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 _____	C 09/25/2023

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
E 000	Initial Comments Survey: 09/25/23 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 Complaint #: NJ 165178 Survey Date: 09/25/23 Census:60 Sample: 15 + 13 = 28 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. During a Recertification Survey conducted on 09/25/23, it was determined that the Facility was found to be in Immediate Jeopardy for F600. The Facility failed to: -Ensure a process was followed to identify an *Ex Order 26. 4B1* . -Ensure a process was followed to ensure a resident who *Ex Order 26. 4B1* , was immediately protected, assessed and a thorough investigation was immediately initiated. -The IJ situation that began on *Ex Order 26. 4B1* , was	F 000		

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

Electronically Signed | 10/13/2023

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F 000	Continued From page 1 identified on 09/19/23 at 4:09 PM. -An acceptable removal plan for the Immediacey was received at 09/19/23 at 8:22 PM and was verified as implemented by the survey team on 09/20/23 at 9:59 AM.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent facility provided documents, it was determined that the facility failed to rule out abuse for an injury of unknown origin and an *Ex Order 26. 4B1* [redacted], for 1 of 2 residents reviewed for reportable events (Resident #29). Resident #29 had diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of an Accident/Incident report, signed by a Licensed	F 600	1) Upon notification of the deficient practice involving Resident #29 the facility immediately began the investigation of the incident on *Ex Order 26. 4B1* which included removing involved staff from the schedule, notifying *Ex Order 26. 4B1* [redacted] of the allegation, interviewing involved parties, and reporting the allegation to the Department of Health and the ombudsman's office. Involved staff received formal re-instruction prior to return to work on the	10/25/23

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F 600	Continued From page 2 Practical Nurse (LPN), dated [NJ Exec. Order 26:4.b.1], revealed a *Ex Order 26. 4B1* with no indication of the origin or if the [NJ Exec. Order 26] had been witnessed or unwitnessed. Further review of the Accident/Incident report revealed an attached Investigation/Witness Statement dated [NJ Exec. Order 26:4.b.1] at 6:45 PM, which included that the resident ...'*Ex Order 26. 4B1* A nurse progress note documented on *Ex Order 26. 4B1* at 18:42 (6:42 PM), revealed ...resident was screaming '[Ex Order 26. 4]' at the top of [his/her] lungs for over an hour ... On 09/19/23, the nurse was interviewed and acknowledged that the resident had been yelling '[Ex Order 26. 4]' and that she did not report the allegation to a supervisor. A nurse progress note documented on [NJ Exec. Order 26:4.b.1] at 14:42 (2:42 PM), revealed at 1:30 PM, a [NJ Exec. Order 26] was noticed on *Ex Order 26. 4B1* ... . 2 [centimeter cm] x 1.5 [cm]. The facility's failure to protect the resident, to rule out abuse, and ensure the *Ex Order 26. 4B1* was investigated resulted in an Immediate Jeopardy (IJ) situation. The IJ situation began on *Ex Order 26. 4B1* and was identified on 09/19/23 at 4:09 PM. The Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were notified of the IJ situation. An acceptable removal plan was received at 09/19/23 at 8:22 PM and was verified as implemented on 09/20/23 at 9:59 AM. The deficient practice was evidenced by the following: On 09/19/23 at 12:02 PM, the surveyor reviewed facility provided incident reports for [NJ Exec. Order 26:4.b] of unknown origin for Resident #29. The reports included a Resident Accident/Incident Report	F 600	updated policy and the responsibility to report. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The policy titled" Abuse, Neglect and Exploitation" was reviewed and updated which included an Abuse Screening tool. The residents on that unit with a BIMS of 10 or higher were interviewed by the Social Worker to ensure that they had no *Ex Order 26. 4B1*. Skin checks were conducted on all residents who could not be interviewed to monitor for any bruises or injuries. Incident reports for the last 6 months were reviewed by the Director of Operations to ensure that all investigations were complete and in compliance. Grievance logs for the last 6 months were reviewed by the Administrator to ensure that all grievances were followed up on and that there were no grievances that required further investigation. 3) Staff received re-education on the Abuse, Neglect and Exploitation policy. All incident/grievance reports will be brought to the morning meeting for review and discussion. Each incident report will be reviewed for completeness, follow-through and reportability. Audits of the incidents reports and grievances will be completed by the Administrator or their designee weekly x 3 months then monthly to ensure investigations are complete and the Abuse, Neglect and Exploitation policy	

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F 600	Continued From page 3 signed and dated [redacted], by a Licensed Practical Nurse (LPN). The Date of Accident/Incident" was [redacted] at 1:30 PM. The Description and Facts of Event: revealed [redacted] in color]; What does the Resident state happened: revealed "[redacted]"; Injury: revealed [redacted] was left blank which included check off boxes for known, unknown, and occurred during care; Resident/Staff Allegations section was left blank which included check off boxes for Physical Abuse, Verbal Abuse, Sexual Abuse, Mental Abuse and Neglect; The Current BIMS (Brief Interview for Mental Status) score was [redacted]/15 which indicated the resident was [redacted], alert, and oriented X 1 [self]. The Interventions Implemented to Prevent Future Occurrences: revealed "24 [hours], [statement] [redacted]3 staff, [rule out] infection, if negative, then [redacted physician service name], (recent increase of [redacted] on [redacted] for [redacted]). The Resident Accident/Incident Report failed to document a conclusive summary of findings of a [redacted] of unknown origin. One "Investigation Witness Statement Form" was attached and revealed the Date/Time of the Incident was [redacted], and was signed by Certified Nurse Aide (CNA #1) at 6:45 PM. The Witness Statement: revealed ... While attempting to transfer Resident #29 to bed, resident grabbed [redacted] and dug [his/her] nails into [redacted] after releasing grip, Resident #29 grabbed [redacted] and started digging his/her nails into [redacted], after releasing his/her grip, Resident #29 grabbed another CNA's [redacted] and dug his/her nails into the CNA's [redacted]. While attempting to put the [Standing [redacted]] sling on Resident #29,	F 600	was followed as necessary. 4) Monthly reviews of the Incident/grievances reports will be reported to the QAPI committee by the Administrator or their designee quarterly x 4 quarters.	

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F 600	Continued From page 4 the Resident began screaming at the top of lungs and was trying to rip the sling off. After Resident #29 had care completed and was in bed, Resident #29 was screaming "[redacted]" ... An attached "Investigation of [redacted] - 24 Hour Look Back" revealed the Type of Occurrence: Bruise, [redacted] at 1:30 PM, and failed to address if the [redacted] of unknown origin was ruled out for abuse. The look back statements were documented by 3 CNAs and depicted the residents condition on [redacted]. There was no Accident/Incident Report to address when Resident #29 screamed "[redacted]" on [redacted], and the Resident Accident/Incident Report also failed to document any additional staff statements, or 24 hour look back statements. A review of the Care Plan included a focus area initiated [redacted], diagnosis and [redacted]. Interventions included but were not limited to; two staff for all care. Caregivers to provide opportunity for positive interaction. Continue to monitor for [redacted] and [redacted] Consult for [redacted] health services. Redirect using calm approaches and distraction. If resistant to care, assure he/she is safe and reapproach at a later time. Monitor [redacted] and attempt to determine underlying cause. Document [redacted] and potential causes. The Care Plan did not include [redacted], or any [redacted]. The surveyor reviewed the Abuse Identification & Prevention Program policy effective September 2018. The policy revealed, C. 4. Nursing and	F 600		

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F 600	Continued From page 5 social workers identify those residents whose personal histories render them at risk for becoming a victim of abuse from others. D. Clues to Help Identify Abuse included but was not limited to; 1. Physical Abuse: color of bruises - red, purple, or black indicated a one-day old bruise. E. Investigation: Upon receipt of information (verbally or in writing) related to observed abuse, overheard abuse, suspected abuse, injury of unknown origin, or misappropriation of resident's property, the director of nursing/designee will ensure an investigation (if one has not been initiated previously) is initiated. 1. The Director of Nursing notifies the administrator of the situation and that an investigation has started. 3. The Director of Nursing/designee will: Have an unusual occurrence/incident report completed, Collect and preserving physical and documentary evidence, Interview alleged victim/s and witness/es, Obtain statements from caregivers, others directly involved with the resident 48 hours prior to the alleged abuse and 24 hours after, Interview other residents to determine if they have been abused or mistreated, Interview staff who worked the same shift to determine if they have been abused or mistreated, Interview staff who worked previous shifts to determine if they were aware of an injury or incident, Obtain statements from caregivers and others directly involved with the resident for the forty-eight hours prior to the alleged abuse and up to twenty-four hours after, Involve other regulatory authorities who may assist, e.g. local law enforcement, elder abuse agency ... The DON will maintain an investigative package which includes ... ... a conclusive summary of findings which indicated why or if and how abuse has been ruled out.	F 600		

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F 600	Continued From page 6 On 09/19/23 at 11:36 AM, the DON stated the above incident was not reported to the state [New Jersey Department of Health]. The DON stated that the facility would have to do an investigation and gather the facts. She stated Resident #29's bruise was unwitnessed and that if there was a "significant injury and we suspect abuse, we call right away." The DON stated Resident #29 moves around a lot and "we figured" it was shear or friction and was not significant and did not suspect abuse. On 09/19/23 at 12:27 PM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The surveyor inquired if the abuse policy reviewed was the facility abuse policy and the LNHA confirmed that it was the abuse policy. The DON stated that the types of abuse included physical, emotional, financial, verbal, sexual, and neglect. The DON stated the abuse policy did "not speak to the injury of unknown origin." The surveyor asked what would constitute an Ex Order 26. 4B1 [redacted]? The LNHA stated "a resident saying someone touched them inappropriately, or an unusual injury and fear of certain people." The surveyor asked the LNHA if a resident verbalizing "[redacted]" would also constitute an Ex Order 26. 4B1 [redacted]. The LNHA stated, "of course". The surveyor asked the LNHA what the process would be if a resident alleged "[redacted]". The LNHA stated the facility would ensure the resident was safe, remove the abuser, interview the resident, and all the caregivers, anyone who had been around the resident, and not only the CNAs. The DON stated that if this happened in the evening, the nurse should contact her, and a head-to-toe physical assessment would be completed, witnessed by	F 600		

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F 600	Continued From page 7 two people and the police would also be contacted. The surveyor asked the DON and LNHA about the statement completed on [NJ Exec. Order 26:4.b.1], regarding Resident #29 exclaiming "[Ex Order 26. 4]". The DON stated that the resident had a history of saying "[Ex Order 26. 4] " and that the family had informed her that the resident had been *Ex Order 26. 4B1*. The surveyor asked what was the process that was completed after Resident #29 stated "[Ex Order 26]". The DON stated she would have to check as she could not recall. On 09/19/23 at 1:17 PM, the surveyor interviewed a Registered Nurse Unit Manager (RN UM) regarding the process if an *Ex Order 26. 4B1* was made or suspected. The RN UM stated she would inform a supervisor, obtain witness statements, and investigate the allegation. On 09/19/23 at 1:30 PM, the surveyors interviewed the DON and asked when she was first made aware of the allegation that Resident #29 made on [Ex Order 26. 4B1]. The DON stated the incident report was brought to morning meeting on [Ex Order 26. 4B1]. The DON stated the nursing unit contacted her via telephone, and she could not recall who she had spoken with on [Ex Order 26. 4B1] and that was about [NJ Exec. Order 26:4.b] that occurred at 1:30 PM. The DON stated that a UM, she could not recall which one, informed her of [NJ Exec. Order 26:4.b.1] that was identified on that the same day, [Ex Order 26. 4B1], for Resident #29. The DON stated that the nurses knew how to complete an investigation and would also complete a 24- hour look back to obtain statements from all caregivers 24 hours prior to the discovery/when the allegation was made. The DON stated the nurses have been educated on	F 600		

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F 600	Continued From page 8	F 600		

how to complete the incident reports and obtain statements only from the staff who provided hands on care. The DON reviewed the investigation in the presence of the survey team and stated that there was a missing statement from one of the CNA's who was in the room with Resident #29 at the time of the allegation. The DON stated she only received a statement from CNA#1 and not from CNA #2. The DON stated she would have CNA #2 write a statement today, 09/19/23. The DON stated she brought the Incident Report to the morning report meeting held on Ex Order 26. 4B1, and at that time the incident report, and the 24 hours look back had not yet been completed and that nothing else had been provided for the investigation.

