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	62200	A. BUILDING: _____ B. WING _____	02/14/2023

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NORTH CAPE CENTER	700 TOWNBANK ROAD CAPE MAY, NJ 08204

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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: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to a) maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 14 of 14-day shifts, 1 of 14 evening shifts, and 1 of 14-night shifts and b) facility failed to maintain a record of influenza vaccinations for contracted employees as required for compliance with N.J.S.A 26:2H-18.79- Influenza vaccination in health care facilities. This deficient practice was evidenced by the following: 1. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	All residents present at the facility during the dates listed had the potential to be affected by failure to meet the required staffing ratios. The facility cannot retroactively correct the staffing on the dates identified. The facility has increased pay rates, offered sign-on and retention bonuses, shift differentials, bonuses, utilized agency staff, utilized nurse managers and others to assist. The facility has also sponsored students to become certified nursing assistants. All residents have the potential to be affected by staffing at the required staffing ratios. The facility endeavors to staff to the staffing ratios under N.J.S.A. 30:13-18	3/22/23

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

Electronically Signed | 03/02/23

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows according to the Nurse Staffing Reports for the weeks of 01/22/2023 to 01/28/2023 and 01/29/2023 to 02/04/2023 filled out by the facility: -01/22/23 had 8 CNAs for 100 residents on the day shift, required 12 CNAs. -01/23/23 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. -01/24/23 had 9 CNAs for 97 residents on the day shift, required 12 CNAs. -01/25/23 had 9 CNAs for 97 residents on the day shift, required 12 CNAs. -01/26/23 had 9 CNAs for 97 residents on the day shift, required 12 CNAs.	S 560	of 1 CNA to every 8 residents on day shift. One direct care staff to every 10 residents on evening shift. One direct care staff to every 14 residents for the night shift. The staffing coordinator will alert the Director of Nursing and Administrator of staffing ratios at least one day in advance to allow for additional staffing interventions. The Staffing Coordinator, Human Resource team members, Director of Nursing and Administrator will be inserviced on the staffing ratio requirements under N.J.S.A. 30:13-18. The weekly Labor Meeting with the Staffing Coordinator, Human Resources team, Director of Nursing, Administrator and corporate supports will include review of the actual week of staffing ratios, recruitment needs to meet those ratios and efforts to fill those needs. The Human Resources Manager will document and report weekly all positions needed to meet staffing ratio requirements, recruiting efforts for the week including advertisement, social media postings, open houses, special events, engagement of current staff, actual interviews and onboarding of new employees. Staffing Coordinator will report the scheduled staffing ratios for each shift to the Director of Nursing and Administrator. The Staffing Coordinator will document opportunities for overtime or other incentives offered to facility staff on a daily basis.	

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S 560	Continued From page 2 -01/27/23 had 9 CNAs for 97 residents on the day shift, required 12 CNAs. -01/28/23 had 8 CNAs for 97 residents on the day shift, required 12 CNAs. -01/29/23 had 7 CNAs for 99 residents on the day shift, required 12 CNAs. -01/30/23 had 8 CNAs for 99 residents on the day shift, required 12 CNAs. -01/31/23 had 8 CNAs for 99 residents on the day shift, required 12 CNAs. -01/31/23 had 4 CNAs to 11 total staff on the evening shift, required 5 CNAs. -02/01/23 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -02/02/23 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -02/03/23 had 10.5 CNAs for 102 residents on the day shift, required 13 CNAs. -02/04/23 had 7 CNAs for 105 residents on the day shift, required 13 CNAs. -02/04/23 had 6 total staff for 105 residents on the overnight shift, required 7 total staff. On 2/08/2023 at 9:21 AM, the surveyor asked CNA #4 if they had enough staff to take care of the facility residents. CNA #4 replied, "We are short a lot. Sometimes we only have 2 or 3 aides for the whole second floor. We can get the work done but it's stressful and there are no breaks." The surveyor asked the Licensed Nursing Home Administrator and visiting Director of Nursing (DON) during an interview on 2/13/2023 at 1:53 PM, if the facility was meeting the minimum staffing requirements mandated on 2/1/2021. The DON stated, "It depends on the day. We try to every day." The surveyor asked the DON if she was familiar with the minimum mandated staffing requirements. The DON responded, "Day shift is	S 560	The Administrator will review the daily staffing sheets to determine if Center is meeting the staff to resident ratios. The Administrator will report findings to the QAPI Committee monthly until 3 months of 90% is achieved. All residents present at the facility during survey had the potential to be affected by contracted staff and outside vendors who are not vaccinated for influenza. All residents have the potential to be affected by this practice in the future. The Infection Preventionist, Human Resource team and Staffing Coordinator, and all department heads will be inserviced on NJSA 26:2H-18.9 which requires influenza vaccination for employees and contracted staff. The influenza history will be obtained and documented upon admission hire for employees, and that the Infection Preventionist maintain a log of contracted employees vaccinated. Human Resources and the Staffing Coordinator will provide copies of contracted staff's influenza vaccine to the Infection Preventionist or designee to obtain approval for the candidate to start. Department Heads will provide copies of contracted vendors' influenza vaccinations to the Infection Preventionist in order for them to be approved to enter the facility. The entry log will be reviewed by the infection preventionist weekly for compliance with this requirement.	

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S 560	Continued From page 3 1 CNA to 8 residents, evening is 1 to 10 residents and night shift is 1 to 14 residents." The facility did not provide a policy or procedure for staffing when requested by the surveyor. 2. Reference: On January 13, 2020, Governor Murphy signed P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute"). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and designate a medical exemption form to be distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as "facility" or "facilities," in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking. Covered Employees All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated. Record Keeping Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department.	S 560	The Infection Preventionist will provide to the QAPI Committee a log reporting the current contracted vendors and staff, and their influenza vaccination status. The QAPI Committee will review the log for changes in contracted vendors or staff from month to month to ensure the facility obtains their influenza vaccination records in compliance with this policy.	

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S 560	Continued From page 4 During entrance conference on 2/6/2023, the surveyor requested a list of all staff documentation for the 2022-2023 Influenza season. A review of the facility provided document that indicated staff flu vaccine status, did not include facility contracted staff influenza vaccine status. During an interview with the surveyor on 2/8/2023 at 10:50 AM, Infection Prevention Nurse (IPN) and the Director of Nursing (DON) stated that they failed to maintain records of influenza vaccinations for outside vendors. During an interview with the surveyor on 2/08/2023 at 1:55 PM, the DON stated they were not tracking the influenza vaccination of the contracted staff until today (2/8/2023). A review of a facility policy titled "IC600 Influenza Immunization Program" effective 9/1/04, review date 11/15/22, revealed, "Influenza immunization history will be obtained and documented upon admission for patients and upon hire for employees." A review of the facility document titled "Center Flu Vaccination Program - Action Plan Employees & Patients" revealed, "Obtain/verify receipt of flu vaccine for both patients & employees...The Center IP (Infection Preventionist) will maintain a log of contracted employees vaccinated."	S 560		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon	S1410		3/22/23

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S1410	Continued From page 5 employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that new employees consistently received the Mantoux tuberculin skin test (a test to check if a person has been infected with TB bacteria) as required. This deficient practice was identified for 5 of 5 new employee files reviewed and is evidenced by the following: On 2/9/2023 at 12:33 PM, during a review of new employee files, it was determined that 4 of 5 new employees had not received the second step of the 2-step Mantoux test and 1 new employee had	S1410	The staff identified were notified that they must have a 2-step PPD or provide a chest xray demonstrating no active disease. Staff who do not complete the 2nd step of Mantoux testing within 30 days of employment will be removed from the schedule until completion of the 2-step Mantoux testing process. All residents have the potential to be affected by this practice. The Human Resources team will audit the	

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S1410	Continued From page 6 no record of receiving the 1st or 2nd step Mantoux test. (Typically, the first step activates the disease and the second step, done 1 to 3 weeks later, shows the existence of a potential problem via a small skin reaction at the site of the test.) Employee #1 received the 1st step on 11/8/2022 and no second step test was performed. Employee #2 received the 1st step test on 1/9/2023 and no second step test was performed. Employee #3 received their 1st step test on 1/4/2023 and no second step test was performed. Employee #4 received their 1st step test on 11/2/2022 and no second step test was performed. The facility was unable to provide any documentation that employee #5 had received the 1st or 2nd step Mantoux skin test. When interviewed on 2/14/2023 at 9:25 AM, the facility Licensed Nursing Home Administrator stated, "We do not have copies of the results for the for the second round of Mantoux tests. We had some turnover in our HR (Human Resources) department and things may have got lost in the shuffle."	S1410	medical files of all current employees and identify those requiring a 2-step Mantoux test. All current staff needing a 2-step Mantoux test will be scheduled to complete 2-step testing within 30 days of notification. The Human Resources team and Staffing Coordinator will ensure that each new employee or contracted employee begins the 2-step Mantoux process as part of facility orientation. The Infection Preventionist will ensure that all new employees or contracted employees receive their 2nd Mantoux test within 30 days of starting at the facility. The Human Resource Manager will present all new hire Mantoux testing records to the Administrator weekly until the 2-step testing process is completed. Those not completed within 30-days of hire will be removed from the schedule until compliant. The Infection Preventionist will report and track all new hires for completion of the 2-step Mantoux testing process to the QAPI committee monthly until 100% compliance has been achieved.	

