| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD OXFORD, NJ 07863** |

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| E 000 | Initial Comments<br><br>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<br><br>Standard Survey:<br><br>Census: 74<br><br>Sample Size: 28<br><br>The facility is 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 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to consistently follow standards of clinical practice in regard to a.) accurately documenting medication administration in the electronic Medication Administration Record (eMAR) and b.) correctly following the physician's orders for 2 of 19 residents, Resident #61, and Resident #49.<br><br>The deficient practice is evidenced by the | F 658 | F658 □ (D) □ Services Provided Meet Professional Standards<br>1) Doctor was advised regarding the medication errors identified during the survey, for residents #61 and #49. The Physician reviewed the medications and assessed the resident for adverse effects. Medication Error reports were generated and signed by the Director of Nursing and the Medical Director as well as the nurse | 8/22/22 |

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

Electronically Signed | 08/12/2022

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| F 658 | Continued From page 1<br>following:<br><br>Reference: New Jersey Statuses Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through 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.<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of 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."<br><br>1. On 6/27/22 at 10:09 AM, the surveyor observed Resident #61 in bed with eyes closed. The surveyor could not interview Resident #61.<br><br>The surveyor reviewed Resident #61's hybrid medical records (paper and electronic) that revealed the following:<br><br>The Admission Record revealed that Resident #61 was admitted to the facility with Ex Order 26. 4B1 that included Ex Order 26. 4B1 | F 658 | involved. All nurses involved in the incident received a 1:1 re-education.<br>2) Medication orders with parameters were audited for compliance with the orders. Any additional medication errors noted were written up and those nurses re-educated as well.<br>3) Policy titled Medication Administration was reviewed and updated.<br>4) Education of all nurses regarding the proper reading of orders and the documentation for residents with parameters.<br>Audits of residents on medications with parameters will be completed weekly x4, monthly x5 and quarterly x2 by the DON or her designee to ensure compliance with documentation and proper holding of medications for those residents with parameters on their medication.<br>5) Results of the medication audits will be submitted to the Administrator monthly and to the QAPI committee quarterly. | |

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| F 658 | | F 658 | | |

Continued From page 2

and *Ex Order 26. 4B1* [redacted]

The Admission Minimum Data Set (MDS) an assessment tool dated [redacted], revealed a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated that the resident was [redacted].

The June and July 2022 eMAR included Physician's orders for:

a.'*Ex Order 26. 4B1* [redacted] by mouth one time a day related to *Ex Order 26. 4B1* [redacted]. Hold for *Ex Order 26. 4B1* [redacted] less than [redacted] or *Ex Order 26. 4B1* [redacted] less than [redacted]." A review of the documentation on the eMAR demonstrated that the *Ex Order 26. 4B1* [redacted] was administered [redacted] in [redacted] and [redacted] in [redacted] when the medication should have been held due to low [redacted].

b. '*Ex Order 26. 4B1* [redacted] by mouth one time a day related to *Ex Order 26. 4B1* [redacted]. Hold for [redacted] less than [redacted] or HR less than [redacted]." A review of the documentation on the eMAR demonstrated that the *Ex Order 26. 4B1* [redacted] was administered [redacted] in [redacted] and [redacted] in [redacted] when the medication should have been held due to low [redacted].

On 7/5/22 at 11:28 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) and discussed the above concerns. LPN #1 stated, "That's an error. That's my fault. I should have held the medications."

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| F 658 | Continued From page 3 | F 658 | | |

A review of the facility policy titled "Medication Administration" with a review date of 6/22 indicated under "Policy: The facility staff will provide safe and accurate medication administration to the residents. Procedure: 7. The nurse takes and records any vital signs as indicated for the order on the Medication Administration Record (pulse, BP, etc.). If the vital sign readings are outside the parameter established by the medication order and/or facility policy, the nurse will hold the medication and if necessary, contact the physician for further instruction."

2. The surveyor reviewed the hybrid medical records of Resident #49 which revealed the following:

The resident's Admission Record listed diagnoses that included *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* [redacted].

The Admission MDS assessment dated [redacted] indicated the facility assessed the resident's *Ex Order 26. 4B1* using a BIMS. The resident was unable to complete the interview for a BIMS score and was coded as having short-term and *Ex Order 26. 4B1* [redacted], and *Ex Order 26. 4B1* [redacted] for daily decision making.

The [redacted] physician's orders and eMAR indicated Resident #49 had an order, dated [redacted], that read, '*Ex Order 26. 4B1* [redacted] Give [redacted] tablet by mouth [redacted] a day related to *Ex Order 26. 4B1* [redacted] HOLD

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| F 658 | Continued From page 4<br>FOR *Ex Order 26. 4B1* GREATER THAN 130".<br><br>The [redacted] and [redacted] eMAR revealed that the *Ex Order 26. 4B1* was administered [redacted] out of [redacted] times in [redacted] and [redacted] out of [redacted] times in [redacted], when the medication should have been held for an [redacted] that was greater than [redacted]<br><br>On 7/5/22 at 11:59 AM, the surveyor interviewed LPN #2 about residents who have medication orders with parameters. LPN #2 stated that parameters would be listed with the medication order, and that she would follow the parameters as ordered by the physician. The surveyor asked LPN #2 about the *Ex Order 26. 4B1* order for Resident #49. LPN #2 reviewed the eMAR and stated that the *Ex Order 26. 4B1* order had a parameter to hold the medication for [redacted] greater than [redacted]. The surveyor reviewed with LPN #2, the [redacted] and [redacted] eMAR. LPN #2 acknowledged that the resident was administered [redacted] at times when the medication should have been held for an [redacted] that was greater than [redacted] as per the physician's orders.<br><br>On 7/5/22 at 12:08 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) about medication orders with parameters. The RN/UM stated it was expected for the nurses to follow the parameters as ordered by the physician. The surveyor reviewed with the RN/UM the [redacted] and [redacted] eMAR of Resident #49. The RN/UM stated the nurses should have held the *Ex Order 26. 4B1* when the [redacted] was greater than [redacted].<br><br>On 7/5/22 at 1:15 PM, the surveyor informed the | F 658 | | |

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| F 658 | Continued From page 5<br>LNHA and DON regarding the above concerns of the administration of *Ex Order 26. 4B1* [redacted] for when the medication should have been held according to the physician's orders.<br><br>The surveyor reviewed the facility policy titled, "Medication Administration", with a reviewed date of 06/2022. Under Policy, it read, "The facility staff will provide safe and accurate medication administration to the residents". Under Procedure, it read, "7. The nurse takes and records any vital signs as indicated or the order on the Medication Administration Record (pulse, BP, etc.). If vital sign readings are outside the parameter established by the medication order and/or facility policy, the nurse will hold the medication and if necessary, contact the physician for further instruction."<br><br>NJAC 8:39-11.2 (b); 29.2(d) | F 658 | | |
| F 689 SS=H | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to provide adequate monitoring and supervision to prevent falls with injury, as well as failed to revise, reassess, and reevaluate for appropriate | F 689 | F689 □ (H) □ Free of Accident Hazards/Supervision/Devices<br>1) Resident # 35 was medically re-evaluated. Resident was re-assessed for [redacted] risk and the Interdisciplinary Care | 8/22/22 |

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| F 689 | Continued From page 6<br>interventions to the care plan (CP) for a resident with a high risk for falls who sustained multiple falls with injuries. This deficient practice was identified for 1 of 4 residents (Resident #35) reviewed for [redacted], and for [redacted] out of [redacted] from [redacted], which resulted in multiple injuries that included the *Ex Order 26. 4B1* [redacted] of the [redacted] with a [redacted] of the *Ex Order 26. 4B1* [redacted] requiring [redacted]. This deficient practice was evidenced by the following:<br><br>On 7/6/22 at 11:26 AM, the surveyor observed Resident#35 sitting in the day room with other residents and there was no staff present. The resident stood up and the surveyor observed the resident wearing a pair of oversized [redacted] pants. The [redacted] pants were [redacted] in the waist and [redacted]<br><br>On 7/6/22 at 11:30 AM, the surveyor interviewed the Unit Manager Registered Nurse (UMRN) who provided information about the resident and stated that the resident was *Ex Order 26. 4B1* [redacted], and required assistance with Activities of Daily Living (ADLs). The UMRN stated that the resident's clothing were [redacted] and in the laundry being cleaned. The UMRN added that they had to put something on the resident, so they put [redacted] on the resident. The UMRN was aware that the [redacted] pants were [redacted] and was also aware that the resident had a history of [redacted].<br><br>The surveyor reviewed Resident#35's hybrid medical records (paper and electronic) that revealed the following:<br><br>According to the Admission Record, Resident #1 | F 689 | Plan team updated the care plan to reflect appropriate interventions.<br>2) All Residents were re-evaluated for [redacted] risk, care plans and CNA [redacted] updated to reflect current interventions.<br>3) Fall Prevention Policy and Procedure was reviewed and revised.<br>Care planning Policy and Procedure was reviewed and revised.<br>Nurses and CNAs were re-educated in the Falls Policy and Procedure.<br>Nurses and CNAs were re-educated on the Care Plan Policy and procedure.<br>A weekly audit of all falls will be completed by the Falls Committee/Interdisciplinary Care Plan team to ensure that root cause analysis is completed, interventions are updated, care plans and CNA [redacted] are updated, and therapy recommendations are reviewed and acted upon.<br>4) Results of these audits are reviewed submitted to the Administrator monthly and submitted to QAPI quarterly. | |