The DON stated she was not provided CNA #1's statement on Ex Order 26. 4B1 regarding "Ex Order 26" and could not recall when she was given that statement. The DON confirmed there were two CNAs in the room with Resident #29 and she just realized that she did not have CNA #2's statement. The DON stated, "I know I read it quickly knowing what had happened" and stated what happened was that resident was throwing food, digging nails, a "horrible scene." The DON stated Resident #29 had a history of *Ex Order 26. 4B1*. The DON stated the expectation was to have received all the statements and that it was "ultimately my [DON] responsibility." The DON stated that on NJ Exec. Order 26:4.b.1, the Accident/Incident report had been signed as reviewed but was not complete and stated the LNHA who also signed the report was no longer at the facility. The DON acknowledged she may have known about the *Ex Order 26. 4B1*, but it was the resident's normal NJ Exec. Order 26:4.b.1. The DON stated that the expectation would have been for the nurse to do a head-to-toe assessment,

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F 600	Continued From page 9 document any [NJ Exec. Order 26:4.b.1] s, and report the allegation. The DON stated that the investigation should have been completed within 24 hours and that it had not been reported to the Department of Health (DOH) or the police. The DON further stated that the facility did not have a written policy and procedure on *Ex Order 26. 4B1*, but the staff should have known what to do because they had been educated. The Licensed Nursing Home Administrator (LNHA) stated she was not working at the facility at that time, but that she would expect the staff to act on an *Ex Order 26. 4B1* , perform an assessment, and report it [to DOH]. The LNHA acknowledged there were no other files or documents regarding the *Ex Order 26. 4B1* by Resident #29. On 09/19/23 at 2:14 PM, during another interview with the surveyor, the RN UM stated she was responsible to initiate the questions on the back page of the Accident/Investigation report, but that the floor nurse would complete the front-page information. The RN UM stated that she would ask the staff to write statements. The RN UM further stated that Resident #29 has expressed [NJ Exec. Order 26:4.b.1] however, had "never made *Ex Order 26. 4B1* ." On 09/19/23 at 2:22 PM, CNA #2 was interviewed by the survey team. CNA #2 stated she had never been educated on what to do if a resident yelled [Ex Order 26]. On 09/19/23 at 3:02 PM, the LPN who cared for Resident #29 on [NJ Exec. Order 26:4.b.1] was interviewed by the survey team. The LPN stated she had cared for Resident #29 and knew the resident had been	F 600		

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F 600	Continued From page 10	F 600		

NJ Exec. Order 26:4.b.1 and would also yell at people. The LPN stated the resident required two- staff assistance to provide care. The LPN's progress note was read to the LPN, and the LPN acknowledged she documented the note, and also recalled the documentation regarding the resident yelling "Ex Order 26." The LPN further stated the resident "*Ex Order 26. 4B1*", but she had not documented before that the resident had screamed "Ex Order 26." The LPN stated she had not reported that the resident had yelled Ex Order 26 because it had "not happened on my watch", and that it was a norma NJ Exec. Order 26:4.b.1 for the resident to yell things for hours. The LPN further stated, "I guess looking back that was something I should have reported. I just did not because the resident NJ Exec. Order 26:4.b.1." The LPN stated, "well I guess I wouldn't know" if something had happened earlier in the day to Resident #29.

A review of the facility provided, "Abuse Identification & Prevention Program" dated September 2018, included but was not limited to; C. Prevention 4. nursing and social workers identify those residents whose personal histories render them at risk for ..... becoming a victim of abuse. D. Identification of Signs and Symptoms of Abuse - clues to help identify abuse 1. physical abuse clues: color of bruises red, purple, or black indicate a bruise one day old. Note: Intentional or unintentional abuses necessitate an immediate investigation. During the investigation, the resident must be protected. E. Investigation 3. obtain statements from the caregivers and others directly involved with the resident 48 hours prior and 24 hours after. Interview other residents to determine if they had been abused or mistreated. Ensure the investigation is completed with three working days of the alleged abuse. The DON will

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F 600	Continued From page 11 maintain an investigative package with the copy of the incident report, all statements obtained and a conclusive summary of finding which indicated why or if and how abuse has been ruled out. A review of the facility provided, "Abuse and Neglect Policy and Procedure" undated, included but was not limited to; prohibiting mistreatment, neglect, and abuse of residents ... ... Such steps include ...monitoring and investigation of incident and accidents. Procedure included but was not limited to; 1. when the abuse is detected remove the resident from the harmful situation; 2. Physically assess the resident for injuries; 3. Get the facts; 4. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation are reported immediately to the DON, LNHA, attending physician, and resident's family/responsible party. The facility will thoroughly investigate and document each alleged violation and will prevent further potential abuse while the incident is under investigation. NJAC 8:39-4.1(a)5; 27.1	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		10/25/23

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	315304	A. BUILDING _____ B. WING _____	C 09/25/2023

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 609	Continued From page 12 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, review of medical records (MR) and other facility documentation, it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) for 2 of 2 sampled residents (Resident # 29 and #50) reviewed for NJ Exec. Order 26:4.b.1. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #50 was admitted to the facility with diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. The Significant Minimum Data Set (MDS) Assessment (an assessment tool used by the	F 609	1) Resident # 50's incident of *Ex Order 26. 4B1* was re-opened, re-investigated and reported to the NJ Department of Health. Resident # 29's incident of *Ex Order 26. 4B1* was reopened, re-investigated, and reported to the NJ Department of Health. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The policy titled" Abuse, Neglect and Exploitation" was reviewed and updated which included an Abuse Screening tool to emphasize reporting guidelines and clarification on injuries of unknown origin. Incident reports for the last 6 months were reviewed by the Director of Operations to ensure that all investigations were complete and in compliance.	

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F 609	Continued From page 13 facility to prioritize care) dated Ex Order 26. 4B1 reflected that Resident #50 had some difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said. Section Ex Order 26. 4B1. NJ Exec. Order 26:4.b.1 was Ex Order 26. 4B1. Resident #50 scored Ex Ord out of 15 on the Ex Order 26. [redacted]. Review of Resident #50's Care Plan (CP) initiated Ex Order 26. 4B1, revealed the following: [Resident #50] had Ex Order 26. 4B1 related to Ex Order 26. 4B1 [redacted]. According to the Progress Notes dated Ex Order 26. 4B1 timed 10:30 AM, the Certified Nursing Assistant (CNA) reported NJ Exec. Order 26:4.b. to the resident Ex Order 26. 4B1 identified during care, measuring Ex Order 26. 4B1 [redacted]. The physician and the family were notified. A statement dated NJ Exec. Order 26:4.b.1 from the CNA who worked the 3:00 PM-11:00 PM shift, revealed that she observed NJ Exec. Order 26:4.b.1 and reported it to the nurse. The root cause analysis revealed that Resident #50 had NJ Exec. Ord on Ex Order 26. 4B1 and was too far back to correlate NJ Exec. Order 26: with NJ Exec. Order 26:4.b.1 on the resident Ex Order 26. 4B1. The investigation reflected that a sensor pad alarm was then added to alert the staff of Resident #50's attempt to get out of the bed without assistance. On 09/19/23 at 10:30 AM, the surveyor reviewed again the facility Accident/ Incident report dated Ex Order 26. 4B1. The Accident/Incident report indicated	F 609	3) Staff received re-education on the Abuse, Neglect and Exploitation policy. Incident reports will be brought to the morning meeting for review and discussion. Each will be reviewed for completeness, follow-through and reportability. Audits of the incident reports will be completed by the Administrator or their designee weekly x 3 months then monthly to ensure investigations are complete and the Abuse, Neglect and Exploitation policy was followed as necessary. 4) Monthly reviews of the Incident/grievances reports will be reported to the QAPI committee by the Administrator or their designee quarterly x 4 quarters.	

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F 609	Continued From page 14 that [NJ Exec. Order 26:4.b.1] was found to the [Ex Order 26. 4B1]. Resident #50 could not explain how he/she got the [NJ Exec. Order 26:4] Review of the Investigation/Nursing Administration Review, Summary and Follow up /Conclusion to the incident, submitted by the DON on 09/19/23, dated [Ex Order 26. 4B1] was left blank. On 09/20/23 at 12:36 PM, the DON stated that the incident was not reported to the NJDOH. Upon inquiry, the DON acknowledged that the [NJ Exec. Order 2] was unwitnessed and should have been reported to the NJDOH. On 09/20/23 at 1:40 PM, the Administrator confirmed that any injury of unknown origin should be reported to the NJDOH. The Administrator explained that the facility does not have a specific policy for reporting injuries of unknown origin to the NJDOH. On 09/21/23 at 9:18 AM the facility did not provide any further information regarding the above incident. 2. A review of the AR revealed that Resident #29 had diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of the person-centered Care Plan included a focus area dated [Ex Order 26. 4B1], dependent on staff for meeting emotional, intellectual, physical, and social needs related to *Ex Order 26. 4B1* [redacted]. Another focus area dated [Ex Order 26. 4B1], has *Ex Order 26. 4B1* [redacted] and mobility deficit related to *Ex Order 26. 4B1*, weakness. Interventions	F 609		

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F 609	Continued From page 15 included but were not limited to; two staff for all care. Resident requires extensive assist. On 09/19/23, two surveyors reviewed facility provided Resident Accident/Incident Reports for Resident #29. The Reports included but was not limited to the following: Date Ex Order 26. 4B1 at 9:15 AM, the Hospice Aide reported to the Registered Nurse (RN) supervisor on the East unit that Resident #29 had an unwitnessed Ex Order 26. 4B1 on the Ex Order 26. 4B1. Resident #29 was unable to inform the staff what happened. A statement from the Hospice Aide was attached and 3 CNA statements related to their observations on Ex Order 26. 4B1. Dated Ex Order 26. 4B1 at 1:30 PM, a description of events revealed Ex Order 26. 4B1 in color. The resident was unable to inform staff what happened. The bruise measured Ex Order 26. 4B1. A statement was attached from one of the two CNAs who were providing care to Resident #29 and was signed with a date of Ex Order 26. 4B1 and a time of 6:45 PM. The statement did not document anything about NJ Exec. Order 26:4.b, but did document that the resident was resistive and 'Ex Order 26. 4B1'. There were statements dated Ex Order 26. 4B1 and were related to their observations on Ex Order 26. 4B1. No NJ Exec. Order 26:4.b.1 were noted from the additional three CNA statements. On 09/19/23 at 11:36 AM, the DON was interviewed in the presence of members of the survey team. The surveyor asked if the unwitnessed incidents of NJ Exec. Order of unknown origin, or the Ex Order 26. 4B1 were reported to NJDOH? The DON stated she "had to do an	F 609		

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F 609	Continued From page 16	F 609		

investigation but did not suspect abuse. We gather the facts first and then call." The DON acknowledged [NJ Exec. Order 26:4.b.1] of unknown origin were unwitnessed and further stated, "if it is a significant [NJ Exec. Order] and we suspect abuse, we call right away. [Resident #29] moves around a lot and we figured it was friction and was not significant and did not suspect abuse so we did not call it in."

On 09/19/23 at 12:27 PM, the DON and LNHA were interviewed in the presence of members of the survey team. The DON stated the Abuse policy did not include injury of unknown origin. The DON further stated that abuse could be physical, emotional, financial, verbal, sexual, or neglect. The DON stated that the Accident/Incident reports were usually reviewed the day after. When asked about Resident #29's *Ex Order 26. 4B1* , the DON stated the resident "has *Ex Order 26. 4B1* and just says these things." The DON stated the resident had a *Ex Order 26. 4B1* . The DON further stated that she "may have known about the *Ex Order 26. 4B1* but it was the residents normal [NJ Exec. Order 26:4.b.1]" The LNHA stated that if a resident made an *Ex Order 26. 4B1* , she would expect the staff to act on that allegation, complete an assessment and report the allegation.

A review of the facility provided, "Abuse Identification & Prevention Program" dated September 2018, included but was not limited to; G. Reporting. All alleged or suspected incidents of abuse, neglect or mistreatment shall be reported promptly to the NJDOH and Senior Services. 2. The Administrator/DON will notify the Department of Health of the alleged abuse, by telephone immediately. Notification will include

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F 609	Continued From page 17 the details known up to this point in time, and that the investigation has been started. 4. The DON / designee will notify the Department of Health (no later than the third working day from the date of the alleged abuse) that the investigation has been completed. 5. The Administrator / designee will communicate with the Department of Health the results of the investigation including the conclusion that A. they feel no evidence of abuse, neglect or mistreatment, or B. not able to determine, or rule out that abuse, neglect, or mistreatment occurred and their findings are inconclusive, or C. there is strong evidence to support the complaint of abuse, neglect or mistreatment. 6. The DON will ensure all documentation corresponding to the investigation has been completed and available for review by the DOH. 7. The DON / designee will notify the individual who reported the incident whether or not the DOH has been notified of the investigation or that abuse has been ruled out. N.J.A.C. 8:39-9.4 (f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		10/25/23

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F 610	Continued From page 18 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate an injury of unknown origin and an Ex Order 26. 4B1 . This deficient practice was identified for 2 of 2 residents (Resident #29 and #50) reviewed for accidents and incidents. The deficient practice was evidenced by the following: 1. According to the medical records, Resident #50 was admitted with diagnoses which included but were not limited to; Ex Order 26. 4B1 . A review of the Care Plan (CP) revealed a focus area of Ex Order 26. 4B1 related to Ex Order 26. 4B1 . Another focus area of at NJ Exec. Order 26:4.b.1 related to Ex Order 26. 4B1 . A review of a facility provided, "Resident Accident/Incident Report" dated Ex Order 26. 4B1 at 10:30 AM, included but was not limited to; Description and facts of even: NJ Exec. Order 26 found on Ex Order 26. 4B1 during A.M. [morning] care. It was documented that the resident reported he/she "had no idea it was there." Measurements of the NJ Exec. Order 26:4 were documented as Ex Order 26. 4B1 . Under the section of NJ Exec. Order 26 there were three areas to be checked off known, unknown, occurred during care. The section was left blank. The resident was noted to have a Brief Interview	F 610	1) Upon notification of the deficient practice involving Resident #29 the facility immediately began the investigation of the incident on NJ Exec. Order 26:4.b which included removing involved staff from the schedule, notifying Ex Order 26. 4B1 of the allegation, interviewing involved parties, and reporting the allegation to the Department of Health and the ombudsman's office. Resident # 29's incident of Ex Order 26. 4B1 was reopened, re-investigated, and reported to the NJ Department of Health. Resident # 50's incident of Ex Order 26. 4B1 was re-opened, re-invested and reported to the NJ Department of Health. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The policy titled" Abuse, Neglect and Exploitation" was reviewed and updated which included an Abuse Screening tool and clarification on injuries of unknown origin. Incident reports for the last 6 months were reviewed by the Director of Operations to ensure that all investigations were complete and in compliance. Grievance logs for the last 6 months were reviewed by the Administrator to ensure	

