New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062004	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	**234 CHESTNUT STREET UNION, NJ 07083**

(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 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed 1.) to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey and 2.) failed to ensure all staff who were eligible for their COVID-19 booster vaccination received it by 5/11/22 or within three weeks of becoming eligible. The required staffing deficient practice was identified for 8 day shifts out of 14 day shifts reviewed and the required COVID-19 booster vaccination deficient practice was identified for 30 of 115 staff members reviewed for COVID-19 vaccination booster status.	S 560	Cornell Care & Rehabilitation Center Leadership understands the importance of staffing appropriately to maintain quality patient care. All residents have the potential to be affected by this deficient practice. In order to comply with the direct care staff to resident ratio mandated by the State of New Jersey, Cornell Care has an active hiring campaign as evidenced by partnering with CNA Training Schools, RN Training School, and collaborating with Temporary Nurse Aides (TNAs). Cornell Care offers referral bonus opportunities and is active on major job search engine	1/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/01/22

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S 560	Continued From page 1 These deficient practices were evidenced by the following. 1.) Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	S 560	platforms. The leadership team along with Recruitment Officer will work weekly on recruiting and hiring new employees for open positions to satisfy appropriate staffing ratios. Cornell Care & Rehabilitation Center Leadership believes that increasing the booster vaccination rate in the center is an important strategy to strengthen our community□s protection against COVID-19. In an effort to increase COVID-19 Booster Adherence among facility staff, Cornell□s Leadership Team will: 1.Continue to conduct Booster Clinics on a regular basis 2.Offer Get Boosted Time Off (if an employee chooses to be boosted at a site other than Cornell, they will be given an equivalent of 4 hours time off to do so. 3.Medical Director and Nurse Practitioner (NP) Providers will conduct Booster Education Sessions in which staff will have the opportunity to discuss the risks vs benefits of getting the booster. 4.Employee Boost-One-Get-One Campaign. If an employee gets another employee to be boosted, they will receive a gift card and a chance to be entered in a raffle. All employees who do not have the first booster must provide a proof of religious and or medical exemption letter. Failure to do so will result in suspension then termination. The completion of the audit for booster	

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S 560	Continued From page 2 place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 10/2/22 and ending 10/15/22 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 8 of 14 day shifts as follows: The facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -10/02/22 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. -10/04/22 had 11 CNAs for 97 residents on the day shift, required 12 CNAs. -10/05/22 had 11 CNAs for 96 residents on the day shift, required 12 CNAs. -10/06/22 had 9 CNAs for 96 residents on the day shift, required 12 CNAs. -10/08/22 had 10 CNAs for 98 residents	S 560	compliance will be monitored by DON/ADON weekly for a completion date of 1/18/2023. Any employee who is not vaccinated must have a letter of exemption. All new hire staff are required to have the first booster and must provide proof of vaccinations. DON/ADON will monitor all employees who are not fully vaccinated and employees who are not boosted on an excel tracking form. All employees who are not up to date are required to wear N95 and face shields while in the facility and must be tested once per week.	

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on the day shift, required 12 CNAs.
-10/09/22 had 9 CNAs for 95 residents on the day shift, required 12 CNAs.
-10/10/22 had 9 CNAs for 95 residents on the day shift, required 12 CNAs.
-10/11/22 had 11 CNAs for 95 residents on the day shift, required 12 CNAs.

On 11/2/22 at 10:27 AM, the surveyor informed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) about the deficient staffing found in 8 of 14 day shifts from 10/2/22 to 10/15/22. Both the DON and LNHA stated that they are experiencing a staffing shortage that they are actively trying to correct.

2.) Reference: New Jersey Executive Directive 294, dated 4/13/22: All covered workers must provide adequate proof that they have received their first booster dose by April 11, 2022, or within 3 weeks of becoming eligible for their first booster dose, whichever is later.

On 10/21/22 at 12:29 PM, the surveyor conducted an Entrance Conference with the LNHA and DON. The surveyor requested the vaccination status of the facility's employees.

A review of the facility policy, "COVID-19 Vaccination" (with a facility review date of 10/22) failed to reveal that facility employees were required to receive COVID-19 booster vaccinations.

On 11/2/22 at 1:25 PM, The surveyor reviewed the COVID-19 Vaccination Employee Tracking Log provided by the DON. This matrix revealed that 30 staff members did not receive COVID-19 booster vaccinations by 5/11/22 or within three weeks of being eligible.

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S 560	Continued From page 4 On 11/3/22 at 10:00 AM, the surveyor interviewed the DON. The DON stated that the staff who did not receive booster vaccinations were tested twice weekly, wear N95 respirator masks and face shields while in the facility. The DON also stated that if possible they are not assigned to work with newly admitted residents or COVID-19 positive residents. On 11/3/22 at 11:34 AM, the surveyor interviewed the DON again. No further information was provided as to why there are 30 staff members at the facility that did not receive the COVID-19 booster as required.	S 560		

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 11/10/22 Census: 98 Sample: 24 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 637	1.The Regional Clinical Reimbursement	12/20/22

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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.