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey 2/14/2023 Census: 106 Sample Size: 25 + 1 closed record The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		3/22/23

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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: Leonard, Daniel Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to create a homelike environment during dining by not removing food from serving trays and not posting the menu in the dining room. The deficient practice was observed on the NJ EX Order, 264b1 floor dining rooms. The deficient practice was evidenced by the following: On 2/06/2023 at 12:49 PM, during lunch in the dining room on the NJ EX Order 2b floor, Surveyor #2 observed that all residents in the dining room had	F 584	Menus were posted in the dining rooms on both floors when brought to the attention of the Dietary Director during survey. All residents who dine in the dining rooms have the potential to be affected by being served on a meal tray. Plates, cups and utensils will be served on the tabletop in the dining room, rather than a tray. All residents will be encouraged to dine in the dining rooms for a more homelike experience. The Resident Food Committee will give input to the dining program to ensure that meal service is provided in a homelike manner. Menus will be posted by the Dietary	

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F 584	Continued From page 2 their meals served on trays. Food was not removed from the trays and set on the table during dining. On 2/07/2023 at 12:26 PM, during lunch in the dining room on the [redacted] floor, Surveyor #1 observed that the menu display on the wall was empty. Further, Surveyor #2 observed that all residents in the dining room had their meals served on trays. Food was not removed from the trays and set on the table during dining. On the same date at 12:27 PM, during lunch in the dining room on the [redacted] floor, Surveyor #2 observed that all residents in the dining room had their meals served on trays. Food was not removed from trays and set on the table during dining. On 2/08/2023 at 8:47 AM, during breakfast in the dining room on the second floor, Surveyor #3 observed [redacted] residents in the dining room had their meals served on trays. Food was not removed from trays and set on the table during dining. On the same date at 12:48 PM, during lunch in the dining room on the [redacted] floor, Surveyor #1 observed six residents in the dining room had their meals served on trays. Food was not removed from the trays and set on the table during dining. On 2/09/2023 at 12:29 PM, during lunch in the dining room on the [redacted] floor, the surveyor observed seven residents in the dining room had their meals served on trays. Food was not removed from the trays and set on the table during dining.	F 584	Department in the resident dining rooms daily. Current facility staff will be inserviced on ensuring that meals are served in a homelike manner, which will include plates, cups and utensils being served on the tabletop, rather than a tray. A manager will supervise meal service in the dining room at lunch and dinner to ensure this occurs. All dietary staff will be inserviced on the daily posting of menus in the dining rooms. The manager will also verify that the daily menus are posted in the dining room. A schedule was developed and Managers were assigned to specific days for monitoring compliance with the posting of daily menus in the dining rooms and serving plates, cups and utensils on the tabletop. The assigned manager will complete reeducation with staff as needed at the time of observation. The assigned manager will complete an observation tool and submit it to the Administrator. Meals will be observed daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months. Compliance issues will be reported to the Administrator or Director of Nursing. The Administrator will report menu posting and tabletop dining results to the QAPI Committee each month until 3 months of 90% compliance is achieved.	

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F 584	Continued From page 3 On 2/13/2023 at 12:17 PM, during lunch in the dining room on the [redacted] floor, the surveyor observed five residents in the dining room had their meals served on trays. Food was not removed from the trays and set on the table during dining. On 2/13/2023 at 12:33 PM, during an interview with the surveyor, Certified Nurse Aide (CNA) #1 stated, "Most of the time." when asked if residents are served on trays in the dining room. On the same date at 12:35 PM, during an interview with the surveyor, CNA #2 stated, "We normally serve them on trays." when asked if residents are served on trays in the dining room. On the same date at 1:31 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator stated, "We would like it to come off the tray for a home-like feel." when asked if meals should remain on the tray when being served in the dining room. A review of the facility policy titled, "Menus" with a revised date of 9/2017 revealed under number "8." that "Menus will be posted in the Dining Services department, dining rooms, and resident/patient care areas." The facility was unable to provide a policy for removing meals from trays.	F 584		
F 623 SS=D	8:39-4.1(a)12 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		3/22/23

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Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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F 623	Continued From page 6 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to notify in writing the representative of the New Jersey Long-Term Care Ombudsman's office of resident emergency transfers to the hospital/discharges, when practicable, as mandated by Federal law. This deficient practice was evidenced by the following: During an interview with the surveyor on 2/13/2023 at 1:20 PM, the Administrator said normally the Social Worker notifies the Ombudsman of discharges/transfers to the hospital. The Administrator went on to say when she left in September, there was a new Social Worker and she also left, and the current Social Worker has been here for [redacted] weeks. It seems it was dropped in the transition, and I can't find any reports in the current office but will look in the other office.	F 623	All residents discharged from September through February were not reported to the Office of the Ombudsman in writing. A notification of all residents discharged during this time period was sent to the NJ Office of the Ombudsman on February 15, 2022. All residents who discharge from the facility have the potential to be affected by this practice. The facility has drafted a policy and procedure to ensure the reporting occurs at least monthly, by the 10th of each month. The social worker, business office and medical records staff will be inserviced on the policy. The Business Office/SS Staff was inserviced on the transfer/discharge policy and procedure. Business Office Manager/SS designee will update the monthly discharge tracking list on a daily basis. A notice of transfer to the hospital	

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F 623	Continued From page 7 During a follow-up interview with the surveyor on 2/14/2023 at 10:28 AM, the Administrator said I can't locate the files from the Social Worker who left in September regarding notification of the state Ombudsman's Office. The Administrator confirmed that since NJ EX Order. 264D1 to present, there has been no State Ombudsman notification of resident discharge/transfers to the hospital. The facility was unable to provide a policy for the notification of the State Ombudsman's office for discharge or transfer. NJAC 8:39-4.1(a) 32	F 623	with the list of residents/patients will be submitted to the Office of the Ombudsman on a monthly basis. The Director of Social Services or designee will maintain documentation of the faxed discharge notification to the NJ Office of the Ombudsman. The Director of Social Services will review the submission confirmation the Administrator by the 10th of each month to ensure completion. The Business Office Manager/Designee will audit all transfer log weekly x3 months to ensure all discharges have been recorded on the log. The Business Office Manager/Designee will report findings to the QAPI Committee monthly for 3 months or until 100% compliance with notification of the Ombudsman is achieved. The Administrator will provide reeducation as needed.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 1 of 26 residents reviewed (Resident # 73) and was evidenced by	F 641	A correction of the MDS was submitted for Resident #73 when the issue was brought to the facility□s attention on 2/13/23. All residents receiving a bolus tube feeding have the potential to be affected	3/22/23