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F 610	Continued From page 19 of Mental Status (BIMS) of [redacted] at the time which indicated the resident was *Ex Order 26. 4B1*. Attached to the Accident/Incident Report, was one statement from the Certified Nursing Assistant (CNA) who discovered and reported the [redacted] Another attachment provided was "Investigation of Past 24 Hours". There were three CNA statements. The CNA who worked the 11 PM to 7 AM shift, dated 10/24/22, documented she had seen the [redacted] and reported it. The second CNA who worked the 3 PM to 11 PM shift, dated 10/23/22, documented she had not given care to that resident. The third CNA who worked the 7 AM to 3 PM shift, dated 10/24/23, was the CNA who found and reported the [redacted] The facility failed to follow their policy and provide statements for a 48 hour look back, a 24 hour post incident statement, or to complete the Accident/Incident Report. The Director of Nursing (DON) documentation included but was not limited to; the resident had [redacted] *Ex Order 26. 4B1*, but it was "too far out from this discovery to correlate." On 09/20/23 at 12:36 PM, the DON acknowledged that the [redacted] was unwitnessed. On 09/20/23 at 1:40 PM, the Licensed Nursing Home Administrator (LNHA) confirmed that this was an [redacted] of unknown origin. 2. A review of the medical record for Resident #29 revealed diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of the Care Plan included a focus area dependent on staff for meeting emotional, intellectual, physical, and social needs related to NJ Exec. Order 26:4.b.1 [redacted].	F 610	that all grievances were followed up on and that there were no grievances that required further investigation. 3) Staff received re-education on the Abuse, Neglect and Exploitation policy. All incident/grievance reports will be brought to the morning meeting for review and discussion. Each will be reviewed for completeness, follow-through and reportability. Audits of the incidents reports and grievances will be completed by the Administrator or their designee weekly x 3 months then monthly to ensure investigations are complete and the Abuse, Neglect and Exploitation policy was followed as necessary. 4) Monthly reviews of the Incident/grievances reports will be reported to the QAPI committee by the Administrator or their designee quarterly x 4 quarters.	

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F 610	Continued From page 20 Another focus area revealed has Ex Order 26. 4B1 self-care performance and Ex Order 26. 4B1 related to Ex Order 26. 4B1, and weakness. Interventions included 2 staff for care. On 09/19/23, two surveyors reviewed the facility provided, "Resident Accident/Incident Report" for Resident #29. The report included but was not limited to the following: Dated Ex Order 26. 4B1 at 1:30 PM, Description: Ex Order 26. 4B1 in color. Resident documented as stated, "Ex Order 26. 4B1 " The resident was documented as being NJ Exec. Order 26:4.b.1 Under the section of NJ Exec. Order 26:4.b.1, there were three areas to choose from known, unknown, occurred during care. The section was left blank. The resident was noted as having a Ex Order 26. 4 of Ex Ord out of 15 which indicated Ex Order 26. 4B . The NJ Exec. Order 26:4 was measured as Ex Order 26. 4B1 in color. Attached to the Report was a "Investigation Witness Statement Form" dated Ex Order 26. 4B1 at 6:45 PM. The statement was completed by a CNA and indicated another CNA was present during care of the resident. The statement revealed, "After PM [evening] care and [Resident #29] was in bed he/she was Ex Order 26. 4B1." Also attached was an "Investigation of Unknown NJ Exec. Order 24 Hour Look Back" form which indicated the date/time of occurrence as Ex Order 26. 4B1 at 1:30 PM. The form was filled out by three CNAs who reported on the resident from Ex Order 26. 4B1. The facility failed to follow their policy by not obtaining any statement from the second CNA providing care on Ex Order 26. 4B1; obtain statements for a 48 hour look back and 24 hour post incident	F 610		

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F 610	Continued From page 21 statements from Ex Order 26. 4B1 ; a witness statement for Ex Order 26. 4B1 the NJ Exec. Order 26 of unknown origin; had not completed the Accident/Incident Report; and had not completed either investigation within 3 days. On 09/19/23 at 11:36 AM, the DON was asked about Resident #29 and the NJ Exec. Order 26 of unknown origin and the Ex Order 26. 4B1 . The DON stated she, "had to do an investigation but did not suspect abuse." On 09/19/23 at 12:27 PM, the DON and LNHA were interviewed in the presence of the survey team. The DON stated the facility Abuse policy did not include NJ Exec. Order of unknown origin. The DON stated that the Accident/Incident Reports were usually reviewed the day after the incident. The DON further stated that she "may have known about the Ex Order 26. 4B1 but it was the residents norma NJ Exec. Order 26:4.b.1 On 09/19/23 at 1:30 PM, the surveyors interviewed the DON and asked when she was first made aware of the allegation that Resident #29 made on Ex Order 26. 4B1 . The DON stated the incident report was brought to morning meeting on Ex Order 26. 4B1 . The DON stated the nursing unit contacted her via telephone, and she could not recall who she had spoken with on Ex Order 26. 4B1 and that was abou NJ Exec. Order 26:4.b.1 that occurred at 1:30 PM. The DON stated that the nurses knew how to complete an investigation and would also complete a 24- hour look back to obtain statements from all caregivers 24 hours prior to the discovery/when the allegation was made. The DON reviewed the investigation in the presence of the survey team and stated that there was a missing statement from one of the CNA's	F 610		

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F 610	Continued From page 22 who was in the room with Resident #29 at the time of the allegation. The DON stated she only received a statement from CNA#1 and not from CNA #2. The DON stated she would have CNA #2 write a statement today, 09/19/23. The DON stated she brought the Incident Report to the morning report meeting held on [NJ Exec. Order 26:4.b.1], and at that time the incident report, and the 24 hours look back had not yet been completed and that nothing else had been provided for the investigation. The DON stated she was not provided CNA #1's statement on [Ex Order 26. 4B1] regarding "[Ex Order 26]" and could not recall when she was given that statement. The DON confirmed there were two CNAs in the room with Resident #29 and she just realized that she did not have CNA #2's statement. The DON stated, "I know I read it quickly knowing what had happened" and stated what happened was that resident was throwing food, digging nails, a "horrible scene." The DON stated Resident #29 had a [Ex Order 26. 4B1]. The DON stated the expectation was to have received all the statements and that it was "ultimately my [DON] responsibility." The DON stated that on 01/27/23, the Accident/Incident report had been signed as reviewed but was not complete and stated the LNHA who also signed the report was no longer at the facility. The DON stated that the investigation should have been completed within 24 hours. On 09/19/23 at 2:14 PM, during an interview with the surveyor, the Registered Nurse Unit Manager (RN UM) stated she was responsible to initiate the questions on the back page of the Accident/Investigation report, but that the floor nurse would complete the front-page information.	F 610		

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F 610	Continued From page 23 The RN UM stated that she would ask the staff to write statements. The RN UM further stated that Resident #29 has expressed [NJ Exec. Order 26:4.b.1] however, had "never made *Ex Order 26. 4B1* ." On 09/19/23 at 3:02 PM, the LPN who cared for Resident #29 on [NJ Exec. Order 26:4.b.1], was interviewed by the survey team. The LPN stated she had cared for Resident #29 and knew the resident had been combative and would also yell at people. The LPN stated the resident required two- staff assistance to provide care. The LPN's progress note was read to the LPN, and the LPN acknowledged she documented the note, and also recalled the documentation regarding the resident yelling '[Ex Order 26.]' The LPN further stated the resident '*Ex Order 26. 4B1* ', but she had not documented before that the resident had screamed '[Ex Order 26.]' The LPN stated she had not reported that the resident had yelled [Ex Order 26] because it had "not happened on my watch", and that it was a normal [NJ Exec. Order 26:4.b.1] for the resident to yell things for hours. The LPN further stated, "I guess looking back that was something I should have reported. I just did not because the resident would [NJ Exec. Order 26:4.b.1]." The LPN stated, "well I guess I wouldn't know" if something had happened earlier in the day to Resident #29. A review of the facility provided, "Abuse Identification & Prevention Program" dated September 2018, included but was not limited to; C. Prevention 4. nursing and social workers identify those residents whose personal histories render them at risk for ..... becoming a victim of abuse. D. Identification of Signs and Symptoms of Abuse - clues to help identify abuse 1. physical abuse clues: color of bruises red, purple, or black indicate a bruise one day old. Note: Intentional or	F 610		

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F 610	Continued From page 24 unintentional abuses necessitate an immediate investigation. During the investigation, the resident must be protected. E. Investigation 3. obtain statements from the caregivers and others directly involved with the resident 48 hours prior and 24 hours after. Interview other residents to determine if they had been abused or mistreated. Ensure the investigation is completed with three working days of the alleged abuse. The DON will maintain an investigative package with the copy of the incident report, all statements obtained and a conclusive summary of finding which indicated why or if and how abuse has been ruled out. NJAC 8:39-4.1(a)5; 9.4(f)	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to: a.) follow acceptable standards of clinical practice and inform the physician that Resident #28 had been refusing *Ex Order 26. 4B1* [redacted], and b.) ensure the accuracy of physician orders for Resident #44. This deficient practice was identified for 2 of 6 residents reviewed during the medication pass observation and was evidenced by the following: Reference: New Jersey Statues, Annotated Title	F 658	1) MD was notified of resident #28 medication refusal. The Physician re-evaluated the resident's medications and educated resident on his diagnoses and risk verse benefits of medications. MD was notified of resident #44 medication error on [redacted] and ordered the Nurse to administer the [redacted] at that time. The Nurse wrote a progress note confirming the notification and the order. Nurses noted in 2567 received formal re-instruction from the DON.	10/25/23

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F 658	Continued From page 25 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." a.) On 09/11/23 at 7:25 AM, Surveyor #1 observed the Licensed Practical Nurse (LPN) administer medications to Resident #28. Resident #28 had refused an *Ex Order 26. 4B1* [redacted] at that time. Resident #28 stated *Ex Order 26. 4B1* [redacted]" At that time, the LPN stated that she would document that the medication was refused and that would trigger a note to be completed in the electronic medical record (EMR) progress notes (PN). A review of the Admission Record revealed that Resident #28 had diagnoses which included *Ex Order 26* [redacted]. A review of the annual Minimum Data	F 658	2) The facility recognizes that all residents have the potential to be affected by this deficient practice. Resident MARs and TARs were audited by the DON to ensure that the doctor was notified of any missing or refused medications or treatments. The policy titled “Medication Refusal “was reviewed and updated. The policy titled “Medication Administration” was reviewed and updated. 3) Medication Pass Competencies were completed on the Licensed Nurses. Licensed Nures were re-educated on the Medication Refusal and Medication Administration Policies. The DON or her designee will Audit all MARs and TARs daily X 1-month, weekly x 3 months and then monthly to ensure that any missed or refused meds are reported to the MD for follow up. 4) Results of the audits will be reported to the QAPI committee by the DON quarterly X 4 Quarters.	

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F 658	Continued From page 26 Set (MDS) an assessment tool dated [redacted], included Section E, Rejection of Care was exhibited 1 to 3 days of the 7 day look back. A review of the person-centered comprehensive Care Plan revealed a focus area of [redacted] dependent date initiated [redacted] Interventions included but were not limited to; [redacted] as ordered by doctor. The care plan did not include [redacted] of refusing [redacted]. A review of the Order Summary Report included a physician's order dated 07/20/23, [redacted] at bedtime. A review of the Medication Administration Record (MAR) dated September 2023 and included through [redacted], Resident #28 had refused his/her night time [redacted]. A review of the PN date range [redacted], revealed there was no documentation that the nursing staff alerted the physician about the resident refusing the night time [redacted] for 6 out of 11 days. On 09/12/23 at 10:18 AM, during an interview with Surveyor #1, an LPN stated the process was that if a resident refused a medication, the staff would attempt three times to administer the medication. If the resident still refused, the staff would educate the resident, call the physician, and document the refusal. The LPN further stated it was important to inform the physician if a resident refused medication. On 09/12/23 at 10:24 AM, during an interview with Surveyor #1, a Registered Professional Nurse (RN) supervisor stated that the process was if a resident refused medication, the staff	F 658		

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would try three times and then notify the physician. The RN supervisor further stated the refusal would be documented and the care plan would be updated.