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| F 689 | Continued From page 7<br>was admitted to the facility with a diagnosis of *Ex Order 26. 4B1* [redacted]. | F 689 | | |

The Quarterly Minimum Data Set an assessment tool dated [redacted], revealed the facility performed a Brief Interview for Mental Status (BIMS). The BIMS score was [redacted], which indicated that the resident had *Ex Order 26. 4B1* [redacted].

The Resident Accident/Incident Reports were obtained from the Director of Nursing (DON) which indicated that the resident had fallen [redacted] times in [redacted] months [redacted] on [redacted] on [redacted], [redacted], [redacted], on [redacted], and [redacted]. [redacted] of the [redacted] resulted [redacted].

The [redacted] occurred on [redacted], the resident was found on the [redacted] at the nurse's station [redacted] on the resident's [redacted], the [redacted] was unwitnessed. Interventions that were listed on the Accident/Incident Report included the resident was sent to the Emergency Department (ED), *Ex Order 26. 4B1* were done, 15-minute monitoring for 72 hours post [redacted] was put into place, *Ex Order 26. 4B1* was done to rule out *Ex Order 26. 4B1* [redacted], & rehabilitation (rehab) screening was done.

The [redacted] occurred on [redacted] the resident was found in the [redacted] with [redacted] noted, the [redacted] was unwitnessed. Interventions that were listed on the Accident/Incident Report included *Ex Order 26. 4B1* [redacted], [redacted] 15-minute monitoring for 72 hours post [redacted] was put into place, and for the resident to wear [redacted]

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| F 689 | Continued From page 8 | F 689 | | |

instead of [redacted] However, after this [redacted] which occurred on [redacted], there was no documentation provided by the facility that the interventions were reviewed and updated in the resident's CP.

The [redacted] occurred on [redacted], the resident was found in the [redacted] on [redacted] the [redacted] was unwitnessed. The resident had a [redacted] to [redacted] Interventions that were listed on the Accident/Incident Report included the resident was sent to ED, [redacted] were done, 15-minute monitoring for 72 hours post [redacted] was continued from the [redacted] and notified the family to bring [redacted].

The [redacted] occurred on [redacted], the resident was found on the [redacted] in room [redacted] with [redacted], the [redacted] was unwitnessed. There was no injury noted. Interventions that were listed on the Accident/Incident Report [redacted] were done, 15-minute monitoring for 72 hours post [redacted] was put into place, and a note to see second report for the [redacted] at 5:50 PM. However, after this [redacted] on [redacted] there was no documentation provided by the facility that the interventions were reviewed and updated for the appropriateness in the resident's CP.

The [redacted] occurred on [redacted] the resident was [redacted] in the [redacted], [redacted], the [redacted] was unwitnessed. The resident sustained [redacted] to the [redacted]. Interventions that were listed on the Accident/Incident Report included the resident was sent to ED, resident received [redacted] to close the [redacted] on the [redacted],

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| F 689 | Continued From page 9<br>checks,15-minute monitoring for 72 hours post [redacted] was put into place, and to implement medication changes.<br><br>The [redacted] occurred on [redacted] the Certified Nurse Aide (CNA) observed the resident [redacted] in the hallway. The resident sustained a [redacted] on [redacted] The resident was sent to ED, *Ex Order 26. 4B1* was [redacted] at the ED and ED reported a *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* age. Interventions that were listed on the Accident/Incident Report [redacted] were done, 15-minute monitoring for 72 hours post [redacted] was put into place, call out to [redacted] for a medication review, offer and assist with periods of rest, monitor nutritious intake, and monito [redacted]<br><br>The [redacted] occurred on [redacted], CNA heard a [redacted] and found the resident on the [redacted], the [redacted] was unwitnessed. The resident sustained a [redacted] to [redacted]. Interventions that were listed on the Accident/Incident Report included follow up with medication changes, resident had a [redacted] staff shadowing for one night until the resident fell asleep, rehab screening, continue 15-minute monitoring for 72 hours post [redacted], and monitor nutrition intake. However, after this [redacted] on [redacted] there was no documentation provided by the facility that the interventions were reviewed and updated in the resident's CP.<br><br>The [redacted] occurred on [redacted], the CNA witnessed the resident [redacted] in the hallway. The resident sustained a *Ex Order 26. 4B1* [redacted]. Interventions that were listed on the Accident/Incident Report included follow up with [redacted] review and 15-minute | F 689 | | |

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monitoring for 72 hours post [redacted] was put into place. However, after this [redacted], there was no documentation provided by the facility that the interventions were reviewed and updated in the resident's CP.

The [redacted] occurred on [redacted] the CNA witnessed the resident running in hallway and [redacted] to [redacted]. The resident sustained a [redacted] on the [redacted]. Interventions that were listed on the Accident/Incident Report included treatment to the *Ex Order 26. 4B1* site, 15 min monitoring for 72 hours post [redacted] was put into place, frequent redirection, assessment to rule out *Ex Order 26. 4B1*, and medication review. However, after this [redacted], there was no documentation provided by the facility that the interventions were reviewed and updated in the resident's CP.

The [redacted] occurred on [redacted], the resident was found on [redacted] in [redacted], the [redacted] was unwitnessed. The resident sustained *Ex Order 26. 4B1* to the [redacted] The resident was sent to ED, was admitted with the following diagnosis, a *Ex Order 26. 4B1* [redacted] and received *Ex Order 26. 4B1* to the [redacted] Interventions that were listed on the Accident/Incident Report included the resident was to be placed on [redacted] monitoring to start indefinitely, to be seen by Advanced Practice Nurse (APN) for anticipated medication changes and added *Ex Order 26. 4B1* as tolerated.

The resident's [redacted] plan reflected an initiation date of [redacted] and a revision date of [redacted] and revised again on [redacted] which indicated that Resident #1 was at risk for *Ex Order 26. 4B1* [redacted]

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| F 689 | Continued From page 11<br>[redacted], and an increased risk of injury from [redacted] due to diagnosis of [redacted]. Interventions that were put into place included 15-minute monitoring after each [redacted] for 72 hours, [redacted], and ED visits (if there were injuries). There were also testing completed to rule out [redacted] completed for medication review.<br><br>There was no documentation that interventions were reviewed or revised, after the resident had the [redacted], which each occurred on [redacted] and [redacted] nor for the [redacted] which occurred on [redacted] and lastly, no documentation for the [redacted] which occurred on [redacted]<br><br>There was also no documentation on the CP that the [redacted] was involved in the review and revision of the CP, and that the recommendations that were made by OT were included as updated interventions. The Rehab Screen/Referral forms revealed that the OT made recommendations for the nursing staff to increase the resident's level of supervision during the month of [redacted].<br><br>On 5/13/22, after the [redacted], OT recommended that the resident required constant supervision with staff to reduce risk of [redacted] The CP did not include the OT recommendation completed on [redacted], regarding the [redacted] which occurred on [redacted].<br><br>On 6/7/22, after the [redacted] on [redacted] recommended that the resident required constant supervision on unit/redirection for increased safety. The CP did not include the [redacted] recommendations completed on [redacted], regarding the [redacted] on [redacted] | F 689 | | |