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F 641	Continued From page 8 the following: During the initial tour on 2/6/2023 at 10:47 AM, Resident # 73 was observed lying in bed with the head of bed elevated. The surveyor observed a NJ EX Order. 264b1) at his/her bedside dated NJ EX Order. 6 am. On 2/7/2023 at 9:23 AM, Resident #73 was observed lying in bed with the head of bed elevated. A NJ EX Order. 264b1 set was observed at the bedside dated NJ EX Order. According to the Admission Record Resident #73 was admitted to the facility with diagnoses including but not limited to; NJ EX Order. 264b1 A review of the admission MDS dated NJ EX Order. revealed Resident # 73 had severely impaired cognition. Section of the MDS revealed that eating activity did not occur. Section indicated that Resident # 73 had a NJ EX Order. while a resident and received or more of total calories NJ EX Order. 264b1 and average intake per day is or more. A review of a quarterly MDS dated 12/20/2022, revealed Resident # 73 was NJ EX Order. 264b1 NJ EX Order. Section revealed under the eating section supervision with 1-person physical assist. Section was unchanged from the admission MDS. A review of the Order Summary Report with active orders as of NJ EX Order. revealed a physician order for times a day	F 641	by this practice. The facility identified two residents receiving NJ EX Order. and reviewed the last two quarters of their MDS assessments to ensure they are coded correctly. There were no issues identified for those two residents. The MDS Coordinators received training from the NJ Market Coordinator for Clinical Reimbursement on proper coding for residents who receive NJ EX Order. as defined in the RAI Manual. The Director of Nursing will review MDS coding of any new admissions with a bolus tube feeding to ensure it was coded correctly. The Director of Nursing will complete a weekly review of MDS assessments for residents who receive NJ EX Order. for NJ EX weeks. Then a monthly review for two months to ensure accuracy of coding of the NJ EX Order. 264b1. Reeducation of the MDS Coordinators will occur as needed based on findings. The Director of Nursing will complete a random careplan audit quarterly to ensure this system remains effective. The Director of Nursing will provide a monthly report to the QAPI committee until three months of 100% compliance in coding is achieved.	

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F 641	Continued From page 9 NJ EX Order. 264b1 Administer bolus NJ EX Order. 264b1 NJ EX O ML, NJ times per day NJ EX Order. 264b1 hrs NJ EX Order. 264b1 texture for NJ EX Order. 264b1 NJ EX Order. 264b1 (milliliter) of water, prior to NJ EX Order. 26 every NJ E hours. During an interview with the surveyor on 2/13/2023 at 9:10 AM, the interim Clinical Reimbursement Coordinator (CRC) regarding MDS coding. The surveyor requested the CRC to look at the admission MDS dated NJ EX Order. 264b1. The CRC said she wasn't here for the NJ EX Order. 264b1 MDS admission. The CRC said at 9:12 AM, Resident # 73's eating was coded as "activity did not occur on admission MDS". She went on to say that residents who receive NJ EX Order. 264b1 should be coded as NJ EX Order. 264b1 for eating. CRC said yes, it was coded incorrectly and should be NJ EX Order. 264b1 with assist of 1 person. The surveyor then requested the CRC to look at the quarterly MDS dated NJ EX Order. 264b1. The CRC confirmed Resident # 73's eating was coded as supervision. The CRC said I wouldn't think it is coded correctly. The CRC confirmed residents with NJ EX Order. 264b1 should be coded as NJ EX Order. 264b1	F 641		
F 656 SS=D	NJAC 8:39-11.2 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		3/22/23

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care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged

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F 656	Continued From page 11 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan to address the use of Intravenous Medication to treat an [redacted] for 1 of 3 residents reviewed for [redacted] use (Resident # 19). This deficient practice was evidenced by the following: During the initial tour of the facility on 2/6/2023 at 10:58 AM, Resident # 19 was observed lying in bed with the head of the bed elevated, [redacted] in use [redacted]. An [redacted] and [redacted] was observed at the bed side. Per the Unit Manager Licensed Practical Nurse (UM/LPN) Resident # 19 was on [redacted] different [redacted] for an [redacted] and [redacted] According to the Admission Record, Resident #19 was admitted to the facility with diagnoses including but not limited to; Aftercare following Explantation [redacted] of) of [redacted], [redacted] and [redacted] can sometimes enter your [redacted] A review of the Order Summary Report with Active Orders as of [redacted] revealed physician orders as follows; [redacted] used to treat [redacted]) [redacted]	F 656	The Unit Manager developed a care plan for Resident #19 to address the use of [redacted] Medication to treat an infection on [redacted]. All residents receiving [redacted] medications for infections have the potential to be affected by this practice. The facility identified two others residents receiving [redacted] medications for infection and reviewed their care plans. Both have a care plan for [redacted] medications in place to address this need. At morning meeting, the clinical team will review new orders for [redacted] medications to ensure that the resident has a careplan initiated for [redacted] medications. If a careplan was not initiated, it will be done at the morning meeting. All current facility nurses will be inserviced on the importance of initiating person-centered care plans, specifically [redacted] medications for infections. Nursing leadership was reinserviced on initiating careplans and specifically [redacted] medications for infections. At morning meeting, the clinical team will review new orders for [redacted] medications to ensure that the resident has a careplan for [redacted] medications. If a careplan was not initiated, it will be done at the morning meeting and the Director of Nursing will reeducate staff as necessary.	

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F 656	Continued From page 12 Use NJ EX Order. 264b1 every NJ EX Order. 264b1 hours for NJ EX Order. 264b1 until NJ EX Order. 264b1 NJ EX Order. 264b1 used to treat NJ EX Order. 264b1 NJ EX Order. 264b1 MG (milligrams) NJ EX Order. 264b1 Give NJ EX Order. 264b1 capsule by mouth NJ EX Order. 264b1 times a day for NJ EX Order. 264b1 until NJ EX Order. 264b1. NJ EX Order. 264b1 used to treat NJ EX Order. 264b1 NJ EX Order. 264b1 GM NJ EX Order. 264b1) Use NJ EX Order. 264b1 every NJ EX Order. 264b1 hours for NJ EX Order. 264b1 until NJ EX Order. 264b1. NJ EX Order. 264b1 Observe NJ EX Order. 264b1 site routinely for NJ EX Order. 264b1 NJ EX Order. 264b1 at a frequency based on therapy and resident condition. Document in PN at least q shift A review of Resident #19's care plan did not include documentation of the resident having an NJ EX Order. 264b1 and the use of NJ EX Order. 264b1. During an interview with the surveyor on 2/13/2023 at 11:37 AM, Unit Manager/LPN (UM/LPN#1) said overall it is MDS (Minimum Data Set) staff that is responsible for the care plans. She went on to say we update them quarterly and as needed if NJ EX Order. 264b1 issues. UM/LPN #1 said Yes, MDS puts all areas of concerns on the baseline care plan. The nurse admitting the resident is responsible for the baseline care plan for NJ EX Order. 264b1 activities of daily living (NJ EX Order. 264b1 and NJ EX Order. 264b1. The comprehensive care plan goes through MDS. I am pretty sure MDS would put in the original start date of NJ EX Order. 264b1 and would update as needed. UM/LPN #1 said Yes, I am responsible to review the care plan to make sure it is all inclusive of resident needs. After admitted I would make sure base line in place	F 656	The MDS Coordinator or designee will audit random care plans to ensure a careplan has been developed to address this need. This audit will occur weekly for 4 weeks, then monthly for 2 months, until substantial compliance is achieved. The Director of Nursing will complete a random careplan audit quarterly to ensure this system remains effective. The MDS Coordinator will report compliance issues to the Director of Nursing for correction and reeducation as necessary. The Director of Nursing will provide a monthly report to the QAPI Committee until 100% compliance has been achieved for three months.	

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and correct. As things come along MDS would add and I would review and add as needed and then quarterly.

During an interview with the surveyor on 2/13/2023 at 11:43 AM, the surveyor requested UM/LPN #1 to review Resident #19's care plan in the computer to tell the surveyor if there is care plan for [redacted]. UM/LPN #1 said No, I don't see care plan for [redacted] I have no idea that there wasn't one in there for him/her. When asked if he/she should have one, UM/LPN #1 said Absolutely. I was told we do the first 4 and update as needed and MDS takes care of the rest.

During an interview with the surveyor on 2/13/2023 at 12:26 PM, the Clinical Reimbursement Coordinator (CRC) said for new admission, floor nurses are responsible for the baseline care plan. 4 things I expect to see on there which are [redacted], adls and [redacted] I believe. Then we (CRC) add to the baseline care plan. When asked if CRC would do a care plan for [redacted], she replied not necessarily would we be doing that. We just got a new Infection Prevention Nurse and would expect it would be part of her responsibilities. The CRC said yes, the floor nurse or unit manager can add to the care plan and it doesn't matter whether it is Registered nurse or Licensed Practical Nurse.