On 09/12/23 at 10:32 AM, a RN stated that if a resident refused their medication, she would attempt to give it again and try to find out why the resident refused it. The RN stated if the resident refused insulin it "could be more dangerous" so the staff would call the physician and monitor the resident blood sugars.

On 09/12/23 at 11:42 AM, the Director of Nursing (DON) stated that if a resident refused medication, the staff would be expected to educate the resident and attempt to administer the medication again. The DON stated that the staff should notify the Nurse Practioner (NP) or the physician and document in the progress notes. The DON and Surveyor #2 reviewed Resident #28's MAR.

On Ex Order 26. 4B1 at 11:27 AM, the DON stated that a Ex Order 26. 4B1 could become Ex Order 26. 4B1 if they refused their Ex Order 26. 4B1. She stated the staff were educated to document when they call the physician or the NP but "they [the staff] did not do that [regarding Resident #28 refusing Ex Order 26. 4B1]". The DON further stated there were no PN documenting that Resident #28 had refused Ex Order 26. 4B1 or that the NP or physician had been made aware of the Ex Order 26. 4B1 being refused. The DON stated, "I will have to talk to my staff about it."

A review of the facility provided, "Medication Refusal" policy and procedure revised 06/2021, included but was not limited to; Policy: the facility staff will document any incident of medication

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refusal by a resident. Procedure: 5. The nurse will notify the resident's attending physician of the medication refusal when the refusal presents unfavorable outcomes.

A review of the facility provided, "Documentation Policy & Procedure" reviewed 06/23, included but was not limited to; Policy: documentation is a professional tracking to enhance the continuity of care. Good clinical practice dictates what goes into a medical record. Key goals of sound clinical documentation are to describe what is happening to the resident. Enhance continuity of care on all shifts and disciplines. Monitor outcomes of care. Procedure: 1. required documentation - included in response to facility policies i.e. behavior monitoring. 2. b. what will be documented - included problem identification to resolution. c. document in the progress notes. d. document at the time of the incident.

b.) On 09/11/23 at 8:15 AM, Surveyor #2 observed an RN administer medications to Resident #44. Resident #44 received the following medications as per the order on the Medication Administration Record (MAR)
Ex Order 26. 4B1 [redacted]
Ex Order 26. 4B1 [redacted]
Ex Order 26. 4B1 [redacted]
Ex Order 26. 4B1
Ex Order 26. 4B1
Ex Order 26. 4B1
Ex Order 26. 4B1

On 09/11/23 at 9:50 AM, during review of the medical record, Surveyor #2 observed *Ex Order 26. 4B1* Physician's Orders (PO) that included a

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F 658	Continued From page 29 Physician's order for the resident to receive *Ex Order 26. 4B1* 2 tablets for *Ex Order 26. 4B1*. The surveyor then observed that the RN administered one tablet only of *Ex Order 26. 4B1*. The dose prescribed was *Ex Order 26. 4B1*. The surveyor reviewed the Physician Order Sheet (POS) and did not observe any change in the order. There was no verbal physician's order documented to reflect the change in dosage. Prior to administering the medications to Resident #44, Surveyor #2 asked the RN to verify the number of medications in the cup, the RN confirmed there were 7 tablets in the medication cup. During an interview on 09/15/23 at 9:47 AM, the RN stated Resident #44 should have received 2 tablets according to the POS. She further stated that she thought that she administered 2 tablets. The RN informed the surveyor that she was aware of the protocol to follow. A nursing Progress notes dated *Ex Order 26. 4B1* timed 11:24 AM, confirmed that the Physician was called and gave an order to administer the *Ex Order 2* at 11:22 AM. During the exit conference held on 09/22/23 at 10:30 AM, the facility did not have any additional information regarding the medication omission. NJAC 8:39-11.2(b) 29.2(d).	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		10/25/23

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F 677	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to ensure that Ex Order 26. 4B1 care was provided to dependent residents in a timely manner for 2 of 2 residents, (Resident #49, Resident #50) reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by the following: 1. On 09/06/23 at 10:22 AM, the surveyor toured the NJ Exec. Orde Unit of the facility and observed Resident #49 in bed. A strong foul Ex Order 26. odor permeated as the surveyor approached the resident's bed. On 09/06/23 at 10:35 AM, the surveyor exited the room and while in the hallway heard an alarm sounding. The surveyor returned to the room and observed the resident was now out of the bed and was wearing a Ex Order 26. 4B1 brief that was observed bulging in the rear. At 10:36 AM, a Certified Nurse Aide (CNA) emerged from the bathroom door inside of the resident room and observed Resident #49 was out of the bed. The CNA then escorted the resident back to bed and told the resident to wait until she had completed care for the resident next door. The CNA informed the surveyor that Resident #49 would try to get out of the bed whenever if he/she was NJ Exec. Order 26 On 09/08/23 at 08:43 AM, the surveyor interviewed the 7:00 AM -3:00 PM Certified Nursing Aide (CNA) #1 on the East Unit. The CNA stated that she currently had 12 residents on her assignment and was the only CNA on the floor. Upon inquiry regarding the workload, the CNA stated, "I tried to find time and I usually	F 677	1) Resident #49 and #50 have been observed as receiving appropriate Ex Order 26. 4B1 care as per facility policy. The residents' plan of care has been revised to include specific interventions to promote consistent and timely Ex Order 26. 4B1 care. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The facility policy on incontinence care has been reviewed and revised. An audit has been conducted on the care plans of incontinent residents and revisions made as needed. 3) The nursing staff have been re-educated on the incontinence care policy including the appropriate usage of incontinence products. The Nursing Supervisors/designee will make random observations of incontinence care daily X 1 month then weekly to assure timeliness of care and that proper technique is being followed. The necessary corrections, education and counseling will be provided immediately to the staff if deficient practices are noted. 4) The results of these audits will be reviewed at the Quarterly Quality Assurance meeting to ensure compliance and to identify any trends or patterns requiring further corrective action.	

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finished my assignment by 12:00 PM or 1:00 PM. The CNA added, "Not all of the residents would be out of bed due to staffing. The residents at risk for falls would be out of the bed almost daily." When inquired regarding if administrative staff were aware, she stated, "They make the schedule they knew about it."

On 09/08/23 at 11:30 AM, the surveyor interviewed the 7:00 AM - 3:00 PM CNA #2 on the [NJ Exec. Orde] Unit who stated that she had been working at the facility for several years and currently had 13 residents on her assignment. CNA #2 stated that she only worked the 7:00 AM - 3:00 PM shift and would usually have 12 to 14 residents on her assignment on the weekends. CNA #2 further stated that the number of residents on her assignment depended upon how many staff were working.

On 09/15/23 at 8:37 AM, the surveyor observed [Ex Order 26. 4B1] rounds in the presence of CNA #2 along with the Infection Control Preventionist (IP) on the East Unit. The surveyor observed that Resident #49 was wearing two [Ex Order 26. 4B1] [NJ Exec. Order 2] which were [NJ Exec. Order 26:4.b.1] with [Ex Order 26.]. CNA #2 stated that in the morning she made rounds to ensure that the residents were safe and in bed, however, did not check for [Ex Order 26. 4B1]. She further added that she had not yet provided care to Resident #49. When inquired about Resident #49 wearing two [Ex Order 26. 4B1] [NJ Exec. Order 2], she stated that was not the protocol but occasionally she would observe residents wearing two [Ex Order 26. 4B1] briefs and would report it to the Registered Nurse/Unit Manager (RN/UM).

On 09/15/23 at 11:11 AM, the surveyor interviewed the IP who assisted with [Ex Order 26. 4B1]

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care that morning. The IP confirmed that occasionally she would observe other residents wearing two Ex Order 26. 4B1 NJ Exec. Order during Ex Order 26. 4B1 care. She stated that she discussed the issue with the RN/UM and could not comment on/or if any in-service education had been completed to address the above issue. She added that the staff had to be careful because wearing two Ex Order 26. 4B1 briefs could damage the skin and could be very uncomfortable.

On 09/21/23 at 08:30 AM, during an interview with CNA #3 who cared for Resident #49 on 09/15/23 during the 11:00 PM-07:00 AM shift, she revealed that she began her last rounds at 4:00 AM, she provided Ex Order 26. 4B1 care to Resident #49 and applied one NJ Exec. Order CNA #3 stated that she had some residents that were, "Ex Order 26. 4B [redacted]" on her assignment and she would change them as needed. CNA #3 added that she would place several blue Ex Order 26. 4B1 on the bed, otherwise she would have to strip the whole bed in the morning. According to CNA #3's interview, approximately four hours had passed since Resident #49's Ex Order 26. 4B1 had been changed.

The surveyor reviewed the medical record for Resident #49. The Admission Face Sheet (an admission summary) reflected that Resident #49 was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26. 4B1 [redacted]. The Admission Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated Ex Order 26. 4B1, reflected that Resident #49 had a BIMS (Brief Interview for Mental Status) of Ex Ord/15, indicative of Ex Order 26. 4B1 [redacted]. A further review of the resident's

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F 677	Continued From page 33 MDS, Section G - Functional Status indicated the resident required NJ Exec. Order 26:4.b.1 of one-person physical assist for personal hygiene. A review of the resident's Care Plan (CP) with revised date of [redacted], reflected a focus area that the resident had an [redacted] self-care performance deficit related to hospitalization, diagnosis of *Ex Order 26. 4B1* [redacted]. The goal was for Resident #49 would improve current level of function in [redacted] and mobility. The interventions for the resident CP included that Resident #49 requires assistance by 1 staff with oral care, personal hygiene, and toileting. 2. On 09/08/23 at 8:37 AM, the surveyor observed *Ex Order 26. 4B1* rounds in the presence of the Hospice Aide (HA) on the [redacted] Unit. The surveyor observed that Resident #50's *Ex Order 26. 4B1* [redacted] was wet and [redacted] stained. The [redacted] liquid was observed to be covering the front and the back part of the resident's *Ex Order 26. 4B1* [redacted] Two *Ex Order 26. 4B1* were also noted on the bed and were also [redacted] stained. The HA stated that she worked for Hospice Monday through Friday and provided care to Resident #50. The HA added that Resident #50 would be wet every day whenever she received the resident. She reported to work and just started her shift at 8:30 AM and had not yet changed the resident. On 09/15/23 at 8:15 AM, the surveyor observed *Ex Order 26. 4B1* rounds in the presence of CNA #1 and the HA on the [redacted] Unit for Resident #50. When the HA removed the resident's *Ex Order 26. 4B1* [redacted] the surveyor observed that two *Ex Order 26. 4B1* were also inside the	F 677		

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	315304	A. BUILDING _____ B. WING _____	C 09/25/2023

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F 677	Continued From page 34 Ex Order 26. 4B1 NJ Exec. Orde and were saturated and Ex Order 26. 4B1. The contents of the Ex Order 26. 4B1 had leaked through the Ex Order 26. 4B1 brief and stained the Ex Order 26. 4B1 that was placed on the bed to protect the bed. The surveyor asked CNA #1 to have a supervisor report to the room. The Licensed Nursing Home Administrator (LNHA) was located on the floor and reported to the room. She informed the surveyor that she would call the DON. The HA remained in the room at the bedside with the surveyor. During a second interview with the HA, she stated that she informed both the nurses and the CNAs that Resident #50 needed to be checked for Ex Order 26. 4B1 every 2 hours. On 09/15/23 at 8:30 AM, the DON entered the room where she observed Resident #50 was in bed, two Ex Order 26. 4B1 soaked with Ex Order 26., the Ex Order 26. 4B1 NJ Exec. Orde also saturated with Ex Order 26. and Ex Order 26. 4B1 stained. The DON stated that the Ex Order 26. 4B1 were in place to prevent Ex Order 26. 4B1 and the resident should have had only one pad inside the Ex Order 26. 4B1 brief. On 09/15/23 at 10:30 AM, the facility provided two packages of the Ex Order 26. 4B1 for review. The surveyors reviewed the package information on the Ex Order 26. 4B1. The packages revealed the products were Ex Order 26. 4B1. The instructions did not correlate with what the facility indicated the intended use was regarding placing the pad inside the Ex Order 26. 4B1 NJ Exec. Order The surveyors requested the facility provide evidenced based	F 677		

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F 677	Continued From page 35 guidance regarding using one Ex Order 26. 4B1 product (Ex Order 26. 4B1) inside of an Ex Order 26. 4B1 NJ Exec. Orde On 09/18/23 at 12:00 PM, the surveyor interviewed the UM/RN of the East Unit. She stated that she was not aware that staff were using two Ex Order 26. 4B1 NJ Exec. Orde and two pads inside the Ex Order 26. 4B1 NJ Exec. Orde She further stated that she could not recall if the CNA or the IP alerted her prior to 09/15/23 of the above concerns. The RN/UM further stated that Ex Order 26. 4B1 rounds were to be performed every two hours and as needed for the residents. The surveyor reviewed the medical record for Resident #50. Resident #50 was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26. 4B1 . The Significant Minimum Data Set (MDS) Assessment (an assessment tool used by the facility to prioritize care) dated Ex Order 26. 4B1 reflected that Resident #50 had some difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said. Section G of the MDS which addressed Ex Order 26. 4B1 reflected that Resident #50 required NJ Exec. Order 26:4.b.1 from staff with bed mobility, transfer, personal hygiene, and toileting. A review of the resident's CP with revised date of NJ Exec. Order 26:4.b.1, reflected a focus area that the resident had an Ex Order 26 self-care performance and mobility deficit related to hospitalization, shuffling Ex Order due to Ex Order 26. 4B1 . The goal of the resident's CP reflected that the resident would be free of	F 677		