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| F 689 | Continued From page 12<br><br>On 6/7/22, after the [redacted] on [redacted]), OT recommended that the resident required constant supervision/redirection to reduce risk of [redacted]. The CP did not include the [redacted] recommendation completed on [redacted], regarding the [redacted] which occurred on [redacted]<br><br>On 6/21/22, after the 6/15/22 [redacted], [redacted] recommended that the resident required supervision at all times for increased safety. The CP did not include the OT recommendation completed on 6/21/22, regarding the [redacted] which occurred on 6/15/22.<br><br>On 6/21/22, after the 6/16/22 [redacted], OT recommended to nursing staff to supervise resident at all times/provide redirection to reduce risk of [redacted]. The CP did not include the OT recommendation completed on 6/21/22, regarding the [redacted] which occurred on 6/16/22.<br><br>On 7/7/22 from 10:52 AM to 11:09 AM, the surveyor observed Resident #1 sitting alone in the alcove/hallway. The resident was out of view of the nurse's station, while sitting in the alcove hallway, and there were no staff nearby.<br><br>On 7/7/22 at 11:10 AM, the surveyor interviewed CNA assigned to the resident who stated the resident sits alone in the alcove/hallway a lot and eventually will come back down the hall. The CNA was unaware of any recent [redacted], or the 15-minute monitoring for 72 hours post [redacted]. This was the current intervention in place for the resident, due to the two most recent [redacted] that occurred on 7/4/22 at 2:50 PM and 3:10 PM. | F 689 | | |

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| F 689 | Continued From page 13<br>On 7/7/22 at 11:15 AM, the surveyor interviewed the UMRN who was at the nurse's station working on a computer with the UMRN's back facing the alcove/hallway. The UMRN was aware of the two recent [redacted] on 7/4/22 and was aware of the 15-minute monitoring for 72 hours post [redacted] intervention currently in place but the UMRN was unaware of the resident currently sitting alone in the alcove/hallway. The UMRN stated that the nurses were responsible for completing the 15-minute monitoring for 72 hours post [redacted] not the CNAs.<br><br>The UMRN added that the CNAs would receive any updates for the resident's care in the Visual/Bedside [redacted] Report and stated the [redacted] was where the CNA would get the most recent information about the resident's falls or any interventions. The UMRN stated the resident was compulsive and moves around very fast and "could benefit from 1:1 but even that was not a sure thing." The UMRN then went down the hallway and escorted the resident into activities. The UMRN came back to the surveyor and added that a [redacted] was being ordered for the resident.<br><br>On 7/7/22 at 11:38 AM, the surveyor interviewed the [redacted] who stated that a rehab assessment was completed after [redacted] and there was no change in the resident's cognition and functional status. The [redacted] stated several recommendations were made for the nursing staff to increase the resident's level of supervision.<br><br>During the interview with OT, the Rehabilitation Director (RD) was present and added that if there was a component of balance and strength or limitation of movement then that would be | F 689 | | |

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| F 689 | Continued From page 14 | F 689 | | |

something they would look into, but the resident's issue is a very functional part of their behaviors. The RD agreed with OT that the resident could benefit from an increase in supervision.

On 7/11/22 at 10:15 AM, the surveyor interviewed the DON concerning the OT recommendations for increased supervision. The DON stated the recommendations were not presented to the physician or the APN because the wording for "constant supervision was incorrectly used". The DON stated the resident received "distant monitoring and the staff was aware of the resident's location at all times". The DON was unable to show where the distant monitoring was being documented and at the time of the interview, the DON had not met with OT for clarification or revision of any of the previously made recommendations.

On 7/11/22 at 10:28 AM, the surveyor reviewed the resident's Morse[redacted] Scale (MFS) in the electronic medical record. The MFS was updated after each[redacted] and reflected that as of 5/12/22, the resident's[redacted] risk was elevated from low-risk status to a high risk for[redacted]. The MFS revealed that the facility calculated the resident's total score to be[redacted]. The range for high is[redacted] and higher.

The interventions listed on the Accident/Incident Reports were not consistently documented in the resident's[redacted] care plan. The facility included the same 15-minute monitoring for 72 hours post[redacted], however the facility failed to properly reassess the interventions that were already put into place nor address the recommendations given by OT on 5/13/22, 6/7/22, or 6/21/22 to increase the resident's level of supervision to prevent further

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| F 689 | Continued From page 15<br>falls and injuries.<br><br>In addition, there was no documentation that interventions were reviewed or revised after the resident had the second [redacted], which occurred on [redacted] and [redacted], nor for the [redacted] which occurred on [redacted], and lastly, not for either of the two [redacted] which occurred on [redacted]<br><br>On 7/12/22 at 10:06 AM, the DON and the Administrator discussed the [redacted] incidents regarding Resident #1. The DON provided background information on the resident's behavior and frequent [redacted]. The DON stated they were at their "wits end". The DON stated that 1:1 staff supervision or "shadowing" the resident increased the resident's [redacted], and the resident gets "upset". The DON further stated that their team looked at each [redacted] and felt the interventions put into place were all they could do. The Administrator was present during the DON's presentation and was in agreement with the DON's explanation of how difficult the resident was to keep from [redacted] and that the interventions put in place were appropriate.<br><br>On 7/12/22 at 11:11 AM, the DON provided the surveyor with the [redacted] Report which provided the CNA with the most up to date information on the resident's care and interventions. The form dated as of [redacted], only listed [redacted] out of the [redacted]. The [redacted] dated [redacted] listed the "15-minute monitoring post [redacted] for [redacted] hours and the [redacted] medication review." The [redacted] which occurred on [redacted], was documented on [redacted] and listed the "1:1 monitoring, [redacted] Nurse [redacted] to review medication management, monitor dietary intake and pain. The [redacted] at all times-monitor for | F 689 | | |

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| F 689 | Continued From page 16<br>increased Ex Order 26. 4B1 " which was included in the [redacted] dated [redacted]. The [redacted] did not document the [redacted] other Ex Order 2 which occurred on [redacted], the two Ex Order 2 on [redacted], the two Ex Order 2 on [redacted], the Ex Order on [redacted] nor the two Ex Order 2 on [redacted]. There was no documentation provided by the facility that the CNAs were provided with the most updated interventions.<br><br>On 7/15/22 at 12:33 PM, the surveyor contacted the DON via telephone to ask for a policy specific to resident Ex Order 2 that would include the 15-minute monitoring for 72 hours post Ex Order. The DON stated the policy for "Incident Reporting for Residents and Visitors" with a revised date of [redacted] that was given to the surveyor at the facility.<br><br>In review of the policy, there was nothing noted in the "Incident Reporting for Residents and Visitors" specific to Falls which identified the 15-minute monitoring to be done 72 hours post [redacted] This was the only policy provided by the facility to address falls. | F 689 | | |
| F 695 SS=D | NJAC 8:39-27.1 (a) (b)<br>Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced | F 695 | | 8/22/22 |

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| F 695 | Continued From page 17<br>by:<br>Based on observation, interview, and record review of facility documentation, it was determined the facility failed to a.) ensure a resident was receiving supplemental oxygen as prescribed by the physician; b.) failed to accurately document in the electronic Treatment Administration Record (eTAR) to indicate that the oxygen was administered to 1of 2 residents (Resident #61) reviewed for the use of [redacted].<br><br>This deficient practice was evidenced by the following:<br><br>On 6/23/22 at 11:34 AM, the surveyor observed Resident #61 in bed wearing a *Ex Order 26. 4B1* [redacted] attached to an *Ex Order 26. 4B1* [redacted]. The surveyor observed that the *Ex Order 26. 4B1* [redacted] was set to [redacted] liters per min (LPM).<br><br>The surveyor reviewed Resident #61's hybrid medical record which revealed the following:<br><br>The Admission Record revealed that Resident #61 was admitted to the facility on [redacted] with diagnoses that included but not limited to *Ex Order 26. 4B1* [redacted], and *Ex Order 26. 4B1* [redacted].<br><br>The Admission Minimum Data Set an assessment tool dated [redacted] revealed a Brief Interview of Mental Status score of [redacted] out of [redacted] which indicated that the resident was *Ex Order 26. 4B1* [redacted].<br><br>The June 2022 Medication Review Report | F 695 | F695 ( D) □ Respiratory/Tracheostomy Care and Suctioning<br>1) Resident #61 was re-assessed by the MD for *Ex Order 26. 4B1*. Oxygen orders were updated to reflect current *Ex Order 26. 4B1* [redacted]. Nurses assigned to resident #61 were re-educated regarding the reading of, documenting and maintaining of *Ex Order 26. 4B1*.<br>2) All residents with *Ex Order 26. 4B1* were reviewed for appropriateness and to ensure that *Ex Order 26. 4B1* was received as ordered. Any updates identified were reviewed and orders updated by the MD.<br>3) All Nurses were re-in-serviced on the proper reading of, documentation of and maintaining treatment orders of *Ex Order 26. 4B1*. The Unit Managers will audit all residents with oxygen orders 5 times a week x 1month, Weekly x 5 months and monthly x 6 month to ensure compliance.<br>4) Results of these audits will be submitted to and reviewed by the DON, Administrator monthly and to the QAPI committee quarterly. | |