During an interview with the surveyor on 2/13/2023 at 1:30 PM, the Director of Nursing (DON) said when someone comes in put in 4 necessary care plans [redacted] and adls. We review care plans as we go along to add what is pertinent to the resident. We look at them during morning meeting. When asked who is responsible to complete care plans for new

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F 656	Continued From page 14 admission, the DON replied everybody, the admitting nurse, supervisor on night shift reviews admissions, and the CRC. When asked what the expectation would be for a resident admitted on NJ EX Order. 264b1 for [redacted] the DON replied, That should be care planned. A review of a facility policy titled Person Centered Care Plan with revision date of 10/24/22, revealed under Policy section Care Plan includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments. NJAC 8:39-11.2(d)	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow their facility policy and procedure for residents who [redacted] for 2 of 2 residents (Resident #1 and #52) investigated for [redacted] This deficient practice was evidenced by the following: 1. On 2/06/2023 at 10:39 AM during the initial tour	F 689	The Administrator met with Residents #1 and #52 on [redacted] to review the [redacted] policy and secure their [redacted] materials. Their [redacted] and [redacted] were placed in bags labeled with their name and secured at the nurses station. All residents have the potential to be affected by residents in possession of	3/22/23

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F 689	Continued From page 15 Resident was interviewed in their room. Resident #1 stated he/she is NJ EX Order. 264b1 and that they can NJ EX Order. 264b1." Resident #1 stated that he/she is allowed to possess their NJ EX Order. 264b1 When asked by the surveyor if he/she currently had possessed their NJ EX Order. 264b1 materials Resident #1 pulled NJ EX Order. 264b1 out of their NJ EX Order. 264b1 and presented it to the surveyor. Resident #1 went on to say, "Certain people are allowed to hold onto their NJ EX Order. 264b1." According to the Admission Record, Resident #1 was admitted to the facility with the following but not limited to diagnoses: NJ EX Order. 264b1 . A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ EX Order. 264b1 Resident #1 had a Brief Interview for Mental Status score of NJ EX Order. indicating NJ EX Order. 264b1 status. According to Section NJ EX Order. Resident #1 required supervision with most activities of daily living, except for dressing, toilet use, and personal hygiene, which required limited assistance of NJ EX Order. 264b1 assist. According to Section NJ EX Order. of the MDS, Resident #1 was not a current user NJ EX Order. 264b1 A review of the comprehensive care plan for Resident #1 revealed that he/she had care plan with a heading of Focus, date initiated: NJ EX Order. 264b1 and revision date: NJ EX Order. 264b1 of : [resident name] may NJ EX Order. independently per NJ EX Order. 264b assessment. The following was observed under the Goal heading: [resident	F 689	smoking materials. NJ EX Order. 264b1 will be supervised by staff at scheduled NJ EX Order. 264b times and NJ EX Order. 264b materials will be kept secured in the locked cart. Residents who are non-compliant with the NJ EX Order. 264b policy will be reported to the Administrator or Director of Nursing. They will address the issue with the non-compliant resident and responsible party. A meeting to review the NJ EX Order. 264b1 Policy and Procedure was held with all NJ EX Order. 264b on 2/10/22. All were offered the opportunity to request a transfer if unwilling to follow facility policy. An email was sent to family members reminding them that NJ EX Order. 264b1 materials may not be supplied to residents directly. They should be given to the nurse to label and secure for the resident in the locked NJ EX Order. 264b1 managed by the NJ EX Order. 264b monitor. Current staff will be inserviced on the facility NJ EX Order. 264b1 Policy, supervising resident NJ EX Order. 264b1 and being alert to residents who may attempt to keep NJ EX Order. 264b materials on their person or in their room. This will include reporting non-compliance to Social Services, Nursing Management or the Administrator immediately for follow up. Department heads or designee will visit smokers assigned to their daily rounds, to audit whether they have NJ EX Order. 264b1 or NJ EX Order. 264b1 their possession. This will	

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	315350	A. BUILDING _____ B. WING _____	02/14/2023

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F 689	Continued From page 16 name] will [redacted] safely throughout next review period, with an initiated date of [redacted] and revised date of [redacted]. Interventions included: "Educate [resident name] on the facility's [redacted] policy, Ensure that there is no [redacted] use in [redacted] area(s), Ensure that appropriate [redacted] disposal receptacles are available in [redacted] areas, and Monitor [resident name] compliance to [redacted] policy, date initiated: [redacted] and date revised [redacted]. A review of Resident #1's [redacted] Evaluation, Effective Date: [redacted] revealed the following under Section [redacted] Evaluation: "1) Independent [redacted] is allowed." Also, under the Evaluation section at #3 it revealed the following: 3. "Residents are not allowed to keep [redacted] at the bedside, [redacted] charging must occur at the nurses station." Under Section [redacted] Care Plan, the following Interventions were listed for Resident #1: "Educate [resident name] on the facility's [redacted] policy, Ensure that there is no [redacted] use in [redacted] area(s), and Monitor [resident name] compliance to [redacted] policy." On 2/07/2023 at 12:39 PM the surveyor observed Resident #1 seated on the bedside when surveyor entered room. Resident #1 was [redacted] in his/her interactions with the surveyor. Resident #1 stated that he/she "Possessed their [redacted] in [redacted]" but would not show the surveyor on this occasion. On 2/08/20233 at 08:54 AM the surveyor observed Resident #1 seated on the side of the bed in their room. Resident #! stated that he/she usually [redacted] at [redacted] to [redacted] The resident	F 689	occur weekly for 4 weeks, then monthly for two months to ensure residents are not keeping [redacted] materials in their possession. Department heads will report non-compliance to the Administrator or Director of Nursing immediately, and submit their rounding tool weekly. The Activities and Social Services Director will hold a monthly meeting with all [redacted] to reinforce the [redacted] policy and procedure, and address any resident concerns. The Social Services Director or designee will provide a monthly report to the QAPI committee regarding [redacted] meeting attendance and the outcome of audits of compliance with the [redacted] policies for 3 months until 100% compliance is achieved	

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then clarified as "[redacted]." The surveyor asked Resident #1 if he/she was in possession of their [redacted]. Resident #1 stated, "[redacted]" The surveyor questioned where the [redacted] was and Resident #1 pointed to the NJ EX Order. 264b1 of his/her [redacted] and stated, "[redacted]." The surveyor could see a [redacted] in the NJ EX Order. 264b1 in the right [redacted], however, the surveyor did not ask the resident to remove [redacted] for the surveyor to see because it may have [redacted] Resident #1.

On 2/08/2023 at 11:13 AM the surveyors interviewed CNA #3 who was responsible for monitoring the designated [redacted] area for that [redacted] session. CNA #3 revealed to the surveyor that she was an orientee and had only worked at the facility for [redacted] days. The surveyor asked CNA #3 what her responsibilities were as the [redacted] monitor. CNA #3 replied, "I supervise them for safety. They have their own [redacted] and their own [redacted]. I don't NJ EX Order. 264b1 or hold their [redacted]. I just watch them for safety. I make sure no [redacted] are coming back in the building."

On 2/09/2023 at 09:51 AM the surveyor observed Resident #1 sitting on the side of their bed playing solitaire. Resident #1 stated that he/she [redacted] at [redacted] and [redacted] AM. The surveyor asked Resident #1 if they were in possession of their [redacted] and Resident #1 stated that their [redacted] was in their [redacted] but would not show it to the surveyor.

2. On 2/7/2023 at 9:11 AM, Resident #52 was interviewed in their room. Resident #52 stated he/she is a [redacted] and [redacted] at the following times, [redacted] AM or [redacted] AM depending on the time he/she wakes up, [redacted] AM, [redacted] PM, and [redacted]

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PM.

On 2/7/2023 at 10:55 AM Resident #52 was observed seated in his/her wheelchair in front of the nurses station NJ EX Order. 264b1. Surveyor #2 observed CNA #4 pass an object to Resident #52. Resident #52 proceeded to the outdoor [redacted] area.

During an interview with the Surveyor #2 on 2/7/2023 at 11:10 AM the CNA #5 replied, "the nurse gives the residents the [redacted] and [redacted], then they [Residents] return them when they [Residents] are finished."