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F 677	Continued From page 36 complications related to immobility[NJ Exec. Orde] [Ex Order 26. 4B1]. The interventions for the residents CP included [NJ Exec. Order 26:4.b.1] of 1 for dressing, toileting, hygiene. (The Care Plan failed to indicate that Resident #50 required [Ex Order 26. 4B1] care every two hours per the HA) When inquired regarding the facility policy for [Ex Order 26. 4], the DON stated that the facility did not have a policy for [Ex Order 26. 4B]. On 09/21/23 at 8:05, the surveyor conducted a telephone interview with CNA #3 who cared for Resident #50 on the 11:00 PM-7:00 AM shift on [NJ Exec. Order 26:4.b.1]. CNA #3 revealed that Resident #50 required [NJ Exec. Order 26:4.b.1], all needs must be anticipated. "You have to do everything for [Resident #50], [he/she] is a heavy [Ex Order 26. 4B]." She stated she started her last rounds at 4:00 AM and changed the resident around 5:00-5:30 AM. This indicated that approximately four hours had passed since the resident had been provided [Ex Order 26. 4B1] care by a staff member, not two hours as was indicated by the HA. CNA #3 further stated that she provided [Ex Order 26. 4B1] care "as much as she could." CNA #3 stated had 24 residents on her assignment that night. CNA #3 added that she left the facility at 7:15 AM on [Ex Order 26. 4B1], and only one CNA reported to the floor for the day shift. She admitted that she put 2 pads inside the [NJ Exec. Orde] and stated that she was never informed how many pads could be placed inside the [Ex Order 26. 4B1] [NJ Exec. Orde] CNA #3 further added that it was the facility protocol to have the pads inside the [NJ Exec. Order 26:4.b.1]. When asked if she received some in-service education regarding how many pads to use, she stated, "No". CNA #3 then stated, "The amount of pads being placed in the [Ex Order 26. 4B1] [NJ Exec. Orde] was never discussed." She acknowledged receipt of	F 677		

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F 677	Continued From page 37 in-service education on Ex Order 26. 4B1 care on 09/16/23, only after surveyor inquiry. On 09/20/23 at 12:30 PM, the above concerns were discussed with the facility administrative staff. During an interview with the DON she confirmed that the facility had been using the pads inside the NJ Exec. Order 26:4.b.1. The Director of Nursing (DON) stated that the protocol dated back when the facility was managed by the County. The DON added that the residents were care planned for the use of the pads inside the NJ Exec. Order 26:4.b.1. When asked about the facility policy for Ex Order 26. 4 the DON stated that the facility does not have a policy for Ex Order 26. 4 and did not provide any evidenced based guidance regarding utilizing one Ex Order 26. 4B1 product inside of another for Ex Order 26. 4B1 care. The facility did not offer any information why residents were not offered more frequent Ex Order 26. 4B1 care. On 09/21/23 the facility provided an in-service policy titled, " Maintaining our Resident's Quality of Life" which included the following: Quality of Life: to improve or at the very least, maintain the resident's level of function in all aspect of life, safeguarding against lost of ability. Health's Care: ADLs provided are "appropriate" for the resident's ability- do for them only what they cannot do for themselves. Incontinence Care Residents require timely care when incontinent. A review of the facility's Job Description for Certified Nursing Assistant indicated under "Essential Job Functions." Assist residents with bathing, dressing, grooming,	F 677		

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F 677	Continued From page 38 dental care, bowel and bladder functions, preparation for medical tests and exams, ear and eye care and positioning in and out of beds, chairs, etc. Performs resident related activities directed throughout the shift including assisting with lifts of residents to wheelchairs/ [recliner], assists residents In transfer activities, assist residents in donning and removing appliances or splints, and guards residents in ambulation. Nursing Care Functions Provide nursing functions as directed by Nurse Manager including daily perineal care, catheter care, turn residents in bed, sponge baths and showers. Resident's Right Functions Maintain resident confidentiality and privacy; treat residents with kindness, dignity, and respect; know and comply with Resident's Rights; and promptly report all resident complaints and incidents to supervisor. The Registered Nurse Supervisor Job Description Provide direct nursing care to the residents and to supervise the day-to-day nursing activities performed by the nursing personnel in accordance with current State, Federal, and Local standards governing the facility and as may be directed by the Director of Nursing to ensure highest level of quality care in maintained at all times. Administrative Functions Oversees day to day functions of the licensed practical nurses and the nursing assistants. Ensures that all nursing service personnel are giving proper resident care and performing their respective duties in accordance with written policies, procedures, and manuals.	F 677		

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F 677	Continued From page 39 Nursing Care Functions Supervise direct care of resident on assigned shift.	F 677		
F 689 SS=E	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on observation, interviews, record and review of other pertinent facility documentation, it was determined that the facility failed to: a.) ensure that a *Ex Order 26. 4B1* resident admitted with a known *Ex Order 26. 4B1* was appropriately supervised and/ or monitored to prevent NJ Exec. Orde including NJ Exec. Order 26:4.b.1 on *Ex Order 26. 4B1* when Resident #50 had an unwitnessed NJ Exec. O and sustained front *Ex Order 26. 4B1* and b.) follow NJ Exec. Order 26:4.b.1 interventions per the Care Plan, and ensure that assistive devices to alert staff of NJ Exec. Orde were functional. This deficient practice was identified for 2 of 3 residents reviewed for incident/ accidents (Resident #49 and #50) and was evidenced by the following: On 09/06/23 at 10:22 AM, the surveyor observed	F 689	1) Residents #49 and #50 fall prevention care plans were reviewed by the Interdisciplinary Care Plan team. The care plans were updated to reflect appropriate NJ Exec. Order 26:4.b.1 which included recreation programming to increase engagement and promote safety. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The Residents who were identified to be at high risk for falls by the Interdisciplinary Care Plan Teams had their care plans and current interventions reviewed with a focus on the resident's daily routine and engagement with the goal to reduce the risk of falls. The facility Fall Prevention Policy and Procedure was reviewed and revised. 3) Staff were re-educated on the Fall Prevention Policy and Procedure.	10/25/23

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F 689	Continued From page 40 Resident #49 in bed, and a strong odor of [redacted] permeated the room. On [redacted] at 10:35 AM, while in the hallway of the [redacted] Unit, the alarm sounded in Room [redacted] Resident #49 attempted to get out of the bed, [redacted] was soaked with [redacted] and bulging from the back. The Certified Nursing Assistant (CNA) emerged from the adjacent bathroom and escorted the resident back to bed. The CNA told the the resident to wait until she could complete care for the other resident that was observed in the bathroom. The CNA informed the surveyor that whenever Resident #49 was wet he/she would try to get out of bed. On 09/06/23 at 12:30 PM, observed Resident #49 in the dayroom with 6 other residents. The residents were unsupervised and there was no staff observed in the dayroom, or at the nursing station at that time. On 09/08/23 at 8:43 AM the surveyor interviewed the CNA who cared for the resident. She stated she was the only CNA on the floor, the other CNA would report to work around 9:00 AM. The CNA further stated that most of the time 2 CNAs would be assigned to the Unit. The Census was 25 and she had 12 residents on her assignment. When inquired regarding the residents observed in the dayroom she stated that the residents who were at risk for falls would be out of the bed first and then placed in the dayroom. She further added that not all residents would be out of bed daily due to staffing issue. When inquired regarding if administrative staff was aware of the concerns with residents care and staffing, she stated, "They made the schedule they were aware."	F 689	A list of residents who are at an increased risk for falling will be maintained, updated weekly at the Falls committee meeting, and shared with appropriate staff. The recreation program has been extended to provide additional support on the unit, so that residents who are at an increased risk for falls can be monitored more closely to promote safety. A weekly audit x 12 months of all falls will be completed by the Falls Committee/Interdisciplinary Care Plan team to monitor for trends and patterns, interventions are updated, care plans and CNA Kardex are updated, and therapy recommendations are reviewed and acted upon. 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 41 On 09/11/23 at 9:39 AM, the surveyor observed Resident #49 sitting in the dayroom with 3 other residents. The residents were unsupervised as there was no staff in present in the day room or at the nursing station. On 09/11/23 at 11:30 AM, the surveyor reviewed Resident #49's medical record. The Admission Face Sheet (an admission summary) reflected that Resident #49 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. The Admission Minimum Data Set (MDS) dated [redacted], an assessment tool used by the facility to prioritize care, reflected that Resident #49 had a BIMS (Brief Interview for Mental Status) of [redacted]/15, indicative of [redacted]. The MDS also reflected that Resident #49 required [redacted] of one person physical assist for bed mobility and transfer, and extensive assist for personal hygiene and toileting. A fall risk assessment completed by the facility on [redacted] indicated that Resident #49 was a high [redacted]. Resident #49 received a score of [redacted] on the [redacted]; Scoring: [redacted] and higher. The surveyor reviewed a nurse Progress Note dated [redacted] timed 12:45 PM, which reflected that Resident # 49 was found lying on the floor on the [redacted] and was asleep on the floor with feet inside the bathroom and head near the bed. Upon assessment, it was noted to have a [redacted] to the [redacted] measuring [redacted] was identified. A review of the	F 689		

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F 689	Continued From page 42 facility's Accident/Incident Report dated [redacted] at 12:45 AM, indicated that Resident #49 was found asleep and was lying on the floor. At that time per the Accident report, the resident got out of the bed unassisted, climbed in and out of the bed. Interventions added: Moved to room [redacted]. Possible alarm to call bell system. Another entry in the nurse Progress Note dated [redacted] timed 6:30 PM, revealed that Resident #49 had another unwitnessed [redacted] that occurred in the dayroom. According to the description of Facts and Event, the CNA heard a "[redacted]" and found Resident #49 sitting on the ground with no [redacted]. Interventions added: 15 minutes monitoring, rehab screen, rule out infection. The CNA's statement revealed that she was at the nursing station and heard the "[redacted]" and then observed Resident #49 on the floor. The root cause analysis of the event provided by the facility revealed that Resident #49 had poor safety awareness, required assistance with transfer and ambulation. The root cause analysis did not identify /address the lack of supervision as a factor. On 09/11/23 at 09:49 AM, the surveyor observed the Registered Nurse Unit Manager (RN/UM) sitting at the nursing station and was entering information into the computer. During an interview with the RN/UM, she stated that Resident #49 was a [redacted] and that the reason to be in the dayroom. When asked who was monitoring the dayroom, the RN/UM stated she could observed the resident while at the nursing station through the [redacted glass-type] window, but the activity staff should be in shortly. The surveyor observed that the glass window was at knee height and did not provide a full view of	F 689		

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F 689	Continued From page 43 the dayroom. The RN/UM further stated that Resident #49 would attempt to ambulate unassisted at times,was not aware of his/her limitation, and [redacted] NJ Exec. Order 26:4.b.1 [redacted]." The surveyor reviewed the following entries in Resident #49's clinical record: On [redacted] Ex Order 26. 4B1 [redacted] at 19:52 PM, the Licensed Practical Nurse documented: Resident #49 frequently leaving his/her wheelchair and attempted to ambulate, resident frequently switching seats, undressed in the dayroom. On [redacted] Ex Order 26. 4B1 [redacted] at 07:13 AM,the Registered Nurse wrote: Toileting x 8 this shift. Would not call for assistance, would jump out of the bed, unsteady walking to bathroom. Sometimes resident was already [redacted] Ex Order 26. 4B1 [redacted] and would remove [redacted] NJ Exec. Orde [redacted] and throw on floor but majority of times would sit on toilet... When interviewed on 09/19/23 at 12:30 PM, in the presence of the team regarding Resident #49's [redacted] NJ Exec. Orde [redacted], the Director of Nursing (DON) stated that the facility does not have staff dedicated to monitor the dayroom. The DON stated that the residents in the dayroom were being monitored by all staff including the nurse on the medication cart and "whomever" was in the hallway or at the nursing station. The DON further added that the facility would provide distant supervision for residents in the dayroom. The DON was unable to provide any documentation to support resident monitoring. A review of Resident #49's Care Plan revealed that the line of supervision required for Resident	F 689		

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F 689	Continued From page 44 #49, who was identified as a [NJ Exec. Order 26:4.b.1] since [Ex Order 26. 4B1], was not addressed. 2. Resident #50 was admitted to the facility with diagnoses which included but were not limited to: [Ex Order 26. 4B1]. The Significant Minimum Data Set (MDS) Assessment (an assessment tool used by the facility to prioritize care), dated [Ex Order 26. 4B1], reflected that Resident #50 scored [Ex Or]/15 on the [Ex Order 26. 4B1]. The MDS also reflected that Resident #50 had some difficulty [NJ Exec. Order 26:4.b.1], for example, being easily [NJ Exec. Order 26:4.b.1]e or having difficulty keeping track of what was being said. Section [Ex Order 26. 4B1] Inattention was [Ex Order 26. 4B1] Section [Ex O] of the MDS which addressed [Ex Order 26. 4B1] reflected that Resident #50 required [NJ Exec. Order 26:4.b.1] assistance from staff with bed mobility and transfer. Resident #50 was assessed to be at [NJ Exec. Order 26:4.b.1], Resident #50 received a score of [Ex Or] on the [NJ Exec. Order 26:4.b.1] dated [Ex Order 26. 4B1] and [Ex Or] on the [NJ Exec. Order 26:4.b.1] [Ex Order 26. 4B1]. On 09/06/23 at 10:33 AM, the surveyor observed Resident #50 sitting in a high back chair in the dayroom, unsupervised, and not respond to the surveyor's greeting. There was no staff in the dayroom or at the Nursing station. On 09/11/23 at 9:58 AM, the surveyor observed Resident #50 unsupervised, and sitting in the dayroom with 3 other residents. There was no staff observed in the dayroom or at the nursing station.	F 689		

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	315304	A. BUILDING _____ B. WING _____	C 09/25/2023

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 689	Continued From page 45 On 09/14/23 at 12:05 PM, the surveyor observed Resident #50 sitting, unsupervised, in the alcove area with 2 other residents. There was no staff present in the hallway. A review of Resident #50's Comprehensive Care Plan for [NJ Exec. Or] initiated on [Ex Order 26. 4B1], revealed the following interventions: 1. Urinal within reach initiated [Ex Order 26. 4B1]. 2. Educate to use call bell for assist initiated [Ex Order 26. 4B1]. 3. Electronic Pad Alarm on bed initiated [Ex Order 26. 4B1]. 4. Hip protectors at all times initiated [Ex Order 26. 4B1]. 5. Sensor Pad to wheelchair initiated 02/04/23. 6. Rehab screen post fall, initiated [Ex Order 26. 4B1]. 7. Common area when out of bed initiated [Ex Order 26. 4B1]. 8. Bolster mattress with egress as well as landing matt initiated [Ex Order 26. 4B1]. On 09/15/23 at 11:15 AM, the surveyor further reviewed the clinical record and noted the following entries: [Ex Order 26. 4B1] 07:10 AM, the Licensed Practical Nurse documented, (Unwitnessed [NJ Exec. O]) Resident #50 was found on the floor with an [NJ Exec. Order 26:4.b.1] A review of the Accident/Incident Report revealed that upon assessment, Resident #50 was observed to have *Ex Order 26. 4B1*, a *Ex Order 26. 4B1* measuring [Ex]. [Ex Order 26. 4B1] 5:30 PM, (Unwitnessed [NJ Exec. Or] Resident #50 was found on the floor in front of the wheelchair in the room. The Director of Nursing documented: "Interview of the nurse at the time of the [NJ Exec. Or] Resident #50 had been at the nurses station. This was just before dinner trays come to	F 689		

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F 689	Continued From page 46 the floor. He had appropriate footwear on. No [NJ Exec. Order 26] was noted by the nurse. The [NJ Exec.] was unwitnessed and [Ex Order 26. 4] -checks were implemented...Resident #50 is [NJ Exec. Order 26:4.b.1] and he/she stands without assist." Root Cause analysis: Increase [NJ Exec. Order 26:4.b.1] with unpredictable due to [Ex Order 26. 4B1]. [Ex Order 26. 4B1] 4:20 PM, The Licensed Practical Nurse (LPN) documented, "While sitting in the dayroom, Resident #50 attempted to get out of [NJ Exec. Order 26:4.b.1] Under observation,the LPN wrote, " Resident in dayroom on the ground in front of the wheelchair" Root Cause Analysis: Poor safety awareness. Overestimates his/her abilities. When inquired who was in the dayroom to monitor the residents, the DON did not provide any information. [Ex Order 26. 4B1] 11:30 PM, (Unwitnessed [NJ Exec. Ord] The LPN documented that the Certified Nursing Assistant found Resident #50 on the floor in the room. The bed alarm did not sound. The facility was not aware of how long Resident #50 had been on the floor. Root cause analysis: Poor safety awareness and overestimates his/ her abilities to stand related to [Ex Order 26. 4B1]. A review of the [NJ Exec. O] investigation revealed that Resident #50 was found on the floor with a [Ex Order 26] and [Ex Order 26.] measuring [Ex Orde]. The root cause analysis revealed that the bed alarm did not sound at time of the [NJ Exec. Ord] Section ([Ex]) of the "Supplemental [NJ Exec. O]	F 689		

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F 689	Continued From page 47 Information" included the following question: Were all of the care planned devices applied prior to the [NJ Exec. O]was checked? "[Ex Orde]" and indicated that Resident #50 did not have the [Ex Order 26. 4B1] implemented ([Ex Order 26. 4B1]) and non skid socks on. Section ([Ex O]) If an alarm was in place was it sounding? According to the documentation, the bed alarm was in place but did not alert alert the staff of [NJ Exec. Order 26:4] The surveyors also observed that on 3 occasions, 09/08/23 at 9:01 AM, 09/11/23 at 8:35 AM, 09/15/23 8:15 AM, Resident #50 was in bed, when checked with the CNA Resident #50 did not have the [Ex Order 26. 4B1] on ([Ex Order 26. 4B1] [NJ Exec. Orde]) implemented since 10/25/22 when Resident was observed to have a [NJ Exec. Order 2] of unknown origin to the [Ex Order 26. 4B1] to minimize [NJ Exec. Order 26:4.b.1]. On [Ex Order 26. 4B1] at 08:36 AM, during an interview with the Hospice CNA (HA), stated that when she cared for Resident #50 in the morning, Resident #50 never had the [Ex Order 26. 4B1] on and she reported the issue to the Unit Manager and the CNAs on the unit. On 09/19/23 at 11:19 AM, the surveyor interviewed the DON, in the presence of the survey team and the Licensed Nursing Home Administrator and the Director of Operations. The surveyor asked who is supposed to supervise the residents who are placed in the dayroom. The DON stated, "there is staff that floats in and out of the dayroom". The surveyor asked who the staff is, and the DON stated, "CNAs, nurses and activity."The surveyor asked the DON who was monitoring Resident #50 when the resident sustained an unwitnessed[NJ Exec. O] on [Ex Order 26. 4B1]. The	F 689		

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F 689	Continued From page 48 DON reviewed the investigation and stated, "it was an unwitnessed [NJ Exec. O]." The surveyor asked who was monitoring the dayroom, and the LNHA responded that" she had just left the dayroom." A statement dated [Ex Order 26. 4B1] revealed that the LNHA left the dayroom and heard an alarm sounding and observed Resident #50 rising from the wheelchair and the alarm sounded and the resident [NJ Exec. O] to the floor. The surveyor asked the DON who can see what is happening in the dayroom if there is no one assigned to monitor, and you are relying on varied staff who float in and out of the dayroom. The DON stated, " we had all the safety interventions in place,"and " if we thought he/she was a fighter risk we would have had someone in the room". The DON further stated, " if their behaviors warrant a closer observation" we would have a staff member with them. The facility failed to address supervision as a mitigating factor to prevent further [NJ Exec. Ord]. The DON confirmed that Resident #50 is a [NJ Exec. Order 26:4.b.1] [redacted], "as are a lot of residents" and the resident "*Ex Order 26. 4B1* ". The surveyor asked if interventions added preclude supervision of a resident? The DON stated there was distant supervision, and the surveyor asked how the facility would know that was occurring and it is documented. The DON stated, "no". The DON confirmed there is no documentation to confirm that there is any supervision from other staff that are around the unit, or going through the unit. On 09/20/23 at 10:28 AM, during an interview with the RN/UM, she stated that the [Ex Order 26. 4B1] were to be always on. She was not aware that the staff had not been compliant with the [Ex Order 26. 4B1]. On [Ex Order 26. 4B1] at 10:33 AM, the RN/UM looked into the room there was no [Ex Order 26. 4B1]. She stated that	F 689		

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F 689	Continued From page 49 the Resident had 3 Ex Order 26. 4B1 assigned to him. The RN/UM in the presence of the surveyor searched the room and could not find any Ex Order 26. 4B1 in the room. There was no Ex Order 26. 4B1 on the unit also. The UM stated that Resident #50 was to have 3 Ex Order 26. 4B1 in the room they could have been NJ Exec. Order 2 and sent to the laundry. On 09/20/23 at 12:30 PM, the surveyor reviewed the CNA's Care Plan initiated NJ Exec. Order 26:4.b.1 and indicated the following: " Ex Order 26. 4B1 on at all times". On 09/20/23 at 1:30 PM, the surveyor reviewed the facility policy Titled, " Falls and Fall Risk Management" The policy indicated that "Based on the resident's previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." Procedure The Interdisciplinary Care Plan Team will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e.; to try one or a few at a time, rather than many at once), # 4 of the procedure indicated the following: "If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains irrelevant." The facility indicated on Ex Order 26. 4B1 that Resident #50 had NJ Exec. Order 26:4.b.1 with unpredictable NJ Exec. Order 26:4.b.1 due to Ex Order 26. 4B1. Resident #50 had recurrent NJ Exec. Or at the facility when he /she was not	F 689		

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F 689	Continued From page 50 being supervised, the facility did not indicate the line of supervision required to prevent [NJ Exec. Order] On 09/21/23 at 8:30 AM, the surveyor interviewed by phone, the CNA assigned to the 11:00 AM-7:00 PM shift regarding the residents placed in the dayroom. The CNA confirmed prior to leaving the facility at 7:15 AM she would cared for some residents including Resident #49 and placed him/her in the dayroom. When inquired about who was responsible to monitor the residents at [NJ Exec. Order 26:4.b.1] who were observed early morning in the dayroom. The CNA stated, she could not be at the facility to monitor the dayroom when her shift was over. She stated that she reported to work timely every day when she was assigned to work. The CNA further added, that the administrative staff needed to reinforce the rule and ensure that the 7:00- 3:00 PM shift reported to work on time. On 09/21/23 at 9:39 AM, during a pre-exit conference with the administrative staff which included the LNHA, DON, Regional staff and the Chief Executive Officer (CEO). When the surveyor presented multiple observations where both residents were observed in the dayroom and the alcove unsupervised, she replied, "noted." The facility did not provided further information regarding the lack of supervision for the residents who sustained multiple unwitnessed falls, including falls with injury. NJAC 8:39-27.1 (a)	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		10/25/23

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F 725	Continued From page 51 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ 165178 Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure sufficient staff were available to: a) provide supervision for resident's who were at [redacted], who sustained multiple unwitnessed [redacted], b) consistently provide resident's with assistance to get out of bed, and c) provide appropriate incontinence care. The deficient practice occurred on two of two resident	F 725	F725 –(D) – License/Comply with Federal/State / Local Law/ Professional Standards 1) The facility is monitoring acuity, nursing staffing hours and CNA ratios daily. Nursing overtime shifts, bonus shifts, per diem and agency shifts are utilized when needed to maintain the required hours and ratios. The facility continues to aggressively recruit, hire, and retain nursing staff.	

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F 725	Continued From page 52 units and was evidenced by the following: Refer to 689E Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. a. On 09/06/23 at 12:30 PM, Surveyor #1 observed Resident #49 in the dayroom with six other residents. The residents were unsupervised and there was no staff observed in the dayroom, or at the nursing station at that time. On 09/08/23 at 8:43 AM, Surveyor #1 toured the East unit and interviewed a Certified Nursing Aide (CNA #1) who stated she was the only CNA for 25	F 725	2) The facility recognizes that all residents have the potential to be affected by this deficient practice. Ancillary staff are utilized to support the nursing staff and provide additional assistance and/or supervision to those residents who may require it. Such as those with behaviors and falls. Nursing Management and the Staffing Coordinator were re-educated on the CNA ratio requirement. 3) Random ADL rounds will be conducted daily x 3 months, 2 x a week x 3 months and weekly x 6 months by the Department Managers/designee to ensure quality resident care. Staffing and assignment sheets have been updated to include Nurses and Nursing Admin staff who are working on the unit to supply CNA support. The Administrator will log recruitment and retention efforts as part of a Recruitment and Retention PIP that will meet bi-weekly x 6 months and monthly for 6 months to review results and new interventions. 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 725	Continued From page 53	F 725		

residents and that most of the time there were two CNAs. Surveyor #1 asked CNA #1 if she were able to complete her assigned tasks daily. CNA #1 stated that she usually finished her assignment, but 12:00 PM or 1:00 PM and "not all of the residents would be out of bed due to staffing". CNA #1 stated she focused on getting the residents who were at risk for falls out of bed. Surveyor #1 inquired to CNA #1 regarding if the management staff were aware of the staffing concerns. CNA #1 stated that they make the schedule and they know about it.

On 09/11/23 at 9:39 AM, Surveyor #1 observed Resident #49 sitting in the dayroom with three other residents. The residents were unsupervised as there was no staff in attendance.

