/2023, revealed that he/she had a Brief Interview for Mental Status score of [redacted] indicating EX Order 26 § 4b1. The MDS further revealed that Resident #79 had an EX Order 26 § 4b1 [redacted]

A review of Resident #79's Care Plan initiated on 4/10/2023 and located in the EMR revealed that he/she required a EX Order 26 § 4b1 related to EX Order 26 § 4 [redacted] during a recent EX Order 26 § 4b1.

On 8/07/2023 at 12:47 PM, during an interview with Surveyor #2, DON stated, EX Order 26 § 4b1 [redacted]." When Surveyor #2 asked where the EX Order 26 § 4b1 [redacted] should be secured when the resident is in bed, the DON replied, "Never" when asked by Surveyor #2 if the EX Order 26 § 4b1 should be in contact with the floor.

3.) 07/31/23 09:05 AM resident in bed receiving medications. observed EX Order 26 § 4b1 lying directly in contact with the floor.

According to the Admission Record Resident #20

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F 690	Continued From page 25	F 690		

was admitted to the facility with EX Order 26 § 4b1 [redacted]

A review of the most recent comprehensive MDS date 02/23/2023, revealed a brief interview for EX Order 26 § 4b1 of [redacted]/15 indicating Resident #20 was EX Order 26 § 4b1. A further review revealed Resident #20 used an EX Order 26 § 4b1.

A review of the Care Plan revealed a focus area of 'EX Order 26 § 4b1 [redacted] with an Date Initiated: 03/14/2022.

During an interview with Surveyor #3 on 08/04/2023 at 11:17 AM, when asked if a EX Order 26 § 4b1 should come into contact with the floor, CNA #3 replied EX Order 26 § 4b1 [redacted]

During an interview with Surveyor #3 on 08/04/2023 at 11:25 AM, when asked how a EX Order 26 § 4b1 is to be cared for and LPN #1 replied EX Order 26 § 4b1 [redacted]." LPN #3 further said no, the EX Order 26 § 4b1 should not be in contact with floor.

During an interview with Surveyor #3 on 08/04/2023 at 1:22 PM, the DON said "No EX Order 26 § 4b1 should not be on the floor at any time."

A review of a facility policy titled EX Order 26 § 4b1 [redacted], revised date of August 2022, revealed

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F 690	Continued From page 26 under Infection Control: 2. Be sure the EX Order 26 § 4b1 and EX Order 26 § 4b1 bag are kept off the floor. N.J.A.C. 8;39-19.4(a)	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		9/5/23

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F 758	Continued From page 27 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation it was determined that the facility failed to A.) limit the timeframe for a EX Order 26 § 4b1 medication, which was not an EX Order 26 § 4b1 medication, to 14 days, unless a longer timeframe was deemed appropriate by the attending physician or the prescribing practitioner and B.) provide a clinical reason or a clinically pertinent rationale for administering a EX Order 26 § 4b1 medication and failed to monitor and accurately document the resident's response to the medication. The deficient practice was identified for 2 of 5 residents (residents #47, #66) reviewed for Unnecessary Medications. The deficient practice was evidenced by the following: 1.) A review of Resident #47's quarterly Minimum	F 758	F758 Free from Unnecessary NJ Exec. Order 26:4.b.1 Meds/PRN Use Resident #66 NJ Exec. Order 26:4.b.1 order was for one time only. A late entry was written in the resident's medical record documenting residents' NJ Exec. Order 26:4.b.1 staff interventions and family notification. Resident #47 current NJ Exec. Order 26:4.b.1 order is for 14 days with a STOP date of 8/31/23. The resident will be reassessed at that time to determine if there is the need for continued use. Any resident who has an order for an NJ Exec. Order 26:4.b.1 medication PRN has the potential to be affected. An audit was completed on PRN	