During an interview with Surveyor #2 on 2/7/2023 at 11:14 AM, while seated in the [redacted] area, Resident #52 replied, "I keep the [redacted] on me," when asked where is the [redacted] kept.

On 2/07/2023 at 11:28 AM, Resident #52 returned to his/her unit and went directly to his/her room and did not surrender his/her [redacted]

During an interview with Surveyor #2 on 02/07/2023 at 1:00 PM, CNA #4 replied, "I gave NJ EX Order. 264b1, [redacted] allowed to have [redacted], I believe every 3 hours." When asked what was handed to Resident #52 at 10:55 AM, CNA #4 continued to state that [redacted] are stored behind the nurses station in a drawer and [redacted] has [redacted]. CNA #4 replied, "yes, certain ones are allowed to have a [redacted] one of them" when asked does Resident #52 keep the [redacted] on his/her person.

During an interview with Surveyor #2 on 2/08/2023 at 11:10 AM, while outside in the [redacted] area, Resident #52 stated the facility

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F 689	Continued From page 19	F 689		

allows [redacted] to keep [redacted] but they keep the [redacted] in the nurses station. Resident #52 continued to state, NJ EX Order. 264b1 [redacted] with a [redacted]

A review of the Admission Record revealed that Resident #52 was admitted to the facility including but not limited to the diagnosis of [redacted] NJ EX Order. 264b1.

According to the MDS dated [redacted] under Section [redacted] Resident #52 was not a [redacted].

A review of the comprehensive care plan for Resident #52 revealed that he/she had a care plan with a heading of Focus, initiated on [redacted] [Name of Resident] is independently capable of pursing [redacted] own activities without intervention from the facility. Interventions initiated on [redacted]: [Name of Resident] is an NJ EX Order. 264b1. Encourage [Name of Resident] to not give [redacted] to other residents.

A review of Resident #52's [redacted] Evaluation with the Effective Date [redacted] revealed the following: under Section [redacted]. Considerations [redacted] Resident has a history of NJ EX Order. 264b1 [redacted] material" Under Section [redacted] Evaluation: "1) Independent [redacted] is allowed 1a. Resident has been educated on [redacted] [his/her] [redacted] gets [redacted] every [redacted] Under Section [redacted] Care Plan, no interventions were selected.

On 2/08/2023 at 11:37 AM, Surveyor #1 entered Resident #52's room after gaining permission to enter. Surveyor #1 whom previously observed

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Resident #52 [redacted] outside in the [redacted] area, asked Resident # 52 if he/she still had possession of their [redacted] Resident #52 responded, [redacted]" Surveyor #1 clarified that he had just witnessed Resident #52 outside [redacted] and that Resident #52 told the surveyor that he/she was able to possess their [redacted]. Resident # 52 then searched the [redacted] of his/her [redacted] but did not find their [redacted]. Resident then stated, NJ EX Order. 264b1 [redacted] t." Resident # 52 then maneuvered over to a chair next to the television and secured the same NJ EX Order. 264b1 that Surveyor #1 and Surveyor #2 observed him/her [redacted] outside with. Resident #52 reached into the [redacted] and obtained a NJ EX Order. 264b1 from the [redacted]

During an interview with Surveyor #2 on 2/08/23 at 01:15 PM Unit Manager/Licensed Practical Nurse (UM/LPN #1) replied, "the [redacted] should be kept on the nurses cart or in the bin behind the nurses station," when asked where should the NJ EX Order. 264b1 be stored. UM/LPN #1 was asked should a resident ever have a [redacted] on his or her person, LPN/UM #1 replied, "no, if they do, I'm not aware that they have that." UM/LPN #1 also stated, even if a resident is determined to be an NJ EX Order. 264b1, he/she should not have a [redacted] on his/her person. "I feel they should not. I am unaware of what the policy is. I wouldn't want them to [redacted] in their room. Anytime I've seen a resident with a [redacted], I've taken it away from them. Its been awhile since I've seen someone with a [redacted]

On 02/09/2023 at 10:38 AM the surveyor conducted an interview with the facility Licensed Nursing Home Administrator (LNHA). The

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surveyor asked the LNHA if residents who were allowed to [redacted] were allowed to possess their own [redacted] materials ([redacted]) The LNHA responded, "There supposed to put there [redacted] materials at the nurse's station and placed in a bin when not [redacted] The LNHA further stated some of our families provide [redacted] materials to the residents without our knowledge. We are purchasing a locked box to keep the [redacted] materials in that will be located at the [redacted] area and whoever is monitoring the [redacted] will be responsible for distributing and collecting the [redacted] materials. Anything that is going to generate heat the residents are not allowed to have."

On 02/09/2023 at 2:21 PM the LNHA stated to the surveyors that she had observed Resident #1 and Resident #52 outside [redacted] Both residents admitted that they were in possession of [redacted] Resident #1 stated that he/she would give their [redacted] to the [redacted] when they were done [redacted] and Resident #52 stated to the LNHA that he/she wanted to be sent to another facility because he/she didn't want to give up his/her [redacted]

The surveyor reviewed the facility policy titled [redacted], effective date: 06/01/96 and revision date: 10/24/2022. On page 3 at 2.6.2 the following was revealed:

2.6.2 "Patients will not be allowed to maintain their [redacted]."

N.J.A.C. 8:39-31.6 (e)

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F 730	Continued From page 22	F 730		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to provide documented evidence that the facility had performed annual performance reviews of certified nurse aides (CNA) employed at the facility at least every 12 months. This deficient practice occurred for 5 of 5 CNA's reviewed for mandatory 12-hour in-service training and performance evaluations and was evidenced by the following: On 02/13/2023 at 8:57 AM, the surveyor reviewed 5 random facility CNA files for mandatory 12 hour in-service education and annual performance evaluations for the period of 1/1/2022 through 12/31/2022. Upon review of the 5 facility provided files it was determined that there was no documentation that the 5 CNA's reviewed received a performance evaluation for the aforementioned timeframe. On 2/14/2023 at 10:18 AM, the surveyor provided the facility Licensed Nursing Home Administrator (LNHA) with the list of 5 CNA's who were reviewed for annual in-service education and performance evaluations. The surveyor requested annual performance evaluations for the 5 CNA's	F 730	Employee files were reviewed and it was determined that annual evaluations had not been done for any CNAs. All will have an annual review completed by their date of hire anniversary date. All residents have the potential to be affected by CNA annual reviews not being completed. All current CNAs will have an annual review completed by their date of hire anniversary date. The facility Human Resources team and department heads were in-serviced on the facility employee annual performance evaluation policy and procedure. HR/designee will be responsible to provide the department heads with a monthly list of employees due for an annual review. The HR/designee will report to the Administrator any evaluations not completed within 30-days of their due date. The Administrator will address non-compliance as necessary. The Campus HR Manager will provide a monthly report to the QAPI committee of	3/22/23

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F 730	Continued From page 23 reviewed under the sufficient and competent nurse staffing facility task. The LNHA and facility Director of Nursing agreed that the facility had not completed performance evaluations for the 5 requested staff in the past year. The LNHA stated, "We have a new Human Resource department now and we will be doing performance evaluations for our staff going forward this year." On 2/14/2023 at 10:50 AM, the facility Campus Human Resources Manager (CHRM) explained the following to the surveyor, "I believe we do an annual performance review as an organization." The DON confirmed that, "I believe that it is the company policy to do annual performance reviews." The CHRM further stated, "We do not have any performance evaluations from the past year for these 5 CNA employees. On 2/14/2023 at 11:09 AM, the LNHA provided the surveyor with a blank copy of the facility Employee Performance Appraisal Form that was to be used for employee performance evaluations.	F 730	the number of evaluations due and completed for three months until 95% compliance in completing annual reviews within 30 days of annual anniversary date is achieved.	
F 755 SS=D	NJAC 8:39-43.17(b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/22/23