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| F 695 | Continued From page 18<br>indicated that Resident #61 had an order dated [redacted] for '*Ex Order 26. 4B1* [redacted] per minute via *Ex Order 26. 4B1* PRN as needed for *Ex Order 26. 4B1* [redacted]"<br><br>On 6/27/22 at 10:09 AM, the surveyor observed Resident #61 in bed wearing a *Ex Order 26. 4B1* attached to an *Ex Order 26. 4B1* [redacted]. The surveyor observed that the *Ex Order 26. 4B1* [redacted] was set to [redacted].<br><br>On 6/27/22 at 10:39 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The surveyor asked why Resident #61 was on *Ex Order 26. 4B1*. The LPN stated that Resident #61 was on *Ex Order 26. 4B1* as needed [redacted]) a [redacted] for comfort. The LPN further stated that "a lot of times" the resident "wears it more at night while in bed."<br><br>On 6/27/22 at 10:44 AM, the surveyor brought the LPN to Resident #61's room to check the [redacted] rate that was administered to the resident. The LPN stated to the surveyor that the rate on the *Ex Order 26. 4B1* [redacted] was set to [redacted] The LPN further stated that the physician's order was for the *Ex Order 26. 4B1* [redacted] to be administered at [redacted].<br><br>The surveyor reviewed June 2022 eTAR and revealed that there were no signatures indicating that the oxygen was administered to the resident on [redacted] and [redacted].<br><br>On 6/27/22 at 11:54 AM, the surveyor interviewed the LPN and acknowledged that the PRN oxygen should have been signed for the dates that it was administered. The LPN stated, "I guess it gets to be a habit that we see it on the resident, we don't get to sign it." | F 695 | | |

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| F 695 | Continued From page 19<br>On 6/27/22 at 1:16 PM, the surveyor expressed her concerns to the Licensed Nursing Home Administrator and Director of Nursing (DON). The DON agreed that the [redacted] was not administered as per physician's orders. The DON further stated that the eTAR should have been signed.<br><br>A review of the facility policy titled "Respiratory Therapy Administration and Equipment Policy and Procedure" with a review date of 6/22 indicated under "Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration."<br><br>A review of the facility policy titled "Medication Administration" with a review date of 6/22 under "Procedure: 11. Nurse records the medication given on the Medication Administration Record. 15. Result of administration of PRN medications will be noted on the Medication Administration Record." | F 695 | | |
| F 711 SS=E | NJAC 8:39- 29.2 (d)<br>Physician Visits - Review Care/Notes/Order<br>CFR(s): 483.30(b)(1)-(3)<br><br>§483.30(b) Physician Visits<br>The physician must-<br><br>§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;<br><br>§483.30(b)(2) Write, sign, and date progress notes at each visit; and | F 711 | | 8/22/22 |

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| F 711 | Continued From page 20<br><br>§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents' current medical regimen was appropriate. This deficient practice was observed for 10 of 18 residents (Resident #64, #25, #35, #59, #56, #1, #6 ,#65, #20 and #48) reviewed and occurred over several months.<br><br>This deficient practice was evidenced by the following:<br><br>The surveyors reviewed the hybrid medical records (paper and electronic) for the residents listed above that revealed the resident's primary physician had not hand signed the Order Summary Reports (monthly physician's orders) located in the residents' chart. In addition, there were no electronic signatures under the physician's orders for the following residents:<br><br>1. Resident #64's hybrid medical records (paper and electronic) revealed that the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] and [redacted]<br><br>2. Resident #25's hybrid medical records revealed that the resident's physician had not hand signed or electrically signed the [redacted] | F 711 | F711 – ( E ) – Physician Visits – Reviews Care/ notes/ Order<br>1) Resident #64's monthly physician orders for May and June 2022 were signed by MD<br>Resident #25's monthly physician orders for April and May 2022 were signed by MD.<br>Resident # 35's monthly physician orders for June 2022 were signed by MD.<br>Resident #59's monthly physician order sheet for June 2022 was re-placed in the chart and was signed by MD.<br>Resident #1's monthly physician orders for May and June 2022 were signed by MD.<br>Resident #56's monthly physician orders for June 2022 were signed by MD.<br>Resident # 6's monthly physician orders for May and June 2022 were signed by MD.<br>Resident # 65's monthly physician orders for May and June 2022 were signed by MD.<br>Resident #20's monthly physician orders for May and June 2022 were signed by MD.<br>Resident #48's monthly physician orders for May and June 2022 were signed by MD. | |

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| F 711 | Continued From page 21<br>and [redacted] monthly physician's orders.<br><br>3. Resident #35's hybrid medical records revealed that the resident's physician had not hand signed or electronically signed the [redacted] monthly physician's orders.<br><br>4. Resident #59's hybrid medical records were reviewed and revealed that the resident's physician had not hand signed or electronically signed the monthly physician order for [redacted]. In addition, there was no Physician's Order Sheet (POS) in the resident's medical record for [redacted].<br><br>5. Resident #1's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] and [redacted].<br><br>6. Resident #56's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders fo [redacted].<br><br>7. Resident #6's hybrid medical records revealed that the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] and [redacted].<br><br>8. Resident #65's hybrid medical records revealed that the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] and [redacted].<br><br>9. Resident #20's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for [redacted] and [redacted] | F 711 | 2) An audit of monthly physician orders on all resident records was completed and any delinquent charts found were immediately signed by the MD.<br>3) The MD was re-educated on the documentation physician responsibilities by the Director of Operations.<br>Medical records will audit 100% of resident records on a monthly basis to ensure physician compliance.<br>4) Results of the Medical records audits with be submitted to the DON and Administrator monthly and to the QAPI committee quarterly. | |

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| F 711 | Continued From page 22<br><br>10. Resident #48's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's order fo [redacted] and [redacted].<br><br>On 7/05/22 at 10:16 AM the surveyor interviewed the Registered Nurse Unit Manager (RNUM) regarding the process for physicians signing monthly orders. The RNUM stated physician orders are signed electronically. The RNUM reviewed the [redacted] and [redacted] physician orders on the electronic record with the surveyor. The RNUM was unable to provide evidence that the physician had signed electronically.<br><br>The RNUM then stated physician orders are signed by the physician both electronically and on paper. She was unable to provide evidence of physician signatures on the paper record for [redacted] and [redacted]<br><br>On 7/05/22 at 10:20 AM the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated the physician does not sign orders electronically. The DON stated the physician signs on the paper record. The surveyor reviewed the unsigned [redacted] physician orders in the paper medical record. The DON did not offer an explanation as to why monthly orders were unsigned by the physician.<br><br>On 7/6/22 at 1:53 PM, the surveyors met and interviewed the Medical Director (MD) who was responsible for signing the monthly physician's orders. The MD stated, "I've been overwhelmed."<br><br>The facility's policy titled "Physician's Visits" with a | F 711 | | |

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| F 711 | Continued From page 23<br>revised date of [redacted] indicated under Policy the following: "Attending Physicians will visit their patients a minimum of each month and as needed." Under Purpose the following was listed: "To ensure that residents receive medical care as needed; To reduce inappropriate hospitalizations; To comply with regulations related to physician visits; and To ensure residents achieve highest practicable level of well-being."<br><br>NJAC 8:39-23.2(b) | F 711 | | |
| F 835 SS=D | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Refer to F689<br><br>Based on interview, review of medical records, and other pertinent facility documentation, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) 1. failed to ensure that the facility's Policy and Procedures for Falls were in place, updated, and implemented, 2. failed to ensure appropriate review, reassessment, and revision of a resident's care plan interventions, and 3. failed to ensure Resident #35 was safely supervised and did not sustain injuries from the [redacted] that included the *Ex Order 26. 4B1* of the right *Ex Order 26. 4B1* with a *Ex Order 26. 4B1* [redacted] | F 835 | F835 □ (D) □ Administration<br>1) Corporate Clinical Nurse directed that resident be re-assessed by the care team and care plan updated for resident #35. Facility hired a new administrator who started on [redacted].<br>2) Corporate Clinical Nurse directed the re-assessment of all residents for [redacted] risk and the review and updating of resident care plans and CNA [redacted] to reflect any changes.<br>3) Corporate Clinical Nurse directed the updating of the Falls and Care Planning policies and procedures.<br>Corporate Clinical Nurse re-educated the DON and the Interdisciplinary Care plan | 8/22/22 |

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| F 835 | Continued From page 24<br>hospitalization. The deficient practice was identified for 1 of 4 residents, for [redacted] out of [redacted] falls that resulted in injuries, which occurred from [redacted], and failed to provide increased supervision to maintain the resident's safety. This deficient practice was evidenced by the following:<br><br>On 7/6/22 at 11:26 AM, the surveyor observed Resident #35 sitting in the day room with other residents and there were no staff present. The resident stood up and the surveyor observed the resident wearing a pair of oversized [redacted] pants. The [redacted] pants were loose fitting in the waist and very long in length.<br><br>On 7/7/22, from 10:52 AM to 11:09 AM, the surveyor observed Resident #35 sitting alone in the alcove/hallway. The resident was out of view of the nurse's station, while sitting in the alcove hallway, and there was no staff nearby.<br><br>The Director of Nursing (DON) provided the surveyor with Resident #35's Accident/Incident Reports for the last three months. The surveyor reviewed the reports that indicated Resident #1 had [redacted] times in the last three months of which [redacted] of the [redacted] resulted in injuries. The dates of the [redacted] included [redacted] the resident had [redacted] with injuries; [redacted], the resident had [redacted], the [redacted] the resident sustained an injury; [redacted], the resident had [redacted] sustaining an injury on the [redacted]; [redacted] the resident had [redacted] with injuries; [redacted], the resident had one [redacted] with injuries [redacted], the resident had two [redacted] with both [redacted] resulting in injuries; and July 8, 2022, the resident had one [redacted] which the resident sustained a [redacted]. | F 835 | team on Falls management and the care planning process.<br>Corporate Clinical Nurse directed the re-education of Nurse and CNAs on the Falls and Care Planning policies.<br>Corporate Clinical Nurse will be reviewing the [redacted] incident reports and the Falls audit weekly with the DON to ensure compliance.<br>4) Corporate Clinical Nurse will ensure that the Falls QAPI is submitted to the QAPI committee monthly. | |

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| F 835 | Continued From page 25 | F 835 | | |

The resident's current [redacted] care plan reflected an initiation date of 1/24/22 and a revision date of 6/16/22 and revised again on 7/5/22, which indicated that Resident #1 was at risk for [redacted], had [redacted], and an increased risk of injury from [redacted] due to diagnosis of [redacted]. Interventions that were put into place included 15-minute monitoring after each [redacted] for 72 hours, [redacted], and ED visits (if there were injuries). There was also testing completed to rule out [redacted] and [redacted] consults completed for medication review.

The resident was seen by the [redacted] after the [redacted] and [redacted] and made the recommendations to provide constant supervision, and redirection for increased safety. On 6/21/22, the [redacted] recommended the resident received supervision at all times to reduce risk of [redacted].

The interventions listed on the Accident/Incident Reports were not consistently documented in the resident's [redacted] care plan. The facility included the same 15-minute monitoring for 72 hours post [redacted], however the facility failed to properly reassess the interventions that were already put into place nor address the recommendations given by [redacted] on [redacted] to increase the resident's level of supervision to prevent further [redacted] and injuries.

In addition, there was no documentation that interventions were reviewed or revised after the resident had the [redacted], which occurred on [redacted] and [redacted], nor for the [redacted] which occurred on [redacted], and lastly, not for either of the [redacted]

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| F 835 | Continued From page 26<br>[redacted] which occurred on [redacted]<br>On 7/11/22 at 10:15 AM, the surveyor interviewed the DON concerning the OT recommendations for increased supervision. The DON stated the recommendations were not presented to the physician or the Advanced Practice Nurse because the wording for "constant supervision was incorrectly used". The DON stated the resident received "distant monitoring and the staff was aware of the resident's location at all times". The DON was unable to show where the distant monitoring were being documented and at the time of the interview, the DON had not met with OT for clarification or revision of any of the previously made recommendations.<br><br>On 7/12/22 at 10:06 AM, the DON and the Administrator discussed the [redacted] incidents regarding Resident #1. The DON provided background information on the resident's behavior and frequent [redacted]. The DON stated they were at their "wits end". The DON stated that 1:1 staff supervision or "shadowing" the resident increased the resident's [redacted], and the resident gets [redacted]". The DON further stated that their team looked at each [redacted] and felt the interventions put into place were all they could do. The Administrator was present during the DON's presentation and was in agreement with the DON's explanation of how difficult the resident was to keep from [redacted] and that the interventions put in place were appropriate.<br><br>The facility provided the surveyor with the Incident Reporting for Residents and Visitors policy and procedure. The surveyor reviewed the policy that had no documentation specific to [redacted] which identified the 15-minute monitoring for 72 hours post [redacted]. The DON stated that this was the | F 835 | | |

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| F 835 | Continued From page 27<br>only policy the facility had specific for falls.<br><br>The surveyor reviewed the job description for the LNHA titled "Administrator Job Description". Under General Purpose indicated the following, "To direct the overall operations of the facility in accordance with current Federal, State, and Local standards governing the facility, to ensure the highest degree of quality of care is maintained at all times." Under Administrative Functions included the following "Ensure that each resident receives the necessary nursing, medical and psychological services to attain and maintain the highest possible mental and physical functional status. Plan, develop, organize, implement, evaluate, supervise, and direct all facility departments and overall operations, its programs and activities and implement changes where necessary. Assist department directors to develop, maintain and periodically update written policies, procedures, manuals, objectives, and philosophies."<br><br>NJAC 8:39-27.1 (a) (b) | F 835 | | |
| F 836 SS=D | License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)<br><br>§483.70(a) Licensure.<br>A facility must be licensed under applicable State and local law.<br><br>§483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards.<br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in | F 836 | | 8/22/22 |

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| F 836 | Continued From page 28<br>such a facility.<br><br>§483.70(c) Relationship to Other HHS Regulations.<br>In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to a.) consistently schedule sufficient nursing staff to meet the needs of residents and b.) failed to schedule sufficient staff to ensure residents received adequate supervision to prevent falls, which occurred for 1 of 7 residents (Resident #35) reviewed for [redacted].<br><br>The deficient practice is evidenced by the following:<br><br>a.) Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. | F 836 | F836 □(D) □ License/Comply with Federal/State / Local Law/ Professional Standards<br>1) The facility is monitoring acuity and nursing staffing hours and CNA ratios daily. Nursing overtime shifts, bonus shifts, and per diem shifts are being utilized when needed to maintain the required hours and ratios. The facility continues to aggressively to recruit, hire and retain nursing staff.<br>2) The facility recognizes that all residents have the potential to be affected by this deficient practice. Ancillary staff is utilized to support the nursing staff and provided additional assistance and/or | |

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| F 836 | Continued From page 29<br>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.<br>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:<br>(1) one certified nurse aide to every eight residents for the day shift.<br>(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<br>(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<br>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.<br>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.<br>(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 | F 836 | supervision to those residents who may require it. Such as those with behaviors and falls.<br>The facility will track and log all the results of the facility recruitment and retention efforts.<br>3) Nursing Management and the Staffing Coordinator were re-educated on the CNA ratio requirement.<br>The facility has enrolled on in the Fully Staffed program and the team lead by the Administrator will be meeting weekly to complete the Fully Staffed program assignments and incorporate them in a newly established Staffing Performance Improvement Project.<br>4) The results of the Performance Improvement Project will be reviewed at the quarterly Quality Assurance Performance Improvement meeting to ensure compliance and to identify any trends or patterns requiring further corrective actions. | |

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| F 836 | Continued From page 30<br>the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.<br>(3) All computations shall be based on the midnight census for the day in which the shift begins.<br>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.<br><br>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks beginning 6/5/22 and 6/12/22 revealed the following information.<br><br>The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 7:00 AM - 3:00 PM shift for 10 of 14 days beginning 6/5/22 and ending 6/16/22 as evidenced by the following:<br><br>The facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:<br><br>-06/05/22 had 7 CNAs for 73 residents on the day shift, required 9 CNAs.<br>-06/06/22 had 8 CNAs for 73 residents on the day shift, required 9 CNAs.<br>-06/07/22 had 7 CNAs for 73 residents on the day shift, required 9 CNAs.<br>-06/08/22 had 8 CNAs for 73 residents on the day shift, required 9 CNAs.<br>-06/09/22 had 6 CNAs for 73 residents on the day shift, required 9 CNAs. | F 836 | | |

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| F 836 | Continued From page 31<br>-06/10/22 had 7 CNAs for 73 residents on the day shift, required 9 CNAs.<br>-06/11/22 had 7 CNAs for 75 residents on the day shift, required 9 CNAs.<br>-06/12/22 had 7 CNAs for 75 residents on the day shift, required 9 CNAs.<br>-06/14/22 had 8 CNAs for 75 residents on the day shift, required 9 CNAs.<br>-06/16/22 had 7 CNAs for 74 residents on the day shift, required 9 CNAs.<br><br>b.) On 7/06/22 at 11:28 AM the surveyor observed Resident #35 seated in the dining room with other residents. There was no staff member in the dining at the time of the observation.<br><br>On 7/07/22 at 10:52 AM the surveyor observed the resident sitting alone in a hallway alcove. There were no staff members visible in the area.<br><br>A review of [redacted] investigations occurring over May 2022, June 2022, and July 2022 revealed the resident had eight [redacted]. Six of the [redacted] were unwitnessed by staff members. Five of the [redacted] resulted in *Ex Order 26. 4B1* and the last [redacted] dated 7/8/22 resulted in a *Ex Order 26. 4B1* of the mandible.<br><br>NJAC 8:39- 25.2 | F 836 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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 | F 880 | | 8/22/22 |

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| F 880 | Continued From page 32<br>diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315304 | A. BUILDING _____ B. WING _____ | 07/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD OXFORD, NJ 07863** |

| (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 33<br>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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection on the [redacted] positive unit. This deficient practice was for 2 of 4 [redacted] positive residents reviewed, Resident #24 and #31, and evidenced by the following:<br><br>On 6/23/22 at 11:31 AM, in the [redacted] unit, the surveyor observed personal protective equipment (PPE) hanging on Resident #24's and Resident #31's doors and a STOP sign was observed on each resident's door as well. The surveyor interviewed the License Practical Nurse (LPN #1), who stated that both residents were [redacted] positive and on droplet precautions. Residents #24 and #31 were in their rooms lying in bed. | F 880 | F880 □(D) □ Infection Prevention and Control<br>1) CNA was re-educated by the Infection Preventionist on Hand Washing, Donning and Doffing of PPE, Droplet precautions and Care of COVID positive residents. CNA was re-competency on Hand washing and Donning and Doffing of PPE. Administrator, Infection Preventionist, DON, Employees involved in the incident and the Corporate Operations and Clinical representatives completed a Root cause Analysis to ascertain why staff did what they did and to put corrective actions in place, so this deficient practice does not recur. Causes of the break in infection control practices are as follows:<br>a) Nurse management failed to ensure | |

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|---|---|---|---|
| | 315304 | A. BUILDING _____ B. WING _____ | 07/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD OXFORD, NJ 07863** |

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|---|---|---|---|---|
| F 880 | Continued From page 34<br><br>The surveyor reviewed Resident #24's and Resident #31's medical records which revealed the following:<br><br>According to the Admission Record, Resident #24 was admitted to the facility with diagnoses that included Ex Order 26. 4B1. There was a Physician's Order (PO) dated 6/20/22 for 'Ex Order 26. 4B1 Precautions: Positive Ex Order 26. 4B1 x 10 days."<br><br>According to the Admission Record, Resident #31 was admitted to the facility with diagnoses that included Ex Order 26. 4B1. There was a PO dated 6/17/22 for 'Ex Order 26. 4B1 Precautions: Positive Ex Order 26. 4B1 Virus x 10 days."<br><br>On 6/27/22 at 11:35 AM, the surveyor observed LPN #2 and a Certified Nursing Assistant (CNA) at the COVID-19 positive unit nurse's station. The CNA was wearing an N95 face mask under her chin with her nose and mouth exposed and she had no eye protection on. The CNA stated that she did not know that she needed to wear the N95 or eye protection on the COVID-19 positive unit while at the nurse's station. The LPN #2 replied to the CNA and said "Yes, you do, it is a COVID-19 positive unit, and it is our facility policy to wear the N95 mask and eye protection even when you are at the nurse's station."<br><br>On 6/27/22 at 12:24 PM, the surveyor observed that the lunch tray truck arrived on the Ex Order 26. 4B1 positive unit and the lunch tray truck was located near Resident #24's door. The surveyor observed the CNA at the entrance of Resident # 24's room and the CNA donned (put on) a gown, N95 mask and eye protection and no gloves were put on her hands. The CNA entered Resident #24's room, | F 880 | that the staff members assigned to the COVID unit had a practical understanding of the requirements of working on a COVID positive unit.<br>b) A lack of understanding of the chain of command was identified. Once it was noted that the staff member wasn□t following proper infection control procedures the direct supervisor (LPN) should have notified the Unit Manager, DON, or Administrator that the staff member needed to be removed from the unit for failure to follow infection control procedures and failing to following the directions of her direct supervision<br>c) A lack of consequences for actions and poor performance was identified.<br>d) It was noted that housekeeping supervisor failed to round on the COVID unit and did not note that resident #31 room lacked a receptacle by the door to discard used PPE.<br><br>2) The facility recognizes that all residents have the potential to be affected by this deficient practice.<br>Policy entitled Infection Control Surveillance has been reviewed and updated including updating the Infection Control Surveillance forms.<br>3) Staff will be re-educated on Handwashing, donning and doffing of PPE, Droplet precautions and Care of COVID positive residents.<br>Topline staff and the Infection Preventionist were re-educated utilizing the following:<br>- Nursing Home Infection Preventionist Training Course | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315304 | A. BUILDING _____ B. WING _____ | 07/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD OXFORD, NJ 07863** |

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|---|---|---|---|---|
| F 880 | Continued From page 35<br>holding the disposable lunch tray and then LPN #2 walked toward the resident's door and from the hallway LPN #2 said to the CNA "You need to wear gloves." The CNA said "No, I do not need to wear gloves, I'm only putting the lunch tray in the room." The surveyor observed the CNA place the disposable lunch tray onto the resident's bedside table, which was next to the resident who was in the bed. The CNA walked toward the doorway and doffed (took off) her gown, eye protection and N95, she put alcohol-based hand rub (ABHR) on her hands and replaced her N95 mask and eye protection.<br><br>On 6/27/22 at 12:35 PM, the surveyor and LPN #2 observed the CNA push the lunch tray truck near the doorway of Resident #31's room. The CNA donned a gown, N95 and eye protection and again, no gloves were put on her hands. The CNA entered Resident #31's room, holding the disposable lunch tray and LPN #2 said again, "You need to wear gloves," the CNA said "No, I'm only putting the lunch tray in the room." The CNA put the disposable lunch tray onto the resident's bedside table, which was located next to the resident, who was in the bed. The CNA took a spoon from the resident's disposable lunch tray and gave it to the resident. The resident gave the spoon back to the CNA and the resident said, "I need a fork." The CNA took the spoon from the resident with her bare hands, placed in on the resident's disposable lunch tray, picked up the fork and gave it to the resident.<br><br>The CNA walked to Resident #31's doorway and LPN #2 said, "You need to wash your hands." The CNA walked to the sink inside the resident's room, turned on the faucet, placed her hands under the running water, put soap on her hands | F 880 | o Module 1 □ Infection Prevention and Control<br>o Module 4 □ Infection Surveillance<br>o Module 5 - Outbreaks<br>o Module 6a □ Principles of Standard Precautions<br>o Module 6b □ Principles of Transmission Based Precautions<br>o Module 7 □ Hand Hygiene<br>- CDC COVID □ 19 You-tube videos<br>o Message to front line staff □ Keep COVID □ 19 Out<br>o Message to front line staff □ Clean hands<br>o Message to front line staff - Use PPE correctly for COVID-19<br>Front Line staff and all staff were re-educated utilizing the following:<br>- Nursing Home Infection Preventionist Training Course<br>o Module 6a □ Principles of Standard Precautions<br>o Module 6b □ Principles of Transmission Based Precautions<br>o Module 7 □ Hand Hygiene<br>- CDC COVID □ 19 You-tube videos<br>o Message to front line staff □ Keep COVID □ 19 Out<br>o Message to front line staff □ Clean hands<br>o Message to front line staff - - Use PPE correctly for COVID-19<br>Infection Preventions will conduct surveillance audits including staff observations of handwashing and use of PPE orders 5 times a week x 1month, Weekly x 5 months and monthly x 6 month observing a minimum of 5 staff members each time. Any staff member | |

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|---|---|---|---|
| | 315304 | A. BUILDING _____ B. WING _____ | 07/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD OXFORD, NJ 07863** |

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| F 880 | Continued From page 36<br>and placed them back under the running water while rubbing her hands for three seconds. She turned off the faucet with a paper towel and walked toward the resident's doorway. The CNA doffed her face shield, gown and N95 mask. The CNA was observed holding her doffed N95 and without putting on another face mask, she walked to the resident's bedside and discarded the N95 in the trash container which was located next to the resident's bed. The CNA exited the resident's room and used ABHR on her hands.<br><br>On 6/27/22 at 12:40 PM, the surveyor interviewed the CNA, who stated that she did not wear gloves because she only entered the room to put the tray down.<br><br>At 1:12 PM, the surveyor discussed the above concerns with the Administrator and the Director of Nursing.<br><br>The surveyor reviewed the policy and procedure titled "Hand Washing" with a review date of 6/2022, which revealed that the procedure for hand washing at the facility is to lather and scrub hands, wrists and forearms vigorously with friction for 20-30 seconds and to not place hands under running water while scrubbing.<br><br>The surveyor reviewed the policy and procedure titled "Droplet Precautions Policy and Procedure" with a review date of 6/2022, which revealed that the personal protective equipment required for a resident who is on COVID-19 droplet precautions are an N95 mask, protective eyewear, isolation gowns and gloves.<br><br>NJAC 8:39-19.4 (a) | F 880 | found to not be following procedure will be immediately re-educated.<br>4) Results of these audits will be submitted to the DON and Administrator monthly and submitted to QAPI quarterly. | |

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 |
|---|---|---|---|
| | 62102 | A. BUILDING: _____ B. WING _____ | 07/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WARREN HAVEN REHAB AND NURSING CENT | 350 OXFORD ROAD OXFORD, NJ 07863 |

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|---|---|---|---|---|
| S 000 | Initial Comments<br><br>THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. | S 000 | | |

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

Electronically Signed | 08/12/22

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315304 | A. BUILDING _____ B. WING _____ | R 09/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD OXFORD, NJ 07863** |

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|---|---|---|---|---|
| {E 000} | Initial Comments<br><br>This was a revisit for the 7/18/2022 Recertification survey. The facility was found to be in substantial compliance with the implementation of their POC/DPOC. | {E 000} | | |
| {F 000} | INITIAL COMMENTS | {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 | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315304 Y1 | A. Building<br>B. Wing Y2 | 9/12/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WARREN HAVEN REHAB AND NURSING CENTER | 350 OXFORD ROAD<br>OXFORD, NJ 07863 |

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 F0658 | Correction | ID Prefix F0689 | Correction | ID Prefix F0695 | Correction |
| Reg. # 483.21(b)(3)(i) | Completed | Reg. # 483.25(d)(1)(2) | Completed | Reg. # 483.25(i) | Completed |
| LSC | 08/22/2022 | LSC | 08/22/2022 | LSC | 08/22/2022 |
| ID Prefix F0711 | Correction | ID Prefix F0835 | Correction | ID Prefix F0836 | Correction |
| Reg. # 483.30(b)(1)-(3) | Completed | Reg. # 483.70 | Completed | Reg. # 483.70(a)-(c) | Completed |
| LSC | 08/22/2022 | LSC | 08/22/2022 | LSC | 08/22/2022 |
| 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 | 08/22/2022 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 7/18/2022 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315304 | A. BUILDING **01**<br>B. WING _____ | **07/18/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD**<br>**OXFORD, NJ 07863** |

| (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<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/14/22 and 07/18/22,was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy<br><br>The facility is a 2-story with a ground floor building that was built in 90's, It is composed of Type I fire resistant construction. The facility is divided into 14 smoke zones. The generator does 100% of the building.<br><br>The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.<br><br>The facility has 180 certified beds. At the time of the survey the census was 74. | K 000 | | |

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

Electronically Signed | 08/12/2022

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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|---|---|---|---|
| | 315304 | A. BUILDING **01**<br>B. WING _____ | **07/18/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 000 | Continued From page 1 | K 000 | | |

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|---|---|---|---|---|
| K 000 | Continued From page 2<br>Health Care Occupancy<br><br>The building is a 2 story (ground floor, floor 1, floor 2) building that was built in 90's, It is composed of Type I fire resistant construction. The facility is divided into 19 smoke zones. The generator does 100% of the building.<br><br>The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.<br><br>The facility has 180 certified beds. At the time of the survey the census was 74. | K 000 | | |
| K 211<br>SS=F | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and documentation review on 7/18/22, in the presence of the Maintenance Director and | K 211 | K211 □ (F) □ Means of Egress<br>1) Fire door inspections were completed and documented by the maintenance | 8/22/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| K 211 | Continued From page 3<br>Administrator, it was determined that the facility failed to a.) inspect fire doors annually in accordance with S&C 17-38-LSC for fifteen (15) of fifteen (15) fire doors observed.<br><br>This deficient practice was evidenced by the following:<br><br>From approximately 10:00 AM, to 2:00 PM, the surveyor reviewed all provided documentation from the Maintenance Director. The annual fire door inspection documentation was not provided for the facility's fire door assemblies.<br><br>An interview was conducted with the Maintenance Director, during the document review. He stated that currently no further documentation could be provided on fire door inspections (Annual) for the last 12-months as identified in the S&C 17-38-LSC documentation.<br><br>The Maintenance Director confirmed the finding during the observation's.<br><br>The Administrator was informed of the finding at the Life Safety Code exit conference on 7/18/22.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 80<br>NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8<br>S&C 17-38-LSC<br>NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1 | K 211 | staff.<br>2) All residents have the potential to be affected by this deficient practice.<br>3) Fire Door Inspection tool was initiated in accordance with S&C 17-38-LSC. Maintenance staff were re-educated on how to perform Fire door inspections and use of the Fire door inspections tool. Fire Door inspections were added to the Life safety Code documentation review spreadsheet that is completed Annually.<br>4) The Life Safety Code Review spreadsheet will be submitted to the Administrator monthly and to the QAPI Committee quarterly. | |
| K 222<br>SS=F | Egress Doors<br>CFR(s): NFPA 101 | K 222 | | 8/22/22 |

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|---|---|---|---|
| | 315304 | A. BUILDING **01**<br>B. WING _____ | **07/18/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WARREN HAVEN REHAB AND NURSING CENTER** | **350 OXFORD ROAD**<br>**OXFORD, NJ 07863** |

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| K 222 | Continued From page 4<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected | K 222 | | |

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| K 222 | Continued From page 5<br>throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, in the presence of surveyor 2, Maintenance Director, Plant Operations Director and Administrator on 07/18/22, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 1 of 2 sets of exterior exit/egress doors observed.<br><br>This deficient practice was evidenced as follows:<br><br>At 11:08 AM, the surveyor, Maintenance Director, and Administrator<br>observed two sets of glass sliding doors, the interior set of sliding doors had a lockset that | K 222 | K222 □ (F) □ Egress Doors<br>1) The lock was disabled on the first of the two sets of sliding doors at the entrance to the building.<br>2) All residents have the potential to be affected by this deficient practice.<br>3) The Lock was disabled on the first of the two sets of sliding doors at the entrance<br>to the building.<br>The means of Egress throughout the building will be monitored by Maintenance daily on the 24 hour report to ensure that NFPA 101 is met.<br>4) Results of the daily checks will be reported to QAPI committee monthly. | |

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| K 222 | Continued From page 6<br>engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route.<br><br>The Maintenance Director and Administrator were interviewed at the time of the observations, where they stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency.<br><br>The Administrator was notified of the findings at the Life Safety Code exit conference on 7/18/22.<br><br>NJAC 8:39-31.2(e)<br>NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6.<br>NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C | K 222 | | |
| K 321 SS=E | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9 | K 321 | | 8/22/22 |

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| K 321 | Continued From page 7<br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, document review and interview on 7/14/22, the facility failed to provide a fire barrier with one hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was evidenced for 3 of 9 hazardous areas observed.<br><br>1. At approximately 12:32 PM, the surveyor observed in the Fire pump control transfer switch room (basement), revealed steel I-beam, was not enclosed fully encased in fire-rated material. An area where contractors and/or vendors removed the fire rated material was observed, approximately a 12" x 8" section.<br><br>2. At approximately 12:40 PM, the surveyor observed in the Simplex panel main power room (basement) revealed steel I-beam, was not enclosed fully encased in fire-rated material. An area where contractors and/or vendors removed the fire rated material was observed, approximately a 6" x 8" section.<br><br>3. At approximately 12:42 PM, the surveyor observed in the Telephone room (basement) | K 321 | K321 □ ( E ) □ Hazardous Areas □ Enclosure<br>1) The 12x 8 section of the steel I-beam in the Fire Pump control transfer switch room in the basement was re-treated with fire rated material.<br>The 6 x 8 section of steel I-Beam in the Simplex panel main power room in the basement was re-treated with fire rated material.<br>The 4 x 4 section of the steel I- beam in the telephone room in the basement was re-treated with fire rated material.<br>The 4 x 4 section of the steel I-beam in the Boiler room in the basement was re-treated with fire rated material.<br>2) All Hazardous areas were audited to ensure that the fire barrier with one hour fire resistance was in place.<br>3) A quarterly audit of the Hazardous areas will be completed by the Maintenance Director to ensure that fire rated materials remain in place.<br>Maintenance staff were re-educated on the fire resistance rating standards. | |

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| K 321 | Continued From page 8<br>revealed steel I-beam, was not enclosed fully encased in fire-rated material. Areas where contractors and/or vendors removed the fire rated material was observed in two areas approximately 4" x 4" each.<br><br>4. At approximately 1:10 PM the surveyor observed in the Boiler room (basement) revealed steel I-beam, was not enclosed fully encased in fire-rated material. Areas where contractors and/or vendors removed the fire rated material was observed in three areas approximately 4" x 4" each.<br><br>The findings were verified by Administrator, Maintenance Director at the times of the observation's.<br><br>The Administrator was informed of the finding at the Life Safety Code exit conference on 7/18/22. | K 321 | 4) Results of the audits of the hazardous areas will be submitted to the QAPI committee quarterly. | |
| K 345 SS=F | NJAC 8:39-31.2(e)<br>Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 7/14/22 and 7/18/22, it was determined that the facility | K 345 | K-345 □ (F) □ Fire alarm System □ Testing and Maintenance | 8/22/22 |

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| K 345 | Continued From page 9<br>failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72.<br><br>This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings noted below:<br><br>1. At approximately 9:40 AM on 7/14/22 and 7/18/22, in the presence of the facility's Maintenance Director, the surveyor observed that the fire alarm annunciator panel indicated, "Trouble" The surveyor observed that the amber trouble light was activated in 2 of 3 panels observed. The main (back) entrance panel and floor two panel outside the nurses station.<br><br>The Administrator and Maintenance Director stated that the Issue with the fire alarm annunciator panels, were a problem with a ground wire causing a communication issue between the two panels. The Maintenance Director stated that the Fire Alarm system was fully functional and that the facility fire alarm vendor was scheduled to respond as soon as possible (ASAP).<br><br>2. On 7/14/22, at 12:15 PM, the surveyor and Maintenance Director reviewed all fire alarm inspections dated: 6/14/22, 06/22/21 and 6/25/20. The 6/25/22 documentation stated the "fire alarm inspection and testing report" indicated that the service was conducted semiannually. The current inspection reports were one year apart and not done on the required semiannual basis. The document indicated that under "Battery Type" the system used Sealed Lead-Acid Batteries requiring a semi annual inspection. | K 345 | 1) Repair to the system was completed on 8/12/22.<br>2) All residents have the ability to be affected by the deficient practice.<br>3) Fire Panel status and any notation of trouble is being added to the Maintenance 24 hour report sheet which is completed on all 3 shifts.<br>The maintenance 24 hour report will be given to the Administrator daily.<br>The Life Safety documentation review sheet was updated to include the Semi-annual Fire Alarm System inspections.<br>4) Fire Panel trouble and issues regarding repair will be reported to the QAPI committee Quarterly.<br>The Life Safety Code Review spreadsheet will be submitted to the Administrator monthly and to the QAPI Committee quarterly. | |

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| K 345 | Continued From page 10<br>An interview was conducted with the Maintenance Director, during the document review, he stated that he was unsure why the fire alarm inspection was now on an annual basis and not on the semi-annual inspection marked on the 6/25/22 report.<br><br>NFPA 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70,National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code.<br><br>The Administrator was informed of the deficiency at the Life Safety Code exit conference on 7/18/22.<br><br>NFPA 70<br>NFPA 72<br>NJAC 8:39-31.2(e) | K 345 | | |
| K 351 SS=E | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Sprinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area | K 351 | | 8/22/22 |

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| K 351 | Continued From page 11<br>of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview on 7/14/22, it was determined that the facility failed to provide automatic fire sprinkler system protection, to all areas in accordance with NFPA 13. This deficient practice was identified for 1 of 4 areas, observed and was evidenced by the following:<br><br>At 1:31 PM, the surveyor, in the presence of the Maintenance Director and Administrator, observed that there was no fire sprinkler protection provided in the kitchen closet approximately 3' x 2'. The closet currently stored kitchen inventory.<br><br>An interview was conducted with the Maintenance Director and Administrator at the time of the observation, they confirmed that the kitchen closet was not provided with any fire sprinkler coverage.<br><br>The Administrator was informed of the observation at the life Safety Code exit conference on 7/18/22.<br><br>NJAC 8:39-31.2(e)<br>NFPA 13, 25 | K 351 | K351 □ ( E ) □ Sprinkler system Installation<br>1) A contract was signed and new Sprinkler was installed in the kitchen closet on 8/15/22.<br>2) Closets will be audited by the Maintenance Director to ensure that no additional sprinkler heads are missing.<br>3) An New sprinkler was installed in the kitchen closet.<br>Maintenance staff were re-educated on NFPA 13 and the sprinkler requirement. Sprinklers will be monitored monthly as part of LSC rounds.<br>4) Results of the monthly sprinkler audits will be reported to QAPI quarterly. | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System | K 918 | | 8/22/22 |

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| K 918 | Continued From page 12<br>Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 7/18/22, in the presence of the Maintenance Director and Administrator, it was determined that the facility did not ensure a remote manual stop station for 1 | K 918 | K918 □ (F) □ Electrical Systems □<br>Essential Electrical Systems<br>1) A contract signed and an Emergency Generator Shut off Switch was installed | |

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| K 918 | Continued From page 13<br>of 1 generator, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following:<br><br>At 1:05 PM, the surveyor, Maintenance Director, and Administrator, observed the exterior diesel generator. There was a manual stop station on the generator cabinet,but not at a manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed outside the enclosure housing the prime mover.<br><br>An interview was conducted during the observation with the Maintenance Director and Administrator, where they stated that at the time of observation, the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located outside the enclosure housing the prime mover.<br><br>The Administrator was informed of the finding at the Life Safety Code exit conference on 7/18/22.<br><br>NJAC 8:39-31.2(e), 31.2(g)<br>NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. | K 918 | on 8/22/22.<br>2) All residents have the ability to be affected by the deficient practice.<br>3) Maintenance staff re-educated on the Emergency Generator emergency shut off requirement.<br>The Manual stop station will be monitored during the weekly Generator test.<br>4) The Generator testing log will be submitted to QAPI quarterly. | |

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 |
|---|---|---|
| 315304 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 9/12/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WARREN HAVEN REHAB AND NURSING CENTER | 350 OXFORD ROAD<br>OXFORD, NJ 07863 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0211 | 08/22/2022 | LSC K0222 | 08/22/2022 | LSC K0321 | 08/22/2022 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0345 | 08/22/2022 | LSC K0351 | 08/22/2022 | LSC K0918 | 08/22/2022 |
| 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 | |
| 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? |
|---|---|
| 7/18/2022 | ☐ YES ☐ NO |