A review of the medical record revealed: a NJ Exec. Order 26:4.b assessment completed by the facility on Ex Order 26. 4B1 indicated that Resident #49 was at a NJ Exec. Order 26:4.b.1 Resident #49 received a score of Ex Ord on the NJ Exec. Order 26:4.b.1; Scoring: NJ Exec. Order 26:4.b.1 Ex Ord and higher. A nurse Progress Note dated Ex Order 26. 4B1, timed 12:45 PM, revealed that Resident # 49 was found lying on the floor with feet inside the bathroom and head was near the bed. Upon assessment, it was noted a Ex Order 26. 4B1 to the Ex Order 26. 4B1 measuring Ex Order 26. 4B1 was identified.

Another entry in the nurse Progress Note dated Ex Order 26. 4B1, timed 6:30 PM, revealed that Resident #49 had another unwitnessed NJ Exec. O that occurred in the dayroom. According to the description of Facts and Event, the [CNA] heard a "Ex Order 26." and found Resident #49 sitting on the ground with no apparen NJ Exec. Order 26. Interventions added: 15 minutes monitoring, rehabilitation screen, rule out

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F 725	Continued From page 54 infection. The CNA's statement revealed that she was at the nursing station and heard the "[redacted]" and then observed Resident #49 on the floor. The root cause analysis of the event provided by the facility revealed that Resident #49 had [redacted], required assistance with transfer and ambulation. b. On 09/06/23 at 10:33 AM, Surveyor #1 observed Resident #50 sitting in a high back chair in the dayroom, unsupervised, and not respond to the surveyor's greeting. There was no staff observed in the dayroom. On 09/11/23 at 9:58 AM, Surveyor #1 observed Resident #50, unsupervised, and sitting in the dayroom with three other residents. There was no staff observed in the dayroom or at the nursing station. On 09/14/23 at 12:05 PM, the surveyor observed Resident #50 sitting, unsupervised, in the alcove area with two other residents. There was no staff present in the hallway. On 09/15/23 at 11:15 AM, the surveyor further reviewed the medical record and noted the following entries: On [redacted] at 7:10 AM, Resident #50 was found on the floor with an [redacted] to the [redacted]. On 09/19/23 at 11:19 AM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team along with the Licensed Nursing Home Administrator (LNHA) and Director of Operations. When the facility was interviewed regarding any staff supervision for residients left unnatended in the day room, the	F 725		

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F 725	Continued From page 55 DON stated there was distant supervision. The surveyor asked how the facility would know that was occurring and was it documented. The DON stated, "no". The DON confirmed there was no documentation to confirm that there was any supervision from other staff that were around the unit, or going through the unit. c. On 09/08/23 at 9:15 AM, Surveyor #2 observed a call bell system blinking at the un-manned nursing station. At that time, the surveyor conducted an interview with a Licensed Practical Nurse (LPN) and a CNA. The LPN stated there were 35 Residents on both the short and long hall, that she had eleven residents and that there were two CNA's for 35 residents. The surveyor asked the CNA and LPN how they managed to get all of the residents out of bed and the LPN stated, "sometimes they don't", and the CNA stated "sometimes we can't get everyone up, and with the machine [*Ex Order 26. 4B1*] it is not easy." On 09/11/23 at 8:52 AM, Surveyor #2 was seated at the unoccupied West nursing desk and observed a blinking call bell unit with a screen that displayed "8 min", "9 min", and "11 min" and a red light was observed blinking outside of the door to room 138. Surveyor #2 observed a nurse standing at a medication cart positioned outside of the room and a staff member was observed going into the room at 8:58 AM. On 09/11/23 at 8:56 AM, Surveyor #2 interviewed the LHNA regarding the current staffing level for CNAs. The LNHA confirmed that she was aware of the New Jersey minimum staffing ratios for CNAs and stated staffing was a "concern" and during the "day shift we don't make it." Surveyor #2 asked the LNHA how does she ensure that	F 725		

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	315304	A. BUILDING _____ B. WING _____	C 09/25/2023

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 725	Continued From page 56	F 725		

residents are getting out of bed and provided with the necessary care required due to the staffing concerns. The LNHA stated that the facility prioritized the residents who get out of bed by ensuring that resident's identified as fall risks get out of bed daily. The LNHA shared the CNA recruitment incentives with Surveyor #2 and strategies, including qualified management staff who help.

c. On 09/06/23 at 10:22 AM, the Surveyor #1 observed Resident #49 lying in bed and a strong [redacted] odor permeated throughout the room.

On 09/06/23 at 10:35 AM, while in the hallway of the East Unit, Surveyor #1 heard an alarm sounding in Resident #49's room. The surveyor observed the Resident attempting to get out of the bed, a *Ex Order 26. 4B1* [redacted] was observed soaked with [redacted] and was bulging from the back. The CNA was observed emerging from the adjacent bathroom and then escorted the resident back to bed. The CNA told the resident to wait until she could complete care for the other resident that was observed in the bathroom. The CNA informed the surveyor that whenever Resident #49 was wet he/she would try to get out of bed and disrobed.

On 09/15/23 at 8:15 AM, Surveyor #1 performed an *Ex Order 26. 4B1* tour with CNA #2, and also in the presence of the facility Infection Preventionist Nurse (IPN). Resident #49 was observed wearing two *Ex Order 26. 4B1* [redacted] and was saturated with [redacted]. At that time, CNA #1 stated that wearing two *Ex Order 26. 4B1* briefs was not the protocol and Resident #49 should have been wearing one [redacted] At 9:06 AM, Surveyor #1, in the presence of Surveyor #2 conducted a follow-up interview with

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F 725	Continued From page 57 CNA #2 regarding the double Ex Order 26. 4B1 NJ Exec. Order. CNA #2 stated staffing was a concern and that it might take all day to complete her assignment, but she would complete it. CNA #2 stated she was trained to only use one Ex Order 26. 4B1 NJ Exec. Ord and that Resident #49 should have had one Ex Order 26. 4B1 NJ Exec. Ord on because it was a "dignity" issue and could affect resident's NJ Exec. Ord. CNA #2 stated she has observed two NJ Exec. Order on Resident #49 in the past and she always alerted the supervisor who informed her that it would be addressed. CNA #2 stated Resident #49 was suppose to be taken by the staff to use the toilet not be wearing two NJ Exec. Order. CNA #2 stated there were two CNA's at present, and a third CNA was due to start at 11:00 AM and typically she had twelve residents on any given day. A review of the Facility Assessment 2023, Sufficiency Analysis Summary revealed a daily meeting reviews the staffing for the day as well as projected needs over the next several days to ensure appropriate, sufficient staffing. On 09/19/23 at 10:55 AM, Surveyor #2 interviewed the LNHA, in the presence of the survey team and with a Corporate Manager regarding the purpose of the Facility Assessment. The LNHA stated to identify our strength and weaknesses annually or more than annually if something changed. Surveyor #2 inquired as to how the staffing had been completed. The LNHA stated a computer program was used to assist with CNA staffing and what areas of the facility would be short. The LNHA stated she and the DON would be made aware of when staffing would be short and when asked if there were days that were short she stated, "yes". When asked if there was a system to monitor call bell	F 725		

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F 725	Continued From page 58 response, the LNHA stated "no". A reivew of the Promoting/Maintaining Resident Dignity Policy, Effective 09/02/15 was reviewed by Surveyor #2 and revealed the following: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recogniting each resident's individuality. Compliance Guidelines included 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights, 4. Respond to requests for assistance in a timely manner. NJAC 8:39- 4.1(a)11; 27.1(a)	F 725		

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00165178 Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey that from (a) 05/21/2023 to 07/18/2023 the facility was deficient in Certified Nursing Assistants (CNA) staffing for 49 of 49 day shifts, deficient in total staff for residents on 7 of 49 evening shifts, deficient in CNAs to total staff on 1 of 49 evening shifts, and deficient in total staff for residents on 2 of 49 overnight shifts and (b) from 08/20/2023 to 09/02/2023 the facility was deficient in CNA staffing for residents on 12 of 14 day.	S 560	S560 – Mandatory Access to Care 1) The facility is monitoring acuity and nursing staffing hours and CNA ratios daily. Nursing overtime shifts, bonus shifts, and per diem shifts are utilized when needed to maintain the required hours and ratios. The facility continues to aggressively recruit, hire, and retain nursing staff. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The facility will track and log all the results of the facility recruitment and retention efforts. Staffing Coordinator job description was reviewed and revised.	10/25/23

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

Electronically Signed | 10/13/23

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S 560	Continued From page 1 This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 05/21/2023 to 07/18/2023 and from 08/20/2023 to 09/02/2023, Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing as follows: 1.For the 7 weeks of staffing from 05/21/2023 to 07/18/2023, the facility was deficient in CNA	S 560	Staffing and assignment sheets have been updated to include Nurses and Nursing Admin staff who are working on the unit to supply CNA support. 3) Nursing Management has been re-educated on the CNA ratio requirement. The Administrator will log recruitment and retention efforts as part of a Recruitment and Retention PIP that will meet bi-weekly x 6 months and monthly for 6 months to review results and new interventions. A staffing PIP team has been established and will meet weekly to review current staffing patterns, PPD, CNA ratios, recruitment, and retention efforts. 4) The results of the PIP 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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S 560	Continued From page 2 staffing for residents on 49 of 49 day shifts, deficient in total staff for residents on 7 of 49 evening shifts, deficient in CNAs to total staff on 1 of 49 evening shifts, and deficient in total staff for residents on 2 of 49 overnight shifts as follows: -05/21/23 had 7 CNAs for 70 residents on the day shift, required at least 9 CNAs. -05/22/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -05/23/23 had 5 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/24/23 had 5 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/25/23 had 7 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/26/23 had 7 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/27/23 had 4 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/28/23 had 5 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/29/23 had 5 CNAs for 68 residents on the day shift, required at least 8 CNAs. -05/30/23 had 6 CNAs for 70 residents on the day shift, required at least 9 CNAs. -05/31/23 had 8 CNAs for 70 residents on the day shift, required at least 9 CNAs. -06/01/23 had 6 CNAs for 70 residents on the day shift, required at least 9 CNAs. -06/01/23 had 6 total staff for 70 residents on the evening shift, required at least 7 total staff. -06/02/23 had 5 CNAs for 70 residents on the day shift, required at least 9 CNAs. -06/02/23 had 6 total staff for 70 residents on the evening shift, required at least 7 total staff. -06/03/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs.	S 560		

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S 560	Continued From page 3 -06/04/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/05/23 had 7 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/06/23 had 4 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/07/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/08/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/09/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/10/23 had 4 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/10/23 had 6 total staff for 69 residents on the evening shift, required at least 7 total staff. -06/11/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/11/23 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -06/12/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/13/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/14/23 had 7 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/15/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/16/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/17/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/18/23 had 5 CNAs for 70 residents on the day shift, required at least 9 CNAs. -06/18/23 had 6 total staff for 70 residents on the evening shift, required at least 7 total staff. -06/19/23 had 7 CNAs for 70 residents on the day shift, required at least 9 CNAs.	S 560		

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S 560	Continued From page 4 -06/20/23 had 4 CNAs for 70 residents on the day shift, required at least 9 CNAs. -06/21/23 had 6 CNAs for 70 residents on the day shift, required at least 9 CNAs. -06/22/23 had 5 CNAs for 71 residents on the day shift, required at least 9 CNAs. -06/22/23 had 6 total staff for 71 residents on the evening shift, required at least 7 total staff. -06/23/23 had 5 CNAs for 71 residents on the day shift, required at least 9 CNAs. -06/23/23 had 4 total staff for 71 residents on the overnight shift, required at least 5 total staff. -06/24/23 had 4 CNAs for 71 residents on the day shift, required at least 9 CNAs. -06/25/23 had 4 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/26/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/27/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/27/23 had 6 total staff for 69 residents on the evening shift, required at least 7 total staff. -06/28/23 had 7 CNAs for 69 residents on the day shift, required at least 9 CNAs. -06/29/23 had 4 CNAs for 68 residents on the day shift, required at least 8 CNAs. -06/30/23 had 5 CNAs for 68 residents on the day shift, required at least 8 CNAs. -07/01/23 had 4 CNAs for 68 residents on the day shift, required at least 8 CNAs. -07/01/23 had 6 total staff for 68 residents on the evening shift, required at least 7 total staff. -07/02/23 had 4 CNAs for 67 residents on the day shift, required at least 8 CNAs. -07/03/23 had 6 CNAs for 67 residents on the day shift, required at least 8 CNAs. -07/04/23 had 5 CNAs for 67 residents on the day shift, required at least 8 CNAs.	S 560		

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S 560	Continued From page 5 -07/05/23 had 5 CNAs for 67 residents on the day shift, required at least 8 CNAs. -07/06/23 had 6 CNAs for 69 residents on the day shift, required at least 9 CNAs. -07/07/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. -07/07/23 had 4 total staff for 69 residents on the overnight shift, required at least 5 total staff. -07/08/23 had 5 CNAs for 69 residents on the day shift, required at least 9 CNAs. 2.For the 2 weeks of staffing prior to survey from 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -08/20/23 had 5 CNAs for 64 residents on the day shift, required at least 8 CNAs. -08/21/23 had 5 CNAs for 64 residents on the day shift, required at least 8 CNAs. -08/22/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -08/23/23 had 5 CNAs for 63 residents on the day shift, required at least 8 CNAs. -08/24/23 had 4 CNAs for 61 residents on the day shift, required at least 8 CNAs. -08/25/23 had 5 CNAs for 61 residents on the day shift, required at least 8 CNAs. -08/26/23 had 5 CNAs for 61 residents on the day shift, required at least 8 CNAs. -08/27/23 had 5 CNAs for 61 residents on the day shift, required at least 8 CNAs -08/28/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -08/29/23 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. -08/30/23 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. -09/02/23 had 5 CNAs for 60 residents on the day	S 560		

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S 560	Continued From page 6 shift, required at least 7 CNAs. During an interview with the surveyor on 09/15/23 at 11:19 AM, the Licensed Practical Nurse (LPN) stated that the weekends can be an issue with staffing because of call outs and the CNA's can be short staffed. During an interview with the surveyor on 09/15/23 at 12:05 PM, the Director of Nursing (DON) stated that she was aware of the state ratio for CNA's as 1:8 dayshift, 1:10 evening shift and 1:14 overnight shift. The DON further stated that it has been difficult to staff the day shift.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		10/25/23

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S1405	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that employees had a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician's Assistant within 2 weeks prior to the first day of employment or upon employment. The deficient practice was evident for 3 of 10 employees reviewed under the Sufficient and Competent Nurse Staffing task and was evidenced by the following: On 09/19/23 at 10:00 AM, the surveyor reviewed the employees' files of ten random and recently hired employees. Employee #1 was hired on [redacted]. Employee #1 "Employee Health Examination" was not completed within 2 weeks to the first day of employment. Employee #2 was hired on [redacted]. Employee #2 "Employee Health Examination" was not completed within 2 weeks to the first day of employment. Employee #3 was hired on [redacted]. Employee #3 "Employee Health Examination" was not completed within 2 weeks to the first day of employment. On 09/20/23 at 11:58 AM, during an interview with the Administrator , Director of Nursing, Regional Nurse, and the Chief Operating Officer(COO), the surveyor requested the new hire physicals for Employee #1, Employee #2, and Employee #3.	S1405	S1405 – Mandatory Infection Control and Sanitation 1) Employees #1, #2, and #3 noted with this deficient practice have had physical exams in accordance with the guidelines outlined in 8:39-19.5 (a) Mandatory Infection Control and Sanitation. 2) All new contracted employees have the potential to be affected by this deficient practice. The health files for the current contracted employees have been audited. The facility policy and procedure for employee physicals has been reviewed and revised to meet the above standards. 3) All Contracted Department Managers have been re-educated on this policy and procedure. All contracted new hire employees' health files will be audited monthly by the Administrator or their designee X 12 months to assure compliance. 4) These monthly audits will be submitted to the QAPI committee at the quarterly Quality Assurance meeting to identify trends or patterns and implement appropriate interventions.	

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 _____	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENT	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) COMPLETE DATE
S1405	Continued From page 8 On 09/21/23 09:18 AM, during an interview with the survey team, the COO stated that the three employees were contracted employees and that the contract company was unable to provide the facility with the admission physicals. The COO further stated that no one at the facility had been checking to ensure the physicals were completed and in the employee files. The COO stated that physicals were required to be completed before they start work. The facility was unable to provide a policy for pre employment physicals.	S1405		

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 B. Wing Y2	11/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD 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 F0600	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	10/25/2023	LSC	10/25/2023	LSC	10/25/2023
ID Prefix F0658	Correction	ID Prefix F0677	Correction	ID Prefix F0689	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	10/25/2023	LSC	10/25/2023	LSC	10/25/2023
ID Prefix F0725	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/25/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315304 (Y1)	A. Building B. Wing (Y2)	11/9/2023 (Y3)

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 10/25/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62102 Y1	A. Building B. Wing Y2	11/9/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/25/2023	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 10/25/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62102 Y1	A. Building B. Wing Y2	11/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/25/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/22/2023 and 09/25/2023, 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 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.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors 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: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		10/25/23

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

Electronically Signed | 10/13/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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K 222	Continued From page 1 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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: REPEAT Deficiency from 07/18/2023 Re-Certification survey. Based on observation and review of facility provided documentation on 09/22/2023 and 09/25/2023 in the presence of facility management, it was determined that the facility failed to provide 1 of 5 designated exit discharge 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. Findings include: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with five (5) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility MD a tour of the building was conducted. During the building on 09/25/2023 at approximately 10:34 AM, the surveyor observed	K 222	K-222 – Egress Doors. 1) An electric lock tied into the fire alarm system was installed at the main entrance to replace the current locking mechanism. 2) All residents have the potential to be affected by this deficient practice. An audit was conducted of all Egress doors by the Director of Maintenance to assure compliance. 3) Maintenance staff were re-educated on Egress doors and the requirements of K-222. The means of egress throughout the building will be monitored by the maintenance staff daily on the 24-hour report to ensure compliance. 4) Results of the daily checks will be reported to QAPI quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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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K 222	Continued From page 3 the main entrance two (2) sets of automatic sliding exit discharge doors (internal and external set of doors) revealed thumb turn lock on the egress side of the inner sliding doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The MD confirmed the findings at the times of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		10/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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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K 321	Continued From page 4 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 09/22/2023 and 09/25/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility MD a tour of the building was conducted. During the building tour the of the facility the	K 321	331 – Hazardous areas – Enclosure 1) The Medical Records room and the Central Supply room have been equipped with an automatic door closure. 2) All residents have the potential to be affected by this deficient practice. All hazardous areas were audited to ensure that there were automatic door closures in place. 3) A quarterly audit will be completed by the Maintenance Director to ensure that all Hazardous areas are equipped with automatic door closures. 4) Results of the audits will be submitted to the QAPI committee quarterly.	

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 321	Continued From page 5 surveyor observed the following hazardous area that failed to have smoke resisting doors, On 09/22/2023: 1) At approximately 10:30 AM, an inspection inside the second (2nd.) floor Medical Records room was performed. The surveyor observed that when the corridor door leading into the Medical Records room was tested and allowed to self-close, the door did not close into its frame. This left an approximately 1-1/4 inch gap between the door and the doors frame. This test was repeated two additional times with the same results. The surveyor observed multiple combustible medical records and 15 filling cabinets filled with medical records in the room. The Medical Records room was larger then 50 square feet. With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 10:49 AM, an inspection inside the second (2nd.) floor Central Supply room was performed. The surveyor observed that when the corridor door leading into the Central Supply room had no means to self-close the door into its frame. This left an approximately 33 inch opening between the door and the doors frame. The surveyor observed multiple combustible boxes and products in the room. The Central Supply room was larger then 50 square feet. With this corridor door not closing into its frame	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

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K 321	Continued From page 6 all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Medical Records room and Central Supply room is the primary and/ or secondary egress route in the event of a fire. The MD confirmed the finding at the time of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 09/22/2023 and 09/25/2023, in the presence of the facility management, it was determined that the facility failed to inspect the fire alarm system on a semi-annual (every 6 months) inspection in accordance with NFPA 72. This deficient practice	K 345	– Fire Alarm System - Testing and Maintenance 1) The Fire Alarm System had its semiannual inspection on 9/ 15/23 and 9/ 18/23. The next inspection has been scheduled for 3/13/24.	10/25/23

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	315304	A. BUILDING **01** B. WING _____	**09/25/2023**

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K 345	Continued From page 7 was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator (Admin) and Maintenance Director (MD) to provide all Mandatory inspections from June 1, 2022 through September 21, 2023 for review later. The surveyor also asked the MD, how long have you worked here. The MD told the surveyor five (5) months. On 09/22/2023 at approximately 12:50 PM, a review of the facility provided semi-annual (every 6 months) kitchen suppression system inspections for the previous 15 months revealed that the system was inspected by a licensed vendor on, 06/14/2022, 09/15/2023 and 09/18/2023. On 09/22/2023 at approximately 1:50 PM, the surveyor made a request to the Admin. and MD to provide any additional semi-annual (every 6 months) kitchen suppression system inspections from 06/14 2022 through 09/15/2023 that had been conducted. On 09/25/2023 (day two of survey) at approximately 9:49 AM, the surveyor made a request to the Admin. if the facility could provide any additional semi-annual kitchen suppression system inspections. The Admin. told the surveyor that the inspection had not been done, because it was in between two Maintenance Directors. The Admin. confirmed the finding at the time. On 09/25/2023 during the survey exit at	K 345	2) All Residents have the potential to be affected by this deficient practice. 3) The Director of Maintenance was re-educated on requirements of K-345. The Life Safety inspections QAPI spreadsheet was updated to include the semi-annual Fire Alarm System inspection. 4) The Life Safety Inspections QAPI spreadsheet will be submitted to the Administrator monthly and to the QAPI committee quarterly.	

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K 345	Continued From page 8 approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING 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. 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. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area 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. 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) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 09/22/2023 and 09/25/2023, in the presence of facility management it was determined that: Failed to provide fire sprinkler coverage to all areas of the facility as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of	K 351	Sprinkler System – Installation 1) A contract was signed and sprinkler heads were installed on the upper landing and the lower landing of stairwell #4. 2) Stairwells will be audited by the Maintenance Director to ensure that ensure that no additional sprinkler heads are missing. 3) Maintenance staff were re-educated on NFPA 13 and the sprinkler	10/25/23

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K 351	Continued From page 9 Sprinkler Systems 2012 Edition The deficient practice is evidenced by the following, On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with six (6) designated exit stairwells (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility's MD a tour of the building was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 09/22/2023: 1) At approximately 10:54 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 17'-6" by 7'-6" stairwell #4 upper landing. At this time a request was made to the MD, do you see a fire sprinkler in the lower landing area. The MD said, no. 2) At approximately 12:26 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 6' by 7'-6" stairwell #4 lower landing. At this time a request was made to the MD, do	K 351	requirement. Sprinklers will be monitored monthly by the Maintenance Staff. 4) Results of the sprinkler audit rounds will be reported to QAPI monthly.	

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K 351	Continued From page 10 you see a fire sprinkler in the lower landing area. The MD said, no. The facility failed to provide fire sprinkler coverage to all areas in the facility. The MD confirmed the finding at the time of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 09/06//2023, in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 2 of 47 portable fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70.	K 355	Portable Fire Extinguishers 1) The Fire Extinguishers in the kitchen and the maintenance shop were inspected and signed off for September 2023. 2) A review of all Fire Extinguishers was completed by the Maintenance Director to ensure that all had been inspected for September 2023. 3) Maintenance staff were re-in serviced the requirements under NFPA 10 Fire Extinguisher inspections.	10/25/23

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K 355	Continued From page 11 Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility MD a tour of the building was conducted. During the building tour of the facility the surveyor	K 355	Maintenance Director will audit all Fire Extinguishers monthly to ensure that inspections are completed timely. 4) Results of Maintenance Directors audit of Fire Extinguishers will be submitted to the Administrator monthly and the QAPI committee Quarterly.	

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K 355	Continued From page 12 observed and inspected forty-seven (47) portable fire extinguishers in various locations that were last annually inspected in June 2023 with the surveyor observing the following issues that were identified: On 09/22/2023: 1) At approximately 11:16 AM, One (1) "ABC-Type" fire extinguisher in the Main Kitchen, last annually inspected June 2023. There was no evidence of monthly visual examination performed and documented for July and August 2023. 2) At approximately 12:17 PM, One (1) "ABC-Type" fire extinguisher in the Maintenance shop, last annually inspected June 2023. There was no evidence of monthly visual examination performed and documented for July and August 2023. The MD confirmed the finding at the time of observations. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/25/23

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K 521	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations on 09/22/2023 and 09/25/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 5 of 7 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 09/22/2023 (day one of survey) during the survey entrance at approximately 9:09 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with forty-eight (48) Resident sleeping rooms and common areas. Starting at approximately 9:37 AM on 09/22/2023 and continued on 09/25/2023 in the presence of the facility's MD a tour of the building was conducted. During the two (2) day building tour the surveyor inspected inside seven (7) Resident sleeping rooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not	K 521	HVAC 1) Exhaust fans in rooms 141, 139, 134, 120 and 117 have been repaired and are now functional. 2) The Maintenance Director will audit all resident area exhaust fans to ensure that they are operational and complete repairs as needed. 3) Maintenance staff were re-in serviced on the importance of working exhaust fans. The Maintenance Director will audit all exhaust fans month and submit results to the administrator. 4) Results of the audit will be submitted to QAPI committee quarterly.	

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K 521	Continued From page 14 function properly in 5 of 7 resident bathrooms in the following locations: On 09/25/2023: 1. At approximately 10:33 AM, inside Resident room #141 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:19 AM, inside Resident room #139 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:50 AM, inside Resident room #134 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. At approximately 10:55 AM, inside Resident room #120 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:15 AM, inside Resident room #117 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on	K 521		

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K 521	Continued From page 15 mechanical ventilation. The MD confirmed the findings at the time. On 09/25/2023 during the survey exit at approximately 12:41 AM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		

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 B. Wing Y2	11/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD 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 K0222	10/25/2023	LSC K0321	10/25/2023	LSC K0345	10/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/25/2023	LSC K0355	10/25/2023	LSC K0521	10/25/2023
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?
9/25/2023	☐ YES ☐ NO