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F 758	Continued From page 28 Data Set (MDS) an assessment tool dated 06/23/2023, revealed that Resident #47 had a brief interview for mental status score of [redacted] indicating that he/she had EX Order 26 § 4b1 [redacted]. The MDS further revealed that Resident #47 had a diagnosis of EX Order 26 § 4b1 [redacted] A review of Resident #47's Physician's orders located in the Electronic Medical Record (EMR) revealed an order for EX Order 26 § 4b1 [redacted] to by given by mouth every twelve hours as needed for major EX Order 26 § 4b1 with a start date of 07/08/2023. The order did not include a duration for use. A review of Resident #47's Care Plan located in the EMR revealed a care plan focus of, EX Order 26 § 4b1 [redacted] The Care Plan revealed a goal for Resident #47 that read, "I will have the smallest most effective dose without side effects through next review period." The Care Plan was initiated 04/04/2023. A review of the Pharmacy Consultant Report dated 07/20/2023, revealed the following documentation, "Recommend review order for EX Order 26 § 4b1 and add 14 day stop date. After completion of this order, may renew EX Order 26 § 4b1 with a stop date exceeding 14 days if clinical rationale and anticipated during of therapy are documented in the resident's medical record. As per new CMS (Centers for Medicare & Medicaid Services) requirement for initial EX Order 26 § 4b1 [redacted] medication, orders are to be limited to 14 days. Requirements	F 758	NJ Exec. Order 26:4.b.1 [redacted] medication. The emphasis was on reviewing 14-day STOP dates and orders clarification. The audit also reviewed NJ Exec. Order 26:4.b.1 and notification of the addition of the NJ Exec. Order 26:4.b.1 [redacted] medication to the family or responsible party. The licensed nursing staff are receiving ongoing education regarding the requirement for any NJ Exec. Order 26:4.b.1 [redacted] medication written as a PRN must have a14-day STOP date and be reviewed after 14 days for possible continued use. In addition, education includes NJ Exec. Order 26:4.b.1 [redacted] and the need to notify the family or responsible party. The Director of Nursing or designee will run an order listing report and a NJ Exec. Order 26:4.b.1 [redacted] report along with reviewing chart documentation daily on any resident who is prescribed a PRN NJ Exec. Order 26:4.b.1 [redacted] medication for 4 weeks, followed by weekly for 4 weeks and monthly for one month. The results of the above audits will be presented by the Director of Nursing to the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at the QAPI Committee meeting.	

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for renewal of [redacted] after physician review and reason for continuation must be documented by the medical practitioner ordering [redacted] use of [redacted] medication in the resident's chart."

On 8/03/2023 at 8:46 AM, during an interview with Surveyor #1, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 confirmed Resident #47 had an active order for [redacted]. She further confirmed that the medication is to be given as needed. LPN/UM #1 stated, "It should" when the surveyor asked if the order should have a fourteen day stop date.

On the same date at 10:17 AM, during a follow-up interview with Surveyor #1, LPN/UM #1 said that Resident #47's Nurse Practitioner was aware of the recommendation from the Pharmacist's 07/20/2023 report, however the [redacted] order was never updated. She concluded by saying as of today, the fourteen day stop date will be included in the order.

A review of the facility policy titled, "[redacted]" with a revised date of July 2022, under "Policy Interpretation and Implementation" number 12. revealed, "[redacted] medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for [redacted] medications are limited to 14 days. (1.) For [redacted] medications that are NOT [redacted] if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order."

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F 758	Continued From page 30 Surveyor: Hondros, Dorothy 2.) A review of the Admission Record for Resident #66 reflected a medical diagnosis that included, but was not limited to: EX Order 26 § 4b1 [redacted] A review of the the MDS dated 06/23/2023, indicated that Resident #66 had a [redacted] EX Order 26 § 4b1 . The MDS also reflected that Resident #66 was prescribed EX Order 26 § 4b1 [redacted] A review of the Physician Order dated 07/16/2023, reflected a telephone order obtained by the nurse, for a one-time order of [redacted] A further review of the EMR and the daily "24 Hour Report Log," did not reveal any clinically significant negative or exacerbating behaviors or documented clinical rationale for administering a EX Order 26 § 4b1 . On 08/02/23 at 10:23 AM, during an interview with Surveyor #2, the Director of Nursing (DON) and Licensed Practical Nurse/Unit Manager #2 confirmed that there were no nursing notes or clinical documentation regarding an indication for the EX Order 26 § 4b1 . The DON stated that there should be documentation in the medical record of the specific targeted behavior and any attempted interventions. In addition, any side effects and effectiveness should also be documented. A review of the facility policy titled, EX Order 26 § 4b1	F 758		