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F 755	Continued From page 24 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to maintain a detailed record of receipts and accurate reconciliation of controlled medications. This deficient practice was evidenced by the following: 02/08/23 01:35 PM the surveyor requested all Drug Enforcement Administration (DEA) 222 forms (a form used for ordering controlled substances) for the last 6 months from the Director of Nursing (DON). The DON provided the surveyor with three (3) DEA 222 forms. The surveyor reviewed the facility's DEA 222 forms and found three of three forms were not	F 755	There were no residents affected by the completion of the DEA 222 form. The Director of Nursing obtained the necessary information to correctly complete the DEA 222 form when the issue was brought to her attention. All residents have potential to receive Schedule I or II narcotics for which the date of delivery and number of packages should be documented on the DEA 222 form. All nurses will be inserviced on proper	

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F 755	Continued From page 25 completed and accurately documented as follows: 1. The DEA 222 form # NJ EX Order. 264b1 was written on NJ EX Order. 264b1 and contained an order for NJ EX packages of NJ EX Order. 264b1 mg tablet, NJ EX packages NJ EX Order. 264b1 mg tablet and NJ package of NJ EX Order. 264b1 mg/ml NJ EX ml bottle. The DEA 222 form was missing the date received. The printed instructions on the front of the DEA 222 form indicated: "To BE FILLED IN BY PURCHASER, number of packages received and date received." 2. The DEA 222 form # NJ EX Order. 264b1, was written on NJ EX Order. 264b1 and contained an order for NJ EX packages of NJ EX Order. 264b1 mg (milligram) tablets and NJ EX packages of NJ EX Order. 264b1 mg tablets. The DEA 222 form was missing the date received and the number of packages received. The printed instructions on the front of the DEA 222 form indicated: "To BE FILLED IN BY PURCHASER, number of packages received and date received." 3. The DEA 222 form # NJ EX Order. 264b1 was written on NJ EX Order. 264b1 and contained an order for NJ EX packages of NJ EX Order. 264b1 mg tablets, NJ EX packages of NJ EX Order. 264b1 mg tablets, NJ EX packages of NJ EX Order. 264b1 mg tablet, NJ EX Order. 264b1 milliliter (ml) NJ EX Order. 264b1 NJ EX mg/ NJ EX ml NJ EX ml bottle and NJ EX packages of NJ EX NJ EX Order. 264b1 mg tablets. The DEA 222 form was missing the date received and the number of packages received. The printed instructions on the front of the DEA 222 form indicated: "To BE FILLED IN BY	F 755	documentation needed for the DEA 222 form. This includes the nurse indicating the date and number of packages accepted from the pharmacy on the retained medication receipt. The Director of Nursing will log this information on the DEA 222 form. The Director of Nursing or designee will review the DEA 222 forms with the Administrator weekly for 4 weeks and monthly for 2 months, ensuring that the form matches the medications received for each receipt. Re-education will be provided as needed. The Administrator or designee will provide a monthly report to the QAPI Committee on the accurate completion of the DEA 222 forms until 95% compliance is achieved for three consecutive months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 26 PURCHASER, number of packages received and date received." During an interview with the surveyor on 2/8/2023 at 1:57 PM, the DON said yes, the number of medications received and date received should be filled in. At that time the DON confirmed the sheets were not filled in. During a follow up interview with the surveyor on 2/13/2023 at 11:14 AM, the Administrator said, "we don't have a policy for DEA 222 forms."	F 755		
F 812 SS=E	NJAC 8:39-29.7 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		3/22/23

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F 812	Continued From page 27 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 2/6/2023 from 9:20 to 10:12 AM the surveyor, accompanied by the Account Manager (AM), observed the following in the kitchen: 1. Upon entry to the dry storage room the surveyor observed (3) bulk storage containers. On top of the middle bulk storage container, which contained sugar, the surveyor and AM observed a plastic scoop used to access the bulk containers. The scoop was not covered and was exposed. The AM stated, "That doesn't belong there." 2. On an upper shelf in the dry storage room, an opened container of Rainbow Sprinkles had an open date of 6/8/2022. On interview the AM stated, "That's good for 6 months. Do you want me to toss that.?" 3. Prior to entering the Walk-In Refrigerator, a review of the Refrigerator Temperature Log, Month: February Year: 2023, revealed that no PM temperature was recorded/monitored on 2/3/2023. In addition, there was no temperature recorded/monitored for the AM temperature on 2/5/2023 and 2/6/2023. On interview the AM stated, "That was a problem when I started here." 4. In a plastic bin within the walk-in refrigerator, (7) 8 ounce containers of chocolate milk had a sell by date of "January 26". The AM stated,	F 812	Corrective actions accomplished for residents found to have been affected by the deficient practice: Plastic scoop found uncovered in bulk sugar container- Scoop removed, cleaned, and placed in proper holding area at time of inspection. (1)Rainbow sprinkles container, and (7) 8 oz chocolate milk containers found past use by date- Product discarded at time of inspection. Walk-in freezer and Walk-in refrigerator temperature logs missing 3/ 2 entries respectively. Frozen fish filet bag, and 2 other unidentified food items found not properly labeled, and no use by dates. Product discarded at time of inspection. 2 stacks of pans found stacked on top of eachother on the drying rack not properly drying. Items that were wet nesting were removed, washed, sanitized and air dried at time of inspection. Open box of (not in use) plastic bowls found in storage room shelf found uncovered. Box containing plastic bowls was closed properly at time of inspection. All dietary staff were educated/inserviced on proper dry food storage policy/processes. Debris/litter observed along baseboard / floor in dish room area. Debris/litter was removed, floors, and walls were cleared at time of survey. Multiple food items in the nursing unit nourishment room refrigerator and cabinets found not properly labeled, and out of date. -Product discarded at time of inspection. Identification of residents who have the	

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F 812	Continued From page 28 "There going in the trash." In addition, on a middle rack of a multi-tiered wheeled cart, a tray had 4 vanilla shakes. The shakes had no dates." 5. A review of the walk-in Freezer Temperature Log, dated February 2023, indicated no freezer temp was recorded on 2/4/2023 PM and 2/5/2023 AM. On interview, the AM stated that temperatures were a problem she identified when starting the new job 3 days prior. 6. On a middle shelf in the walk-in freezer a plastic bag contained fish filets. The bag had been previously opened and had no dates. On the same shelf a clear plastic bag with an unidentifiable food had been previously opened. The bag had no dates. The AM threw both undated bags in the trash. An additional bag of the same unidentified food product was on a middle shelf under the refrigeration unit. The bag had no dates. In addition, a white plastic bag that was partially opened contained strawberries, according to the AM. The bag had no dates and was opened, exposing the strawberries to the air. The AM removed both bags to the trash. 7. A stack of (6) 4 -inch 3rd pans, a stack of (10) 4-inch half pans, a stack of (3) 6-inch half pans, a stack of 2 6" 3rd pans and a stack of (4) 6th pans were on a middle shelf of the pot and pan storage rack drying rack. All pans were stacked on top of each other in the inverted position. Upon removal of all pans listed, the surveyor and AM observed that all pans were wet with a water like substance visible to the eye. The pans were determined to be wet to the touch by the surveyor and AM. The AM stated, "This is wet nesting and explained to the staff that all pans must be air dried prior to stacking on the storage rack. AM stated all pans	F 812	potential to be affected by the same deficient practice. Center acknowledged that all residents have the potential to be affected by these deficient practices Measures put into place or systemic changes to ensure that the deficient Practice will not recur. All dietary staff were educated/inserviced on proper label and dating policy/processes. Manager's daily checklist put in place to monitor and observe proper label and dating processes are being followed All dietary staff were educated/inserviced on proper execution of cleaning schedule. Manager□s daily checklist put in place to monitor and observe Cleaning schedule/Assignments are being executed All dietary staff were educated/inserviced on proper dry storage policy/processes. Manager's daily checklist put in place to monitor and observe dry storage policy/processes are being followed All dietary staff were educated/inserviced on cold food storage policy/processes. Manager's daily checklist put in place to monitor and observe dry storage policy/processes are being followed Date of Completion: Daily Monitoring of corrective actions	