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F 637	Continued From page 1 review it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 1 of 21 residents reviewed, Resident #47 as evidenced by the following: According to the Resident Assessment Instrument Manual Version 3.0 of Centers for Medicaid and Medicare Services (CMS) guidelines, updated October 2019 a SCSA MDS is required if there is a "Decline in two or more of the following: ... Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); ... Emergence of a new tus; ..." "The ARD [Assessment Reference Date] must be less than or equal to 14 days after the IDT's [Interdisciplinary Team's] determination that the criteria for an SCSA are met (determination date + 14 calendar days). On 10/21/22 at 11:47 AM, two surveyors observed Resident #47 lying in bed. The resident did not respond to the surveyors' voice, when addressed. The surveyor reviewed the electronic medical record (EMR): The Admission Record revealed that Resident #47 was admitted to the facility with diagnoses that included but were not limited to	F 637	Coordinator in-serviced the MDS Coordinator on capturing significant change. A Root Cause Analysis was conducted. The employee was educated on identification of changes noted in patients physical, mental and psychosocial well-being. 2.All residents/patients have the potential to be affected by the deficient practice. The RAI Significant Change in Status Assessments-Comprehensive Assessments was reviewed with MDS Coordinator to identify and document significant changes in the resident status. 3.MDS Coordinator was educated on capturing the significant change. Significant change alert Form was implemented and will be reviewed daily in the morning meeting with the Interdisciplinary Care Team. 4.The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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The quarterly MDS revealed a Brief Interview for Mental Status (BIMS) score of out of which indicated that Resident #47 had a . The MDS also revealed that Resident #47 had a that was not present upon admission or reentry to the facility.

The MDS also revealed that the resident had a or more in the last month or a or more in the last six months while not on a prescribed regimen.

A review of Resident #47's weights documented in their EMR revealed that Resident #47 weighed pounds (Lbs.) on and weighed Lbs. on . This reflected a decrease in of the resident's in less than six months.

The Health Status Note dated documented in the resident's Progress Notes indicated, "Noted area ...".

The Care Visit Report dated indicated that Resident #47 had a to their with an acquired date of

The Nutrition Note dated indicated that "Resident #47 has this Month and in 180 days per wt. record. Resident 47 is on ...".

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F 637	Continued From page 3 On 11/1/22 at 12:17 PM, the surveyor interviewed the Registered Nurse (RN)/MDS Coordinator. The surveyor discussed with the RN/MDS Coordinator, Resident #47's decline in two areas identified by the RAI Manual which includes [redacted] and the development of [redacted] in [redacted]. The RN/MDS Coordinator acknowledged that in September Resident #47 had a [redacted] and stated that she was not fully aware of the resident's [redacted] being more than [redacted]. The surveyor asked if Resident #47 should have had a SCSA initiated and when it should have been initiated. The RN/MDS Coordinator stated that there should have been a SCSA inititiated for Resident #47 after the [redacted] quarterly MDS, which was an assessment that was missed. On 11/2/22 at 10:19 AM, the surveyor expressed concern to the Licensed Nursing Home Administrator and the Director of Nursing regarding the missed SCSA. There was no additional information provided. NJAC 8:39-11.2(i)	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the Minimum Data Set, an assessment of all residents in Medicare or Medicaid (MDS) for [redacted] residents reviewed for	F 641	1.The Regional Clinical Reimbursement Coordinator in-serviced the MDS Coordinator. A Root Cause Analysis was conducted, and the employee was educated on coding of pain, insulin,	12/20/22

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F 641	Continued From page 4 accurate MDS completion, Resident #69, #32, #36, #85, #47, #64, #44, and #49. The MDS is a federally mandated process for the clinical assessment of all residents to facilitate the management of care. This deficient practice was evidenced by the following: 1. On 10/27/22 at 12:01 PM, the surveyor observed Resident #69, [redacted], seated in their wheelchair watching T.V. in their room. The surveyor reviewed Resident #69's hybrid medical record: The Admission Record (an admission summary) (AR) revealed that Resident #69 was admitted to the facility with diagnoses that included but was not limited to [redacted] The Significant Change in Status MDS for Resident #69, with an Assessment Reference Date (ARD) of [redacted], indicated a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had [redacted] The Significant MDS further documented under Section I (the section used to list active diagnoses in the last 7 days) did not identify [redacted] The Significant MDS further documented, under Section N (the section used to indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days) that the resident was on an [redacted]	F 641	anti-coagulants, and depression. 2.All residents/patients have the potential to be affected by the deficient practice. Coding and timeframes were reviewed with the MDS Coordinator and instructions reviewed in the RAI manual. The MDS coordinator will code in accordance with the resident level of care. 3.MDS Coordinator was educated on proper coding of [redacted], and [redacted] diagnosis. Timeframes, coding by classification of medications, and review of notes and evaluations to verify diagnosis was reviewed with the MDS Coordinator and demonstrated competency in coding. 4.The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 641	Continued From page 5	F 641		

and , and not on a and

The Order Summary Report (OSR) revealed the following physician's orders (POs):
Tablet mg- Give 1 tablet by mouth one time a day for).
Tablet mg- Give 1 tablet by mouth every hours for (an
) Tablet mg- Give 1 tablet by mouth at bedtime for (an .

The OSR revealed that there was PO for any even though the MDS dated coded that Resident #69 received an

A review of paper chart psychiatry progress notes dated that indicated to "Start mg po at bedtime (qHS) for , target

A review of the electronic Medication Administration Record (eMAR) for Resident #69 revealed that the resident received , and medications within the 7-day look back period. It was further indicated that the resident had not received any medication.

2. On 10/21/22 at 12:47 PM, Resident #32 was observed , seated in their wheelchair having lunch in the dining room.

The surveyor reviewed Resident #32's hybrid medical record:

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F 641	Continued From page 6 The AR revealed that Resident #32 was admitted to the facility with diagnoses that included but were not limited to [redacted] The Annual MDS for Resident #32, with ARD of [redacted], indicated a BIMS score of [redacted] of [redacted] indicating that the resident had [redacted]. The Annul MDS further documented under Section N that the resident received [redacted] days, which was inaccurate. The [redacted] OSR revealed the following PO: [redacted]) [redacted] before meals for [redacted] A review of the [redacted] eMAR for Resident #32 revealed that the resident received [redacted] for [redacted] days within the 7-day look back period. 3. On 10/24/22 10:46 AM, the surveyor observed Resident #36 on their left side-lying position in bed, awake but with no response to surveyor's questions. The surveyor reviewed Resident #36's hybrid medical records: The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted], [redacted] The quarterly MDS (qMDS) for Resident #36, with	F 641		

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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 641	Continued From page 7 an ARD of [redacted] revealed that the BIMS interview was not completed due to resident's [redacted]. The qMDS further documented under Section N that the resident received an [redacted] for [redacted] days, which was inaccurate. The [redacted] OSR revealed the following POs: [redacted]- Apply 1 patch transdermally every [redacted] hours for [redacted] Management and remove per schedule (a [redacted] [redacted] tablet [redacted] mg- Give 1 tablet via [redacted] every [redacted] hours for [redacted] Management (an [redacted] The [redacted] eMAR for Resident #36 revealed that the resident had received the [redacted] patch on August 7 and 10 and [redacted] on August 5, 6, 9, 10, and 11, for a total of 6 days. 4. On 10/25/22 at 12:14 PM, the surveyor observed Resident #85, [redacted], seated in their wheelchair watching T.V. in their room. The surveyor reviewed the hybrid medical record of Resident #85: The AR revealed that Resident #85 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The qMDS for Resident #85, with an ARD of [redacted], indicated a BIMS score of [redacted], which indicated that the resident had an [redacted]. A further review of the qMDS	F 641		

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documented under Section N that the resident was on an [redacted], which was inaccurate.

The [redacted] OSR revealed that there was PO for any [redacted]

A review of the [redacted] eMAR for Resident #85 revealed that the resident had not received any [redacted] during the MDS look-back period.

According to the Resident Assessment Instrument (RAI) Manual Version 3.0 of CMS guidelines, updated October 2019 under Chapter 3 page I-7, included that, "1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered."

The RAI manual under [redacted] page [redacted] further included that, "[redacted]: Record the number of days an [redacted] medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code [redacted] medications such as [redacted] here."

On 10/31/22 at 11:07 AM, the surveyor

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interviewed the MDS Coordinator in the presence of 2 surveyors. The MDS Coordinator stated that she used the RAI manual to complete residents' MDS. The MDS Coordinator stated that under Section I, she reviews the medical diagnoses in the residents' primary physician or psychiatrist's progress notes and codes them. She added that under Section N, she reviews the residents' eMAR for the 7-day look back period and records the number of days a resident received medications such as injection, insulin, opioid, antidepressant, anticoagulant, antipsychotic, antianxiety, and diuretic.

The surveyor and the MDS coordinator reviewed Resident #69's [redacted] progress notes dated [redacted] which documented a diagnosis of [redacted] The MDS Coordinator acknowledged that she did not code [redacted] under Section I in Resident #69's Significant Change MDS with ARD of [redacted] and stated, "I could have missed the progress notes from the [redacted] in the resident's chart."

After reviewing Resident #69's [redacted] eMAR, she acknowledged that she did not code [redacted]) and [redacted]) in the MDS. She stated that she was not aware that [redacted] I was classified as an [redacted] and that she coded [redacted]) as an [redacted]

The surveyor and the MDS Coordinator reviewed Resident #32's Annual MDS with ARD of [redacted] and [redacted] eMAR and she acknowledged that she inaccurately coded that the resident received [redacted] for 7 days instead of 5 days.

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The surveyor and the MDS Coordinator reviewed Resident #36's qMDS with an ARD of [redacted] and [redacted] eMAR and acknowledged that once again she was not aware that [redacted] was classified as an [redacted] and therefore did not code it as such.

The surveyor and the MDS Coordinator reviewed Resident #85's qMDS with an ARD of [redacted] along with the [redacted] and [redacted] eMAR. She acknowledged that the resident did not receive any [redacted] medications within the 7-day look back period. She stated, "It's an error." She further stated that she coded [redacted] (an [redacted]) as an [redacted].

5. On 10/25/22 at 12:10 PM, the surveyor observed Resident #47 being fed by the Certified Nursing Assistant (CNA).

The surveyor reviewed the hybrid medical record for Resident #47:

The Admission Record revealed that Resident #47 was admitted to the facility with diagnoses that included but were not limited to [redacted].

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The [redacted] quarterly MDS, revealed a BIMS score of [redacted] out of [redacted] which indicated a [redacted] [redacted]. The MDS also indicated that Resident #47 required, "supervision" and "setup help only" with eating under Section G, which was inaccurate.

The Dietary Alert Sheet dated [redacted] indicated, "Resident needs to be fed as per ST [Speech Therapy]".

The Activities of Daily Living (ADL) Tracker Form dated [redacted] for Resident #47 indicated that on 4 days of the MDS look-back period, [redacted], that the resident's eating was coded, "Total dependence- full staff performance" and "One Person Physical Assist".

On 11/2/22 at 9:00 AM, the surveyor interviewed the MDS Coordinator. The MDS Coordinator stated that when she reviewed the ADL Tracker Form it said that the resident needed to be [redacted] [redacted] by staff. The surveyor asked if the [redacted] quarterly MDS was coded correctly. The MDS Coordinator stated that the MDS was miscoded because the resident did require assistance.

On 11/2/22 at 10:19 AM, the surveyor expressed her concern to the LNHA and DON regarding the inaccurately coded MDS. The administrative team did not provide additional information.

6. On 10/21/22 at 11:30 AM, two surveyors interviewed Resident #64. The resident stated that they experience pain but that taking [redacted] medications is effective.