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F 758	Continued From page 31 EX Order 26 § 4b1 " with a revised date of July 2022, under "Policy Interpretation and Implementation" number 12. revealed, "EX Order 26 § 4b1 medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for NJ Exec. Order 26:4.b.1 medications are limited to 14 days. (1.) For EX Order 26 § 4b1 medications that are NOT EX Order 26 § 4b1 : if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order." A further review of the policy indicated under #3 Resident, families and/or the representative are involved in the medication management includes: indications for use, dose, duration, adequate monitoring for efficacy and adverse consequences; and preventing, identifying and responding to adverse consequences. A review of the facility policy titled, "Administering Medications," with a revised date of April 2019, under #23 states; "As required or indicated for a medication, the individual administering the medication records in the resident's medical record: e: Any complaints or symptoms for which the drug was administered; f: Any results achieved and when those results were observed." N.J.A.C. 8:39-29.2 (d)	F 758		
F 812 SS=E	Surveyor: Hondros, Dorothy Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		9/11/23

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F 812	Continued From page 32 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 07/25/2023 from 9:15 to 9:41 AM, the surveyor, accompanied by the Account Manager (AM), observed the following in the kitchen: 1. In the walk-in refrigerator a plastic pan on top of a wheeled cart contained sliced pears. The pan was covered with plastic wrap and dated "7/21." The AM removed the pears to the trash.	F 812	1. During the walkthrough of the kitchen on 7/25/23 multiple items were found out of compliance. The first was a pan of pears not dated properly, which the account manager disposed of. The second was the walk in floor had debris and ice chunks on it. The walk in fridge floor was deep cleaned to remove the ice build up and debris. The 3rd was a stack on pans were on top of each other wet. These pans were re washed and dried properly. On 8/3/23 the pantry fridge had a sandwich not dated properly. The sandwich was thrown away immediately. On 8/7/23 turkey was found dated improperly. The turkey was thrown away immediately.	

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F 812	Continued From page 33 2. During the observation of the walk-in freezer it was noted that the walk-in floor was covered with unidentified debris and ice chunks. When interviewed the AM stated that the freezer is on the cleaning schedule and is generally cleaned on delivery day. 3. A stack of four (4) 1/4 pans on the middle shelf of the pan rack were stacked on top of each other. The surveyor removed the top 1/4 pan on the stack and observed a wet, watery substance on the base of the 1/4 pan below. The DD stated, "that's wet." The DD removed the stack of wet nested 1/4 pans to the dirty dish area to be cleaned and sanitized. On 08/03/2023 from 9:05 to 9:13 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM#1) observed the following on the 2nd floor pantry: 1. In the right lower bottom drawer of the pantry refrigerator the surveyor observed a sandwich inside a clear plastic bag. The label on the bag read "Tuna" and was dated "7/18." According to facility policy the sandwich should have been discarded on 7/21. The 2nd floor LPN/UM #1 stated, "That should have been thrown away. I missed that." LPN/UM #1 removed the sandwich to the trash. On 08/07/2023 from 9:37 to 9:51 AM the surveyor, accompanied by the AM, observed the following in the kitchen: 1.In the walk-in refrigerator on an upper shelf, a previously opened deli style roast turkey was placed on top of a box and was wrapped in plastic wrap. The turkey was dated "8/2-8/6". The	F 812	2. All residents have the potential to be affected 3. Center dining will be educated by the Dining Services Management team on the process for dating, labeling, wet nesting and adherence to cleaning assignments. Center Registered Dietician and Dining Services Management will review and complete 100% audit of dating and labeling of food in the kitchen and in the pantry room fridges/freezers. Dining Services Management will review and complete 100% audit of the walk in floor to ensure the cleaning assignments are followed weekly and the floor is clean. Dining Services Management will review and complete 100% audit of the pans to ensure there is no wet nesting. 4. The Dining Management Team will complete 5 random audits for dating, labeling, wet nesting and cleaning assignment adherence for x4 weeks to begin 8/28/23, then bi-weekly x2 weeks, then monthly x1 month. 5. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Food service director/District manager will be responsible for implementation of the plan. Date of Compliance: 8/28/23	

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F 812	Continued From page 34 AM removed the deli turkey to the trash. The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, revised March 2022. The following was revealed under the heading Policy Interpretation and Implementation: 6. The nursing staff will discard perishable foods on or before the "use by" date. The surveyor reviewed the facility policy titled Food Storage: Cold Foods, HCSG Policy 019, revised 4/2018. The following was revealed under the heading Procedures: 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The surveyor reviewed the facility policy titled Daily Cleaning Assignments, undated. Review of the daily cleaning assignment form revealed that the on Thursday an unassigned or "N/A" was assigned to "Detail Freezer Floor." In addition, the 11-8 Aide #2 was assigned to "Detail Walk in Floor" on Thursday. N.J.A.C. 8:39-17.2(g)	F 812	During the walkthrough of the kitchen on 7/25/23, multiple items were found out of compliance. The first was a pan not dated properly, the second was the walk in floor had debris and ice chunks on it. The third was a stack of pans on top of each other that were wet. On 8/3/23, the pantry refrigerator had a sandwich not dated correct. On 8/7/23, turkey was found dated improperly. All residents have the potential to be affected. Center Registered Dietician and Dining Services Management will review and complete 100% audit of dating and labeling of food in the kitchen and in the pantry room refrigerators and freezers. Dining services management will review and complete 100% audit of the walk in floor to ensure the cleaning assignments are followed weekly and the floor is clean. Dining services management will review and complete 100% audit of the pans to ensure there is no wet nesting. Center dining service employees are being educated by the dining service management team on the process for dating, labeling, wet nesting and adherence to cleaning assignments. The dining management team will complete five random audits for dating, labeling, wet nesting and cleaning assignment adherence for four weeks for one month, then bi-weekly for two weeks, foloowed by monthly for one month.	

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F 812	Continued From page 35	F 812	Results of these audits will be brought forth before the Quality Assurance Performance Improvement (QAPI) Committee for any additional monitoring or modification of this plan monthly for three months for additional recommendations and to ensure the facility remains in compliance. The Food Service Director and or District Manager will be responsible for implementation of this plan.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/5/23

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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 880	Continued From page 36 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	C 08/08/2023

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F 880	Continued From page 37 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to implement appropriate infection prevention and control practices during medication administration specifically by a staff member lathering with soap and water for less than twenty seconds and by a staff member administering eye drops to a resident without wearing gloves. The deficient practices were identified for 2 of 2 nurses during the Medication Administration task. On 07/26/2023 at 8:20 AM, during medication administration, the surveyor observed Licensed Practical Nurse (LPN #1) finish administering medications to a resident. At 8:27 AM, the surveyor observed LPN #1 enter the bathroom in the residents room with the door open. The surveyor observed LPN #1 turn on the faucet, use the soap dispenser to apply soap to her hand, wet both hands with running water, and began lathering her hands outside of the water. The surveyor used the Department of Health issued computer clock to determine that LPN #1 lathered her hands for 7 seconds. On the same date at 8:28 AM, during medication administration, the surveyor observed LPN #1 finish administering medications to another resident. At 8:31 AM, the surveyor observed LPN #1 enter the bathroom of the room with the door open. The surveyor observed LPN #1 turn on the faucet, use the soap dispenser to apply soap to her hand, wet both hands with running water, and began lathering her hands outside of the water.	F 880	F880 Infection Prevention & Control LPN #1 and #2 received 1 on 1 education on the timing for handwashing, on donning gloves and the procedure for eye drop administration. All residents have the potential to be affected. The Nursing educator and Infection Preventionist have in-serviced the licensed Nursing staff on Infection Control with an emphasis on hand hygiene. Hand washing competencies have been completed by the Nursing educator and Infection Preventionist. The Director of Nursing or the designee will conduct random audits during the medication pass for compliance on handwashing, donning of gloves and eye drop administration five times weekly for four weeks, then two times every other week for four weeks, followed by once every other week. Results of the above audits will be presented by the Director of Nursing to the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the	

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F 880	Continued From page 38 The surveyor used the Department of Health issued computer clock to determine that LPN #1 lathered her hands for 10 seconds. On the same date at 8:39 AM, during an interview with the surveyor, LPN #1 replied, "twenty five seconds" when asked by the surveyor how long she should lather with soap and water during hand hygiene. LPN #1 replied, "No." when asked by the surveyor if she met the minimum time when she washed her hands. On the same date at 9:15 AM, during the medication administration on the second floor, the surveyor observed LPN #2 administer eye drops to a resident. LPN #2 handed the resident one tissue before the administration. Without donning gloves, LPN #2 administered one drop to the resident's right eye and then administered one drop to the left eye. The resident wiped his/her right eye with the tissue and then his/her left eye with the same tissue. On the same date at 9:30 AM, during an interview with the surveyor, LPN #2 replied, "They are best practice but I usually put them on." when asked by the surveyor if she needed gloves for eye drop administration. On 8/07/2023 at 12:47 PM, during an interview with the surveyor, the Director of Nursing (DON) replied, "At least fifteen to twenty seconds." when the surveyor asked how long should a nurse lather with soap before rinsing their hands. The DON replied, "Yes" when the surveyor asked if the nurse should wear gloves during the administration of eye drops. The DON concluded by stating, "It's double protection against infection. There could be something on the bottle	F 880	interdisciplinary team at QAPI Committee meeting.	

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F 880	Continued From page 39 from somebody else." A review of the facility provided policy titled, "Handwashing/Hand Hygiene" revised date of May 2019, revealed under "Policy Statement" that, "This facility considers hand hygiene the primary means to prevent the spread of infections." Further, under the subsection titled, "Washing Hands" number 2 revealed, "Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers." A review of the facility provided policy titled, "Instillation of Eye Drops" with revised date of January 2014, revealed under, "Steps in the Procedure" number 3 to, "Put on gloves." N.J.A.C. 8:39-19.4(n)	F 880		

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H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical records and other facility documentation, it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer Form (UTF) as part of the medical record for 5 of 5 residents reviewed for [redacted] (Resident # 20, Resident #98, Resident #4, Resident #19, and Resident #299). This deficient practice was evidenced by the following: Reference: New Jersey Hospital Association "Provider Resources" Section 6: The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when a patient is transferred from one care setting to another. 1 a. According to the Admission Record Resident #20 was admitted to the facility with diagnoses including but not limited to: [redacted]	H5790	H5790 UNIVERSAL TRANSFER FORM: MANDATORY USE OF FORM The Universal Transfer Forms for residents #20, #98, #4, #19 and #299 were obtained and placed in the residents' medical record. Any residents who are transferred out of the facility have the potential to be affected. An audit was completed on Universal Discharge Forms for the past month. Residents who have been transferred out of the facility for the month of August have the completed Universal Transfer Form on their medical records and an accompanying Physician order for the transfer. The nurse educator has educated the	9/5/23

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

Electronically Signed | 08/30/23

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H5790	Continued From page 1 NJ Exec. Ord). A review of a Progress Note (PN) dated 04/15/2023 revealed Resident #20 was received in bed, NJ Exec. Order 26:4.b.1 to name, very NJ Exec. Order 26:4 stating feeling tired all day requesting to stay in bed this shift.1700: Patient seen in bed sound asleep, NJ Exec. Order 26:4.b.1 noted, arousable to verbal stimuli. EX Order 26 § 4b1 checked, controlled as per parameter, due meds administered. NJ Exec. Order 26:4.b.1 this shift, patient stated not feeling hungry, unable to hold a conservation without falling asleep V/S (vital signs) checked temp. NJ Exec. Order 26:4.b.1 . Supervisor notified. Supervisor Received order to Supervisor notified. Supervisor Received order to send pt. out to NJ Exec. Order 26:4.b.1 A review of the medical record did not include a copy of the UTF for Resident #20's transfer to the NJ Exec. Order 26:4.b.1. b. A review of a PN dated 05/27/2023 revealed Resident #20 approached this writer earlier in shift stating that he/she was not feeling well. When this writer tool his/her Temperature, it was EX Order 26 § 4b1 Towards close of shift, resident stated that he/she feels worse, complaining of NJ Exec. Order 26:4 and NJ Exec. Orde. This writer took resident's temp and noted it had increased to NJ Exec. Order 26:4.b.1 Resident stating, "I haven't felt this bad in my life." Physician notified and recommended to send to NJ Exec. Order 26:4.b A review of the medical record did not include a copy of the UTF for Resident #20's transfer to the NJ Exec. Order 26:4.b.1. 1c. A review of a physician order dated	H5790	licensed nursing staff of the necessity for completing the Universal Transfer Form, making a copy and placing it in the identified binder on the unit and writing a Physician order for the transfer. The Director of Nursing or designee will audit all transfers daily for four weeks, followed by weekly for four weeks, followed by monthly for one month for completion of the Universal Transfer Form, Physician order and the family or responsible party notification. The results of the above audits will be presented by the Director of Nursing to the Administrator for review at the monthly Quality Assurance Performance Improvement (QAPI) Committee monthly for a period of three months. Any revisions to the audit plan will be reviewed and implemented with coordination of the interdisciplinary team at QAPI Committee meeting.	

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H5790	Continued From page 2 06/17/2023 revealed an order to send to [redacted] for eval (evaluation) r/t (related/to) [redacted]. A review of the medical record did not include a copy of the UTF for Resident #20's transfer to the NJ Exec. Order 26:4.b.1 2. A review of the Admission Record for Resident # 98 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 [redacted] A review of a Medication review Report dated on or after 07/01/2023 revealed a physician order dated [redacted] to send to [redacted] for [redacted] EX Order 26 § 4b1 [redacted] A review of the medical record did not include a copy of the UTF for Resident #20's transfer to the NJ Exec. Order 26:4.b.1. 3a. According to the Admission Record Resident #4 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 [redacted] A review of the PN dated 12/23/2022 revealed Resident #4 complained of EX Order 26 § 4b1 [redacted]	H5790		

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H5790	Continued From page 3 EX Order 26 § 4b1 [redacted]. A review of the Medication Review Report dated 21/1/2022-12/31/2022 revealed a physician order to 'EX Order 26 § 4b1 [redacted] A review of the medical record did not include a copy of the UTF for Resident #4's transfer to the NJ Exec. Order 26:4.b.1. b. A review of the progress noted dated 02/06/2023 at 2141 revealed that Resident #4 was EX Order 26 § 4b1 [redacted] A review of the Medication Review Report dated 02/06/2023 revealed a physician order "Send to ER for eval." A review of the medical record did not include a copy of the UTF for Resident #4's transfer to the NJ Exec. Order 26:4.b.1 4a. According to the Admission Record Resident #19 was admitted to the facility with the following but not limited to diagnoses: EX Order 26 § 4b1 [redacted]	H5790		

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H5790	Continued From page 4 EX Order 26 § 4b1 [redacted] A review of the PN dated 08/06/2022 revealed that Resident #19 made the nurse aware that he/she had EX Order 26 § 4b1, NP made aware, new order to be sent to NJ Exec. Order 26:4.b.1. A review of the MR did not include a copy of the UTF for Resident #4's transfer to the NJ Exec. Order 26:4.b.1 [redacted] b. A review of the PN dated 09/30/2022 revealed that Resident #19's primary nurse found Resident #19 in bed with a significant NJ Exec. Order 26:4.b.1 [redacted] Resident NJ Exec. Order 26:4.b.1, able to answer questions. Unable to perform NJ Exec. Orde [redacted] Resident displayed complete NJ Exec. Order 26:4.b.1 [redacted]. Resident could not NJ Exec. Order 26:4.b.1 on the right side. Resident NJ Exec. Order 26:4.b.1 side. Discussed with NP and received new orders to send resident to NJ Exec. O [redacted] immediately for further eval. Resident transported to NJ Exec. Order 26:4.b.1 A review of the medical record did not include a copy of the UTF for Resident #19's transfer to the NJ Exec. Order 26:4.b.1. During an interview with Surveyor #1 in the presence of the survey team, on 08/04/2023 at 1:18 PM, the Director of Nursing (DON) and the Licensed Nursing Home Administrator both said "yes, there should be a copy of UTF for our medical records." When asked where the copies of the UTF's provided by the facility came from the DON confirmed the facility obtained them	H5790		

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H5790	Continued From page 5 from the hospital. A review of a facility provided a policy titled "Transfer Form" with revised date of March 2017, did not include documentation that the facility was to maintain a copy of the UTF. A review of a facility policy titled "Transfer or Discharge, Emergency" with revised date of December 2016, did not include documentation to indicate a copy of the form should be retained in the residents medical record. A review of Resident #299's Admission Record located in the Electronic Medical Record (EMR) revealed a diagnoses but not limited to EX Order 26 § 4b1 [redacted] A review of the facility's "Reportable Event Record/Report" document revealed that on 6/03/2023 at 11:50 AM, Resident #299 sustained a NJ Exec from a NJ Exec. Order 26:4.b.1 while being NJ Exec. Order 26:4.b.1 into a EX Order 26 § 4b1. The document further revealed that Resident #299 EX Order 26 § 4b1 [redacted] Resident #299 was transferred to the NJ Exec. Order 26:4.b.1 for evaluation. A review of the medical record did not include a copy of the Universal Transfer Form for Resident #299's transfer to the NJ Exec. Order 26:4.b.1.	H5790		

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S 000	Continued From page 6	S 000		
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ164925 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 1.) 6 of 7 day shifts and 1 of 7 overnight shifts for the period 05/28/2023 to 06/03/2023 and 2.) 12 of 14 day shifts and 2 of 14 overnight shifts for the period 07/09/2023 to 07/22/2023. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 Mandatory Access to Care No residents were affected during the dates of May 28 through June 3, 2023, and July 9 through July 22, 2023. All residents have the potential to be affected. The requirements for minimal staffing in nursing homes have been reviewed. The facility will increase the number of Job Fairs held. There will be an increase in the number of postcard mailings. The facility has launched their own agency where the	9/5/23

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S 560	Continued From page 7 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. For the week of staffing from 05/28/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -05/28/23 had 9 CNAs for 92 residents on the day shift, required 11 CNAs. -05/30/23 had 10 CNAs for 92 residents on the day shift, required 11 CNAs. -05/31/23 had 10 CNAs for 92 residents on the day shift, required 11 CNAs. -05/31/23 had 6 total staff for 92 residents on the overnight shift, required 7 total staff. -06/01/23 had 10 CNAs for 92 residents on the day shift, required 11 CNAs. -06/02/23 had 9 CNAs for 92 residents on the day	S 560	hired employees only work for this facility. Referral bonuses and Incentive Programs continue to be offered to entice prospective employees. The Administrator, Director of Nursing and Staffing Coordinator will conduct daily staffing audits to ensure appropriate staffing ratios for Certified Nursing Assistants (CNAs) are maintained as required by law. Results of the audits will be presented monthly for three months to the Quality Assurance and Performance Improvement (QAPI) Committee for review. Action will be implemented as deemed appropriate by the Committee.	

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S 560	Continued From page 8	S 560		

shift, required 11 CNAs.
-06/03/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs.

2. For the 2 weeks of staffing prior to survey from 07/09/2023 to 07/22/23, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows:

-07/09/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs.
-07/10/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs.
-07/12/23 had 10 CNAs for 91 residents on the day shift, required 11 CNAs.
-07/14/23 had 9 CNAs for 91 residents on the day shift, required 11 CNAs.
-07/15/23 had 9 CNAs for 91 residents on the day shift, required 11 CNAs.

-07/16/23 had 9 CNAs for 97 residents on the day shift, required 12 CNAs.
-07/17/23 had 10 CNAs for 97 residents on the day shift, required 12 CNAs.
-07/18/23 had 11 CNAs for 96 residents on the day shift, required 12 CNAs.
-07/19/23 had 10 CNAs for 95 residents on the day shift, required 12 CNAs.
-07/20/23 had 10 CNAs for 95 residents on the day shift, required 12 CNAs.
-07/20/23 had 6 total staff for 95 residents on the overnight shift, required 7 total staff.
-07/21/23 had 9 CNAs for 95 residents on the day shift, required 12 CNAs.
-07/22/23 had 8 CNAs for 95 residents on the day shift, required 12 CNAs.
-07/22/23 had 6 total staff for 95 residents on the overnight shift, required 7 total staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061524	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTEI	859 WEST BAY AVE BARNEGAT, NJ 08005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 9 On 08/07/23 at 09:02 AM the surveyor conducted an interview with the facility staffing coordinator (SC). The surveyor asked the SC if she was familiar with state mandated minimum staffing requirements. The SC stated that she is familiar with the mandated minimum staffing levels for CNA's. When asked if the facility is meeting the minimum staffing standards the SC stated, "Yes." The surveyor asked the SC if they met the minimum standards for every shift every day and the SC replied, "Not every shift but we strive to every shift. I try and replace call outs when they occur and we utilize agency to fill positions."	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING _____ B. WING _____	R-C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE BARNEGAT, NJ 08005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 9/20/2023 to verify the facility's POC for compliance for the 8/8/2023 Recertification survey. The facility was found to be in compliance.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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)
315222	A. Building B. Wing	9/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 09/05/2023	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	
8/8/2023	☐ 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
315222 Y1	A. Building B. Wing Y2	9/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