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F 812	Continued From page 29 needed to be re-washed and sanitized. On 2/9/2023 from 9:26 to 9:39 AM, the surveyor, accompanied by the Registered Nurse/Unit Manager (RN/UM #1), observed the following on the first floor nourishment room: 1. On a middle shelf in the refrigerator, a round plastic take out style container was inside a plastic bag. The plastic bag was labeled, "Do not throw out" [resident last name] 119 B. The bag had no date labeled. On a lower shelf an unidentified food item was in a brown paper bag. The bag was labeled, "107." The bag had no name or date. In an upper cabinet above the sink the surveyor observed what appeared to be a brownie on a white paper plate. The brownie was on an upper shelf, was uncovered and exposed. On visual inspection the surveyor and RN/UM #1 observed a bite out of the brownie. On the same shelf just behind the brownie, a plastic container of what appeared to be chocolate chip cookies was opened and exposed. There were 5 cookies left in the plastic container and the container was opened and exposed to the air. The cookie package had no date, name, or room number. On interview RN/UM #1 agreed that all foods in the unit pantry are to be labeled with name, room number and the date. She also agreed that all food products are good for 7 days from the label date, according to facility policy. RN/UM #1 removed all undated and exposed foods to the trash in the presence of the surveyor. On 2/13/2023 from 11:10 to 11:53 AM, the surveyor, accompanied by the AM, observed the following in the kitchen: 1. In the rear of the dry storage room, an opened	F 812	The monitoring of Label and Dating will be completed by the FSD/Designee using Daily audit form for 4 weeks or concern is corrected. Label and dating audits will be reported reported to the Administrator weekly. The monitoring of proper cold food processes will be completed by the FSD/Designee using Daily audit form for 4 weeks or concern is corrected. Cold food storage daily will be reported reported to the Administrator weekly. The monitoring of proper dry food processes will be completed by the FSD/Designee using Daily audit form for 4 weeks or concern is corrected. Dry food storage daily will be reported reported to the Administrator weekly. The monitoring of Cleaning schedule execution will be completed by the FSD/Designee using Daily audit form for 4 weeks or concern is corrected. Cleaning schedule audits will be reported reported to the Administrator weekly. The FSD/Designee will report audit results to the QAPI committee monthly for 3 months.	

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F 812	Continued From page 30	F 812		

cardboard box on a middle shelf in the storage area contained maroon plastic bowls used to serve resident meals. The card board box top was open, and the bowls were exposed to the air and contamination. The bowls were uncovered and not inverted.

2. The surveyor observed the baseboard moulding and floor in the three- compartment sink/manual dishwashing area and adjacent to the steamer in the kitchen. The floor was littered with unidentified debris and brown stains all along the baseboard moulding and on the moulding. The surveyor directed the AM's attention to the area and the AM replied, "That needs a little attention. No denying that."

The surveyor reviewed the facility policy titled Food: Safe Handling for Foods from Visitors, [company name] Policy 031, revised 7/2019. The following was revealed under the heading Procedures:

4. When food items are intended for later consumption, the responsible facility staff member will:

"Ensure that the food is stored separate or easily distinguishable from the facility food."

"Ensure that foods are in a sealed container to prevent cross contamination."

"Label foods with the resident name and the current date."

5. Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and:

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F 812	Continued From page 31	F 812		

"Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for > 7 day. (Storage of frozen foods and shelf stable items may be retained for 30 days)."

The surveyor reviewed the facility policy titled Food Storage: Cold Foods, [company name] Policy 019, revised 4/2018. The following was revealed under the heading Procedures:

4. "An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded."

5. "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination."

The surveyor reviewed the facility policy titled Food Storage: Dry Goods, [company name] Policy 018, revised 9/2017. The following was revealed under the heading Procedures:

4. "The Dining Services Director or designee regularly inspects the dry storage area to ensure it is well lit, well ventilated and not subject to sewage or wastewater back flow or contamination by condensation, leakage, rodents or vermin."

The surveyor reviewed the facility policy titled Manual Warewashing, [company name] Policy 023, revised 9/2017. The following was revealed under the heading Procedures:

3. "All serviceware and cookware will be air dried prior to storage."

The surveyor reviewed the facility policy titled

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F 812	Continued From page 32 Warewashing, [company name] Policy 022, revised 9/2017. The following was revealed under the heading Procedures: 4. "All dishware will be air dried and properly stored." The surveyor reviewed the facility provided Daily Cleaning Assignments form for the kitchen, undated. The following assignments were revealed: "11-8 Aide #1 Tuesday Detail walls in Pot Room" "Friday Detail walls in Pot Area" "Utility Aide #2 Sunday Detail walls in pot Area" "Friday Detail walls in Pot Room." N.J.A.C. 8:39-17.2 (g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		3/22/23

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F 880	Continued From page 33 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 34 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure staff properly wore the appropriate personal protective equipment (PPE; barriers, such as gowns, face shields, and gloves worn to protect the eyes, mouth, and skin from infectious disease), specifically eye protection and masks. The deficient practice occurred on the first and second floor. The deficient practice was evidenced by the following: On 2/06/2023 at 12:34 PM, during the initial tour on the [redacted] floor, Surveyor #2 observed multiple staff members wear their surgical mask below their nose. The staff members pulled the mask over their noses upon seeing Surveyor #2. On the same date at 12:41 PM during the initial tour on the [redacted] floor, Surveyor #1 observed three staff members not wearing eye protection while in the hallway. On the same date at 12:42 PM, during an interview with the surveyor, Certified Nurse Aide (CNA) #3 stated, "Not that I'm aware of." when asked if eye protection was to be worn while on	F 880	All residents and staff have the potential to be affected by staff members not wearing their PPE properly. Staff observed not wearing PPE properly were addressed by the management team during rounds. All current staff will be reinserviced and complete a competency on properly donning and doffing PPE, specifically their masks and protective eyewear. The facility management team will be inserviced on the importance of observing during rounds how staff are wearing their PPE. Facility managers are responsible to address non-compliance on the spot and to report the issue to the employee□s manager for follow up. The Director of Nursing and Administrator will conduct random rounds twice a week for 4 weeks and monthly for 2 weeks to monitor staff compliance with proper wearing of PPE including masks and eyewear. They will submit their findings to the Infection Control nurse for reeducation. The Infection Control nurse will provide a report to the QAPI	

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F 880	Continued From page 35 this floor. On the same date at 12:43 PM, during an interview with the surveyor, Licensed Practical Nurse (LPN) #1 stated, "Only in [redacted] rooms." when asked if eye protection was to be worn while on this floor. On 2/08/2023 at 8:07 AM, while in the second floor hallway, Surveyor #2 observed the Infection Prevention Nurse wearing her mask under her chin exposing her nose and mouth. The Infection Prevention Nurse pulled the mask over her nose and mouth upon seeing Surveyor #2. On 2/13/2023 at 10:45 AM, during an interview with the surveyor, the Infection Prevention Nurse stated, "N95 and eye protection. We expect it during patient care and in the hallways." when asked what the expectation of PPE on the first floor is. On the same date at 1:31 PM, during an interview with the surveyor, the Director of Nursing (DON) stated, "Yes." when asked if staff should be wearing eye protection when in the hallway on the first floor. The DON said staff have been required to wear eye protection since January; when the NJ EX Order. 264b1 outbreak started. Lastly, the DON said that surgical masks should be worn over the nose. A review of a facility document titled, "PPE REQUIRED EDUCATION" presented to Surveyor #1 by the DON revealed that on the [redacted] floor, "EYE PROTECTION MUST BE WORN WHILE IN THE HALLWAY AND RESIDENT ROOMS." The document further revealed that on the [redacted] floor, "MASKS MUST BE PULLED UP ON THE	F 880	Committee monthly for evaluation and suggestions, until three months and substantial compliance is achieved. DPOC On February 14, 2023, a Federal Recertification Survey with [redacted] Focused Infection Control was conducted. Participants: Administrator, Dir. of Nursing; Infection Preventionist; Medical Director. Description of Event During the centers Federal Recertification survey there were observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure staff properly wore the appropriate personal protective equipment PPE (barriers such as gowns, face shields, and gloves worn to protect the eyes, mouth and skin from infectious disease), specifically eye protection and masks. Contributing Factor A) The facility has an opening for a Nurse Practice Educator for which it is actively recruiting. The Nurse Practice Educator assists in rounding and educating staff based on her observations or needs determined by the nursing administrative team. B) The Infection Preventionist and Unit Managers are relatively new to the team. They are key to observing staff behavior	

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F 880	Continued From page 36 NOSE, NO EXCEPTIONS." A review of the facility's undated "Outbreak Response Plan" revealed under "b. Personal Protective Equipment (PPE)" that "PPE is also an essential element to prevent the spread of an infections disease (including NJ EX Order 264(5)) to our residents/patients and to employees, essential workers, healthcare personnel and all other permitted visitors." N.J.A.C. 8:39-19.4(a)	F 880	and re-educating/reinforcing appropriate wearing of PPE on a daily basis. C) Covid masking fatigue is a problem for the community at large. Identify Root Cause All department heads and supervisory staff need to reinforce proper wearing of PPE for all staff and report non-compliance for reeducation and counseling as observed. Staff must be held accountable for non-compliance with proper wearing of PPE. Corrective Actions A) Staff will be inserviced on PPE(barriers such as gowns, face shields, and gloves worn to protect the eyes, mouth and skin from infectious disease) and how to properly wear them for infection control. B) Staff will be re-inserviced regarding infection control and infection control mandates, and repercussions for non-compliance. C) Department heads and management staff will be re-inserviced on observing staff for proper wearing of PPE, immediately addressing and correcting observations of non-compliance, and reporting mechanisms for re-education and counseling of staff for PPE non-compliance.	

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Directed In-service Training

The facility shall provide in-service training to appropriate staff, with staff competency validated by the Director of Nursing, Medical Director or Infection Preventionist, as follows:

Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces https://youtu.be/t70HXORr5Ig Provide the training to: Frontline staff
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMULY7qiE Provide the training to: Frontline staff
CDC GOVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents https://youtu.be/1zbrinjv6xA Provide the training to: Frontline staff
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATW9yav4 Provide

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38	F 880	the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/1081803/ Provide the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 11B - Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/1081802) Provide the training to: Topline staff and infection preventionist only Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315350	A. BUILDING _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880	Nursing Home Infection Preventionist Training Course Module 11A - Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814/ Provide the training to: Topline staff and infection preventionist only Completion Date: 3/11/23	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to adequately monitor the use of an [redacted] by administering the [redacted] without a duration end date. This deficient practice was identified for 1 of 3 residents that were reviewed for [redacted] (Resident #44). This deficient practice was evidenced by the following: According to the Admission Record, Resident #44 was admitted with the following diagnosis: [redacted]	F 881	A physicians order for a stop date to the medication for resident #44 was obtained when brought to the attention of the Infection Preventionist on 2/9/23 Other residents who receive [redacted] orders could be affected by failure to document a stop date for the medication. All orders for residents currently on [redacted] medications were reviewed to ensure a stop date is indicated in the physician's order. All current licensed nurses will be educated on the importance of obtaining	3/22/23

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F 881	Continued From page 40 NJ EX Order. 264b1. A review of Resident #44's Physician Order Summary Report revealed an order: NJ EX Order. 264b1 Oral Capsule NJ EX Order. 264b1 MG. Give NJ EX Order. 264b1 capsule by mouth NJ EX Order. 264b1 times a day for NJ EX Order. 264b1. The order and start date were NJ EX Order. 264b1. A further review of the OSR did not include an NJ EX Order. 264b1 duration or end date. A further review of the Pharmacy Consultant Recommendations dated NJ EX Order. 264b1, in a report sent to the facility physician for review indicated; "Resident is currently receiving an NJ EX Order. 264b1 NJ EX Order. 264b1 without a duration or stop date. Please review this NJ EX Order. 264b1 and if clinically appropriate please add a duration of therapy for treatment or stop date to the order. NJ EX Order. 264b1 " There was no follow-up by the facility to address the recommendation. During an interview with the surveyor on 2/13/2023 at 10:48 AM, the Infection Prevention Nurse stated that it is not appropriate for an NJ EX Order. 264b1 order to not have a duration or stop date as per the facility policy. A review of the facility provided policy titled, "Infection Control Policies and Procedures-NJ EX Order. 264b1," with a review date of 10/24/22, under #2 Accountability; 2.1.2; Medical Providers (physicians and APPs): 2.1.2.4, "Document antibiotic orders containing the dose, duration, and indication for use." NJAC 8:39-19.4 (d)	F 881	the dose, duration and indication for use of all antibiotic orders. Unit Managers will be inserviced to address NJ EX Order. 264b1 orders lacking a stop date within 48-hours of receiving a Pharmacy Consultant recommendation. The clinical team will review new antibiotic orders at morning meeting to ensure that a stop date is indicated for each. The Unit Manager or designee will review all physician orders for NJ EX Order. 264b1 monthly to ensure that a stop date is included in the order. The Unit Manager will obtain stop dates as necessary and report compliance issues to the Director of Nursing. The Director of Nursing or designee will address noncompliance in order transcription and provide staff reeducation as necessary. The Director of Nursing will report compliance with obtaining physician orders for NJ EX Order. 264b1, including stop dates, to the QAPI committee monthly until three consecutive months of 95% compliance has been achieved.	
F 888 SS=E	COVID-19 Vaccination of Facility Staff	F 888		3/22/23

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F 888	Continued From page 41 CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in	F 888		

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F 888	Continued From page 42 paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;	F 888		

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F 888	Continued From page 43 (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for	F 888		

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F 888	Continued From page 44 those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to accurately track and document the COVID-19 vaccination status of the vendors/contracted staff . This deficient practice was evidenced by the following: On 2/6/2023, during entrance conference, the facility was asked to provide documentation of their staff and contracted staff vaccination status. During an interview with the surveyor on 2/8/2023 at 10:50 AM, the Infection Prevention Nurse (IPN) and the Director of Nursing (DON) stated that they failed to track and maintain records of COVID-19 vaccinations for outside vendors/contractors. During an interview with the surveyor on 02/08/23 at 1:55 PM, the DON stated they were not tracking the COVID-19 vaccination status of the contracted staff until today (2/8/23). A review of a facility policy titled, "HR232 Universal COVID-19 Vaccination" effective date 8/2/21, reviewed /revised on 8/15/22, revealed "Policy...Administrators/Executive Directors, supervisors, and business location managers are responsible for communicating the requirements of the Universal COVID-19 Vaccination Program to all individuals mentioned above, and for	F 888	No residents were affected by this practice. All residents have the potential to be affected by vendors or contracted staff who have not been vaccinated for Covid-19 as part of the Universal Covid-19 Vaccination Program. All current vendors were contacted and a copy of their vaccination cards obtained during survey. All department heads will be inserviced on the federal and state requirements for vendor or contractor's Covid-19 vaccination for long term care.. The facility has an electronic Covid screening system which all guests must use prior to entry to the facility. Infection Preventionist will be responsible to add new vendors to the electronic Covid screening system, which will ensure that a copy of their vaccination card has been obtained. The Infection Preventionist will review the electronic Covid screening report to ensure that all vendors checking into the facility have their Covid vaccination on file. She will complete this check weekly for four weeks, monthly for	

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F 888	Continued From page 45 ensuring appropriate compliance. ...1.6 Students, members of medical staff volunteers, care partners, nonemployed caregivers, physicians/advanced practice providers (APPs), intermittent providers, and contracted personnel must provide proof of vaccination." NJAC 8:39-19.4(a)	F 888	2 months. She will provide a monthly report to the QAPI Committee of new vendors or contractors and their compliance with providing their Covid-19 immunization records for 3 months or until 100% compliance is achieved.	

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
315350 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPE CENTER	700 TOWNBANK ROAD CAPE MAY, NJ 08204

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 F0584	Correction	ID Prefix F0623	Correction	ID Prefix F0641	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(g)	Completed
LSC	03/22/2023	LSC	03/22/2023	LSC	03/22/2023
ID Prefix F0656	Correction	ID Prefix F0689	Correction	ID Prefix F0730	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.35(d)(7)	Completed
LSC	03/22/2023	LSC	03/22/2023	LSC	03/22/2023
ID Prefix F0755	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/22/2023	LSC	03/22/2023	LSC	03/22/2023
ID Prefix F0881	Correction	ID Prefix F0888	Correction	ID Prefix	Correction
Reg. # 483.80(a)(3)	Completed	Reg. # 483.80(i)(1)-(3)(i)-(x)	Completed	Reg. #	Completed
LSC	03/22/2023	LSC	03/22/2023	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?
2/14/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
62200		4/4/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPE CENTER	700 TOWNBANK ROAD CAPE MAY, NJ 08204

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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 03/22/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 03/22/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
2/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO