STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315332	A. BUILDING _____ B. WING _____	04/06/2022

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SOUTHERN OCEAN CENTER	1361 ROUTE 72 WEST MANAHAWKIN, NJ 08050

(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 000	INITIAL COMMENTS Survey Date:04/06/22 Census:116 Sample:27+24=51 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		5/10/22

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

Electronically Signed | 04/26/2022

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review and review of other pertinent documentation, it was determined that the facility failed to ensure resident dignity by failing to ensure a [redacted] privacy cover was in place over the [redacted]. This deficient practice was identified for 2 of 4 residents reviewed (Resident #54 & Resident #69) for [redacted] use. The deficient practice was evidenced by the following: a.) On 03/17/22 at 9:40 AM, during a tour of the facility, the Surveyor observed Resident #54 seated in the Dining Room (DR) with three other residents. The [redacted] bag was underneath the chair and had a visible [redacted] inside the [redacted] and did not have a privacy cover. On 03/17/22 at 10:36 AM, the Surveyor observed Resident #54 attending an activity in the DR with	F 550	Resident #54 and Resident #69 [redacted] were covered with a privacy bag as soon as they were identified as missing. All residents with [redacted] have the potential to be affected by this deficient practice. The Direct care nursing staff will be inservice by the Nurse Practice Educator or Designee on the importance of maintaining [redacted] privacy. Unit Manager or designee will conduct random weekly audits for 4 weeks then monthly for 3 months of residents with [redacted] to ensure placement of privacy cover. Results of weekly audits will be presented monthly by the Unit Manager or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions	

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F 550	Continued From page 2 other residents present. The [redacted] bag was observed [redacted] and was without a privacy cover. On 03/17/22 at 12:18 PM, the Surveyor, in the presence of another Surveyor, observed Resident #54 in the DR eating with nine other residents present. Both Surveyors observed the Resident #54's [redacted] bag was visible and contained a large amount of [redacted]. There was no privacy cover observed. On 03/17/22 at 12:21 PM, an interview with the Licensed Practical Nurse (LPN) revealed that Resident #54 was transferred to the floor three months prior and had the [redacted]. At that time the LPN stated that her role was to check the [redacted] check the [redacted] record the [redacted] every shift, and ensure that there were no kinks in the [redacted] When asked about the [redacted] bag, she stated, "Everybody, especially nurses should ensure that the [redacted] bag was in a [redacted] [privacy cover]. We can offer a [redacted] during the day for privacy, this was the facility's policy and the resident's rights". A review of Resident 54's medical record revealed the following: The Admission Record (an admission summary) revealed Resident #54 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]. Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #54 was [redacted] required total dependence of one staff for toileting and required	F 550	needed or taken during the course of the audit.	

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F 550	Continued From page 3 two persons for assist with transfer. A review of Resident #54's Care Plan (CP) initiated [redacted], revealed that Resident #54 had an [redacted] in place due to [redacted]. The CP interventions included: Monitor and record [redacted], monitor for signs and symptoms of infection and report to the physician, provide privacy and comfort, keep [redacted] off the floor. On 03/18/22 at 11:05 AM, the Surveyor interviewed the LPN Unit Manager (LPN/UM) regarding the [redacted] care. The LPN/UM stated that nurses and Certified Nursing Assistants (CNA) were responsible to ensure the [redacted] was patent (not blocked), ensure that the resident needed the [redacted] and maintain the scheduled [redacted] appointments. The LPN/UM stated that the [redacted] must be in a privacy cover. The LPN/UM stated that the CNAs, or nurses were responsible to place the [redacted] in [redacted]. The UM further stated that she did not want the [redacted] in the [redacted] to be on display, and all staff should ensure that a [redacted] was in place. On 03/18/22 at 11:18 AM, the Surveyor interviewed the Nurse on the [redacted] hall. The Nurse stated that [redacted] were available on the floor in the clean utility room or in central supply. The Nurse escorted the Surveyor to the clean utility room and showed the [redacted] bags, that were located on the shelf, to the Surveyor . On 03/25/22 at 9:51 AM, the Surveyor conducted an interview with the CNA who cared for Resident #54. The CNA stated that in the morning she	F 550		

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F 550	Continued From page 4 would provided [redacted] care to the resident, ensure there were no kinks in the [redacted], empty the [redacted] bag, secure the [redacted] bag to the wheelchair and ensure that a [redacted] bag was over the [redacted] bag. b.) On 03/17/22 at 9:20 AM, the Surveyor toured the [redacted] floor unit and observed Resident #69 in bed. The Resident spoke briefly to the surveyor and closed his/her eyes. The Surveyor observed the [redacted] bag was hanging on the door side of the bed. The [redacted] bag contained [redacted] and did not have a privacy cover. On 07/17/22, the Surveyor made the additional observations of Resident #69's [redacted] bag: At 10:14 AM, the [redacted] bag contained visible urine and had no privacy cover . At 12:10 PM, the [redacted] contained visible [redacted] and had no privacy cover. At 1:39 PM, [redacted] bag contained visible [redacted] and had no privacy cover. On 03/18/22 at 9:21 AM and 12:19 PM, the Surveyor observed Resident #69 lying in bed with his/her eyes closed. The Surveyor observed the [redacted] bag hanging on the door side of the bed, the privacy cover was pushed up and exposed the [redacted] inside the [redacted] bag. On 03/22/22 at 8:38 AM, the Surveyor observed Resident #69's direct care CNA in the Resident's room after finishing morning care. The Surveyor	F 550		

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F 550	Continued From page 5 interviewed the CNA at that time, who stated that she would provide [redacted] care to Resident #69, and then cover the [redacted] with a privacy cover for dignity. The CNA stated there should always be a privacy cover over the bag [redacted], and she had not worked on 03/17/22 or 03/18/22, and could not speak to why the [redacted] bag was without a privacy cover. On 03/24/22 at 10:58 AM, the Surveyor interviewed the LPN who cared for Resident #69. The LPN stated that the [redacted] was being used to help promote [redacted] and for [redacted] The LPN stated the [redacted] would be changed monthly unless there was a problem, [redacted] care was completed each shift, [redacted] was measured by the CNAs, and a privacy cover was used for the dignity of the resident. The LPN added that it did not matter if the resident was in bed, in a chair, or in the activities room and that staff should always use a privacy cover over the [redacted] A review of the Admission Record revealed Resident #69 had been admitted to the facility with diagnoses which included, but were not limited to, [redacted] A review of the most recent Quarterly MDS dated [redacted], revealed a BIMS of [redacted] which indicated Resident #69 had a [redacted]. [redacted] revealed that the resident had an [redacted]. A review of the Medication Review Report revealed an order dated [redacted] for a [redacted]	F 550		

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F 550	Continued From page 6 [redacted] with a [redacted] to bedside [redacted]. A review of the on-going Care Plan revealed a focus area that the resident required an [redacted] due to: [redacted] condition) and [redacted] in area. Interventions included, but were not limited to, provide privacy and comfort, and provide a [redacted]. A review of the facility provided, "Treatment: Considerate and Respectful", revised 07/01/19, included but was not limited to: Policy: centers will promote respectful and dignified care for patients in a manner and in an environment that promotes maintenance or enhancement of quality of life; Purpose: to provide patients the right to a quality of life that supports independent expression, decision making, and respect; Process: 1.9 Demeaning practices: staff will refrain from practices that are demeaning to patients such as: 1.9.1 keeping [redacted] bags uncovered. The facility administrative staff was made aware of the above concerns on 03/25/22 at 12:56 PM. On 03/28/22 at 11:41 AM, the facility had no further information to provide.	F 550		
F 561 SS=E	NJAC 8:39-4.1(a)(12)(16) Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		5/10/22

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F 561	Continued From page 7 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of facility documentation, it was determined that the facility failed to: a.) follow the facility policy for Activities of Daily Living (ADL's), and b.) ensure that a resident had the right to make choices about aspects of his/her life in the facility that were significant to the resident. Specifically, the facility failed to identify and honor a resident's bathing request. This deficient practice was identified for 1 of 27 residents reviewed (Resident #50) and was evidenced by the following: On 03/17/22 at 9:50 AM, the Surveyor observed	F 561	Resident #50 was offered a shower as soon as it was brought to the Unit Manager's attention. All residents have the potential to be affected by this deficient practice. The direct care nursing staff will be inserviced by the Nurse Practice Educator or Designee on the importance of documenting when residents receive or refuse their showers. Unit Manager or designee will conduct random weekly audits for 4 weeks then monthly for 3	

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F 561	Continued From page 8 Resident #50 in bed with their eyes closed. On 03/17/22 at 12:19 PM, the Surveyor returned to Resident #50s room during the lunch meal, and observed a [redacted] of Resident #50 that was visiting at the bedside. The [redacted] informed the surveyor he had been trying to get Resident #50 a shower for the past two months. The Friend stated that the facility had not been able to accommodate Resident #50's preference for a shower. A Review of Resident #50's medical record revealed the following: The Admission Face Sheet (an admission summary) reflected that Resident #50 had [redacted] and need for assistance for personal care. A review of the Quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], revealed that Resident #50 was alert and able to make her/his needs known. Resident #50 scored [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident was [redacted]. [redacted] the MDS assessment which referred to Activities of Daily Living (ADLs), revealed that Resident #50 was totally dependent on staff for all ADLs including bathing. [redacted] of the MDS which addressed behavior, was coded [redacted] which indicated that Resident #50 did not exhibit any behavior. [redacted] which referred to rejection of care was coded [redacted] which indicated that Resident #50 was compliant with all care. A review of the on-going care plan for ADL care,	F 561	months will be done to ensure documentation for compliance. Results of audits will be presented monthly by the Unit Managers or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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included the goal that Resident #50 would improve current level of functioning in bathing, grooming/personal hygiene. The care plan for preferred activities indicated under focus, [Resident #50] stated that it was important that [he/she] had the opportunity to engage in daily routines that were meaningful relative to their preferences. The goal: [Resident #50] "will plan and choose to engage in preferred activities" was implemented on 11/02/21. Review of the interventions included: "It is important to me to choose between a tub bath, shower, bed bath or sponge bath. It is important for me to have family or a close friend involved in discussions about my care."

On 03/17/22 at 12:41 PM, the Surveyor interviewed the Licensed Practical Nurse (LPN) regarding the facility shower schedule process. The LPN stated that showers were scheduled during the 700 AM -3:00 PM and 3:00 PM -11:00 PM shifts. The LPN stated the Certified Nursing Assistants (CNAs) were responsible to complete the showers. Upon inquiry to the LPN regarding where the CNAs would document that a shower was provided, she indicated that the CNAs would document on the kiosk (computer system) used by the facility to document ADLs care provided. She further stated that ADLs care can be viewed under the "Tasks" section of the electronic medical record.

On 03/17/22 at 12:49 PM, a review of the CNA's assignment book revealed that Resident #50's shower was scheduled on [redacted] and [redacted] on the 300 PM - 11:00 PM shift. The Surveyor interviewed one of the CNAs assigned to the unit regarding documentation in the kiosk. The CNA explained the process would be if the task was completed the documentation would be in green,

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and if the task was not completed, the documentation would be in pink. The CNA reviewed the bathing task for Resident #50 from March 1 through March 17, 2022 with the Surveyor. The documentation was observed in pink, which indicated that the bathing task had not been completed. A further review of the ADLs sheet provided by the facility confirmed that Resident #50 had not received a shower for the past two months.

On 03/18/22 at 8:53 AM, the Surveyor observed Resident #50 in bed. Resident #50 was awake and alert and the Surveyor interviewed the resident at that time. The Resident stated stated that he/she had not had a shower for two months and would like to take a shower.

On 03/18/22 at 9:58 AM, the Surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that her role was to oversee staff, assist with care, administer medications if the nurse called out, attend care conference with other disciplines and families, rounding with the [redacted] nurse every [redacted] and to communicate with residents and assist with care planning. She further stated that staff would inform her of any complaints, and the family would also inform her of any issues that needed to be addressed. The Surveyor inquired to the LPN/UM regarding Resident #50's request for shower. The LPN/UM acknowledged that she had been informed by the LPN assigned to the low hall of Resident #50's about the request for a shower, and she had informed the 3:00 PM -11:00 PM Nurse.

On 03/18/22 at 10:10 AM, the Surveyor interviewed the LPN assigned to the [redacted] about the process for shower. The LPN stated

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that the CNA would ask/inform the resident of the shower and if the resident refused, the CNA would inform the nurse, then the nurse would document into the notes that the resident had refused the shower.

A review of the Nurse's Notes from 03/01/22 to 03/17/22 failed to indicate that a shower was offered to Resident #50, and refused on the following dates: 02/01/22, 02/04/22, 02/08/22, 02/11/22, 02/15/22, 02/18/22, 02/22/22, 02/25/22, 03/01/22, 03/04/22, 03/08/22, 03/11/22 and 03/15/22. On 03/17/22, a late entry was entered for 03/15/22, which revealed that Resident #50 had refused a shower on 03/15/22 (The resident was not provided with approximately sixteen showers).

On 03/18/22 at 10:40 AM, the Surveyor requested the [redacted] ADLs documentation from the LPN/ UM. The Unit Manager and the Assistant Director of Nursing indicated that they could not print the documentation as requested. At 12:55 PM, partial documentation was provided by the MDS Coordinator which confirmed that Resident #50 had not had a shower as scheduled for the last two months.

On 03/22/22 at 9:15 AM, the Surveyor observed Resident #50 in bed. An interview with Resident #50 at that time revealed the resident denied refusing a shower on 03/15/22. Resident #50 stated, "[redacted]".

On 03/22/22 at 10:09 AM, during an interview with Resident #50 in the presence of the UM, Resident #50 revealed that he/she had not had a shower since he/she had been at the facility. Resident #50 stated, "[redacted]" and stated

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"Would that be a scheduled shower?"

On 03/22/22 at 10:17 AM, the Surveyor reviewed the Nurse's Notes and could not locate documentation that Resident #50 had refused a shower on 03/18/22. The UM confirmed that the Nurse's Notes did note did not reflect that Resident #50 had refused a shower on 03/18/22 as scheduled.

On 03/23/22 at 9:36 AM, the Surveyor interviewed Resident #50 and inquired as to how it felt not to having his/her scheduled shower, Resident #50 replied, "I felt that was negligence on the part of the nursing home".

On 03/28/22 at 9:51 AM, the Survey Team conducted a meeting with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing. The DON stated that when a resident was scheduled to have a shower, the CNA was responsible to communicate with a nurse if the resident refused.

A review of the facility provided policy for, "Activities of Daily Living" revised 06/01/21, stated in part: Based on the comprehensive assessment of a resident, and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living ADL'S activities are maintained or improved and do not diminish unless circumstances of the individual's clinical condition demonstrate that a change was unavoidable.

Activities of daily living (ADLs) include Hygiene-bathing, dressing, grooming, and oral care....

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F 561	Continued From page 13 Purpose: To ensure ADLs are provided with accepted standards of practice, the care plan, and the patient's choices and preferences. Under Practice Standards the following were noted: Patients are assessed upon admission, quarterly, and with a significant change to identify his/her status in all areas of ADLs, risks for decline in any ADL ability to improve in identified ADLs. The care plan will address the patient's ADL needs and goals, including the provision of ADLs if the patient is unable to perform ADLs. A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. ADL care is documented every shift by the nursing assistant. The licensed nurse will document ADL care he/she provided, when applicable.	F 561		
F 578 SS=E	NJAC 8:39- 4.1(a)22 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		5/10/22

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F 578	Continued From page 14 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to: a.) follow the facility policy for Advance Directives to ensure a complete and updated Advance Directive was maintained in a resident's medical file, and b.) inform and offer educational material regarding Advance Directives. This deficient practice was	F 578	Resident #2 code status was changed as soon as missing data was identified to reflect the resident's wishes. All residents have the potential to be affected by this deficient practice. Facility wide audits initiated for patients or residents code status.	

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F 578	Continued From page 15 identified for 1 of 1 resident (Resident #2) who was reviewed for Advance Directives. The deficient practice was evidenced by the following: On 03/17/22 at 9:43 AM, the Surveyor observed Resident #2 in their room with their [redacted]. Resident #2 spoke to the Surveyor and was confused at times. A review of Resident #2's medical records revealed the following: The Admission Record revealed Resident #2 had been admitted to the facility with diagnoses, which included but were not limited, [redacted]. The most recent Quarterly Minimum Data Set (MDS) an assessment tool, dated [redacted] revealed a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted], and that family or significant other participated in goal setting. The on-going Care Plan (CP) revealed a focus area that the resident has an established advanced directive initiated [redacted] with interventions which included full code (full support provided if a person has no heartbeat or stops breathing); all opportunities for expression of feelings; and inform resident/patient and/or healthcare decision maker of any change in	F 578	The Nurse Practice Educator or Designee will provide in-service to license nurses, social workers and Medical providers of the code status policy and procedure. Social Worker or designee will conduct random weekly audits for 4 weeks then monthly for 3 months to capture resident's code status. Results of audits will be presented monthly by Social Worker or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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F 578	Continued From page 16 status or care needs. On 03/18/22 at 9:37 AM, the Surveyor reviewed a form located in Resident #2's medical chart. The Resident's name and a note was observed in the upper right-hand corner '9/2/20 Full Code' with no other information filled out and there was no signature. The form indicated to 'circle: DNR [Do Not Resuscitate] DNH [do not hospitalize] DNI [do not intubate]; the form included the following sections to be filled out: 1. Reason for the DNR/DNH/DNI order; 2. Discussion of DNR/DNH/DNI status has occurred with resident - family/responsible party - nursing staff - other; 3.) discussion of DNR/DNH/DNI order has not taken place with family because ...; 4.) Intervention aimed at curing the resident or restoring the resident to a better than present state of health are deemed futile, of no medical benefit, and hence medically inappropriate. The dying process is irreversible. Resuscitation to prevent or reverse death, when it occurs , would only impose additional burden and discomfort upon the resident without any reasonable hope of benefit. Therefore, I am ordering a. emphasis on comfort, support and symptom control, b. do not resuscitate, c. do not hospitalize, d. do not intubate, e. the resident is not to be disturbed with tests, unless the information thereby obtainable is expected to be utilized to increase the resident comfort or otherwise benefit the resident, f. additional orders. These orders are based upon a sound medical assessment, after consultation with the resident/responsible party of the resident's condition. On 03/18/22 at 9:46 AM, the Surveyor reviewed the Initial Services Assessment and Documentation form, dated [redacted] and documented by the previous Social Worker (SW),	F 578		

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F 578	Continued From page 17 which indicated Resident #2 was a DNR do not resuscitate. A review of the Social Services Assessment and Documentation quarterly forms dated [redacted], and [redacted] all included but were not limited to the following information: 5. Resident Rights / Healthcare Decision Making / Advance Directives b. Advance Directives (e.g. Living Will, Healthcare Power of Attorney or Healthcare Proxy) in place? NO c. Additional conversation regarding advance care planning provide NO d. opportunity to complete advance directive offered YES e. Separate Healthcare Orders (Physician Order for scope of Treatment, Physician Orders for Life Sustaining Treatment, Medical Order for Life Sustaining Treatment) completed? NO Resident Rights / Advance Directive Comments, g. Use to further elaborate on healthcare decision making [area left blank]. On 03/18/22 at 9:49 AM, the Surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN UM) on the [redacted] floor. The LPN UM stated that a resident's Advance Directive would be documented in the computer, and all updates would be the responsibility of the SW. The LPN UM stated it was important for residents to have Advance Directives so the staff would know what the residents' wishes were. On 03/18/22 at 10:30 AM, the present SW stated that Advanced Directives sometimes would be completed through the admissions department, or if the family wanted to change anything, the facility will have the Nurse Practitioner (NP)	F 578		

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address changes along with the SW. The SW stated Advance Directives were important because the resident needed to be able to voice their rights and decisions. The SW stated the Advance Directives would be reviewed every month by the NP or SW.

On 03/18/22 at 10:41 AM, the Surveyor reviewed a progress note dated [redacted] entered by the NP which revealed Full Code. The progress note revealed she had spoken to Resident #2's daughter on the phone from 11:30 am to 11:47 am and that the daughter was looking for the living will. The NP's progress notes further revealed that in the interim, Resident #2 would be made a Full Code as the [redacted] tried to locate the Advance Directives or living will documents.

On 03/18/22 at 10:48 AM, the Surveyor reviewed the progress notes in Resident #2's medical records and was unable to find any follow up regarding Advanced Directives to date or follow up with the resident's [redacted]

On 03/22/22 at 9:18 AM, during a follow-up interview, the SW stated Resident #2 was a full code and knew that because he had asked the business office. The SW stated he would have to look for any paperwork regarding the resident's code status or Advance Directives.

On 03/22/22 at 9:36 AM, the Director of Social Services (DSS) stated that when a resident was admitted to the facility, social services would ask if they had any Advance Directives. If the resident did not have one, they would be offered to formulate an Advance Directive, and it would be discussed during the quarterly care conference. The DSS added that documentation of the discussion of Advance Directives should be in

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located in the progress notes because it was important to know what a resident's wishes were. The DSS stated she had no explanation as to why no one had followed up on the Advance Directive for Resident #2.

On 03/22/22 at 10:07 AM, the Surveyor attempted to contact Resident #2's [redacted]

On 03/22/22 at 11:26 AM, the Surveyor attempted to ask Resident #2 about an Advance Directive, wishes or life choices. The resident was confused and was unable to answer.

On 03/24/22 at 10:34 AM, the SW stated he would review the file to see if anything was updated in the chart about Advanced Directives. The SW further stated that the process was to ask the family or resident upon admission, and that would be on the UDA [Initial Services Assessment and Documentation] assessment. The SW further stated that the health care decision and Advance Directives would be tracked via the computer system, or there should be a copy in the file. The SW stated when he completed his assessment, that he asked the Resident's daughter and he was unsure of the date. The SW stated he did not document in the medical record and that the assessment was the quarterly assessment. He stated there was no documentation who attended, and the SW was unable to confirm who was at the meeting, or who he spoken to. The SW further stated that the conversation was not documented, and that he would just check off the questions on the assessment form.

On 03/24/22 at 11:05 AM, the DSS stated she would review Advance Directives during care conference. She stated that Advance Directives

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would be addressed during the initial assessment and during care conferences that were done quarterly, and the attendants should be listed in the progress notes. The DSS reviewed the [redacted] progress note and acknowledged the note reflected Resident #2 was a DNR, but the following note reflected Resident #2 was a full code. She stated the documentation did not follow up as to when the subsequent Social Worker completed the quarterly assessment, and that the Social Worker listed the resident as not having an Advanced Directive. The DSS stated per the documentation there was no proof that we [the facility] did what we were supposed to do. She stated that copies of the Advance Directive should be kept in the resident's chart, and she had no explanation as to why there was no education or information provided to the resident, or daughter regarding an Advance Directive.

On 03/24/22 at 11:33 AM, the Surveyor made a second attempt to contact Resident #2's daughter but there was no answer.

A review of the facility provided policy and procedure, "Health Care Decision Making" revision 3/1/22, revealed Policy: it is the right of all patients / residents to participate in their own health care decision making including the right to decide whether they wish to request, accept, refuse, or discontinue treatment, and to formulate or not formulate an Advance Directive.

Centers must: inform and provide written information to all patients concerning the right to accept or refuse medical or surgical treatment and the patient's option formulate an advance directive; provide a written description of the centers policies to implement advance directives; approach a capable patient who does not have an

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advance directive upon admission, the patient will be approached by the SW or another designated staff on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive; inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advance directive has been complete/executed in accordance with state law; and establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care.

Advance Care Planning: an ongoing process of communication between patients and their healthcare decision makes to understand, reflect on, discuss, and plan for future healthcare decisions for a time when patients are not able to make their own healthcare decisions. Advance care planning includes two key parts: 1. Face-to-face conversations with physician, healthcare professional and patients or their healthcare decision makers to discuss advance directives and treatment decisions; and 2. Documenting treatment or wishes preferences. Advance Directive: written instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provision of health care. Instructive Directive: Living will or similar state form that is used to document the medical treatment wishes. It serves as information for the family, physician, and/or surrogate decision maker to base health care decisions on the patient's personal desires for treatment.

Practice Standards: 1. Upon admission, determine whether the patient has a copy with them, make copies, place in medical record, and

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F 578	Continued From page 22 notify interprofessional team. 1.1.1.1 request that patient/patient representative bring the documents to the Center [facility] as soon as possible. 1.2 If the patient does not have an advance directive: 1.2.3 provide advance directive information. 2. Throughout the stay, advance care planning conversations will be conducted as part of the care plan process and with significant change in condition to identify, clarify, and review existing advance directives and/or portable medical orders and determine whether the patient wishes to change or continue these instructions. On 03/25/22 at 12:56 PM, the concerns were discussed with the facility. The facility had no additional information to provide.	F 578		
F 609 SS=D	NJAC 8:39-4.1(a)(2)(4), 9.6(a) Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		5/10/22

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F 609	Continued From page 23 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, review of clinical records and other pertinent facility documentation, it was determined that the facility failed to report an allegation of abuse to the state survey agency, Department of Health (DOH). This was identified for 1 of 1 resident reviewed for abuse (Resident #51) and was evidenced by the following: On 03/18/22 at 8:55 AM, the Surveyor interviewed Resident #51 who stated that he/she remembered reporting a complaint about a Certified Nursing Assistant (CNA) to the human resources manager (HRM). The resident that stated that he/she reported that the CNA did not provide care to [redacted] anymore or since he/she reported it to the administration. The resident stated that the CNA was rude and was talking about him/her in the hallway loudly enough so that he/she could hear him/her. On 03/18/22 at 9:13 AM, the Surveyor interviewed HRM who identified herself as the Workforce Specialist which was the human resources director. The HRM told the surveyor that she remembered about one year ago that Resident #51 reported that he/she did not care for of his/her CNAs. She stated that the previous social worker (SW) investigated the resident's	F 609	Resident #51 was interviewed by the Assistant Director of Nursing and Social Worker on 3/18/22. An investigation was initiated and the incident was reported to the Department of Health, no negative outcome occurred. All residents have the potential to be affected by this deficient practice. All staff will be inservice on Abuse policy and procedure to include timely reporting of occurrences by the Nurse Practice Educator or designee. Director of Nursing or Designee will audit all allegations of abuse and ensure timely reporting of occurrences weekly x 4 weeks then monthly x 3 months Results of audits will be presented monthly by the Director of Nursing or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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complaint and that the previous SW was not employed by the facility any longer, but that there should be an investigation regarding that complaint. She stated that the resident reported to her that the CNA rushed him/her and talked about him/her to other CNAs in the hallways and that the resident could hear her. The HRM stated that after the investigation, the CNA was restricted from going into Resident #51's room or providing care to him/her. She also stated that the conclusion of this investigation reflected that there was no evidence of abuse and that the resident was reassured that the CNA would not go into the resident room, nor provide care to the resident. The HRM stated that the resident had not reported any recent concerns that he/she was having issues with staff members.

On 03/18/22 at 9:28 AM, the Surveyor interviewed the Director of Social Work (DSW) who stated that she would find the investigation that the previous SW conducted for Resident #51's allegations that a CNA was rude and talking about him/her in the hallway so the resident could hear her. She stated that the resident did not inform her of any problems or concerns he/she was having with the staff but that she would go and speak with the resident.

The facility Admission Record (AR) indicated that Resident #51 was admitted to the facility with diagnoses which included but were not limited to, [redacted] The quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], reflected that Resident # 51 scored a [redacted] on the basic interview for mental status (BIMS) which indicated that he/she was [redacted]. [redacted] of the MDS indicated

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that the resident did not exhibit any behaviors during this review and required complete care of two staff members for all aspects of activities of daily living.

On 03/18/22 at 10:15 AM, the Surveyor reviewed the progress notes which revealed the following information:

On 6/22/20 at 15:33 (3:33 PM), a Social Service note revealed the following:
The SW met with the resident to discuss his/her behaviors over the weekend related to cursing at the aides and refusing some care. The SW documented that the resident stated that he/she was upset because he/she heard a CNA in the hallway on the weekend. The SW explained to the resident that the CNA was not assigned to him/her and that she was assigned to care for other residents in his/her hall. The documentation reflected that the resident stated, "didn't care and didn't want to...even hear her in the hallway...because she talks about me".

On 03/28/22 at 9:56 AM, the Administrator (LNHA) and Director of Nursing (DON) confirmed that an investigation was not conducted for the Resident #51's allegation of abuse to the SW on [redacted] at 15:33 (3:33 PM). They also confirmed that the allegation was not reported to the state agency NJ DOH. The LNHA provided the surveyor with an investigation and reportable event record (RER) that was conducted on [redacted].

The facility policy titled, "Abuse Prohibition" with a revision date of 04/09/21, indicated that the facility center prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This included,

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but was not limited to, freedom from corporal punishment, involuntary seclusion, and physical or chemical restraint not required to treat the patients' medical symptoms.
The center will implement an abuse prohibition program through the following:
--Reporting of incidents, investigations, and center response to the results of investigations.

The federal definitions:
Mental abuse includes but is not limited to humiliation, harassments, threats of punishment or deprivation. Mental abuse may occur through either verbal or non-verbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation.

7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following:
7.2 Report allegations involving abuse (physical, verbal, sexual, mental) no later than two 2 hours after the allegation is made.
7.9 Failure to report in the required time frames may result in disciplinary action up to and including termination.
9. The CED or designee will:
9.2 Report findings of all completed investigations within 5 working days to the DOH using the state on-line reporting system

The facility policy titled, "Accidents/Incidents" indicated that staff will use the Risk Management System (RMS) to report, review, and investigate all accident/incidents which occurred, or allegedly occurred, on the centers property and involved, a patient who is receiving services. The policy indicated that an incident is defined as any

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F 609	Continued From page 27 occurrence not consistent with the routine operation of the center or normal care of the patient. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety and security. The licensed nurse will utilize the RMS to report accidents/incidents and assist with completion of timely investigation to determine root cause. The information entered will: -Flow to individualized state reporting forms to assist with completing the state and federal reporting requirements as indicated. Any incident that may be considered an allegation of abuse, neglect, misappropriation of patient property and or crime against an elderly person is managed in accordance with the centers state specific Abuse prohibition policy. 3.4 Notification of state reportable events will be made using the RMS forms except in states that require reporting through the state database. NJAC 8:39-9.4 (f), 13.4	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		5/10/22

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F 610	Continued From page 28 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to follow the facility Abuse Prohibition policy by failing to thoroughly investigate an allegation of abuse. This deficient practice was identified for 1 of 1 resident reviewed for abuse (Resident #51) and was evidenced by the following: On 03/17/22 at 9:49 AM, during the tour the surveyor observed Resident #51 in his/her room in bed who stated that there were nurses and Certified Nursing Assistants (CNAs) in the facility that were "mean". Resident #51 stated that last [redacted] he/she requested the CNA to change him/her because he/she had a bowel movement (BM). Resident #51 stated that the CNA assigned to his/her care did not change him/her for four hours and he/she was left sitting in BM. Resident #51 stated that he/she did not report this concern, and gave the Surveyor permission to report the concern to the Social Worker (SW). On 03/18/22 at 8:55 AM, the Surveyor interviewed Resident #51 who stated that he/she remembered reporting a complaint about a CNA to the human resources manager (HRM). The resident stated that he/she reported that the CNA did not provide care to him/her anymore or since he/she reported it to the administration. Resident #51 stated that the CNA was rude talked about him/her in the hallway so that he/she could over hear.	F 610	Resident #51 was interviewed by the Director of Nursing, Assistant Director of Nursing and Social Worker on [redacted]. An investigation was initiated and the incident was reported to the Department of Health, there was no negative outcome. All residents have the potential to be affected by this deficient practice. The Nurse Practice Educator or designee will inservice all staff on the requirement to investigate all allegations of abuse and neglect immediately. The Director of Nursing or Designee will audit all allegations of abuse and ensure timely reporting of occurrences weekly x 4 weeks then monthly x 3 months. Results of audits will be presented monthly by the Director of Nursing or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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On 03/18/22 at 9:13 AM, the Surveyor interviewed the HRM who identified herself as the Workforce Specialist which was the human resources director. The HRM told the surveyor that she remembered about one year ago that Resident #51 reported that he/she did not care for one of his/her CNAs. She stated that the previous Social Worker (SW) investigated the resident's complaint and that the previous SW was not employed by the facility any longer, but that there should be an investigation regarding that complaint. She stated that the resident reported to her that the CNA rushed him/her and talked about him/her to other CNAs in the hallways so the resident could hear her. The HRM stated that after the investigation, the CNA was restricted from going into Resident #51's room or providing care to him/her. She also stated that the conclusion of this investigation reflected that there was no evidence of abuse and that the resident was reassured that the CNA would not go into the resident room, nor provide care to the resident. The HRM stated Resident #51 had not reported any recent concerns he/she was having issues with staff members.

On 03/18/22 at 9:28 AM, the Surveyor interviewed the Director of SW (DSW) who stated that she would locate the investigation that the previous SW conducted for Resident #51's allegations that a CNA who was rude and talked about him/her in the hallway so the resident could hear over hear. She stated that the resident did not inform her of any problems or concerns he/she was having with the staff but that she would go and speak with him/her.

The facility Admission Record (AR) indicated that Resident #51 was admitted to the facility with the diagnoses which included, but was not limited to,

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[redacted] The quarterly Minimum Data Set (MDS) an assessment tool dated [redacted], reflected that Resident #51 scored a [redacted] on the basic interview for mental status (BIMS) which indicated that he/she was [redacted] the MDS indicated that the resident did not exhibit any behaviors during this review, and [redacted] of the MDS indicated that Resident #51 required complete care of two staff members for all aspects of activities of daily living (ADLs).

On 03/18/22 at 10:15 AM, the Surveyor reviewed the progress notes which revealed the following information:

On 06/22/20 at 15:33 (3:33 PM) a Social Service note revealed the following:

The SW met with the resident to discuss his/her behaviors over the weekend related to cursing at the aides and refusing some care. The SW documented that the resident stated that he/she was upset because he/she heard a CNA in the hallway on the weekend. The SW explained to the resident that the CNA was not assigned to him/her and that she was assigned to care for other residents in his/her hall. The documentation reflected that the resident stated, "didn't care" and didn't want to "even hear her in the hallway" because "she talks about me".

The resident's Care Plan reflected the following problems:

Resident '[redacted] towards staff related to: Poor [redacted], History of [redacted]

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F 610	Continued From page 31 directed toward others (e.g., use of abusive language, pattern of challenging/confrontational, verbal behavior), [redacted]., poor [redacted], [redacted], and [redacted] towards staff. Date Initiated: 03/05/2019 Created on: 03/05/2019 Resident '[redacted] behavior related to: [redacted] Staff." Date Initiated: [redacted] Created on: [redacted] Resident "exhibits or is at risk for [redacted] towards staff) affecting relationships/personal loss/functional changes." Date Initiated: [redacted] Created on: [redacted] On 03/18/22 at 10:23 AM, the Surveyor interviewed the Registered Nurse (RN) who had been employed in the facility since [redacted]. The RN stated that when hired she was in-serviced on abuse, infection control, COVID-19 rules, etc. She stated that if a resident had an allegation of abuse (such as verbal, physician, mental, emotional, withholding food or medications, neglect) she would report to supervisor. "If I witnessed any abuse, I would intervene to stop the abuse and then I would report. I would always make sure that the resident was safe that's the priority." On 03/18/22 at 10:30 AM, the Surveyor interviewed the Licensed Practical Nurse (LPN)	F 610		

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employed since [redacted] who stated that she received mandatory training regarding abuse quarterly. She stated that the types of abuse included neglect, physical, verbal, emotional, and financial. The LPN stated that if she witnessed abuse she would remove the resident from the situation, remove the employee from the situation and be suspended until the investigation was completed. The Director of Nursing (DON), SW, Unit Manager (UM), Supervisor, Licensed Nursing Home Administrator (LNHA) would be notified so that an investigation would be completed. The LPN also stated that statements would need to be obtained from the resident, CNA, and all other employees that were involved. The LPN then added that if it was unwitnessed, the facility would have to go back 24 and obtain statements from all employees that cared for the resident, and if there was an alert and oriented roommate, that the facility would obtain a statement from that person, and other alert and oriented residents in the surrounding area to ensure the abuse was not a widespread problem.

On 03/18/22 at 10:41 AM, the Surveyor conducted and interview with a CNA what employed at the facility for [redacted] The CNA stated that in-services were conducted 3-4 times per year on abuse, and stated that abuse can be verbal, physical, neglect, and also emotional. The CNA stated that if she ever witnessed abuse, she would make sure that the resident was safe and then would report the abuse. "I would report to DON [Director of Nursing] and Supervisor, and if it didn't help, then the ombudsman and state. The CNA stated "that speaking about a resident in the hall in a resident's earshot could be considered emotional abuse."

On 03/18/22 at 10:51 AM, the Surveyor

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interviewed the DSW who stated that the Administrator (LNHA) was the abuse officer at the facility. She stated that the facility completed yearly online mandatory training on abuse and all new hires received abuse training. The DSW stated that abuse could be described as verbal abuse, neglect, financial exploitation, mental, involuntary seclusion, or sexual and she stated that if any reports of abuse were reported and depending on the type of abuse with actual injury, that the DON, LNHA and then the police would be notified. The DSW stated that if abuse was witnessed, the following events would occur immediately and included to protect the resident, report to state and an investigation would be initiated. The DSW stated if it was a nurse or a CNA that had direct contact with victim, then she would interview and obtain statements from other residents or CNA's that worked and had contact with the aggressor to find out if the abuse happened to them, or if anyone witnessed anything. The DSW stated this would be done to ensure everyone's safety and she stated she was responsible to interview the residents, and nursing was responsible to interview the staff. The DSW then added that the employee involved would be suspended pending a thorough investigation, and that if there were any unwitnessed signs of abuse the facility would obtain statements from everyone that had contact with the resident which included housekeeping, dietary, CNAs, nurses, etc.

On 03/18/22 at 11:11 AM, the Surveyor interviewed the DON who stated that the LNHA was the facility abuse officer. She stated that abuse could be defined as physical, mental, verbal, financial exploitation, sexual, emotional, or mental. She stated that mandatory abuse training was done yearly, and reeducation was provided

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F 610	Continued From page 34 to staff as needed. She stated that if the staff reported abuse, first and foremost was to protect the resident and make sure the resident was safe. The DON further added that if it was a staff member who was the alleged perpetrator then the staff member would be put on administrative leave pending an investigation. She stated that nursing supervisor would start the investigation and would fill out an incident report (RMS). The DON stated "I then start an investigation and report to the DOH, MD [medical doctor] and family." She then stated that she would obtain statements from the staff and the SW was the designee to obtain a statement from the resident and from the roommate and we expand the statements to other residents in the CNA's assignment. The DON also stated that any allegations of abuse would be reported to the Department of Health (DOH) as a reportable event. She further added that if abuse was unwitnessed, statements would be obtained from the resident, the roommate, a full body assessment would be performed and that the resident would be sent to the hospital. She stated that statements would also be obtained from other residents and staff going back 72 hours. The DON reviewed the SW progress note dated [redacted] at 15:33 (3:33 PM) with the surveyor and stated "I was not the DON at the time of the incident of [redacted] but I would have started an investigation." On 03/18/22 at 11:29 AM, the LNHA stated that he was the abuse officer in the facility. He stated that he ensured all staff knew the abuse policy and that all staff were trained on abuse annually, upon hire, and as needed. He stated that he was ultimately responsible for any abuse issues in the facility. He stated that all employees were trained to report abuse to the supervisors and that when	F 610		

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abuse was suspected the staff would know to report to the LNHA. He stated that abuse was any physical, mental, sexual, verbal, misappropriation of funds, retaliation, coercion, isolation of seclusion, or neglect. He stated that if he was notified about any allegations of abuse, he would immediately report to Department of health (DOH) and police (if warranted), Ombudsman, MD, and the family or responsible party. He further added that he would make sure the resident was safe and assessed for any signs of injury. The LNHA stated that all allegations of abuse were taken seriously. He added that the alleged perpetrator would be suspended immediately pending an investigation and that during the investigative process the facility would interview other residents to assure that the issue was not widespread. He stated that a risk management system facility incident report (RMS) would be completed and "typically" the nurse would fill that out. He stated that the RMS/Incident report was a checklist and guide to ensure everything was covered.

The surveyor reviewed the SW progress note dated [redacted] at 3:33 PM with the LNHA who stated that an RMS/Incident report should have been completed for the resident's allegation, and that he would investigate to see if he could locate the documentation.

The LNHA stated that Resident #51 had a history of being [redacted] staff and when the staff refused to [redacted], he/she retaliated against them and tried to get staff fired. He stated that the facility tried to assign male CNAs to the resident's care when available, and have two CNAs present in the resident's room during care because of the resident's allegations against the CNAs.

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F 610	Continued From page 36 On 03/18/22 at 1:13 PM, the DON stated to the Surveyor that there was no investigation completed into Resident #51's allegation of abuse from [redacted] at 3:33 PM. On 03/22/22 at 8:33 AM, the Surveyor interviewed the LNHA who stated that they had to move the CNAs (who the resident heard in the hallway talking about him) assignment around to accommodate the resident so that the resident did not hear the CNAs voice per the incident of [redacted]. He stated that the resident continued to complain about the CNA because previously the CNA politely refused [redacted] regarding shaving the residents' [redacted] The LNHA further stated that even though a resident had a history of making allegations. The Surveyor inquired to the LNHA what the facility would do if the resident made further allegations and the LNHA stated that they would still investigate. The LNHA stated that he would "look into" the allegation of [redacted] to see if an investigation was conducted. The LNHA could not provide the surveyor with a completed investigation of an allegation of abuse reported by the resident to a SW on [redacted] 15:33 (03:33 PM). On 03/28/22 at 9:56 AM, the LNHA and DON confirmed that an investigation was not conducted for the Resident #51 allegation of abuse to the SW on [redacted] at 15:33 (03:33 PM). They also confirmed that the allegation was not reported to the state agency Department of Health (DOH). The LNHA provided the surveyor with and investigation and reportable event record (RER) that was conducted on [redacted]. The facility policy titled, "Abuse Prohibition" with a	F 610		

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revision date of 04/09/21 indicated that the facility center prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and physical or chemical restraint not required to treat the patients' medical symptoms.
The center will implement an abuse prohibition program through the following:
-Identification of possible incidents and allegations which need to be investigated.
-Investigations of incidents and allegations.

The federal definitions:
Mental abuse includes but is not limited to humiliation, harassments, threats of punishment or deprivation. Mental abuse may occur through either verbal or non-verbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation.

7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following:
7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on:
7.7.1 whether abuse has occurred and to what extent.
7.8 The investigation will be thoroughly documented within the RMS and ensure that documentation of witnessed interviews is included.
7.8.1 Conduct interviews using Alleged perpetrator/victim interview record and witness interview record.

The facility policy titled, "Accidents/Incidents"

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SOUTHERN OCEAN CENTER	1361 ROUTE 72 WEST MANAHAWKIN, NJ 08050

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F 610	Continued From page 38 indicated that staff will use the Risk Management System (RMS) to report, review, and investigate all accident/incidents which occurred, or allegedly occurred, on the centers property and involved, a patient who is receiving services. The policy indicated that an incident is defined as any occurrence not consistent with the routine operation of the center or normal care of the patient. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety and security. The licensed nurse will utilize the RMS to report accidents/incidents and assist with completion of timely investigation to determine root cause. The information entered will: -Trigger specific investigation tools based on the type of event and/or injury of the patient. -Any incident that may be considered an allegation of abuse, neglect, misappropriation of patient property and or crime against an elderly person is managed in accordance with the centers state specific Abuse prohibition policy. 4. Follow-up/Investigation. 4.2 the CED or designee will coordinate all investigations and: 4.4 When investigating, the CED, CNE or designee will: 4.4.1 Make every effort to ascertain the cause of the incident or accident. 4.4.3 Investigations will be documented using the appropriate RMS investigation/QA form. 4.4.4 Monitor all aspects of the accident/incident and investigation involving are documented in the RMS. 4.4.7 Complete investigation within 5 working days. NJAC 8:39-9.4 (f), 13.4	F 610		
F 657	Care Plan Timing and Revision	F 657		5/10/22

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F 657 SS=D	Continued From page 39 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to update and revise resident Care Plans (CP) to include interventions for: a.) 1 of 3 residents reviewed for [redacted] (Resident #11), and b.) 1 of 4 resident reviewed for accidents (Resident #17). This deficient practice and was evidenced by the following:	F 657	Resident # 11 [redacted] care plan was revised and updated to reflect the resident's current [redacted] status. Resident #17 [redacted] care plan was revised and updated to match the resident's current [redacted] status. All residents have the potential to be affected by this deficient practice.	

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F 657	Continued From page 40 a.) On 03/17/22 at 10:05AM, during the initial tour the Surveyor interviewed Resident #11 in his/her room who stated that he/she did not remember when he/she developed the [redacted] to the [redacted]. The Surveyor reviewed the clinical record which revealed the following information: The Admission Record revealed that Resident #11 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]. The Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed [redacted] indicated that there were [redacted], the resident was at [redacted] and there were [redacted]. The MDS also reflected that the resident was [redacted] and required extensive to limited assistance with activities of daily living (ADLs). The nurse practitioner (NP) progress notes with time of 00:00 and dated [redacted], did not reflect that the resident had a [redacted]. The Skin Check (V 4) report dated [redacted] at 20:52 (8:52 PM), indicated that the resident had [redacted]. There was no documentation of a [redacted]. The skin check included the following interventions: off [redacted] while in bed and observe skin for signs or symptoms of [redacted]. The NP note dated 12/28/21 at 15:05 (3:05 PM) indicated that there was a change in the resident's condition: [redacted]. The note indicated that nursing observations, evaluation and recommendations were that while	F 657	Nurse Practice Educator or Designee will provide an inservice to licensed nurses to update resident's skin care plans to reflect their care/need. Nurse Practice Educator or Designee will provide education to licensed nurses and Social Worker to update resident's [redacted] care plans to reflect their current [redacted] status. United Manager or designee will conduct random weekly audits for 4 weeks then monthly for 3 months to ensure [redacted] and [redacted] care plans are updated timely. Results of audits will be presented monthly by the Unit Managers or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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F 657	Continued From page 41	F 657		

performing dressing changes to the resident [redacted] noticed an [redacted] to the [redacted]. The note indicated that the resident denied pain to the [redacted] and stated that he/she was not aware that the [redacted] was there.

The Surveyor reviewed the Clinical Physician Orders (CPO) dated [redacted] which indicated that resident #11's [redacted] were to be elevated on pillows at all times while in bed and a CPO dated [redacted] reflected an order to apply [redacted] to [redacted] every day and evening shift.

The Care Plan was reviewed and there was no documentation in the CP regarding the [redacted] identified on [redacted], and there were no further interventions for [redacted]

The Care Plan reflected the following:

[Resident #11] "exhibits or is at [redacted]
Date Initiated: [redacted]
Created on: [redacted]
-An intervention for [redacted] was initiated [redacted].

The resident was a risk for [redacted] related to advanced age, [redacted] skin, limited mobility, poor safety awareness, shear and friction risk, [redacted] and [redacted]
Date initiated: [redacted]
Created on: [redacted]

On 03/23/22 at 8:37 AM, the Surveyor interviewed Resident #11 in his/her room who stated that he/she had the [redacted] on the [redacted] for quite some time. Resident #11 stated

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he/she could not remember the date or month when he/she developed the [redacted] and stated "I think I got it by using my [redacted] to push myself up in bed." Resident #11 stated that he/she wore a [redacted] pad to the [redacted] while in bed and had a special mattress. He/she stated that he/she had [redacted] issues and was going out to see the [redacted] doctor today and stated that [redacted] care was completed in the evening.

On 03/23/22 at 8:52 AM, the Surveyor conducted an interview with the Licensed Practical Nurse (LPN #1) who stated that she had been employed at the facility for [redacted]. The LPN #1`stated that Care Plans (CP) were started upon admission with the focus being on [redacted] and [redacted]. The LPN #1 stated that interventions were added in at that time of admission to either prevent an occurrence or treat a current issue. She stated that the CP had goals and interventions and if a [redacted] developed while in the facility, or was new that a RMS/Change in condition/ Incident report would be initiated so that all disciplines would know that the resident had a new [redacted]. She stated that a CP would be developed immediately with interventions, the physician would be notified, treatment would be ordered, and the family notified unless the resident was alert and oriented and was own responsible party.

On 03/23/22 at 8:59 AM, the Surveyor interviewed an LPN #2 who stated that CPs were initiated upon admission with the focus being on [redacted], and [redacted] She further stated that the CP wound also be developed to tailor diagnoses and resident conditions on admission, and interventions would be added to promote care, prevent [redacted], [redacted] and [redacted] The LPN

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#2 stated that it would be important to put the CP in because it drove care with all disciplines. The LPN #2 stated that the CP [redacted] be updated with a new conditions, such as [redacted] or when family conferences were held, and when that process was completed in the computer it notified all disciplines to get involved, develop interventions and update the CP.

On 03/23/22 at 9:17 AM, the Surveyor interviewed a Registered Nurse (RN) who stated that an RMS (risk Management System) is the facility incident report. If a resident should [redacted] or develop a [redacted] or if there was a medication error, then this report would be generated in the computer. "The RMS would instruct the nurse or person filling out the report to start an investigation and what steps needed to be done according to what the incident was." The RN/UM also stated that a CP with new interventions would be developed for a new [redacted].

On 03/23/22 at 10:29 AM, the Surveyor interviewed the Director of Nursing (DON) who stated that, and incident report should have been completed when the nurse discovered the [redacted] on Resident #11's [redacted] on [redacted]. The DON stated that the nurse should have implemented a CP concerning the new [redacted] but that was not completed.

On 03/28/22 at 9:55 AM, the DON confirmed that the CP was not revised to include the development of the [redacted].

Surveyor: [redacted]

b.)Refer to F689

On 03/18/22 at 11:30 AM the Surveyor conducted

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a record review of Resident #17's electronic medical record. According to the Admission Face Sheet, Resident #17 was admitted to the facility with diagnoses which included, [redacted]

The Significant Change Minimum Data Set (MDS) dated [redacted] an assessment tool to prioritize residents care revealed that Resident #17 was [redacted]. Resident #17 scored [redacted] out of 00-15 on the Brief Interview for Mental Status (BIMS) indicated a [redacted].

A review of Resident #17's Care Plan for [redacted] initiated [redacted], revised [redacted] and included the goal that Resident #17 would [redacted] safely x 90 days per [redacted] assessment.

The interventions included :
1. Inform of and reinforce [redacted] restriction
2. Inform and remind Resident #17 of [redacted] areas and times.
3. Ensure that there is no [redacted] use in [redacted] area (s)
4. Monitor Resident #17 compliance to [redacted] policy.
5. Maintain lighting materials at nurse's station.

The Quarterly "[redacted] Evaluation" (SE) dated [redacted] and provided by the facility on [redacted] at 11:01 AM was not signed by Resident #17. A boxed note on the SE read: Resident #17 did not use [redacted] when he/she went out and used [redacted] while in the room. According to the facility, Resident #17 was assessed to be an [redacted] and was able to adhere to the facility's policy for [redacted]

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F 657	Continued From page 45 The Surveyor further reviewed the electronic clinical record and noted a Progress Notes dated [redacted] timed 6:33 which revealed the following: Staff noticed resident's room smelled like [redacted] and found [redacted] of [redacted] with a [redacted] and a [redacted] in a coffee cup. Resident admitted to [redacted] in the room while she/he had the [redacted] on and the [redacted] was running. [redacted] and [redacted] removed from room and resident counseled on behavior. Supervisor aware... The Care Plan for [redacted] initiated [redacted] and last revised [redacted] was not revised to to include interventions after the resident was found [redacted] in his/her room while wearing [redacted]. An interview conducted with the DON on [redacted] at 12:50 PM confirmed that Resident #17's CP was not revised after the incident of [redacted] On 03/25/22 at 1:30 PM, the Surveyor interviewed the UM and reviewed Resident #17's CP. The UM confirmed the resident's CP had not been updated to include frequent monitoring, monitoring for the presence of [redacted] in the room and implement room search to prevent recurrence of the behavior. The facility policy titled. "Skin Integrity Management" with a revision date of 06/01/21 indicated the following information: The policy indicated that the implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patient changes and implements revisions to the plan of care as needed.	F 657		

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F 657	Continued From page 46 The purpose of the policy is to provide safe and effective care to prevent the occurrence of [redacted], manage treatment, promote [redacted] of all [redacted] -Identify patient's skin integrity status and need for prevention interventions or treatment modalities through review of all appropriate assessment information. -Develop comprehensive interdisciplinary CP including prevention of wound treatments, as indicated and Implement [redacted] prevention for identified risk factors. The facility policy, "Person-Centered Care Plan" with a revision date of 07/01/19 indicated that the center must develop and implement a baseline person-centered care plan within 48 hours for each patient that included the instructions needed to provide effective and person-centered care that meet professional standards of quality of care. The baseline care plan will ensure that patients who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for patients experiences and preferences. Purpose: is to attain or maintain the patients highest practical physical, mental and psychological well-being, eliminate or mitigate triggers that may cause re-traumatization of the patient, to promote positive communication between patient, resident representative, and team to obtain the patient's and resident representative's input into the plan of care, ensure effective communication and optimize clinical outcomes. The comprehensive person-centered care plan must be developed for each patient and must describe the following:	F 657		

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F 657	Continued From page 47 4.1 Services that are to be furnished. 4.2 Any services that would otherwise be required but are not provided due to the patient's exercise of rights including the right to refuse treatment. 4.3 Any specialized services or specialized rehabilitative services. Care Plans will be: 7.1 Communicated to appropriate staff, patient resident representative, family. 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, an as needed to reflect the response to care and changing needs and goals. NJAC 8:39-11.2 (1), (2), 12.1, 27.1 (a)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation it was determined that the facility failed to follow standards of practice by failing to accurately document a locked emergency cart. This deficient practice was identified on 2 of 3 units ([redacted] unit and [redacted] unit) and was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating	F 658	Emergency Cart Checklist was updated to reflect current lock status and signatures added. All residents have the potential to be affected by this deficient practice. The Nurse Practice Educator or Designee will provide inservice to license nurses regarding crossing off legal documentation and accurately completing new Emergency cart checklist. The Unit Managers or designee will conduct random weekly audits of accuracy of the	5/10/22

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F 658	Continued From page 48 human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:" Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 03/22/22 at 9:25 AM, the Surveyor inspected the crash (emergency cart) on the [redacted] floor. The emergency medication box that was located on top of the cart was locked with a green lock and the emergency cart (EC) was unlocked. The form located on a clipboard on top of the emergency cart titled, "Emergency Cart Checklist (ECC)" and dated [redacted] had instructions that indicated: "nurse should place a yes or no in the box for the cart to be locked." The ECC stated "if the cart is unlocked, check each item, replace missing or expired items, initial each item, lock the cart and initial that it was locked." The surveyor observed that there were nurses' signatures located on the ECC which indicated that the emergency cart was locked. On 03/22/22 9:35 AM, the Surveyor interviewed the registered nurse (RN) on the [redacted] floor who stated that the EC had been unlocked as far as	F 658	Emergency Carts checklists for 4 weeks then monthly for 3 months to ensure this process is done. Results of audits will be presented monthly by the Nurse Practice Educator or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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she could remember and that there was "never" a key to the cart. She stated that the nurse on the 11:00 PM to 7:00 AM shift checked the EC and signed the ECC that the items were all in place on the EC and that the cart was locked. She further added that the nurse was also signing the ECC that the cart was locked, however the cart on the [redacted] floor has "never" had a key and was "never" locked. She added that the nurse should not be singing the ECC that it was locked when it wasn't.

On 03/22/22 at 9:42 AM, the Surveyor interviewed the RN #2 on the [redacted] floor who stated that the EC on the [redacted] floor was also not able to be locked and it was covered with a plastic tarp. She added that if the EC on the [redacted] floor did not need to be locked then why did the [redacted] floor emergency cart needed to be locked.

On 03/22/22 at 9:55 AM, three Surveyors observed the EC on the [redacted] floor and observed that the medication emergency box was located on top of a cart and was locked. The EC was covered with a pink plastic tarp and could not be locked. The Surveyor interviewed the RN nurse educator (RNE) at this time who stated that she had not been employed at the facility for very long but in her experience the EC should not be locked and should be accessible if needed. The RNE reviewed the ECC in the presence of the surveyor and confirmed that the nurses were signing the ECC that the cart was locked when the EC could not be locked.

On 03/22/22 at 10:36 AM, the Surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the EC should only have items in the cart that was listed on the ECC. She stated that if an item was not on the ECC then it

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F 658	Continued From page 50 should not be in the EC. She stated that the ECC that was signed by a nurse which indicated that the supplies were all in place on the cart in case there was an emergency and that the cart was locked, but that the ECC was not updated to reflect that the EC was to remain unlocked. She stated that the EC on the second floor could not be locked. On 03/28/22 at 10:08 AM, the Surveyor interviewed the Director of Nursing (DON) who did not have an explanation as to why the nursing staff on the 11:00 PM to 7:00 AM shift nurses were signing the ECC that the medication cart was being locked when the EC on the [redacted] and [redacted] floor were not able to be locked. She further added that the staff crossed off the area on the ECC March 2022 regarding the EC being locked but confirmed that they should not be crossing information off facility documents and that they should have communicated to administration that the ECC form was not accurate regarding the locking of the EC. On 03/28/22 at 10:30 AM, the DON and Licensed Nursing Home Administrator (LNHA) did not provide the Surveyor with any additional information. NJAC 8:39-1.1 (a), 3.1 (a, b)	F 658		
F 689 SS=D	. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		5/10/22

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	315332	A. BUILDING _____ B. WING _____	04/06/2022

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F 689	Continued From page 51 §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, record review and review of other facility documents, it was determined that the facility failed to investigate an incident of unsafe [redacted] This deficient practice was identified for 1 of 5 residents reviewed for accidents (Resident #17) and was evidenced by the following: On 03/17/22 at 10:13 AM, the Surveyor observed Resident #36 resting in bed with his/her eyes open. The Surveyor observed the resident had [redacted]) that was connected to an [redacted] (an electronic device that removes [redacted] . On 03/17/22 at 12:41 PM, the Surveyor observed Resident #17 self-propelling in a wheelchair in the hallway. On 03/17/22 at 12:50 PM, the Surveyor reviewed Resident #17's medical record which revealed the following: The Admission Face Sheet (an admission summary) revealed that Resident #17 had diagnoses which included but were not limited to,	F 689	Resident # 17 was reeducated on the [redacted] policy, residents' [redacted] assessment was updated to reflect current [redacted] status. All residents have the potential to be affected by this deficient practice. Licensed nurses will be inserviced by Nurse Practice Educator or designee on timely initiation of incident reports. All staff will be inserviced on the [redacted] policies and procedures by the Nurse Practice Educator or designee. Residents who smoke and experience a change in condition will be reassessed for ability to [redacted] independently. [redacted] measures will be documented on each resident's care plan and communicated to staff. Residents that [redacted] will be reminded and educated to the facilities [redacted] policies quarterly and upon change in condition, to include that they are not allowed to keep their own [redacted] . Unit Manager or designee will audit residents [redacted] compliance weekly x 4 weeks and monthly x 3 months. Resident council meeting was convened and all residents	

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F 689	Continued From page 52 [redacted] The significant change Minimum Data Set (MDS), an assessment tool dated, [redacted] revealed that Resident #17 was [redacted]. Resident #17 scored 09 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated a [redacted]. Review of the Progress Notes dated [redacted] through [redacted] revealed that Resident #17 was [redacted] with periods of [redacted]. The surveyor reviewed Resident #17's [redacted] Evaluation (SE) dated [redacted] and [redacted] On 03/18/22 at 9:24 AM, the Surveyor observed Resident in bed with his/her eyes closed and [redacted] was running via a [redacted] that was connected to an [redacted]. On 03/18/22 at 11:30 AM, the following entry was noted in the electronic medical record (EMR) dated [redacted] and timed 06:33: "Staff noticed resident's room smelled like [redacted] and found [redacted] with a [redacted] and a [redacted] in a coffee cup. Resident admitted to [redacted] in the room while [he/she] had the [redacted] on and the [redacted] was running. Resident is very apologetic and states [he/she] won't do it again. [redacted] and [redacted] removed from room and resident counseled on behavior. Supervisor aware." On 03/18/22 at 12:40 PM, the Surveyor requested Resident #17's Care Plan (CP) and all investigative reports. The Director of Nursing (DON) provided the surveyor with two fall investigative reports, and she stated there were	F 689	that [redacted] were updated and reminded about [redacted] policies. Results of resident [redacted] audits will be presented monthly by the Unit Managers or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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F 689	Continued From page 53 no other investigations conducted for Resident #17. A review of Resident #17's CP for [redacted], initiated [redacted], revealed the following under focus: Resident #17 may smoke independently per [redacted] assessment related to history of [redacted]. The goal was for Resident #17 to smoke safely X 90 days per [redacted] assessment with the following interventions: 1. Inform of and reinforce [redacted] restriction. 2. Inform and remind Resident #17 of [redacted] areas and times. 3. Ensure that there is no [redacted] use in [redacted] area(s). 4. Monitor Resident #17's compliance to [redacted] policy. 5. Maintain [redacted] materials at nurse's station. On 03/22/22 at 12:50 PM, the Surveyor conducted a subsequent interview with the DON regarding any additional investigations for Resident #17. The DON confirmed that there were no additional investigations for Resident #17. On 03/22/22 at 1:10 PM, the Surveyor conducted an interview with a Certified Nursing Assistant who was familiar with Resident #17's routine and had been working at the facility for over [redacted] years. The CNA revealed that Resident #17 was a [redacted]. She stated she was not assigned to Resident #17 that day the resident was found [redacted]. The CNA stated that Resident #17 was a [redacted] and he/she used to go outside to [redacted]. On 03/22/22 at 1:12 PM, the Surveyor conducted an interview with a CNA assigned to Resident #17	F 689		

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F 689	Continued From page 54	F 689		

that day. The CNA revealed that Resident #17 was very sociable, must be encouraged to participate with care, and liked to stay in bed and watched television. The Surveyor inquired to the CNA regarding the facility rules regarding [redacted]. The CNA stated that she had recalled an incident that happened in Resident #17's bathroom. Resident #17 was found [redacted] in the bathroom and had been found with a [redacted] and [redacted] in the room. The CNA stated the Administrator was called and gave a paper to the resident regarding the incident. The CNA indicated that the incident took place on the 11:00 PM-07:00 AM shift.

On 03/22/22 at 1:25 PM, the Surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) about Resident #17. The LPN/UM stated the resident was a [redacted] and was very sick and was hospitalized in [redacted] The LPN/UM stated Resident #17 had not [redacted] since, and that she was not aware of any incident involving the resident [redacted] in the room.

On 03/22/22 at 1:35 PM, the Surveyor interviewed Resident #17 in his/her room. Resident #17 stated that he/she became very sick a few months ago and had not [redacted] since.

On 03/22/22 at 1:42 PM, the Surveyor, accompanied by another Surveyor, conducted an interview with the Administrator regarding the [redacted] process at the facility. The Administrator stated that the facility had a [redacted] policy tied to the corporate policy which included: the designated areas for [redacted] times, storage of [redacted] and [redacted] materials. The Administrator stated that residents were

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F 689	Continued From page 55 allowed to keep [redacted] with them and were not allowed to keep [redacted] materials. The Administrator stated that based on the facility's policy, [redacted] materials were kept at the front desk. The Surveyor inquired to the Administrator regarding if he had addressed any resident noncompliance with the [redacted] policy recently. The Administrator stated," No, not recently". The Surveyor further inquired about [redacted] assessments. The Administrator indicated that [redacted] assessment were completed by the nursing department. The Administrator provided the facility's [redacted] policy to the Surveyors. The Administrator stated to both Surveyors that if a resident was caught [redacted] in a room, or a non-designated area for [redacted], an incident report should have been completed. (There was no incident report completed when Resident #17 was found [redacted] in the room on [redacted]). On 03/23/2022 at 08:00 AM, the surveyor reviewed the facility provided 24 Hour Summary dated [redacted] .The incident regarding Resident #17 found [redacted] in his/her room was not documented on the 24 Hour Summary report. On 03/23/22 at 10:05 AM, the Surveyor interviewed the DON regarding the [redacted] incident with Resident #17 that occurred on [redacted]. The Surveyor inquired to the DON regarding if an incident report was completed when Resident #17 was found [redacted] in his/her room. The DON stated that an incident report was not completed. She stated that she was not at the facility when the incident occurred and the Assistant Director of Nursing (ADON) who was covering, was new on the role and did not complete an incident report.	F 689		

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F 689	Continued From page 56	F 689		

On 03/23/22 at 11:03 AM, the Surveyor interviewed the Social Worker (SW) regarding the [redacted] incident with Resident #17. The SW stated that he was informed of the incident by the nurse on the morning of [redacted]. The SW stated that Resident #17 was aware that he/she should not be [redacted] in the room. The SW stated that Resident #17 did not disclose how he/she got the [redacted] and the [redacted]

On 03/23/22 at 11:23 AM, the Surveyor interviewed the ADON who stated that the nurse smelled the [redacted], searched the room, and documented and reported the incident. The ADON stated that the [redacted] and the [redacted] were returned to the Administrator on the morning of [redacted]. The ADON stated that she reported the incident to the DON and to the Corporate Office and she was told that it was not a reportable event. The ADON confirmed that she did not interview the resident and did not generate an incident report. The ADON stated that Resident #17 was interviewed by the nurse and the Social Worker after the incident. The ADON indicated that she reviewed the [redacted] policy with Resident #17 at a later date but could not recall the date, and she did not provide the Surveyor with an entry in the medical record regarding her conversation with Resident #17 regarding the [redacted] incident.

On 03/25/22 at 8:35 AM, the survey team conducted a face to face interview with the LPN who worked on [redacted] on the 11:00 PM-07:00 AM shift. The LPN stated that on [redacted] she was in the hallway checking on the residents and then she smelled the [redacted] by Resident #17's room. The LPN then called to the CNA who confirmed the same. The LPN stated she then entered Resident #17's room and

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F 689	Continued From page 57 observed [redacted], and a [redacted] r on the bedside table. The LPN stated she also observed the remainder of a [redacted] in a coffee cup. The LPN stated that she interviewed Resident #17 who admitted that he/she had been [redacted] in the room, while the [redacted] was running that night. The LPN stated that she documented the incident and reported the incident to the Nursing Supervisor and the ADON. The LPN further stated that the next morning the Administrator came into the facility, and she discussed the incident with him. The LPN stated, "I was aware that residents could have [redacted], not [redacted], in the room. That was bad enough, [he/she] had [redacted] on if [he/she] lit it [he/she] could [redacted] place". The Surveyor inquired to the LPN about any interventions that were put into place after the incident to prevent recurrence, and the LPN indicated she was not sure of any and she was informed by the DON that she should have initiated a change in condition. She told the Surveyors that she notified the ADON and did not have to do anything else. The incident was not entered onto the 24-hour report and there were no monitoring tools put into place. She stated that she notified the ADON and that she did not have to do anything else. When asked about the process on On [redacted] at 1:30 PM, the Surveyor interviewed the Administrator regarding the process that should have been followed if a resident was found [redacted] in his/her room. The Administrator stated that an incident report should have been completed. On 03/23/22 at 1:27 PM, the Surveyor interviewed the front desk staff regarding accountability for the [redacted] materials. She indicated her role was to provide the [redacted] upon request, and that the residents were responsible	F 689		

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F 689	Continued From page 58 to return the [redacted]. On 03/24/22 at 9:35 AM, the Surveyor interviewed the Medical Director (MD). The MD stated that he visited the facility several times a week and could be reached at any time. When asked if he was made aware of the [redacted] incident with Resident #17 on [redacted] he indicated that he could not recall if he was made aware. The MD stated that he would have encouraged him/her not to [redacted], and "residents should not be [redacted] in the room, it is a fire hazard". On 03/25/22 at 9:30 AM, the Surveyor interviewed the UM regarding Resident #17's behavior. The UM stated that she heard of an incident that happened while she was on vacation. When asked to elaborate she informed the Surveyor that Resident #17 was reportedly [redacted] in the room. The Surveyor asked her to elaborate on the process of such an incident. The UM stated she would expect that the incident be reported to the Nursing Supervisor on duty, remove the [redacted] in the room, and ensure that the resident and the roommate were safe. The UM stated "I would check the [redacted], ensure that the DON was made aware of the incident and basically follow the chain of command. The UM stated she would initiate an incident report, do a significant change because it was something out of the norm [normal] and it was "possible harm". She further stated that if Resident #17 was [redacted] in the room and there was [redacted] and a roommate, there could be an explosion. The UM stated all [redacted] were held at the front desk and residents were not allowed to have [redacted] materials in the room. She further stated that she would investigate and would call the family, and she would ask the staff to find out	F 689		

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F 689	Continued From page 59 how he/she got the [redacted] materials. The UM stated I would monitor to ensure it did not happen again. A review of the facility policy titled, "Accidents/Incidents" dated 06/01/1996 and last revised 11/28/16 revealed the following: The facility will use the Risk Management System (RMS) report, review, and investigate all accidents/ incidents which occurred, or allegedly occurred on Center property and involved, or allegedly involved, a patient who is receiving services. Policy: An accident is defined as any unexpected and unintentional incident which may result in injury, or illness to a resident/ patient. This does not include adverse outcomes are a direct consequence or treatment or care that is provided in accordance with current standards of practice. An incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the patient. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or security. The licensed nurse will utilize RMS to report accidents/ incidents and assist with completion of a timely investigation to determine root cause.... Purpose: Provide standards for review and investigation of accidents/ incidents. To define causative/ contributing factors and institute preventive measures to avoid further occurrences as part of the Quality Assurance Performance Improvement.	F 689		

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F 689	Continued From page 60 Process. To meet regulatory requirements for analyzing and reporting accidents/ incidents. Under Assessment it indicated that the nurse would document the accident/incident on the 24-Hour Report. The Policy was not being followed. A review of the facility policy for [redacted] dated 06/01/1996 last revised 11/202018 documented also the following: [redacted] (including electronic cigarettes) will only be allowed in designated areas. [redacted] use is prohibited in [redacted] areas... The care plan will be updated as necessary. [redacted] supplies (including, but not limited to, [redacted] etc.) will be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station. Patient will not be allowed to keep their own [redacted]. The policy was not being followed.	F 689		
F 695 SS=E	NJAC 8:39-27.1 (b)8:39- 33.1 (d) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		5/10/22

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F 695	Continued From page 61 Based on observation, interview, record review and review of pertinent documents, it was determined that the facility failed to: a.) administer [redacted] per the physician order for 2 of 5 residents sampled for [redacted] (Resident #36 and Resident #17), b.) ensure that all [redacted] supplies were changed, labeled and dated weekly for 4 of 5 residents sampled for [redacted] and c.) post cautionary signage to indicate that [redacted] therapy was in use for 4 of 5 residents reviewed for [redacted] (Resident #36, #17, # 63 and Resident #27). The deficient practice was evidenced by the following: 1. On 03/17/22 at 10:13 AM, the Surveyor observed Resident #36 resting in bed with eyes open wearing [redacted] by way of [redacted] used to deliver [redacted]). The [redacted] was connected to an [redacted] (an electronic device that removed [redacted]) that was sitting beside the bed and set to deliver [redacted]. On 03/18/22 at 9:24 AM, the Surveyor observed Resident #36 resting in bed with his/her eyes closed. Resident #36 was observed wearing [redacted] by way of [redacted]. The [redacted] was connected to an [redacted] tor sitting next to the bedside and the [redacted] was set to deliver [redacted]. A review of Resident #36's medical record revealed: the resident was admitted to the facility with diagnoses which included but not limited to, [redacted]. A review of a physician order dated [redacted] at [redacted]	F 695	Resident #36 and Resident #17 [redacted] and [redacted] were immediately changed and labeled with date and initial. Resident #36 and Resident #17 [redacted] on the [redacted] was adjusted to correspond with orders. Caution sign was posted at the door to indicate [redacted] in usage for Resident #36 and Resident #17. Resident #63 [redacted] was immediately changed with the correct date and initial. Resident #63 care plan was initiated to reflect the resident [redacted] needs. Resident #63 caution sign was posted at the door to indicate [redacted] in usage. Resident #27 [redacted] and [redacted] were immediately changed labeled with date and initial. Resident #27 caution sign was posted at the door to indicate [redacted] in usage. All residents have the potential to be affected by this deficient practice. All licensed nurses will be inserviced by the Nurse Practice Educator or designee on the following, checking [redacted] every shift or as needed, changing [redacted] with initial and dates, [redacted] change and date, respiratory care plan, and ensuring caution signs at the door when applicable. The Unit Managers or designee will conduct random weekly audits for 4 weeks then monthly for 3 months. Results from audits will be presented monthly by the Unit Managers or designee	

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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 695	Continued From page 62 [redacted] hours daily every shift, [redacted] change weekly, label each component with date and initials every night shift every [redacted] and label each component with date and initials. A review of the Quarterly Minimum Data Set (MDS an assessment tool) dated [redacted] revealed that Resident #36 was [redacted] and required limited assistance with activities of daily living. On 03/18/22 at 11:32 AM, the Surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that she was not too sure of the setting for the [redacted] and that she indicated that she checked the [redacted] this morning. On 03/18/22 at 11:35 AM, the Surveyor accompanied by LPN #1 into Resident #36's room only to verify that the [redacted] was connected to the [redacted] with a [redacted]. The surveyor observed that the [redacted] was not labeled with a date and was resting on the floor. The surveyor also observed the [redacted] (a medical device used to [redacted]) was dated [redacted]. The Surveyor observed that there was no cautionary signage posted at the door to indicate that [redacted] was in use. LPN #1 confirmed that the [redacted] and that she would check the physician order and adjust the [redacted] On 03/18/22 at 11:40 AM, the Surveyor conducted another interview with LPN #1 who confirmed that she was responsible for Resident #36 that morning and that the 11:00 PM -7:00 AM shift was responsible to change the [redacted] and [redacted] every [redacted]. LPN #1	F 695	at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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F 695	Continued From page 63 confirmed that Resident #36's order was to receive [redacted]. On 03/25/22 at 8:55 AM, the Surveyor interviewed the LPN (LPN #2) who worked the 11:00 PM-07:00 AM shift. LPN #2 stated that she had not been at the facility for the last two weeks and that the other nurse that covered the shift should have changed and dated the [redacted] LPN #2 indicated that upon return to work she did not check to ensure that the [redacted] was changed as it was the facility's policy for the [redacted] to be changed every week on [redacted]. 2. On 03/17/22 at 10:15 AM, the Surveyor observed Resident #17 in bed. Resident #17 had the [redacted] on and the [redacted] was dated [redacted]. The surveyor observed the [redacted] to deliver [redacted]. The surveyor observed that there was no cautionary signage posted at the door to inform of [redacted] usage in that room. The Surveyor reviewed Resident #17's medical record which revealed the following: Resident #17 was admitted to the facility with diagnoses which included but was not limited to [redacted]. A physician order sheet dated [redacted] reflected an order for [redacted] to be delivered at [redacted] hours every shift. The order continued to reveal that [redacted] was to be changed weekly and that the staff was to label each component with date and initials every shift on every [redacted]. On 03/18/22 at 11:42 AM, the Surveyor interviewed the LPN #1 regarding the process for [redacted] administration and use of [redacted]. LPN#1 revealed that the nurse should ensure that	F 695		

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cautionary signage was posted at the entrance door to inform of [redacted] being in use and to check the flow rate. She further stated the 11:00 PM - 7:00 AM shift was responsible to change the tubing every Saturday. The LPN admitted that she did not check the date on the [redacted].

On 03/18/22 at 11:52 AM, the Surveyor observed Resident # 17 in bed, awake and alert with the head of the bed elevated. Resident #17 was receiving [redacted] by way of a [redacted] connected to the [redacted] next to the bed. The [redacted] was set to deliver [redacted]. The [redacted] was dated [redacted]. According the facility policy the [redacted] was to be changed every [redacted], the [redacted] had not been changed for two weeks, and the [redacted] was not dated.

The surveyor accompanied LPN #1 to Resident #17's room and both the surveyor and the LPN #1 observed that the [redacted] was set to deliver [redacted]. The nurse then verified the physician's order and adjusted the [redacted] to [redacted] as ordered.

3. On 03/17/22 at 10:18 AM, the Surveyor observed Resident #63 sleeping in bed with [redacted] being administered at [redacted] which was connected to an [redacted]. The Surveyor observed that the [redacted] was dated [redacted]. The Surveyor also observed that there was no cautionary signage posted on Resident #63's door to indicate [redacted] was in use.

On 03/17/22 at 12:38 PM, the Surveyor, in the presence of another Surveyor, observed Resident #63 sitting up in the bed without [redacted] by [redacted] being administered. The Surveyor attempted to interview Resident #63 who was

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unable to participate in the interview due to [redacted]. The Surveyors observed the [redacted], dated [redacted], was lying on the floor next to Resident #63's bed.

On 03/18/22 at 9:14 AM, the Surveyor observed Resident #63 sleeping in bed with [redacted] being administered at [redacted]. The Surveyor observed that the [redacted] was dated [redacted]

On 03/18/22 at 9:42 AM, the Surveyor reviewed Resident #63's medical record.

A review of Resident #63's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with [redacted].

A review of Resident #63's quarterly MDS, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that Resident #63 was unable to complete the interview. Further review of the MDS indicated that Resident #63's skills for daily decision making were [redacted]

A review of Resident #63's Medication Review Report included the following physician's order: [redacted]) may [redacted].

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F 695	Continued From page 66 A review of Resident #63's care plan indicated that the resident did not have a care plan for the use of [redacted]. On 03/18/22 at 11:22 AM, in the presence of another Surveyor, the Surveyor asked the LPN #2 to inform the Surveyors what date she observed on Resident #63's [redacted]. LPN #2 confirmed that the date on the [redacted] was [redacted] and stated that the tubing was usually changed every [redacted] on the 11 PM -7 AM shift, and that Resident #63's [redacted] should have been changed. She added that she always looked at the [redacted] of the [redacted] and that sometimes she looked at the date on the [redacted]. The Surveyor then informed LPN #2 about the observation that the two surveyors made of Resident #63's [redacted] on the floor on [redacted]. LPN #2 stated that if the [redacted] was on the floor that the [redacted] should have been changed. The Surveyor then asked LPN #2 if there should be a sign on Resident #63's door that would indicate [redacted] was in use. LPN #2 confirmed that there was not a cautionary sign on the door and stated that she believed there should be one. On 03/18/22 at 11:33 AM, in the presence of the LPN #2, the Surveyor asked the Unit Manager (UM) of the [redacted] floor what date she observed on Resident #63's [redacted]. The UM confirmed that the date on Resident #63's nasal [redacted] was [redacted] and revealed that the tubing should have been changed. On 03/22/22 at 12:04 PM, the Surveyor interviewed the UM who confirmed that Resident #63 did not have a care plan for [redacted] use and that Resident #63 should have had one.	F 695		

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4. On 03/17/22 at 9:58 AM, the Surveyor observed Resident #27 sleeping in bed with O2 at [redacted]. The Surveyor observed that the [redacted] was dated [redacted]. The Surveyor observed that a water bottle that was connected to the [redacted] was dated [redacted] The Surveyor also observed that there was not a cautionary sign on Resident #27's door to indicate [redacted] was in use.

On 03/18/22 at 9:25 AM, the Surveyor observed Resident #27 in bed with [redacted] being administered at 2[redacted]. The Surveyor observed that the [redacted] was dated [redacted]. The Surveyor observed that a [redacted] bottle that was attached to the [redacted] was dated [redacted]. The Surveyor interviewed Resident #27 who stated that he/she used the [redacted] mostly at night but also used it during the day.

On 03/18/22 at 11:20 AM, the Surveyor reviewed Resident #27's medical record which revealed the following:

The Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]

The quarterly MDS, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated that Resident #63 was [redacted].

The Medication Review Report (MRR) included the following orders: [redacted] every shift for [redacted] change

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weekly and label each component with date and initials every night shift every [redacted].

The Care Plan, with a created date of [redacted] indicated that the resident had a care plan for COPD which included the use of [redacted].

On 03/18/22 at 11:25 AM, in the presence of another Surveyor, the Surveyor asked LPN #2 to explain to the Surveyors date she observed on Resident #27's [redacted] and [redacted] bottle. LPN #2 confirmed that the date on the [redacted] was [redacted] and the date on the [redacted] bottle was [redacted]. LPN #2 stated that the [redacted] was usually changed every [redacted] on the 11-7 shift and that Resident #27's [redacted] and [redacted] bottle should have been changed. She added that [redacted] bottle was changed at the same time the [redacted] was changed. The Surveyor then asked LPN #2 if there should be a cautionary sign posted on Resident #27's door that would indicate [redacted] was in use and LPN #2 confirmed that there was not a sign and believed there should be a sign.

On 03/18/22 at 11:34 AM, the Surveyor asked the UM of the [redacted] d floor what dated was posted on Resident #63's [redacted] and [redacted] bottle. The UM confirmed that the date on Resident #63's [redacted] was [redacted] and the date on the [redacted] bottle was [redacted]. The UM admitted that the [redacted] and [redacted] bottle should have been changed and added that it should be changed weekly and that it was usually done on [redacted] evening and believed that it gets documented.

The Surveyor then reviewed Resident #27's Treatment Administration Record (TAR) which

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F 695	Continued From page 69 indicated that on [redacted] and [redacted] Resident #27's [redacted] was documented to have been changed by the nurse. On 03/18/22 at 12:02 PM, the Surveyor interviewed the UM. The UM stated that the nurses had signed that they changed the [redacted] but that all she knew was that the date on the [redacted] did not match what the nurses signed for on the TAR. An interview was conducted with the Director of Nursing (DON) on 03/28/22 at 11:20 AM. The DON stated that the nurses should be checking the [redacted] of the [redacted] at least every shift. Her expectations were that the [redacted] and [redacted] bottled would be changed, dated and labeled weekly. A review of the facility provided policy titled [redacted]" with a revision date of 06/1/21, included the following: 1. Verify order. 2. Determine appropriate [redacted] source and need for [redacted] by the using the following table ... 3. Gather supplies:.. 3.2 [redacted] labeled with date of initial set-up ... 3.8 [redacted] sign ... 6. ...Post [redacted]" sign on patient's door.. 10. If [redacted] is used: 10.1 Label with date ... 11. ...set the [redacted] to the prescribed [redacted] ... 16. Replace disposable set-up every seven days. Date and store in treatment bag when not in use ...	F 695		

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F 695	Continued From page 70 N.J.A.C. 8:39-11.2 (b); 27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other pertinent facility documentation, it was determined that the facility failed to: a.) consistently communicate information to the dialysis center by failing to document an assessment and pre-dialysis treatment, on the [redacted] Communication Record [redacted]), per facility policy, for 22 of 35 scheduled [redacted] treatments, b.) document an assessment, post [redacted] treatment, on the HCR, per facility policy, for 33 of 35 scheduled [redacted] treatments, c.) accurately monitor and account for the intake of all [redacted] administered for a resident with a physician ordered [redacted], d.) ensure a physician ordered medication that required additional [redacted] for administration would not exceed the [redacted] and was documented. This deficient practice was evidenced for 1 of 2 resident's reviewed for dialysis (Resident #4) and was evidenced by the following: On 03/17/22 at 11:25 AM, during initial tour, the Surveyor observed Resident #4 lying in bed. Resident #4 stated that he/she received [redacted]	F 698	Resident #4 [redacted] orders were revised to reflect MD orders. Licensed nurses were educated on accurate documentation on [redacted] communication books. All residents have the potential to be affected by this deficient practice. All direct care staff in-service resident fluid restriction including medication and dietary orders within a 24 hour period by Nurse Practice Educator. All licensed nurses will be in-serviced on dialysis policy and procedure to include complete documentation in [redacted] communication books. Unit manager or designee will audit residents on [redacted] to ensure MD orders followed and [redacted] communication books weekly x 4 weeks then monthly x 3 months. Results from audits will be presented monthly by the Unit Managers or designee at the Monthly Quality Assurance Meeting monthly for 3 months with corrective actions needed or taken during the course	5/10/22

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F 698	Continued From page 71 blood) treatments on [redacted] and that he/she had just returned from a [redacted]. Resident #4 stated that he/she was on a [redacted] but was unsure of the amount. On 03/18/22 at 10:02 AM, the Surveyor interviewed the Licensed Practical Nurse (LPN #1) regarding Resident #4's [redacted] and [redacted]. LPN #1 stated that the total amount of [redacted] for the day was divided into two totals, one for nursing and one for dietary. She then stated that the nurses would check to make sure there was no water at the resident's bedside, and that nursing would educate the resident about the [redacted]. She added that sometimes the resident asked for more water. LPN #1 stated that Resident #4 had a communication book that the nurse would fill out prior to Resident #4 leaving for [redacted], and the book would go along with Resident #4 to the [redacted] center. The LPN #1 added that when Resident #4 returned from the [redacted] center the nurse would check the resident's [redacted] (a way to reach the [redacted]) and vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicated the state of a patient's essential body functions). On 03/18/22 at 10:00 AM, the Surveyor reviewed Resident #4's [redacted] Binder from [redacted] through [redacted] which included the following: There was no HCR documented for [redacted]	F 698	of the audit.	

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There was no pre [redacted] treatment assessment documented on the [redacted] by the facility Licensed Nurse o [redacted]

There was no post dialysis treatment assessment [redacted] an undated form, [redacted] and [redacted].

On 03/22/22 the Surveyor reviewed Resident #4's medical record which revealed the following:

The Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] The resident's BIMS score indicated that Resident #4 was [redacted]. The MDS was coded to indicate that Resident #4 received dialysis. The Care Plan (CP), with an initiated date of [redacted], indicated the resident was on a [redacted]

The Medication Review Report included the following physician order:

[redacted] Give [redacted] by mouth one time a day for [redacted] (Mix in [redacted] to [redacted] ounces [redacted] milliliters (ml)] of liquid).

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On 03/22/22 at 11:52 AM, the Surveyor interviewed Resident #4, and at that time, LPN #2 entered the resident's room with a medicine cup of pills and a plastic cup filled approximately three quarters of water. Resident #4 took one sip of water with the pills and the nurse instructed the resident to take another sip of water. Resident #4 took another sip of water and then LPN #2 took the cup of water and left the resident's room.

On 03/22/22 at 12:00 PM, the Surveyor interviewed LPN #2 regarding the process of the [redacted]. LPN #2 stated when Resident #4 returned from the [redacted] treatment the LPN#2 would check Resident #4's vital signs and check the [redacted] for any communication from the [redacted] center. The Surveyor then asked LPN #2 if each section of the [redacted] should be completed, and if there should be an [redacted] for each [redacted] treatment. The LPN #2 confirmed that there should be a [redacted] for each [redacted] treatment and all three sections should be completed.

On 03/22/22 at 12:06 PM, the Surveyor interviewed the [redacted] floor Unit Manager (UM) regarding the [redacted]. The UM stated that the HCR was for communication between the facility and the [redacted] center, and the facility received information about the resident's [redacted] weight, and any other recommendations from the [redacted] center. She added that there were three sections on the [redacted] and stated the nurse would complete the [redacted] sections, and that the [redacted] center would complete the middle section. The Surveyor then asked the UM if all three sections of the HCR should be completed, and the UM stated that the nurse could either put a note in the computer or fill out the [redacted] The Surveyor then asked the UM if there was another place that the facility kept the

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F 698	Continued From page 74 [redacted] records. The UM stated that the [redacted] would be kept in the [redacted] book or in the resident's physical medical record. The UM then proceeded to review Resident #4's medical record and did not locate the [redacted] in the resident's chart. At that time, the UM confirmed that there were multiple missing [redacted] forms and multiple [redacted] forms that were incomplete. The UM, in the presence of the Surveyor, viewed Resident #4's electronic medical record (EMR). The UM was unable to provide documented evidence that an assessment [redacted] treatment was documented in the EMR for the missing [redacted] or the missing documentation on the [redacted]. The UM confirmed that a [redacted] treatment assessment should have been documented. On 03/22/22 at 12:39 PM, the Surveyor observed Resident #4's lunch tray which included [redacted] ([redacted] ml) of coffee. Resident #4 stated that he/she only received [redacted] with his/her meals and that he/she did not drink anything between meals. On 03/22/22 at 12:45 PM, the Surveyor interviewed LPN #2 regarding Resident #4's [redacted]. LPN #2 stated that Resident #4's total [redacted] was divided between [redacted] ml from dietary and [redacted] ml from nursing. The Surveyor then asked LPN #4 the reason she brought a [redacted] cup of water (approximately [redacted] ml), in for the resident to take his/her medication. At that time, the LPN #2 confirmed the cup was a 9-ounce cup and LPN #2 stated that the resident was in [redacted] and did not receive his/her full allotment of [redacted] for that shift. She added that Resident #4 took "2 sips" and that she needed to give the resident [redacted] to take medications. The LPN #2 did not confirm how much [redacted] from 2 sips of fluid.	F 698		

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On 03/22/22 at 1:33 PM, the surveyor reviewed Resident #4's [redacted] Medication Administration Record (MAR) which included the following physician's order:

Monitor Daily Fluid Restriction Total [redacted] ml; [redacted] Dietary; [redacted] nursing. every shift for Abnormal labs; which was [redacted] ml for 7-3 shift, [redacted] ml for 3-11 shift and [redacted] for 11-7 shift.

Further review included the following:
Resident received [redacted] ml on the 11-7 shift on 03/01/22, 03/02/22, 03/07/22, 03/08/22 and 03/18/22.
Resident received [redacted] ml on the 11-7 shift on 03/03/22.
Resident received [redacted] ml on the 11-7 shift on 03/09/22 and 03/16/22.
Resident received [redacted] ml on the 11-7 shift on 03/10/22.
Resident received [redacted] ml on the 11-7 shift on 03/17/22 and 03/21/22.
According to the physician's order, Resident #4 should have received [redacted] ml on the 11-7 shift. (According to the physician's order, Resident #4 should not have received more than a total of [redacted] ml from nursing for the day. Resident #4 received [redacted] ml on 03/17/22, [redacted] ml on 03/18/22 and 610 ml on 03/21/22).

On 03/23/22 at 9:49 AM, the Surveyor interviewed Resident #4 regarding his/her [redacted]. Resident #4 stated that he/she usually took medications with applesauce. Resident #4 added that if he/she had a nurse that was not his/her usual nurse that the nurse would come in with water. Resident #4 then stated that he/she would only take a small sip of the water.

On 03/23/22 at 9:59 AM, the Surveyor

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interviewed LPN #3 regarding Resident #4's medications and [redacted] LPN #3 stated that Resident #4 was on [redacted] of [redacted] ml from nursing on the day shift. She added that Resident #4 received medications several times during the day shift, and that Resident #4 received [redacted] in [redacted] oz ([redacted] ml) of water.

On 03/23/22 at 10:20 AM, the Surveyor asked LPN #3 to explain the different times that Resident #4 received medications and how she calculated the amount of [redacted] that Resident #4 received during the day shift. LPN #3 stated that Resident #4 received [redacted] in [redacted] oz ([redacted] ml) of water at 10 AM and received other pills at the same time. She added that Resident #4 would use the [redacted] that was with the [redacted] to take the pills at that time. She then stated that on days that Resident #4 did not have [redacted] the resident received [redacted] l (used to treat [redacted]), [redacted], and [redacted]) at 8:30 AM. She then added that Resident #4 received [redacted] (used to relieve [redacted] at 2 PM. The Surveyor then asked LPN #3 if Resident #4 had been receiving more than the allowed [redacted] ml on the day shift. LPN #2 stated that Resident #4 could be receiving more than [redacted] ml on the day shift. The Surveyor then asked LPN #3 how it was possible for a nurse to document that Resident #4 had only received [redacted] ml during the day shift if the minimum required fluid that was ordered to be used with the [redacted] was [redacted] oz [redacted] ml). LPN # 3 confirmed that the minimum documented on the MAR for the day shift would be at least [redacted] ml.

On 03/23/22 at 11:47 AM, the Surveyor interviewed the UM regarding Resident #4's medications and [redacted] The UM stated that the physician order divided the amount of

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[redacted] that the resident would receive between the nursing department and the dietary department. She added that nursing would use[redacted] oz ([redacted] ml) cups and the[redacted] ml medicine cups to calculate the amount given. The Surveyor then asked the UM about Resident #4's physician's order for [redacted]. The UM stated that whatever the order had written was what the nurse would provide. She added that if the order was [redacted] oz ([redacted] to [redacted] ml), then the nurse would give at least 4 oz ([redacted] ml) but that it would depend on what the resident's [redacted] was. The Surveyor asked the UM what amount of [redacted] was documented on the MAR. The UM stated that only the nursing amount of [redacted] should be documented on the MAR, and that the dietary amount would not be included in that amount. The Surveyor then asked the UM if the [redacted] order of [redacted] to [redacted] oz ([redacted] to [redacted] ml) was appropriate for a resident that was on a [redacted] and limited to [redacted] ml on the day shift. The UM stated that the order for [redacted] could be adjusted. The Surveyor then asked the UM to view Resident #4's MAR and the amount of [redacted] that was documented for [redacted] and [redacted]. The UM confirmed that Resident #4 received more than the [redacted] ml allotted for those days. The UM stated that Resident #4 was noncompliant with the [redacted] and added that Resident #4 was [redacted] and knew of the [redacted]. The UM stated that Resident #4 could have requested more [redacted], and the nurse would have educated Resident #4 but still provided the [redacted] The Surveyor then asked the UM if she would expect documentation if the resident would have asked for more [redacted] and the nurse educated the resident. The UM confirmed that there was no documentation in the EMR to support that the resident was educated and if it happened the nurse should have documented it. The Surveyor

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then asked the UM how the nurses documented that Resident #4 had received [redacted] ml on the day shift on multiple days in [redacted] Resident #4 had received [redacted] in [redacted] ml of fluid on those days. The UM stated that the nurses had not accurately documented the amount of [redacted] Resident #4 received.

On 03/25/22 at 8:43 AM, the Surveyor interviewed LPN #4 who was Resident #4's 11-7 shift nurse and had documented the amounts of [redacted] that were over the allotted [redacted] ml on the [redacted] MAR. LPN #4 stated that Resident #4 was noncompliant with the [redacted] and that the resident would sneak [redacted] She added that sometimes the extra [redacted] she documented was from Resident #4's breakfast tray. The Surveyor then asked LPN #4 if Resident #4 was noncompliant with the [redacted] during LPN #4's shift, and if she should document the noncompliance in the EMR. LPN #4 confirmed that a note should be documented in the EMR.

On 03/28/22 at 10:05 AM, in the presence of the survey team, the DON confirmed that there should be documentation on the [redacted] filled out by the facility nurse. The DON added that she educated the nursing staff on [redacted].

A review of the facility provided policy titled, "NSG253 [redacted] (HD)-Communication and Documentation" with a revision date of 6/1/21, included the following: Policy: Center staff will communicate with the certified dialysis facility prior to sending a patient for [redacted] by completing the [redacted] Communication Record [HCR] ...or other state required form and sending it with the patient. The form will also be completed upon return of the patient from the certified [redacted]

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F 698	Continued From page 79 facility. Practice Standards: 1. Prior to a patient leaving the Center for [redacted], a licensed nurse will complete the top portion of the [redacted] ...and send with the patient to his/her [redacted] facility visit. 2. Following completion of the [redacted], the [redacted] facility nurse should complete the form and return it or other communication to the Center with the patient. 3. Upon return of the patient to the Center, a licensed nurse will: 3.1 Review the [redacted] center communication. 3.2 Evaluate/observe the patient; and 3.3 Complete the [redacted] treatment section on the [redacted]... 4. Notify the certified dialysis facility if the form is not returned with the patient and ask that it be faxed to the Center. 4.1 Document notification of certified [redacted] facility regarding return of form or other communication. 5. Maintain the [redacted] ...in the patient's medical record. A review of the facility provided policy titled, "NSG216 Fluid Balance", with a revision date of 6/1/21, included the following: When a physician/advanced practice provider (APP) orders a [redacted] due to specific clinical condition, close monitoring of [redacted] intake will be provided to maintain adequate hydration. Orders must include [redacted] permitted during a 24-hour period. Staff will notify the Dietary Department ...Dietary will calculate the amount of fluids to be provided on the meal trays. Nursing will calculate the remaining amounts of fluids allotted for each shift. Intake and output will be monitored and documented as follows: ...	F 698		

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F 698	Continued From page 80 [redacted]: Monitor [redacted] intake; monitor [redacted] if ordered. If ordered by physician/APP ... 1. Notify staff caring for patient that patient is on [redacted]. 2. Inform the patient and responsible party of [redacted].	F 698		
F 725 SS=E	N.J.A.C. 8:39-27.1 (a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		5/10/22

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F 725	Continued From page 81 by: Based on interview, record review, and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure: a.) a resident was offered a shower on scheduled shower days, and b.) that residents were consistently offered evening snacks. The deficient practice was evidenced by the following: Refer to F561 and F809 The facility failed to: a.) follow the facility policy for Activities of Daily Living (ADLs), and b.) ensure that a resident had the right to make choices about aspects of his/her life in the facility that were significant to the resident. Specifically, the facility failed to identify and honor a resident's bathing request. This deficient practice was identified for 1 of 27 residents reviewed (Resident #50). On 03/17/22 at 12:19 PM, the Surveyor returned to Resident #50s room during the lunch meal, and observed a [redacted] of Resident #50 that was visiting at the bedside. The [redacted] informed the surveyor [redacted] had been trying to get Resident #50 a shower for the past two months. The [redacted] stated that the facility had not been able to accommodate Resident #50's preference for a shower. On 03/22/22 11:00 AM, the Surveyor conducted a Resident Council meeting with five residents. Five out of five residents in attendance stated staffing at night was short with long wait times. On 03/22/22 at 11:06 AM, the Surveyor conducted resident council meeting with five residents. During that time, the Surveyor inquired about HS snacks. All five residents commented	F 725	All residents present in the facility were affected by the deficient practice on the dates and shifts noted. Facility will continue to work on staffing daily. Resident #50 was offered and received a shower and is on schedule to receive showers on a routine basis. Staff were re-educated on offering snacks and responding to call bells timely. All residents have the potential to be affected by this deficient practice. The Direct care staff will be inserviced by the Nurse Practice Educator or Designee on the importance of offering resident showers, HS snacks and responding to call bells appropriately. Random weekly call bell audits, HS snacks audits and resident shower audits will be conducted weekly x 4 weeks then monthly x 3 months by the Unit managers or designee with corrective actions needed or taken during the course of the audit. Staffing hours are reviewed and audited daily by the staffing coordinator or designee for compliance. Center recruitment efforts have consisted of Virtual center job fair on March 16th, Social Media boosting promotions initiated on March 18th, State cna in house program class conducted on March 23rd, class graduation was May 6th. Significant Financial retention/sign on incentives. In addition, 6 Agency contracts are being used to assist with staffing levels. Results of staffing, HS snack, call bell response and resident shower audits will	

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F 725	Continued From page 82 that they do not always get offered bedtime snacks and that it would depend on how the staff felt that evening. On 03/25/22 at 9:56 AM, the Surveyor interviewed the Director of Nursing (DON) regarding snack distribution. The DON stated the snacks were the nurses responsibility to ensure the snacks were delivered. The DON stated "I never reviewed the logs" and the unit managers should have reviewed the logs and "I should have but never have". The DON stated "we have been short staffed because of Covid". The DON stated without documentation she could not state for certain that the snacks were being provided. Per the New Jersey State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. The facility was deficient in Certified Nurse Aide (CNA) staffing for residents on 14 of 14 day shifts, and was deficient in total staff for residents on 3 of 14 overnight shifts as follows: -02/27/22 had 9 CNAs for 126 residents on the day shift, required 16 CNAs. -02/28/22 had 9 CNAs for 125 residents on the day shift, required 16 CNAs. -03/01/22 had 10 CNAs for 125 residents on the day shift, required 16 CNAs. -03/01/22 had 8 total staff for 125 residents on the overnight shift, required 9 total staff. -03/02/22 had 12 CNAs for 125 residents on the day shift, required 16 CNAs.-03/02/22 had 8 total staff for 125 residents on the overnight shift, required 9 total staff. -03/03/22 had 13 CNAs for 125 residents on the day shift, required 16 CNAs. -03/04/22 had 11 CNAs for 122 residents on the	F 725	be reviewed by the Director of Nursing or designee monthly for 3 months in our Monthly Quality Assurance Meeting for compliance. LNHA or designee will obtain feedback from the next resident council meeting regarding the effectiveness of this plan of correction.	

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F 725	Continued From page 83 day shift, required 16 CNAs -03/05/22 had 8 CNAs for 122 residents on the day shift, required 16 CNAs. -03/06/22 had 8 CNAs for 124 residents on the day shift, required 16 CNAs. -03/07/22 had 10 CNAs for 124 residents on the day shift, required 16 CNAs. -03/08/22 had 10 CNAs for 122 residents on the day shift, required 16 CNAs. -03/09/22 had 11 CNAs for 121 residents on the day shift, required 16 CNAs. -03/10/22 had 10 CNAs for 121 residents on the day shift, required 16 CNAs. -03/11/22 had 11 CNAs for 120 residents on the day shift, required 15 CNAs. -03/11/22 had 8 total staff for 120 residents on the overnight shift, required 9 total staff. -03/12/22 had 11 CNAs for 118 residents on the day shift, required 15 CNAs. The Facility Assessment Tool revealed: Individual staff assignment, 3.3 Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments. The approach for this center as it relates to direct care staffing is in pattered approaches. NJ requires acuities to be taken into consideration with staffing. We would adjust based upon acuities and census. Discussions are held in staffing meetings about unit staffing. Unit Managers provide updated information on patient needs with nursing management. The scheduler will make adjustments as needed. Discussion on staffing is an on-going task that is discussed several time throughout a given day. Consistent staffing patterns are the ultimate goal with staff assigned patient assignments. NJAC 8:39-5.1(a)	F 725		

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F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review it was determined that the facility failed to provide foods at the appropriate hot and cold temperatures on 1 of 2 units, and for 1 of 3 Residents reviewed for food (Resident #57). The deficient practice was evidenced by the following: On 03/17/22 at 10:40 AM, Surveyor #1 conducted an interview with Resident #57. The resident stated that the food sat on the trays, there was no temperature control for the food, and the food was cold at times. The Surveyor reviewed the 02/24/22 Resident Council Minutes. Complaints for Food Committee revealed: "Food is extremely cold- Not using plate warmers". On 03/22/22 at 12:04 PM, the Surveyor observed the tray-line in progress. At that time, the Surveyor reviewed the lunch meal food temperature log as identified by the Cook. The Surveyor observed that the temperature log was blank in the milk, dessert (peaches) and vegetable (broccoli) was not listed. On 03/22/22 at 12:07 PM, the Surveyor requested a test tray that included the main and alternate entree, milk and dessert. The tray exited the	F 804	Cranberry meatballs, Broccoli, milk and peaches were discarded. Any food products served at inappropriate temperatures were replaced prior to resident consumption. All residents have the potential to be affected by this deficient practice. All meal temperatures are monitored daily to ensure all temperature recording procedures are properly followed. Cooks will be inserviced by the Food Service Director/Designee to ensure that temperatures of all food items are recorded prior to meal service and are in the appropriate ranges. The Dietary Cooks will be able to demonstrate the correct procedure for temperature recording, they will also be able to verbalize the correct way according to policy. Random weekly auditing of temperature test trays will be conducted by the Food Service Director or designee for 3 months. Results of audits will be presented	5/10/22

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F 804	Continued From page 85 kitchen at 12:10 PM, and the Surveyor was accompanied by the FSD, and arrived on the 2nd floor Garden Unit at 12:13 PM. The Surveyor interviewed the FSD director at that time regarding the appropriate food temperatures for resident service, and the FSD stated that the dessert and cold food should be less than 41 degrees Fahrenheit (F) and hot foods should be served at 145 F or above. The last resident meal tray was passed at 12:21 PM. At that time the FSD and Surveyor proceeded to measure the following food temperatures: FSD Surveyor Breaded Fish: 155.8 F 149F Potato: 146 F 146F Cranberry Meatball: 133 F* 132 F* The FSD stated the meatball should have been at 135 degrees and stated all hot foods should have been the same. Broccoli: 128 F* 121F * Milk: 61.4 F* 61.3F* Peaches: 64.6* 66.2F* On 03/23/22 at 1:01 PM, the Surveyor conducted an interview with the FSD regarding the parameters for meal trays. At that time, the FSD provided the surveyor with a Food and Nutrition Services Meal Assessment Blank Form. The Form revealed the Holding temperature standard for the Entree at 135 degrees F minimum, and cold beverages and dessert should be 41 degrees F maximum. The FSD stated that she would want the milk and juice cold. The Surveyor	F 804	monthly by the Food Service Director or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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F 804	Continued From page 86 inquired if the temperature of the should be checked, and the FSD stated 'yes", the milk should be checked. The Food and Nutrition Services Policies and Procedures, Meal Service, Effective Date: 07/01/98 revealed: Policy Meals are served accurately, timely, and at the appropriate temperatures. Process: 1.7, Cold beverages are either kept under refrigeration or are placed on ice with proper drainage., 4. Employees are gathered for pre-service meeting, 4.2, Cook or designee takes and records temperatures on Production Worksheets. The Food and Nutrition Services Policies and Procedures, 7.2 Food Service Wuality Indicaotrs, Effective 07/01/98 revealed: 8.1, Food Service Satisfaction: Standard: Patients/Residents will be satisified with their meals.	F 804		
F 809 SS=F	8:39-17.4(a) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 809		5/10/22

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F 809	Continued From page 87 §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to consistently offer residents HS (hour of sleep) snacks. This deficient practice was identified for 5 of 5 residents (Resident #17, #23, #68, #44, and #25) during resident council meeting and was evidenced by the following: On 03/22/22 at 11:06 AM, the Surveyor conducted resident council meeting with five residents. During that time, the Surveyor inquired about HS snacks. All five residents commented that they do not always get offered bedtime snacks and that it would depend on the staff that evening. On 03/23/22 at 8:09 AM, the second floor Licensed Practical Nurse Unit Manager (LPN UM) stated that the process would be for the evening snacks to be delivered from the kitchen about 6:45 PM to 7 PM. The LPN UM stated some snacks are assigned to certain residents and the other snacks would be offered to the rest of the residents. The LPN UM stated that the Certified Nursing Assistants (CNAs) would either document on the computer or on the Activities of Daily Living (ADL) log if the resident refused or accepted the snack and how much was consumed. On 03/23/22 at 9:15 AM, the Surveyor reviewed all residents Kardex (the CNA Care Plan to assist with resident needs), the ADL logbook from	F 809	Residents #17, #23, #68, #44, #25 will be offered HS snacks. All residents have the potential to be affected by this deficient practice. The Nurse Practice Educator or designee will inservice direct care staff on the importance of offering residents their snack and documenting if the resident accepts or refuses. Random weekly HS snack audits x 4 weeks then monthly x 3 months will be completed by the Unit Manager/designee. Results from audits will be presented monthly by the Unit Managers or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit. Licensed Nursing Home Administrator or Designee will obtain feedback from the next resident council regarding the effectiveness of this plan.	

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03/01/22 through 03/22/22, for all five residents and found the documentation to be incomplete. The Surveyor reviewed the electronic documentation from 03/01/22 through 03/22/22, for HS snacks for all five residents and found the documentation to be incomplete. The documentation reflected the following:

Resident #17's Kardex indicated under Eating to provide with HS yogurt, and PB and J (peanut butter and jelly), and to offer snacks. The ADL logs and electronic record combined reflected that the resident was not offered an HS snack 16 of the 22 days in March 2022.

Resident #23's Kardex indicated under Eating; that the resident likes to snack between meals. The ADL logs and electronic record combined reflected that the resident was not offered an HS snack 18 of the 22 days in March 2022.

Resident #25's Kardex indicated under Eating; to offer snacks. The ADL logs and electronic record combined reflected that the resident was not offered an HS snack 18 of 22 days in March 2022.

Resident #44's Kardex indicated under Eating; to offer additional snacks. The ADL logs and electronic record combined reflected that the resident was not offered an HS snack 20 of 22 days in March 2022.

Resident #68's Kardex indicated under Eating; to offer additional snacks. The ADL logs and electronic record combined reflected that the resident was not offered an HS snack 21 of 22 days in March 2022.

On 03/23/22 at 11:34 AM, a CNA stated her

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normal shift was 11 AM to 11 PM. She stated the process was that the snacks would be delivered from come the kitchen and that the CNAs should start handing them out to the residents. She further stated the CNAs would document in the computer or the ADL log if a resident refused or accepted the snack and how much was consumed

On 03/23/22 at 1:28 PM, the Director of Nursing (DON) provided the surveyor with the task accountability sheets for the five residents who attended resident council. The DON and the Surveyor reviewed the sheets and noted many blanks on all five residents. The DON stated that would indicate that the CNAs did not offer the snacks, and that the task was not done.

A review of the facility provided, "Meal Service" indicated that breakfast starts at 7:15 AM, lunch starts at 11:50 AM, dinner starts at 4:30 PM and snacks between meals at 10 AM, 2 PM, and nightly before bedtime.

A review of the facility provided policy and procedure, "Snacks, Nourishments, Supplements, and Pantry Stock' revised 06/15/18, included but was not limited to the following information. Policy snacks, nourishments, supplements, and pantry stock are available to complement meal service ...Definitions Snack evening snack is planned as part of the menu. Purpose to provide an evening snack for all patients/residents. Process 1. Snacks 1.4 nursing or designated staff offer an evening snack to every patient/resident. 5.2 completed logs are used to assist the facility in problem analysis and resolution.

This concern was presented to the facility

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F 809	Continued From page 90 administration on 03/25/22. The facility had no additional information to provide. NJAC 8:39-17.4(b)	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to maintain the kitchen in a clean and sanitary manner to limit the spread of infection and potential food borne illness by failing to ensure: a.) the environment and kitchen equipment was maintained in a manner to limit the potential for microbial growth and to prevent physical contaminants from entering the food, b.) staff practiced appropriate hand hygiene and restrained hair appropriately, c.) food items were maintained in a manner to ensure they were not	F 812	1)Walls of the Walk-In refrigerator were cleaned & label and date on the cheese was corrected. 2)Insulated Bases and lids were properly cleaned, sanitized, dried and stored prior to use 3)Ceiling vents and ceiling heat/air conditioner vent were cleaned 4)Shelving was cleaned. 5)Can opener & base was cleaned and added to the daily cleaning assignment sheet. Can Opener blade was replaced on	5/10/22

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F 812	Continued From page 91 used past their "use by date", and d.) a process was in place to ensure bottled water was maintained in a manner to ensure the water was not used by a "use by date". The deficient practice was evidenced by the following: On 03/17/22 at from 9:32 AM to 11:30 AM, the Surveyor conducted an initial tour of the kitchen with the Food Service Director (FSD), and observed the following: 1. The refrigerated walk-in unit had a dark spot affixed to the interior of the wall by the door, and what appeared as greenish dark stained areas throughout the interior of the walls of the walk-in unit. The FSD stated the spot was a "little dirt spot", and the interior was cleaned once per week and that spot was probably missed. A block of opened Swiss cheese was located on a shelf and was wrapped in plastic. The cheese did not contain a "use by date". 2. A dietary worker (DW #1) stacked insulated bases on top of one another at the tray line area. The bases appeared visibly wet inside. Upon interview, the DW #1 stated stated that the bases were dry, and she continued to stack them on top of one another. The Surveyor then observed the bases with the FSD, and the Surveyor inquired to the FSD if the the lids were supposed to be dry. The FSD stated they were supposed to be dry and that they were "wet nesting". There were 83 insulated bases stacked that were visibly wet inside, and one base had visible debris caked on it. The FSD stated they if the bases were wet, that "they won't heat up" because the system was a heat on demand system (an insulated base would be inserted into a machine which would assist with maintenance of the food temperature upon meal transport). The Surveyor observed 34/34	F 812	3/17/22. Any product affected by can opener was disposed of prior to consumption. 6)Utensil rack was cleaned 7)Personal belongings were removed. Maintenance personnel replaced gaskets. 8)All products affected by the can opener were disposed of prior to consumption. All Dietary Employees were inserviced on proper cleaning procedures. 9)Trays were properly cleaned, sanitized, & dried prior to use. Chipped trays were discarded. 10)Cutting boards were replaced 11)Blender Gasket was replaced 12)Cook #1 put a hair restraint on 13)Any affected foods were disposed of & Dietary Staff washed hands 14)Employee properly adjusted a hair/beard restraint. All dietary staff inservice on proper restraint of facial hair with use of beard guards. 15)Employee properly adjusted and secured facial hair with beard restraint. 16)Any affected foods were disposed of & Dietary Staff washed hands. 17)Any affected foods were disposed of & Dietary Staff washed hands. 18)Any affected foods were disposed of & Dietary Staff washed hands 19)Employee properly adjusted with appropriate size hair/beard restraint 20)Dented can was removed from storage. 21)Food Product was disposed of. 22)Any affected foods were disposed of & Dietary Staff washed hands. 23)Affected products were disposed of & cutting boards were replaced. 24)Emergency water that had expired,	

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F 812	Continued From page 92 insulated lids that were stacked, and visibly wet inside. The FSD stated that the lids/bases were supposed to be stacked sideways to dry them and the staff did not do that. 3. Two ceiling grates and a ceiling heat/air conditioner vent above the tray line area had visible dark dust like debris in the vents and on the ceiling tile adjacent to the vents. The FSD observed the ceiling and stated that maintenance usually cleaned the grate once per month and she was not sure if it was scheduled to be completed. The FSD observed the vents and stated "maybe from heat and that it was not okay, "absolutely not", the dust could fall onto the food. The FSD stated she was able to contact maintenance if something needed to be cleaned. 4. Two stainless steel shelves affixed to the front of the tray line were visibly soiled with various colored debris underneath the shelves. The FSD stated the shelves were used during the meal service to hold food items. The FSD observed the debris and stated the staff usually wiped the shelves down. The Surveyor inquired as to what the debris was and the FSD stated "food splats" and responded "probably not" when the surveyor inquired if the underneath of the shelves was cleaned. The FSD stated it should be cleaned daily. 5. A can opener was affixed to a metal table in the kitchen. The blade appeared visibly worn, and a copious amount metal shavings were visible at the blade area. The Surveyor inquired to the FSD about the can opener blade and the FSD stated the can opener blade was worn. The Surveyor inquired as if it was okay to use the can opener in that condition and she stated it was "not okay". The FSD confirmed that the can opener was	F 812	stored directly on floor and within the storage trailer was discarded and replaced with new emergency water bottles stored in containers within the facility and not directly on floor and not around hazardous material. Emergency water bottles were stamped with identification and expiration date. Center acknowledged that all residents have the potential to be affected by these deficient practices. Kitchen safety and sanitation inspection audits continue daily by the Food Service Director or designee and corrective action will be taken immediately to rectify any items found to be out of compliance. Maintenance staff were inserviced by the Nurse Practice Educator or designee on proper storage of hazardous waste. All Dietary staff was inservice by the Food Service Director or designee on proper hand washing, completion of daily cleaning assignments, proper ware washing, service ware storage and stacking, hair/beard restraints and food storage policies including storing personal food items with the corrective action to take place when procedure is not met. Service ware storage, hand hygiene, hair/beard restraints, and food storage audits will be completed weekly by the Food Service Director or designee. Daily Cleaning Assignments will be signed off by the dietary staff at the close of their shift and verified by the Food Service Director or designee for completion.	

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F 812	Continued From page 93 used that morning to open cans of applesauce, and stated the metal shavings could fall into the food. The plastic type insert that contained the can opener appeared soiled. The FSD removed the insert, and the Surveyor observed a dark sticky in appearance substance, and the FSD stated "it's dirty" and that the insert was hard to remove. The FSD stated it was probably not cleaned last night. The Surveyor requested a cleaning log from the FSD. The FSD directed the Surveyor to a bulleting board that had A Daily Cleaning Assignment (one sheet for each day of the week) affixed to a bulletin board. The Daily Cleaning Assignment list dated 3/16 revealed the Bottom of the Prep Table number 1 and 2 (Bins included and legs) was signed off and initialed as completed. The underneath of the shelves, and the can opener and base was not listed on "The Daily Cleaning Assignment dated 3/16. 6. A steel preparation table had a utensil rack over the table with visible dust like debris affixed to it. The surveyor inquired to the FSD regarding the debris and she stated, "it shouldn't be there". The FSD stated she was responsible to monitor the kitchen environment for cleanliness. 7. A reach-in refrigeration unit, #17, contained a 1/2 empty 12 ounce soda bottle. The FSD stated the items were from a staff member, and that personal items should not be kept in that refrigerator. The gasket to the reach-in refrigeration unit was heavily soiled with a dark substance and was ripped. The Surveyor inquired if it had been cleaned, and if the ripped gasket was acceptable. The FSD acknowledged the ripped gasket and stated that the refrigeration unit can loose temperature if the gasket was ripped and it was not okay. She stated the gasket had also not been cleaned.	F 812	Sanitation and food safety inspection audits will be completed weekly by the Food Service Director or designee and reported to the Monthly Quality Assurance Meeting for 3 months with the corrective action to take place when procedure is not met.	

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8. At 10:42 AM, the Surveyor interviewed the Assistant Food Service Director (AFSD), in the presence of the FSD about the observations of the can opener and the process for cleaning it. The AFSD stated that she had used the can opener yesterday, and she had observed shavings on the lid of the tomato sauce can. She stated she had worked at the facility for twenty years and the Surveyor inquired if she had received education about the can opener, and shavings from the can opener. The AFSD stated "no". The Surveyor inquired as to the process for cleaning the can opener insert and the AFSD stated it was "pretty stuck" and it was not always pulled out. The Surveyor inquired to the FSD regarding what should have been done when the AFSD identified there were metal shavings on the can opener and also on the lid of the can. The FSD stated when the can opener blade was dull there was a potential for shavings. The FSD stated "I don't have any recent training on the can opener".

9. A stack of black meal trays were located at the beginning of the tray line. The FSD stated the trays were clean. There were 96 wet nested trays, 6 trays with debris on them and 8 trays that were visibly chipped and worn. The FSD confirmed the surveyors observations and stated the chipped trays should not be used because the fiberglass from the trays could potentially get into the food.

10. There were five large cutting boards stacked by the food preparation table. A yellow, two white, one red and one blue cutting board were observed with deep gauges and appeared worn, discolored with imbedded debris. The AFSD and FSD were present and the AFSD stated that "food can get stuck" and that it was wear and tear. The

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FSD stated that the 5/5 cutting boards shouldn't be used.

11. A large blender was stored upright on a preparation table. The gasket was soiled with debris. The FSD stated the gasket was not clean.

On 03/18/22 at 11:31 AM, the Surveyor conducted a follow-up kitchen observation during the meal service preparation, and the observed the following:

12. A cook (Cook #1) was observed placing frozen dinner rolls on a tray. The cook was wearing a surgical mask on his face, and had facial hair that was visible and not restrained.

13. At 11:38 AM the FSD was observed placing milk on resident meal trays after she exited the tray line to retrieve the milk, adjusted her personal clothing and then touched various tray items without first performing hand hygiene.

14. At 11:40 AM, a staff member was observed in the kitchen at the end of the tray line and had a facial type restraint that did not fully cover the sides of his protruding facial hair. The staff identified himself as a Regional Manager (RM). The surveyor inquired to RM what he was wearing on his face and he stated it was a surgical mask and a beard guard-beard restraint was over it. The Surveyor inquired to the RM if all of the beard should be covered. The RM stated "as much as can be for the beard, not the sides". At 12:22 PM, the Surveyor interviewed the FSD regarding if a surgical mask was acceptable to use as a facial hair restraint. The FSD stated "no", and the Surveyor inquired to the FSD regarding the policy regarding how much facial hair should be covered, and if it was only for hair

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at a certain length. The FSD stated she was unsure.

15. At 11:48 AM, the RM was observed assisting moving items at the tray line, while the tray line was in progress, and the RM had visible facial hair that was exposed and was not covered by the beard restraint.

16. At 11:49 AM, Cook #1 was observed wearing gloves as he entered the kitchen with a pan of oranges. He then proceeded to wash the oranges and cut the oranges. Upon Surveyor inquiry, Cook #1 stated the oranges were to be used to replace the grapes that were on the menu, and he proceeded to provide the oranges to the tray line, and then brought the soiled pan and a strainer back to the dirty area in the kitchen. The Cook #1 returned to the tray line wearing gloves, removed the gloves and put on a new pair of gloves, without first washing his hands. The Cook #1 then proceeded to cut and serve a grilled cheese sandwich on a resident's meal plate.

17. At 11:57 AM, the FSD was observed on the tray line touching resident meal trays. The phone rang and the FSD exited the tray line to answer the phone opposite of the tray line, then returned to preparing resident meal trays on the tray line without performing hand hygiene.

18. At 12:27 PM, the Surveyor interviewed the FSD regarding when hand washing should be performed. The FSD stated when tasks were changed, or when someone touched their hair of face, that the hands should be washed after.

19. A Dietary Staff (Dietary Staff #2) was observed working in the kitchen and on the tray line with hair protruding from his hair restraint.

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The surveyor informed the FSD of the observation and the FSD stated that she had bigger hair nets for him and that sometimes he wore them. The FSD proceeded to show the Surveyor the larger sized hair net.

20. The dry food storage room contained a dented #10 can of beans on a rack. The FSD stated the dented can needs to be sent back, because "they can get sick" from dented cans. The FSD confirmed the can was dented.

21. The dry food storage room contained seven loaves of Texas toast bread, imprinted with a best if used by date of March 16. There was no other use by date located on the loaves and the FSD stated that the bread was used by the best by date.

22. The Surveyor interviewed the FSD regarding the observation made with the Cook # 1 preparing the oranges, without washing his hands between tasks. The FSD stated the Cook #1 should have washed his hands between clean and dirty. The Surveyor also interviewed the FSD regarding the observation when the FSD exited the tray line to answer the phone and returned to the tray line without washing her hands. The FSD stated "I probably should have washed my hands".

23. On 03/22/22 at 12:04 PM, the Surveyor observed the tray-line in progress. The AFSD was observed cutting a sandwich on a very worn, discolored white cutting board that had deep gauges in it that was affixed to the tray line, and then placed the sandwich on a resident meal tray.

24. On 03/23/22 at 9:37 AM, the Surveyor accompanied the Maintenance Director (MD) and

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observed the storage of the on-site emergency water supply. The MD stated the 5 gallon water containers were stored in various areas and he had 128, 5 gallon water containers. The MD stated he purchased them, inventoried them and that the water would be used for drinking, food preparation, bathing and to flush toilets. An area for water storage was observed with 33, 5 gallon water containers that were stored under the stairwell #1, and an additional water supply was located under a rear stairwell. The 5 gallon water containers stored under the stairwell were observed to be stored directly on the floor. The Surveyor could not ascertain how many bottles were located under the rear stairwell. There water was not stamped or identified with an expiration date. The Surveyor inquired to the MD regarding the process and expiration for the water. The MD stated he did not have a sticker or label on the water for an expiration date, and stated he thought that he had the bottles for about four years. The MD stated that he checked the inventory, but not the expiration. The Surveyor observed the third location for the water which was in a trailer outside the rear of the facility. The trailer was located in the rear of the facility parking lot. There were 51 bottles of water stored in the trailer, there was various debris and dust observed around the bottles and cob-webs observed on the bottles. The bottles were also observed to be stored with various types of mechanical equipment, and 3 large cardboard boxes labeled with a red biohazard (containing blood and regulated medical waste) emblem affixed to the box, and labeled "Regulated Medical Waste". The MD then, proceeded to bring a 5 gallon bottle of water and place it on the floor of the trailer, directly next to the hazardous waste. The MD showed the Surveyor the stamp on the 5 gallon bottle of water that was dated

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3/31/16 on bottle. The MD stated "I guess it has been longer. The Surveyor requested a policy/ information regarding the expiration of the water. At 11:22 AM the MD stated the date on the bottle was the best use date and he would look for a policy. At 12:42 PM, the Surveyor interviewed the FSD regarding the water supply and if beverages are considered food storage. The FSD stated that beverages would be considered part of food storage and the food storage policy would apply. At 1:35 PM, the MD provided the Surveyor with an invoice from 2017 for water and the MD stated he did not know about the water dated 2016, and did not provide any additional information regarding the process for water storage and the expiration date.

The Food and Nutrition Services Policies and Procedures Policy, 4.7 Food Handling, effective 07//01/98 revealed: Foods are stored, prepared and served in a safe and sanitary manner., Purpose: To prevent bacterial contamination and possible spread of infections., 2.1. Employees wear disposable gloves when handling food. Disposable gloves are considered a single-use item and are discarded when damaged, soiled and after each use. 2.1.1. Employees must wash hands before putting on disposable gloves...

The Food and Nutrition Services Policies and Procedures Policy, 2.2 Personal Hygiene, Effective 07/01/98, revealed: Food and Nutrition Services employees present a neat, clean, professional appearance and wear the uniform that meets the established guidelines of the department., Purpose: To maintain a professional appearance at all times. 7. Hair restraints such as hats, hair coverings, or nets are worn to effectively keep hair from contacting exposed food. Facial hair coverings are used to cover

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facility hair of a substantial length., 9. Disposable gloves are singe use and are changes between tasks.

The Food and Nutrition Services Policies and Procedures, 5.6 Dry Storage, Effective 07/01/98 revealed: Products stored in dry storage areas are maintained in a safe and sanitary manner. Purpose: To prevent damage, spoilage, contamination, and infestation of products., 1. General Practices: 1.1 All shelves storage racks, and platforms are at least six inches off the floor...,13. Routine cleaning and pest control procedures are followed., 2. 2.2 Food is stored and rotated following first- in-first- out procedures., 2.3 Food stock is dated on the day of receipt. Items that are removed from the original box are individually dated. 2.4 Dented cans that are deemed unusable are separated from stock and clearly marked for return., 2.6 Open packages are stored in closed containers, tightly secured with ties or in food quality storage bags and include the "use by date"...

The Food and Nutrition Services Policies and Procedures, 4.6 Hand Washing, Effective 07/01/98 revealed: Hand washing is performed frequently and using correct hand washing technique, Purpose: To minimize the spread of Disease., Process: 1. Handwashing is performed: 1.2, Before putting on disposable gloves to begin a task that involves food; 1.3, During food preparation, as often as necessary to clean soiled hands and exposed portions of arms, 1.7 After contacting any soiled equipment or utensils, 1.8, When moving from one task to another.

The Food and Nutrition Services Policies and Procedures, 5.7 Refrigerated/Frozen Storage, Effective 07/01/98, revealed: Food stored under

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F 812	Continued From page 101 refrigeration/freezer storage is maintained in a safe and sanitary manner, Purpose: To prevent damage, spoilage, and contamination of products. Process: 1. Refrigeration: 1.4 All foods are labeled with name of product and the date received and "use by" date once opened. Manufacturer "use by" dates are used until opened. 1.11 Refrigeration units are kept clean and organized. Cleaning is routinely scheduled and completed. A review of the Facility Job Description for the Dining Services Director/Account Manager revealed: Manages the dining services program in a single site according to [management company] policies and procedures, and federal/state requirements. Provides leadership, support and guidance to ensure that food quality standards, inventory levels, food safety guidelines and customer service expectations are met. Review of the Emergency Water Supply Policy, provided by the MD on 03/23/22 at 10:00 AM, revealed: Policy: [Facility] will provide a safe and healthful environment for all resident, staff and visitors., Purpose: To establish procedure in the event of a loss of water supply., The following Action Steps will be taken:	F 812		
F 883 SS=D	8:39-17.2(g) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		5/10/22

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F 883	Continued From page 102 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883		

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F 883	Continued From page 103 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a [redacted] vaccine. This deficient practice was evidenced for 1 of 7 residents reviewed for immunizations (Resident # 50). The deficient practice was evidenced by the following: On 03/25/22, the Surveyor reviewed Resident #50's medical record. A review of Resident #50's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to, [redacted] t). A review of Resident #50's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], which indicated that Resident #50 was [redacted]. Further review of the MDS reflected that under [redacted] l Vaccine [redacted] indicated that Resident #50 was not up to date with the [redacted] and that the [redacted] was not offered. A review of Resident #50's [redacted] Vaccine Informed Consent reflected that the information	F 883	Resident #50 [redacted] status was evaluated and will be updated by the Medical Director accordingly. Residents and resident representatives will be involved in this process. All residents have the potential to be affected by this deficient practice. Infection Preventionist or Designee will inservice license nurses on the immunization policy and procedure to include family consent. All residents will be initially audited on immunization status and updated accordingly. Random Audits will be conducted weekly x 4 weeks then monthly x3 months by the Unit Managers or designee with corrective actions needed or taken during the course of the audit. Results of audits will be presented by the Unit Managers or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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F 883	Continued From page 104 was incomplete and the resident's signature was not on the consent. On 03/25/22 at 9:41 AM, the Surveyor interviewed the Licensed Practical Nurse (LPN) regarding Resident #50's PV. The LPN stated that Resident #50 was admitted through the [redacted] unit and that on admission the nurse did not fill out the form for [redacted]. The LPN then added that when a resident was admitted, the nurse would ask the resident if they had the [redacted]. The LPN stated if the resident was not up to date with the [redacted] then the [redacted] would be offered to the resident. On 03/25/22 at 9:46 AM, the Surveyor interviewed the [redacted] floor Unit Manager (UM) regarding Resident #50's [redacted]. The UM stated that she called two facilities that Resident #50 had previously resided in to determine if Resident #50 had received the [redacted]. She added that she did not hear back from either facility, and that she had not followed up with either one. She then stated that Resident #50's Power of Attorney (legal authorization for a designated person to make decisions about another person's property, finances, or medical care) did not know about Resident #50's immunizations and that she would follow up now. A review of the facility provided policy titled, "IC601 [redacted] l Vaccination-Prevnar 13 (PCV13) or [redacted] (PPSV23)" with a revision date of 09/02/20, included the following: Policy: ...Centers will provide the opportunity to receive the [redacted] vaccine to all patients ... Purpose: To prevent [redacted] disease and its complications to patients ... Process:	F 883		

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F 883	Continued From page 105 1. Upon admission, obtain the [redacted] vaccination history of all patients. 1.1 Patient or resident representative may self-report vaccination history. 1.2 Document [redacted] vaccination history in PointClickCare (PCC). 2. Based on the patient's [redacted] vaccination history, offer (unless the vaccination is medially contraindicated or the patient has already been vaccinated) the appropriate vaccination following the recommended schedule. N.J.A.C. 8:39-19.4(i)	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;	F 886		5/10/22

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F 886	Continued From page 106 (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. 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 develop a	F 886	Facility will monitor and follow state and federal regulations for testing.	

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F 886	Continued From page 107 process to track and perform weekly: a.) COVID-19 testing for staff that did not receive a COVID-19 vaccination, and b.) COVID-19 testing for staff who were not up-to-date with all recommended COVID-19 vaccinations. This deficient practice was evidenced by the following: Reference: CMS QSO-20-38-NH dated revised 09/10/21, "Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their community transmission level as the trigger for testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID-19 Integrated County View site:https://covid.cdc.gov/covid-data-tracker/#county-view." "Table 2: Routine testing Intervals by County COVID-19 Level of Community Transmission... Level of COVID-19 Community Transmission: Moderate (yellow); Minimum testing Frequency of Unvaccinated Staff: once a week." ... "The guidance above represents the minimum testing expected." Reference: CMS QSO-20-38-NH dated revised 03/10/22, "Facilities should use their community transmission level as the trigger for staff testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID-19 Integrated County View site: https://covid.cdc.gov/covid-data-tracker/#county-view." "Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission ...Level of COVID-19 Community Transmission: Moderate (yellow); Minimum Testing Frequency of Staff who are not up-to-date: once a week."..." The facility should	F 886	All residents and staff have the potential to be affected by this deficient practice. The Infection Preventionist or Designee will provide inservicing to all staff who are unvaccinated, not up to date or have received a medical exemption on the requirement of testing per CMS regulation and CDC guidance. Audits will be conducted weekly x 4 weeks the monthly x 3 months by the Infections Preventionist or designee with corrective actions needed or taken during the course of the audit. Results from audits will be presented by the Infection Preventionist or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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test all staff, who are not up-to-date, at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week." ..." The guidance above represents the minimum testing expected." ..." Documentation of Testing. Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following:..For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g., every week), and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test."

On 03/17/22 at 2:10 PM, the Director of Nursing (DON) provided the Surveyor a document titled "Staff Vaccination Status for Providers" which included three staff members that had received a non-medical exemption which indicated they were not required to receive a COVID-19 vaccination. The staff were: a Dietary Aide (DA), a Nurse Practitioner (NP) and a Speech Therapist.

On 03/22/22 at 10:57 AM, the Surveyor interviewed the Infection Preventionist (IP) who stated she worked part-time, 20 hours a week. The Surveyor asked the IP what the process was for staff that had an exemption for the COVID-19 vaccination. The IP stated that she tested staff that had an exemption once per week. She added that she was currently not testing all employees because the facility was no longer in an outbreak.

On 03/22/22 at 11:16 AM, the Surveyor interviewed the DON who stated that she was aware of one contracted hire/outside vendor that was unvaccinated. She stated the vendor was a

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NP that came to the facility every Thursday to see residents that had [redacted]. The Surveyor requested that the DON provide the weekly COVID-19 testing for the unvaccinated NP.

On 03/22/22 at 1:45 PM, the IP provided the surveyor the test results for the unvaccinated NP which included the following COVID-19 testing dates and results:
09/24/21 negative
11/30/21 negative
12/7/21 negative
01/11/22 negative
01/25/22 negative
02/22/22 negative
(The facility was unable to provide documented evidence that the NP was tested for COVID-19 weekly).

On 03/22/22 at 2:05 PM, the Surveyor reviewed the IP's COVID-19 POC (point of care) Testing log book. On 03/14/22 there were 57 handwritten names of staff that were tested for COVID-19. On 03/17/22 there were 3 handwritten names of staff (1 staff that needed a COVID-19 booster) that were tested for COVID-19. On 03/18/22 there was 1 handwritten name of staff that was tested for COVID-19. The IP did not have documented evidence of how she tracked that unvaccinated staff or staff that were not up to date with all recommended vaccines were tested each week.

On 03/23/22 at 12:52 PM, the Surveyor interviewed the IP regarding the process of COVID-19 testing. The IP stated that she tested everyone in the building on 03/14/22. She stated that if staff did not work the day that she performed COVID-19 testing, that the staff would come and find her when they returned to work. She stated that typically she performed

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F 886	Continued From page 110 COVID-19 testing on [redacted] and [redacted] She then stated that staff that had an exemption from COVID-19 vaccination, or needed a COVID-19 booster needed to be tested weekly. The Surveyor requested to the IP to review the document of the NP's COVID-19 testing. The Surveyor then asked the IP to confirm that the NP was not tested weekly. The IP confirmed that the NP was not tested weekly. The IP then stated that the NP was told she needed to be tested every week since she had an exemption for the COVID-19 vaccination. The IP stated that if she observed the NP at the facility, that she would test her, or that the NP could refuse if the NP had been tested somewhere else the day prior. The Surveyor then asked if the NP could provide the results from where she had been tested and provide it to the IP. The IP added that the NP was getting tested elsewhere but that the NP did not bring the test results to her. The IP confirmed that the NP should be tested weekly. The Surveyor then asked the IP for at least 4 weeks of COVID-19 testing for the DA. On 03/23/22 at 1:25 PM, the Licensed Nursing Home Administrator provided a copy of the New Jersey Department of Health Communicable Disease Service (NJDOH CDS) COVID-19 Activity Level Report for the week ending March 5, 2022, which included that the region that the facility was in had a moderate (yellow) activity level of COVID-19. On 03/24/22 at 9:20 AM, the IP provided the Surveyor with COVID-19 test results for the [redacted] which included the following: 02/2/22 negative 02/4/22 negative 02/7/22 negative 02/22/22 negative	F 886		

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F 886	Continued From page 111 03/1/22 negative 03/14/22 negative The facility could not provide documented evidence that the DA was tested for COVID-19 the week of 02/14/22 and the week of 03/7/22. On 03/24/22 at 10:23 AM, the Surveyor interviewed the IP regarding the COVID-19 testing for the DA. The IP stated that the DA might not have been here on the day she was performing COVID-19 testing. She added that the DA was good about getting tested. She added that the expectation was that she tried to get all the staff [that required testing] tested on the days that she was at the facility. She added that supervisors test on weekends but that they did not always write the tests in the log book. The Surveyor then asked the IP if she had a process to track that the staff, who were required to be tested, were getting tested weekly. The IP stated that she did not have a roster of the staff to keep track but that she could start doing that. She added that it would be easier moving forward to keep track. On 03/25/22 at 10:15 AM, the Surveyor reviewed the testing log which included an additional staff that was tested on 03/23/22 (an unvaccinated staff) and two staff that were tested on 03/24/22 (1 unvaccinated staff and 1 staff that was required to have a COVID-19 booster). On 03/25/22 at 11:56 AM, the DON provided the Surveyor a document titled [redacted] Employees due Booster Vaccine". The document was a handwritten list of eighteen employee's names and was dated 03/25/22. The document did not contain the titles of the employees and 12 of the 18 employees listed had a date written next to their name indicating the date their booster	F 886		

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vaccine was due to be given. One of the eighteen employees listed had LOA written next to their name. Five of the eighteen employees listed did not have anything written next to their name. The facility could not provide weekly testing for 16 staff that were not up to date with their COVID-19 vaccinations since 03/14/22.

On 03/28/22 at 8:47 AM, the Surveyor reviewed the facility provided Time Sheets for the DA which included the following:
For the week of 02/14/22, the DA worked 02/14/22, 02/15/22, 02/16/22, and 02/18/22.
For the week of 03/7/22, the DA worked 03/7/22, 03/8/22, 03/9/22 and 03/11/22.

On 03/28/22 at 10:10 AM, in the presence of the survey team, the DON confirmed that the facility missed one week of testing for the staff that were not up to date with their COVID-19 vaccinations.

A review of the facility provided policy titled, "IC405 COVID-19", with a revision date of 06/7/21, included the following:
Testing for COVID-19: 31. Patients, facility staff, and visitors will be tested according to CMS and state Department of Health requirements and Genesis guidance. 31.1 COVID-19 testing results will be documented.
A review of the facility provided policy titled, "Screening Tests for Coronavirus-Residents and Staff" dated 03/15/22, included the following:
Definitions: "Up-to-Date" means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible ...
Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community ...Facilities should use their community transmission level as the trigger for staff testing frequency. Table Criteria: Test

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F 886	Continued From page 113 positivity 5%-7.99% and incidence 10-49.99 per 100,000; Descriptive Label: CMS "Yellow" (Moderate) Testing Frequency for Staff Who Are Not Up-To-Date: Weekly ...For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g., every week) and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test. Non-employed facility staff (including non-employed agency staff coming from third-party vendors and working a multi-week contract at a Center) are included in this guidance and must be screened at the same frequency as employed staff (See Table above). This includes full-time independent physicians, APPs, hospice providers, consultants, contractors, ...and all others who come into contact with residents and/or staff ...Obtaining and Documenting Proof of Testing and Test Result for Non-Employed Staff: The screener must ask for proof of COVID-19 testing performed within the Center's testing frequency per the table below. Non-employed staff are not permitted to enter the Center until proof of negative test is provided, POC is administered with negative result, or PCR specimen is collected ...If non-employed staff member refuses testing, do not permit the person to remain in the Center. Center will provide/arrange for alternate care/services. N.J.A.C. 8:39-5.1(a);19.4(a)	F 886		
F 888 SS=D	COVID-19 Vaccination of Facility Staff 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	F 888		5/10/22

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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 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

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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;
(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

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F 888	Continued From page 116 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 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 observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to: a.) develop	F 888	Facility will develop a process for tracking and securely documentation covid-19 vaccination requirements per state and	

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F 888	Continued From page 117 and implement a policy to track and securely document the COVID-19 vaccination status for all staff, and b.) ensure all staff were vaccinated for COVID-19. The deficient practice was evidenced by the following: Reference: Centers for Medicare and Medicaid Services (CMS) QSO-22-07 ALL, dated 12/28/21, included the following: Within 30 days after issuance of this memorandum 2, if a facility demonstrates that: Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; and 100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is compliant under the rule; or Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is non-compliant under the rule. Reference: CMS QSO-22-07 ALL Attachment A included the following: Definitions: ... "Staff" refers to individuals who provide any care, treatment, or other services for the facility and/or its residents, including employees; licensed practitioners; adult students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangements. This also includes individuals under contract or by arrangement with the facility,	F 888	federal requirements. All residents and staff have the potential to be affected by this deficient practice. The Infection Preventionist or Designee will educate all staff in regards to covid-19 vaccination policy and procedures to include tracking and documentation status. Audits will be conducted weekly x 4 weeks then monthly x 3 months by the Infection Preventionist or designee with corrective actions needed or taken during the course of the audit. Results from audits will be done and presented by the Infection Preventionist or designee at the Monthly Quality Assurance Meeting for 3 months with corrective actions needed or taken during the course of the audit.	

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including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, licensed practitioners, or adult students, trainees, or volunteers Facilities have the flexibility to use the tracking tools of their choice; however, they must provide evidence of this tracking for surveyor review. Additionally, facilities' tracking mechanism should clearly identify each staff's role, assigned work area, and how they interact with residents. This includes staff who are contracted, volunteers, or students.

Reference: CMS COVID-19 STAFF VACCINATION MATRIX INSTRUCTIONS FOR PROVIDERS included the following: The Matrix is used to identify the vaccination status for all staff. The facility completes this form, including section I, staff name, and columns 1-11, which are described in detail below, or provide a list containing the same information required in the matrix. Unless stated otherwise, for each staff mark an X for all columns that are pertinent. 1. Direct facility hire (DH), Contracted hire (C), or Other (O): Direct facility hires (DH) are employees who are directly hired by the facility. Contracted hires (C) provide care, treatment, or other services for the facility and/or its residents under contract or by other arrangements. Other (O) includes adult students, trainees, and volunteers.

On 03/17/22 at 1:00 PM, during entrance conference with the facility the survey team requested the COVID-19 Staff Vaccination Matrix (used to identify the vaccination status for all staff) as per the CMS Entrance Conference Worksheet (guide given to the facility which lists all the documentation the facility must provide to the survey team).

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On 03/17/22 at 2:10 PM, the Director of Nursing (DON) provided the Surveyor a document titled "Staff Vaccination Status for Providers" which included the COVID-19 vaccination status of 137 staff. The document included direct hire staff and some contracted staff. The contracted staff included on the document were Therapists, Housekeeping staff, Dietary Staff, Laundry staff, Agency Nursing Staff and Nurse Practitioners. The document did not include contracted hires that provide care, treatment, or other services for the facility and/or its residents under contract or by other arrangements which would include but was not limited to physicians and hospice providers. The document also did not include volunteers that provided services which would include but was not limited to pet therapy. The document included an "X" to indicate if the staff member received the COVID-19 vaccination and a booster. The document did not include the dates the staff received the doses. The document also included if the staff member was granted an exemption from the COVID-19 vaccination.

On 03/22/22 at 10:03 AM, the Surveyor observed a pet therapy dog that had two pet therapy handlers on the second floor with an unsampled resident in a wheelchair.

On 03/22/22 at 10:24 AM, the Surveyor reviewed the National Healthcare Safety Network (NHSN) (a data tracking system which provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections) data, that the facility is required to report, for the week ending 03/6/22 which included the following: Staff fully vaccinated 95.8%.

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On 03/22/22 at 10:57 AM, the Surveyor interviewed the Infection Preventionist (IP) regarding the COVID-19 Staff Vaccination Matrix provided by the DON which did not include all the facility's contracted hires/outside vendors. The IP stated that the facility had physicians that came to the facility but that she did not have them or their vaccination status on her list. She added that the receptionist may have the physicians on her list. The surveyor then asked the IP if she kept track of the vaccination status of any of the hospice providers that came to the facility. The IP stated that she did not keep track of the hospice providers. The Surveyor then asked the IP how she kept track of when staff were due for their next dose of vaccination or their booster dose since there were no dates on the COVID-19 Staff Vaccination Matrix provided by the DON. The IP stated that she had a different COVID-19 Staff Vaccination Matrix that included the dates of the staff's vaccinations and boosters. The surveyor requested a copy of the IP's COVID-19 Staff Vaccination Matrix. The surveyor then asked the IP if she reported the Vaccination status of the facility to NHSN. The IP stated that she was not the person that reported that information.

On 03/22/22 at 11:16 AM, the Surveyor interviewed the DON regarding who reported the vaccination status to NHSN. The DON stated that she reported to NHSN and that it asked for the numbers. The Surveyor then asked the DON what the reason was that the COVID-19 Staff Vaccination Matrix did not include contracted hires/outside vendors. The DON stated that it included all staff that work in the building and that she had not included contracted hires/outside vendors. She added that at the front desk the staff asked for a copy of the persons vaccination card when they came in but that she did not know

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if they were all vaccinated.

On 03/22/22 at 1:45 PM, the IP provided the Surveyor a document titled, "COVID-19 Vaccine Administration Batch Entry Log" which included 156 employees of the facility. The document did not include the titles of the staff or if the staff were direct facility hires, contracted hires or others that would include volunteers.

On 03/24/22 at 11:35 AM, the Surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the vaccination status for all staff. The LNHA stated that he reported to NHSN by filling out a weekly survey. He added that when anyone entered the building that they were screened, and their vaccination status was put in the computer. He then stated that corporate had that information and that they reported it. The surveyor then asked the LNHA if the 137 number that was listed on the first COVID-19 Staff Vaccination Matrix that was provided to the Surveyor included contracted hires/outside vendors. The LNHA stated that 115 of the 137 were staff that were "in house." He added that all vendors are vaccinated and that he had to fire the beautician and the fish tank cleaner because they were not vaccinated.

On 03/24/22 at 12:49 PM, the Surveyor asked the LNHA to provide a complete COVID-19 Staff Vaccination Matrix that would include contracted staff including pet therapy. The LNHA stated that he could not print the "line list". He added that he did not think pet therapy would be included as a contracted hire/outside vendor since they were volunteers and were not paid.

On 03/28/22 at 9:57 AM, in the presence of the survey team, the LNHA stated that corporate had

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	315332	A. BUILDING _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 888	Continued From page 122	F 888		

the contracted hires/outside vendor list and that corporate handled the submission to NHSN. The surveyor asked the LNHA if there was someone at the facility to make sure the list was conclusive of all staff. The LNHA stated that the receptionist would let him know if there was an issue. The LNHA then stated that they had three vendors with exemptions for the COVID-19 vaccination. The surveyor then asked the LNHA what staff did not have the COVID-19 vaccination or an exemption since what was reported to NHSN was that not all staff had the COVID-19 vaccination or an exemption. The LNHA could not provide that information.
The facility did not provide a complete COVID-19 Staff Vaccination Matrix. The facility did not provide documented evidence that the facility had a process to track the COVID-19 vaccination status of all staff which included contracted hires. According to the data reported to the NHSN by the facility, the facility did not have the required 100 % of their staff vaccinated for COVID-19.

A review of the facility provided policy titled "IC604 COVID-19 Vaccination", with a revision date of 11/15/21, included the following:
Policy: Centers will provide the opportunity to receive COVID-19 vaccinations for all doses (this includes dose 1, dose 2, additional dose, booster-not immunocompromised, and any future doses) following Centers for Disease Control and Prevention (CDC) recommendations subject to availability, to patients/residents (hereinafter "patient"), employees (as defined below), visiting healthcare personnel (as defined below), and visitors (as defined below)

Definitions: Employees are defined as full-time and part-time of Center ...Visiting Healthcare Personnel (HCP) are defined as medical

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F 888	Continued From page 123 providers (e.g., physician, NP, PA), contractual workers (e.g., hospice, mental health professionals, lab, x-ray, ambulance personnel, students, trainees, volunteers, etc.) ... Purpose: To prevent the spread of SARs-CoV-2 infection and its complications to patients/staff ... A review of the facility provided policy titled "HR232 Universal COVID-19 Vaccination" with a revision date of 3/8/22, included the following: Policy: The "Company" requires that all personnel are fully immunized against COVID-19 as follows: All center-based personnel or Corporate, Regional, or Divisional personnel who regularly and/or intermittently work in or visit centers ... Definitions: Personnel: Employees, Students, Members of the medical staff, Volunteers, Care partners, non-employed caregivers, intermittent providers: Service providers and Contractors. Purpose: To protect the health and safety of patients, employees, personnel and employee family members, and the community from COVID-19 infection. To reduce the risk of transmission of COVID-19 to patients from unvaccinated personnel .... 1. COVID-19 Immunization:1.6 Students, members of medical staff, volunteers, care partners, non-employed caregivers, Physicians/advanced practice providers (APPs), intermittent providers and contracted personnel must provide proof of vaccination. 2. Corrective Actions: 2.1 Non-compliance with this policy will result in corrective action up to and including termination, termination of a contract/services, or removal from the facility. N.J.A.C. 8:39-5.1(a)	F 888		

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility provided staffing, and a review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for per the required minimum staffing standards as mandated by the State of New Jersey. Reference: New Jersey State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes	S 560	All residents present in the facility were affected by the deficient practice on the dates and shifts noted. All residents have the potential to be affected by this deficient practice. The Administrator, Director of Nursing and Staffing Coordinator were re-educated on the NJ minimum staffing mandate. Agency staff is currently being utilized to help maintain staff-to-resident ratios. The Center will continue its recruiting efforts using various forms of media to increase the number of applicants. The Center will	5/10/22

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

Electronically Signed | 04/26/22

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S 560	Continued From page 1 effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins.	S 560	convert temporary CNAs into permanent CNAs with their in-house CNA class. Agency Requisitions will be posted to bring in outside CNA□s. The Center will have weekly staffing calls with the corporate regional support team. The Human Resources Manager or designee will manage a list of on-going recruiting efforts and document the results of these attempts five days a week. The Staffing Coordinator or designee will audit daily staffing sheets to determine if Center is meeting the minimum staff-to -resident ratios. Center recruitment efforts have consisted of virtual center job fair on March 16th, Social Media job search boosting promotions initiated on March 18th, State cna in house program class conducted on March 23rd, class graduation was May 6th. Significant Financial retention/sign on incentives. In addition, 6 Agency contracts are being used to assist with staffing levels. The Administrator or Designee will report findings to the Monthly Quality Assurance Meeting for three months. The Quality Assurance Meeting will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S 560	Continued From page 2 d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... The facility was deficient in Certified Nurse Aide staffing for residents on 14 of 14 day shifts, and was deficient in total staff for residents on 3 of 14 overnight shifts as follows: -02/27/22 had 9 CNAs for 126 residents on the day shift, required 16 CNAs. -02/28/22 had 9 CNAs for 125 residents on the day shift, required 16 CNAs. -03/01/22 had 10 CNAs for 125 residents on the day shift, required 16 CNAs. -03/01/22 had 8 total staff for 125 residents on the overnight shift, required 9 total staff. -03/02/22 had 12 CNAs for 125 residents on the day shift, required 16 CNAs.-03/02/22 had 8 total staff for 125 residents on the overnight shift, required 9 total staff. -03/03/22 had 13 CNAs for 125 residents on the day shift, required 16 CNAs. -03/04/22 had 11 CNAs for 122 residents on the day shift, required 16 CNAs -03/05/22 had 8 CNAs for 122 residents on the day shift, required 16 CNAs. -03/06/22 had 8 CNAs for 124 residents on the day shift, required 16 CNAs. -03/07/22 had 10 CNAs for 124 residents on the day shift, required 16 CNAs. -03/08/22 had 10 CNAs for 122 residents on the day shift, required 16 CNAs. -03/09/22 had 11 CNAs for 121 residents on the day shift, required 16 CNAs. -03/10/22 had 10 CNAs for 121 residents on the	S 560		

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S 560	Continued From page 3 day shift, required 16 CNAs. -03/11/22 had 11 CNAs for 120 residents on the day shift, required 15 CNAs. -03/11/22 had 8 total staff for 120 residents on the overnight shift, required 9 total staff. -03/12/22 had 11 CNAs for 118 residents on the day shift, required 15 CNAs. The Facility Assessment Tool revealed: Individual staff assignment, 3.3 Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments. The approach for this center as it relates to direct care staffing is in pattered approaches. NJ requires acuities to be taken into consideration with staffing. We would adjust based upon acuitites and census. Discussions are held in staffing meetings about unit staffing. Unit Managers provide updated information on patient needs with nursing management. The scheduler will make adjustments as needed. Discussion on staffing is an on-going task that is discussed several time throughout a given day. Consistent staffing patterns are the ultimate goal with staff assigned patient assignments.	S 560		