The surveyor reviewed the hybrid medical record

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for Resident #64:

The AR revealed that Resident #64 was admitted to the facility with diagnoses which included but were not limited to

The MDS indicated that Resident #64 had a BIMS score of out of which indicated that their The MDS also indicated that the resident did not receive a scheduled medication regimen.

The OSR revealed a active PO for Capsule MG to give 1 capsule by mouth in the afternoon for usually in the).
The Order Summary Report also revealed a active PO for Tablet MG to give 1 tablet by mouth two times a day for

The Physician Progress Note dated indicated that Resident #64 had severe and was receiving pain control medication with every hours as needed and

The Medication Administration Record revealed that Resident #64 received daily during the MDS look-back period.

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On 11/1/22 at 10:34 AM, the surveyor interviewed the MDS Coordinator about why the MDS was inaccurately coded with the resident receiving regularly scheduled pain medication. The MDS Coordinator stated, "I usually code it".

7. On 10/21/22 at 11:57 AM, the surveyor observed Resident #44 in the room seated in a wheelchair fully dressed. Resident#44 stated that they expected to return home.

On 10/26/22 at 11:54 AM, the surveyor observed a [redacted]) attached to Resident #44's [redacted] which was [redacted]

On 10/31/22 at 10:23 AM, the surveyor reviewed Resident # 44's hybrid medical record.

Review of the AR revealed that Resident #44 was admitted to the facility with diagnoses that included but were not limited to [redacted].

Review of the resident's eMAR revealed that on [redacted] Resident #44 started receiving [redacted] mg [redacted]y one time a day for [redacted]

A review of the resident's MDS dated [redacted] documented under Section N (the section used to record the number of days, during the last 7 days

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the medication received), that Resident #44 was not receiving [redacted] medication, which was inaccurate.

On 10/31/22 at 11:07 AM, the surveyor interviewed the MDS Coordinator who was responsible for completing the MDS assessment. The MDS Coordinator stated that she failed to code the [redacted] solution ([redacted]) medication in section N of the MDS assessment.

8. On 10/21/22 at 12:30 PM, the surveyor observed Resident #49 in the room seated in a wheelchair fully dressed and prepared to eat lunch. Resident #49 that they liked the food the facility served.

On 10/31/22 at 11:48 AM, the surveyor reviewed Resident #49's hybrid electronic medical record.

The resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted]

A review of the resident's qMDS dated [redacted] failed to document under Section I that Resident #49 had a diagnosis of [redacted]

On 10/31/22 at 11:07 AM, the surveyor interviewed the MDS Coordinator who was responsible for completing the MDS assessment. The MDS Coordinator stated that she missed the Progress Note from the [redacted] in the resident's chart and therefore did not code [redacted] as a diagnosis in the I section for Resident #49.

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F 641	Continued From page 15 On 11/2/22 at 10:19 AM, the surveyors discussed all concerns regarding MDS accuracy to the Licensed Nursing Home Administrator and Director of Nursing. No further information provided. NJAC 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		12/20/22

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F 656	Continued From page 16 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan (CP) for residents at the facility. This deficient practice was identified for 3 of 24 residents reviewed for comprehensive care plans (Resident #69, #44, and #48), and was evidenced by the following: 1. On 10/27/22 at 12:01 PM, the surveyor observed Resident #69, awake and alert, seated in a wheelchair watching T.V. in their room. The surveyor reviewed the hybrid medical record belonging to Resident #69. Review of the Admission Record (an admission summary) (AR) belonging to Resident #69 documented a diagnosis that included but was not limited to [redacted] A Significant Change in Status in the Minimum Data Set (MDS), an assessment record used to facilitate the management of care, dated [redacted]	F 656	1.Director of Nursing in-serviced the Interdisciplinary team and the Unit Manager on comprehensive care plan. A Root cause Analysis was conducted, IDCP team and the Unit Manager were educated on comprehensive person-centered Care Plan for the residents. Care plans for residents 69, 44, and 48 were updated. 2.All residents/patients have the potential to be affected by the deficient practice. Reviewed Person Centered Care Plan and individualizing the plan of care for each patient with the IDCP team and the Unit Manager. Unit Manager will do the final review of the comprehensive Plan of care during Care Plan meeting. 3.The IDCP team and the Unit Manager were educated on comprehensive person centered care plans. The care plan will be reviewed and revised by the IDCP Team	

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indicated a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated that the resident had [redacted].

The [redacted] Order Summary Report (OSR) revealed the following physician's order (PO), [redacted]) Tablet [redacted] mg- Give 1 tablet by mouth at bedtime (Q HS) for [redacted] with an order start date of [redacted].

Another order found on the OSR for Resident #69 was "treated with [redacted] for the indication of [redacted]." The order included a Monthly [redacted] Summary to evaluate effectiveness of an [redacted]. This order directed the documentation to be every evening shift, once monthly on the the 3rd of each month.

A paper chart [redacted] progress note dated [redacted] indicated a diagnosis of Depression and to "Start [redacted] mg po QHS for [redacted]."

A review of Resident #69's care plans (CP) revealed that there was nothing documented that related to the resident receiving an antidepressant medication.

A review of the Nurse's Progress Notes dated [redacted], revealed the following, "Monthly [redacted] Note: Resident started on [redacted] mg Q HS for [redacted]. PO intake has improved and resident is now more vocal and social with others."

On 10/27/22 at 12:13 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM stated

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after each assessment and updated with the new and modified interventions to reflect current resident needs.

4.The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months.
Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.

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F 656	Continued From page 18 Resident #69 "had episodes of decreased and [redacted] a couple months back" and that they were seen by the [redacted] and started on [redacted] for [redacted] and [redacted]." After the surveyor and LPN/UM reviewed the resident's CP, the LPN/UM acknowledged that there should have been a CP initiated for the resident who receives an [redacted] medication. She stated, "I don't know. I may have missed it." On 11/2/22 at 10:50 AM, the surveyor discussed the concern with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON acknowledged that a CP should have been initiated for all residents who is receiving an antidepressant. 2. On 10/21/22 at 11:57 AM, the surveyor observed Resident #44 in the room seated in a wheelchair wearing fully dressed. Resident #44 was [redacted] during a short interview. Resident #44 stated that they expected to return home. On 10/26/22 at 11:54 AM, the surveyor observed a [redacted]) attached to Resident #44's [redacted] which was [redacted] The surveyor reviewed Resident#44's hybrid medical record. The AR revealed that Resident #44 was admitted	F 656		

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F 656	Continued From page 19 to the facility on [redacted] with diagnoses that included but were not limited to [redacted]. The [redacted] OSR revealed a PO for [redacted] mg [redacted]y one time a day for [redacted] starting on [redacted] until [redacted] The Quarterly MDS dated [redacted] revealed a BIMS score of [redacted] out of [redacted] which indicated that the resident had a [redacted]. The [redacted] OSR included a PO for [redacted] mg [redacted] one time a day for [redacted]" which placed the resident at a higher risk for [redacted] with a start date of dated [redacted] The surveyor reviewed the resident's CP. There was no CP developed regarding the resident's use of [redacted] medications. 3. On 10/21/22 at 12:06 PM, the surveyor observed Resident #48 in bed, with eyes open. During the interview, the resident was observed to be [redacted] and [redacted] to the surveyor via [redacted]. The surveyor also	F 656		

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observed a [redacted] inside the resident's room.

The surveyor reviewed the Admission Record which indicated that Resident #48 was admitted to the facility with diagnoses that included, [redacted]

According to the MDS, an assessment tool used to facilitate management of care dated [redacted] reflected that Resident #48 had a Brief Interview for Mental Status score of [redacted] indicating [redacted]

The surveyor reviewed Resident #48's centered care plan which revealed that there was no care plan addressing the resident's [redacted] including the use of [redacted].

On 11/1/22 at 11:18 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #48 who stated that the resident communicates via [redacted] and uses the [redacted].

A review of the facility's policy and procedure titled, "Comprehensive Care Plans" with a review date of [redacted] stated under policy, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment."

On 11/2/22 at 10:50 AM, the surveyors discussed the concerns with the LNHA and DON and

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F 656	Continued From page 21 acknowledged that there was no care plan initiated for the resident upon admission to the facility. No further information was provided. NJAC 8:39-11.2(e)(2)(f)	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident was weighed weekly and monthly in accordance with physician's orders and facility policy. This deficient practice was identified for 1 of 7 residents (Resident #47)	F 692	1.The contracted Regional Dietician was educated on communicating and following up with nursing on [redacted] documentations. Director of Nursing educated all nursing staff, dietician and Unit Manager in documenting residents	12/20/22

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reviewed for [redacted] The deficient practice was evidenced by the following:

On 10/21/22 at 11:47 AM, two surveyors observed Resident #47 lying in bed. The resident did not respond to the surveyors' conversation.

The surveyor reviewed the hybrid medical record for Resident #47.

The Admission Record revealed that Resident #47 was admitted to the facility with diagnoses that included but were not limited to [redacted]

Review of the [redacted] quarterly MDS, an assessment tool used to facilitate the management of care, revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that Resident #47 had a [redacted]

The MDS also revealed that the resident had a [redacted] or more in the last month or a [redacted] or more in the last six months while not on a prescribed [redacted] regimen.

Review of the [redacted] Order Summary Report (Physician's Orders (PO)) revealed that Resident #47 had a [redacted] active PO for monthly [redacted] which should be documented in the electronic medical record (EMR). The Order Summary Report also indicated a [redacted] active PO for weekly [redacted] for 4 weeks.

The [redacted] Order Summary Report

weights in the Electronic Medical Record on a timely manner and with emphasis on [redacted] policy and procedure.

2.All residents/patients have the potential to be affected by the deficient practice. Root cause was conducted. The Dietician was interviewed and educated on communication to the Unit Manager or charge nurse of any concerns regarding data needed to accomplish nutritional assessment on [redacted] change and or monthly monitoring.

3.Dietician will use weight monitoring log to ensure [redacted] is collected. The log will be reviewed in the morning meeting with the Interdisciplinary Care Plan (IDCP) team.

4.The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months.
Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.

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indicated that Resident #47 had an [redacted] active PO for weekly [redacted] for 4 weeks every Wednesday day shift for 4 weeks.

The [redacted] Order Summary Report indicated that Resident #47 had a [redacted] active PO for Weekly [redacted] for 4 weeks to be performed during the day shift every Wednesday for 4 weeks.

The Nutrition care plan initiated [redacted] indicated that the resident's [redacted]t should be monitored and indicated that the resident was to have weekly weights for 4 weeks as of [redacted].

A review of Resident #47's Weights documented in their EMR, revealed that Resident #47 weighed [redacted] pounds (lbs.) on 5/5/2022, weighed [redacted] lbs. on 8[redacted], weighed [redacted] lbs. on 8/30/22, weighed [redacted] lbs. on 9/30/22, weighed [redacted] lbs. on [redacted], and weighed [redacted] lbs. on 10/12/22.

The EMR failed to reveal that monthly weights were documented for [redacted] or [redacted].
The EMR also failed to reveal that weekly [redacted] were documented on 6/8/22, 6/15/22, 6/22/22, 6/29/22, 9/7/22, 9/14/22, 9/21/22, 10/19/22, or 10/26/22.

On 10/31/22 at 9:22 AM, the surveyor asked the Unit Secretary (US) if there was a weight book for the unit. The US stated that there was a weight book (WB) but that weights are supposed to be documented in the EMR.

On 10/31/22 at 9:25 AM, the surveyor reviewed the WB.
The form located in the WB dated, "[redacted]

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indicated that Resident #47 weighed [redacted] Lbs. The form failed to indicate what date in June the [redacted] was taken.

The surveyor observed weekly [redacted] sheets dated "6/8/22", "6/13/22", and "6/22/22" which all failed to indicate Resident #47's name or weight.

Continued review of the forms in the WB presented:
-The form dated, "[redacted]" revealed Resident #47's name but had no weight recorded for the resident.
-The form dated, "9/7/22" indicated that Resident #47 weighed [redacted] Lbs.
-The form dated, "914/22" failed to indicate Resident #47's name or weight.
-The form dated, "9/21/22" indicated that Resident #47 weighed [redacted] Lbs.
-The form dated, "9/28/22" indicated that Resident #47 weighed [redacted] Lbs.

On 10/31/22 at 10:29 AM, the surveyor interviewed the Certified Nursing Assistant (CNA). The surveyor asked how CNAs were expected to obtain and document resident weights. The CNA stated that weights are recorded in the WB.

On 10/31/22 at 10:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The surveyor asked the LPN who is responsible for documenting resident weights. The LPN stated that the CNA is responsible for the documentation of the weights in the WB. The LPN added that the nurse documents the weights in the resident's EMR.

The surveyor asked the LPN about Resident #47's monthly weights for [redacted] and [redacted], and the

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several missing weekly weights. The LPN stated that they should have been documented in the computer (EMR). The surveyor asked about the most recently ordered weekly weights, for 10/19/22 and 10/26/22. The LPN stated that they were probably documented on paper.

On 10/31/22 at 11:22 AM, the surveyor interviewed the Registered Dietitian (RD). The surveyor asked what interventions the RD put in place for Resident #47. The RD stated that among other interventions that the resident was ordered to have weekly weights. The surveyor asked where the weights should be documented. The RD stated that they should be in the EMR under, "Weights." The surveyor asked if the staff were completing the weekly weights. The RD stated that staff were, "way behind." The surveyor asked about her expectation for how weekly weights should be completed. The RD stated that if a resident is ordered weekly weights then the staff should be doing them. The surveyor asked about the [redacted] monthly weights. The RD stated, "some of the weights are missing, [redacted] and [redacted] The surveyor stated that she saw several additional weights in the WB and asked if the RD reviewed the WB. The RD stated that she works for a company contracted with the facility and that her company does not allow her to review the WB. The RD stated that she can only review weights documented in the EMR.

On 10/31/22 at 11:38 AM, the surveyor interviewed the LPN/Unit Manager (UM). The surveyor asked about the LPN/UM's expectation for monthly weights. The LPN/UM stated that she expected that monthly weights should be finished by the 9th of the month so that they can be documented by the 10th of the month, the latest.

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The LPN/UM stated that weights needed to be documented in the EMR. The LPN/UM reviewed the EMR for documented weights and stated, "I don't see it in here." The LPN/UM stated that once the physician orders weekly weights is identified by the nurse, the resident should be added to the weekly weight sheet. The LPN/UM acknowledged that if weekly weights were ordered then they needed to be completed and documented in the EMR.

On 10/31/22 at 12:25 PM, the LPN/UM handed the surveyor two CNA Assignment Sheets and stated that some of the CNAs were documenting weights on the nursing Assignment Sheets. The LPN/UM stated, "This is not an official record" and that, "It should not be documented here."

Review of the CNA Assignment sheets presented:
-On the sheet dated 9/4/22, Resident #47 weighed [redacted] lbs. was documented.
-On the sheet dated 10/18/22, Resident #47 weighed [redacted] lbs. was documented.

On 10/31/22 at 12:25 PM, the surveyor conducted a follow-up interview with the RD. The surveyor asked for the rationale of why weekly weights were performed. The RD stated that when someone lost weight that they had to make sure that the weight was stabilized.

On 10/31/22 at 1:11 PM, the surveyor interviewed the RD in the presence of the survey team. The surveyor asked what role the RD had if the ordered weekly weights were not completed. The RD stated that according to the facility policy that the resident had to have the weights completed but that she had, "no control" over the weights being completed. The RD stated that if there were

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no weights that she would speak with the nurse. The surveyor asked if the RD would request to have a weight done by the CNA at that time if she noticed that a weight was missing. The RD stated that staff could do the weights whenever they wanted and that it was a nursing responsibility to make sure the weights were completed.

The surveyor reviewed the undated, "Position Title: Dietitian" job description for the RD indicated under the "Responsibilities/ Accountabilities" section that the RD "Maintains two-way communication with facility Administrator, Food Service Director and Nursing Services Management" and should "Report non-compliance with policies, procedures, regulations or breaches in confidentiality to appropriate personnel."

The surveyor reviewed, "Weight Monitoring" facility policy with a reviewed date of 9/2022 indicated under the "Documentation" section "f. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate."

On 10/31/22 at 1:45 PM, the surveyor expressed their concerns to the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON stated that resident weights should be in the WB and that at that time they should be documented in the EMR. The DON stated that the RD should follow-up with the Charge Nurse or Assistant Director of Nursing if an ordered weight was not completed. The DON added that there needed to be more communication between the RD and nursing staff.

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F 692	Continued From page 28 On 11/1/22 at 10:02 AM, the LNHA and DON met with the survey team. The DON stated that she found a monthly weight for Resident #47 from [redacted] and that it was recorded on the back of the CNA assignment sheet. The DON stated that it should have been recorded in the EMR. The DON acknowledged that she was unable to locate any documented weekly weights for 6/8/22, 6/15/22, 6/22/22, 6/29/22, 9/14/22, or 10/26/22. No further information was provided. NJAC 27.2(a)	F 692		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 712		2/7/23

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F 712	Continued From page 29 Based on interview, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes (PN) at least once every sixty days. This deficient practice was identified for 4 of 21 residents reviewed for physician visits, Resident #4, #26, #77, #79. This deficient practice was evidenced by the following: 1.) On 10/24/22 at 10:51 AM, the surveyor observed Resident #4 in bed with eyes closed. The resident was also observed lying on a [redacted] and was wearing [redacted]. The surveyor reviewed the Admission Record (AR) which indicated that Resident #4 was admitted to the facility with diagnoses that included but were not limited to, [redacted] According to the Minimum Data Set (MDS), an assessment tool used to facilitate management of care which was dated [redacted] the Brief Interview for Mental Status (BIMS) score of [redacted] reflected that Resident #4 had a [redacted]. A review of the Physician's PN reflected the following: [redacted] Physician PN completed by Advanced Practice Nurse #1 ([redacted]) [redacted] Physician PN completed by [redacted] #1 [redacted] Physician PN completed by [redacted] #1	F 712	1.Physicians responsible for supervising the care of residents were educated and notified that a resident must be seen by a physician at least once every 30 days for the first 90 days after admission and, and at least once every 60 days thereafter. After the initial physician visit in the SNF, a Nurse Practitioner may make every other required visit. Physicians confirmed their understanding of this regulation and have visited their residents. Physicians saw and examined resident 4 on 1/4/23, resident 26 on 12/21/22, resident 77 was seen on 11/11/22, resident 79 seen on 11/11/22 2.All patients/residents have the potential to be affected by the deficient practice. The federal regulation on physician visits was provided to all credentialed physicians. They were all educated on the frequency of visits to maintain compliance. 3.Physicians were educated on the frequency of visits. Physicians were reminded that residents must have a face to face visit and that a Nurse Practitioner may make every other required visit. Resident charts we be audited 4.The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance/Performance Improvement Committee meeting. QAPI	

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F 712	Continued From page 30 Physician PN completed by #1 Physician PN completed by #1 Physician PN completed by #1 Physician PN completed by #1 There was no documented evidence that the physician visited and examined Resident #4 a minimum of every 60 days. In fact, there were no physician's visits or completion of a PN from 4/27/22 to 10/19/22. 2.) On 10/21/22 at 10:45 AM, the surveyor observed Resident #26 in their room seated on the bed. The resident was alert but not oriented. The surveyor reviewed the AR which indicated that Resident #26 was admitted to the facility with diagnoses that included but was not limited to, According to the MDS dated the BIMS score of reflected that Resident #26 had a n. A review of the Physician's PN reflected the following: Physician PN completed by #1 Physician PN completed by #1 Physician PN completed by #1 Physician PN completed by #1 Physician PN completed by #1 Physician PN completed by #1 There was no documented evidence that the physician visited and examined Resident #26 a minimum of every 60 days. In fact, there were no physician's visits or completion of a PN from 5/25/22 to 10/5/22.	F 712	committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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On 11/3/22 at 10:42 AM, the surveyor interviewed Physician #1 via a phone conversation, who stated that he was not aware of the federal regulation that required a physician to visit and examine their residents a minimum of every 60 days.

3.) On 10/21/22 at 10:54 AM, Resident #77 was observed in their room seated in a chair with eyes closed.

The surveyor reviewed the AR which indicated that Resident #77 was admitted to the facility with diagnoses that included but were not limited to [redacted].

According to the MDS dated [redacted], the BIMS score of [redacted] reflected that Resident #77 had a [redacted].

A review of the Physician's progress notes reflected the following:
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2

There was no documentation from Physician #2 that he visited and examined Resident #77 a minimum of every 60 days. In fact, there were no physician's visits or completion of a PN from

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5/6/22 to 10/7/22.

4.) On 10/21/22 at 10:54 AM, Resident #79 was observed in the room seated in a wheelchair. The resident was alert but not oriented.

The surveyor reviewed the AR which indicated that Resident #79 was admitted to the facility with diagnoses that included but were not limited to [redacted]

According to the MDS dated [redacted], the BIMS score of [redacted] reflected that Resident #79 had an [redacted].

A review of the Physician's PN reflected the following:
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2
[redacted] Physician PN completed by [redacted] #2

There was no documentation from Physician #2 that he visited and examined Resident #79 a minimum of every 60 days. In fact, there were no physician's visits or completion of a PN from 5/6/22 to 10/7/22

On 11/3/22 at 10:40 AM, the surveyor attempted to contact Physician #2, via a phone conversation but was unavailable for an interview.

On 11/3/22 at 10:49 AM, the surveyor then interviewed APN #2 via a phone conversation. The [redacted] stated that she visited and examined the residents with Physician #2. The APN #2

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	315104	A. BUILDING ______ B. WING ______	11/10/2022

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F 712	Continued From page 33 stated that only she documents in the physician PN. The surveyor stated to [redacted] #2 that there was no documentation from the physician showing that they were present for the actual visit. On 11/2/22 at 10:50 AM, the surveyor discussed the above concerns to the Administrator and the Director of Nursing who did not provide any further information. NJAC 8:39 - 23.2 (d)	F 712		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined that the facility failed to 1.) maintain food items in a manner to ensure	F 812	1.The Food Services Director was in-serviced to ensure that all expiration dates on food items are checked daily. All	1/31/23

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F 812	Continued From page 34 they are not used past their "use by date", 2.) maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and the potential for developing food borne illness, and 3.) prevent staff from handling resident's food in a non-hygienic manner. This deficient practice was evidenced by the following: 1. On 10/21/22 at 10:15 AM, two surveyors in the presence of the Food Service noted a 2.05 once (oz) container of dried Bay leaves with an expiration date of 9/16/2022 and a 16 oz container of Cumin with an expiration date of 3/25/2021 were observed in the dry storage area. The FSD could not explain why both expired items had not been thrown away. 2. During the continued inspection of the kitchen, the two surveyors in the presence of the FSD observed a blackish/grey debris covering the fans and grey particles on the ceiling, found in the walk-in refrigerator located in the basement area. While inspecting the kitchen, the two surveyors along with the FSD, also observed grey particles on the vents of two air conditioning units. Both air conditioning units were located above the food preparation areas. Along with the above concerns, while inspecting the kitchen the two surveyors along with the FSD also observed a heavy blacked caked-on debris located on the grate covering for the exhaust fan, above the dishwashing area. The FSD stated that the maintenance department	F 812	expired products were discarded immediately. The Food Services Director and Maintenance Director were also educated to routinely check and maintain all equipment in accordance with manufacturer directions and training materials. All non-food contact equipment will be cleaned and free of debris. The CNA was educated on food handling. CNA must perform hand washing or sanitize hands using an alcohol-based hand rub in between serving residents. 2.All residents/patients have the potential to be affected by the deficient practice. All nursing staff were in-serviced on proper handling of resident food in hygienic manner. Routine environmental checks will be conducted monthly and as needed. 3.Maintenance personnel will use a monthly log to ensure areas of concern are addressed. Food Services Director will complete a daily checklist to ensure kitchen equipment is clean and in working order. The CNA will demonstrate competency in performing appropriate food handling practices. The CNA's performance will be audited weekly for four weeks and then monthly for three months. 4.Food Services Director and Maintenance Director will conduct weekly audits for four weeks and then monthly for four months to ensure compliance. Director of Nursing/Assistant Director of Nursing or designee will perform weekly audits on proper hygienic food	

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F 812	Continued From page 35 should be doing rounds in the kitchen and are responsible for cleaning air conditioners and the exhaust fan grate. On 10/25/22 at 10:22 AM, the surveyor interviewed the Corporate Director of Environmental Services (CDES). The CDES stated that their department is responsible for cleaning the air conditioning vents and exhaust fan grate. CDES further stated they all should be cleaned at least monthly. The CDES was unable to state if the monthly cleaning was occurring as there was no documented cleaning schedule or record of it available. On 10/26/2022 at 9:03 AM, the Licensed Nursing Home Administrator (LNHA) provided a copy of a document titled, "Kitchen Exhaust Fan/AC Filter Cleaning - Monthly cleaning Or As Needed." The surveyor observed the cleaning date documented as 10/21/2022 and signed by the CDES. On 11/1/2022 at 12:51 PM, the (LNHA) provided copies of the Dietary Opening and Closing Checklist from 9/25-11/1/22 and the facility's policy titled "Equipment" with a revision date of 9/2017. The Dietary Opening Checklist under the section "Description" explains: "All food storage areas checked to ensure proper labeling and dating procedures are being adhered to. All expired products discarded. All refrigerators and freezers checked inside and out. Cleaned and sanitized. Job assignments completed, cleaning assignments reviewed and verified, staff's signatures upon completion." The Dietary Closing Checklist under section	F 812	competency for four weeks and then monthly for three months. The results of the audit will be provided to the quality assurance committee. The results of the audit will be provided to the quality assurance committee at least quarterly for 6 months.	

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F 812	Continued From page 36	F 812		

"Description" explains: "Refrigerator and freezers are neat, clean, and temperatures recorded. Check all equipment record problems in Maintenance log." All item descriptions were signed off being completed from 9/25-11/1/22.

The facility policy titled "Equipment" explains under section Policy Statement:
"All food service equipment will be clean, sanitary, and in proper working order."

The surveyor reviewed section "Procedures" of the "Equipment" policy which explained:
1. All equipment's will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials.
4. All non-food contact equipment will be cleaned and free of debris.
5. The Dining Services Director will notify the Administrator and/or Maintenance Director for routine maintenance concerns and/or repairs as needed.

3.) On 10/27/22 at 12:27 PM, during the dining observation at the [redacted] nursing unit, the surveyor observed a Certified Nurses Assistant (CNA) setting up a resident's tray for lunch. The surveyor observed the CNA picked up the resident's roll with her bare hands. The CNA placed the roll on top of the lid that was used to cover the Resident's food plate. The lid was previously used to discard the paper from the resident's straws, and any other trash from lunch. The CNA was then observed spreading butter on the roll with her bare hands and serving it to the resident. The CNA, without hand sanitizing or hand washing, proceeded to get another meal tray to serve another resident.

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F 812	Continued From page 37 On 10/27/22 at 12:30 PM, the surveyor interviewed the CNA who stated that she was supposed to perform handwashing or sanitize her hands using an alcohol based hand rub in between serving different residents meal. On 11/2/22 at 10:50 AM, the above concerns was discussed with the LNHA and the Director of Nursing. No further information was provided. NJAC 8:39-17.2(g)	F 812		