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 F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0689	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	09/05/2023	LSC	09/05/2023	LSC	09/05/2023
ID Prefix F0690	Correction	ID Prefix F0758	Correction	ID Prefix F0812	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	09/15/2023	LSC	09/05/2023	LSC	09/11/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/05/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/8/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061524 Y1	A. Building B. Wing Y2	9/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 09/05/2023	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 8/8/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061524 (Y1)	A. Building B. Wing (Y2)	9/20/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/05/2023	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	
8/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING **01** B. WING _____	C **08/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE** **BARNEGAT, NJ 08005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1980s with no current major renovations or noted additions. It is a two story building Type II (000) construction and is fully sprinklered. The outside 275 KW diesel generator does approximately 70% of the facility. The facility is divided into 7-smoke zones and has an electric fire pump to support the fire sprinkler system. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, electric fire pump and cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility has 116 certified beds. At the time of the survey the census was 97. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 8/03/2023, in the presence of facility	K 281	A licensed electrician rewired support lighting in second floor dining room and to	9/5/23

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

Electronically Signed | 08/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING **01** B. WING _____	C **08/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE** **BARNEGAT, NJ 08005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 281	Continued From page 1 Maintenance Director (MD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 4 occupied access areas observed and was evidenced by the following: At 9:29 AM, the surveyor in the presence of the MD, observed in the resident occupied second floor dining/day room across from the 2-elevators, that 3-wall switches shut-off all five (4'x2' drop ceiling) light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The MD confirmed the finding's at the time of observations. The Administrator was informed of these findings at the Life Safety Code survey exit conference on 8/03/2023. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	assure operation during a power failure and/or Generator testing. All residents residing in the facility have the potential to be affected by the deficiency or lack of emergency lighting in the second-floor dining room. The Administrator conducted walking rounds to audit all lighting on the facility to ensure that there is proper illumination during a power failure. The Administrator and Maintenance Director reviewed the necessity of ensuring proper illumination is provided during a power failure. The Administrator will conduct twice weekly physical plant rounds for a period of 3 months to ensure that there is proper and sufficient lighting during a power failure. All findings will be reported at Quarterly Quality Assurance meetings for a period of 6 months.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing	K 321		9/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING **01** B. WING _____	C **08/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE** **BARNEGAT, NJ 08005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/02/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified for 1 of 8 hazardous area doors observed and was evidenced by the following: At 11:14 AM, the surveyor and Maintenance	K 321	The door closure device was adjusted by the Maintenance Director to assure proper closing when the fire alarm is activated. In addition, the electrical wiring was inspected to assure the fan in question ceases to operate when the fire alarm system is activated, thus negating the negative airflow issue in this area. All residents residing in the facility have the potential to be affected by the deficiency. The Administrator conducted walking	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. BUILDING **01** B. WING _____	C **08/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	**859 WEST BAY AVE** **BARNEGAT, NJ 08005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 Director observed that the soiled linen room door (entrance to the washing machine room to the exit/egress staff corridor), would not fully close, when released from the electro-magnetic device due to air pressure from the interior of the room pulling the auto closing door in approximately 1" from fully closing and latching into its frame. The MD confirmed the findings at the time of the observations. The Administrator was notified of the findings at the Life Safety exit conference on 08/04/2023. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	rounds to audit all fire doors in the facility to ensure that the doors close properly during a power failure. The Administrator and Maintenance Director reviewed the necessity of proper door closing during a power failure. The Administrator will conduct twice weekly physical plant rounds for a period of 3 months to ensure that all fire doors close properly during a power failure. All findings will be reported at Quarterly Quality Assurance meetings for period of six months.	

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)
315222	A. Building 01 - MAIN BUILDING 01 B. Wing	9/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNEGAT REHABILITATION AND NURSING CENTER	859 WEST BAY AVE BARNEGAT, NJ 08005

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 09/05/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 09/05/2023	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

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	
8/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO