STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 COMPLAINT# NJ00155306, NJ00160909, NJ00162038, NJ00155867, NJ00162082 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Survey Date: 03/31/23 Census:86 Sample: 20 + 2 closed records 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 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours	F 609		5/3/23

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

Electronically Signed | 04/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 609	Continued From page 1 if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) incidents pertaining to a.) a bruise of unknown origin and b.) four incidences of resident-to-resident physical abuse. This deficient practice was identified for 2 of 3 residents reviewed for abuse (Resident #21 and #81) and was evidenced by the following: 1. On 03/22/23 at 11:14 AM, the surveyor observed Resident #21 sitting in a wheelchair in the hallway. The surveyor interviewed the resident at this time. The resident stated that they have been at the facility for [redacted] According to the Admission Record, Resident #21 was admitted to the facility with diagnoses which included, but were not limited to,	F 609	F 609 1. The outcome of the investigations into these allegations of abuse was reviewed with the survey team. Resident #21 was re-informed of the investigation outcome by the Administrator and was satisfied with the same. Resident #81 was monitored for any injury, distress or change in behaviors as result of the alleged incident with NJ Exec. Order 26:4.b.1. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. The facility policy titled “Abuse Identification and Prevention Program” has been reviewed and revised to reemphasize the reporting guidelines. This also includes a revised screening tool to be used in reporting the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 609	Continued From page 2 [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated that Resident #21 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident had [redacted]. The MDS also indicated that the resident required NJ Exec. Order 26:4.b.1 with activities of daily living (ADLs) including NJ Exec. Order 26:4.b.1 from staff members. Review of Resident #21's Care Plan, dated 08/14/21, indicated that the resident had an "ADL self care performance deficit related to [redacted]." An intervention for this care plan was that the resident required one staff to participate with their NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 needs. Review of Resident #21's Progress Notes revealed a [redacted] Social Service Note which indicated, "Director of Social Services was made aware that [Resident #21] made an allegation that a CNA [certified nursing assistant] at the facility by the name of [CNA #1] pulled [his/her] hair hard and on purpose when in the shower. According to [Resident #21] the CNA said, 'You better listen to me or I'm going to pull your hair!' Administrator and Director of Social Services were both made aware of the situation [redacted]. Both Administrator and Director of Social Services spoke with Resident #21 together and [he/she] stated that yes, the CNA pulled [his/her] hair on purpose and hard. It was also stated by other staff that the aide in question confessed to	F 609	allegations and conducting the investigation. This tool acts as a guideline to assure the reporting procedure is followed and the investigation is thorough and complete. All concerns/grievances and incident reports for the past 3 months have been reviewed by Administrator/designee for any allegation and investigations completed if necessary. 3. All Department Managers have been re-educated reporting all allegations of abuse, neglect, exploitation, or mistreatment as outlined in the facility policy by the Corporate Director of Operations. The Administrator/designee will audit the screening tools of any allegation of abuse, neglect, exploitation, or mistreatment monthly x 12 months to assure the incident has been reported as per facility policy. 4. The results of these audits and any investigations of abuse will be reviewed at the quarterly Quality Assurance meeting to identify trends or patterns and determine corrective action. Date of Completion:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 609	Continued From page 3 pulling [Resident #21's] hair on purpose." On 03/23/23 at 10:13 AM, the surveyor attempted to interview Resident #21 about the allegation of abuse. Resident #21 stated that they did not remember the incident. On 03/27/23 at 12:02 PM, the surveyor reviewed the investigation into the allegation that was provided by the facility. The Resident Concern Form indicated that the event occurred on [redacted] and that the investigation began on [redacted]. On 3/27/23 at 12:05 PM, the surveyor requested the reportable event form that was submitted to the NJDOH from the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he was responsible to report but that this was not something that he would have reported because the investigation determined that there was no abuse. During an interview with the surveyor on 3/27/23 at 12:16 PM, the LNHA stated, in the presence of the survey team, that he interpreted the regulation about reporting allegations of abuse to be about, "intent." The LNHA stated that he knew CNA #1's intent after the investigation was completed. On 03/30/23 at 2:01 PM, the surveyor expressed concerns to the LNHA, Director of Nursing (DON), Director of Operations, and Chief Operating Officer (COO). The COO stated that the allegation should have been reported. No additional information was provided.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 609	Continued From page 4	F 609		

2. On 03/24/23 at 12:17 PM, the surveyor observed Resident #81 sitting at a table during the lunch meal service. The resident was [redacted] and showed no [redacted] or [redacted] of [redacted] or [redacted].

According to the Admission Record, Resident #81 was admitted to the facility with diagnoses which included, but were not limited to: [redacted]

Review of the admission MDS, dated [redacted] reflected that Resident #81 was [redacted], had [redacted] not directed toward others one to three days out the week, and significantly intruded on the privacy or activity of others.

Review of Resident #81's Care Plan, initiated on [redacted] indicated the resident was prescribed [redacted] for [redacted], which included [redacted] for [redacted] and [redacted] (an [redacted]) for [redacted].

Review of Resident #81's Unusual Occurrence Incident Report (Incident Report), dated [redacted], revealed that the CNA observed another residen[redacted] Resident #81 on the [redacted]. The residents were separated, Resident #81 was assessed and had no [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 609	Continued From page 5 Review of Resident #81's Incident Report, dated [redacted], revealed that Resident #81 [redacted] his/her [redacted] and [redacted] another resident in the [redacted] with the [redacted] The residents were [redacted] and monitored. Review of Resident #81's Incident Report, dated [redacted], revealed that Resident #81 was [redacted] on the [redacted] by another resident. The residents were [redacted], Resident #81 was assessed and had no [redacted]. Review of Resident #81's Incident Report, dated [redacted], revealed that Resident #81 was [redacted] on the [redacted] by another resident. The residents were separated, Resident #81 was assessed and had no [redacted]. During an interview with the surveyor on 03/31/23 at 11:00 AM, the DON stated Resident #81's resident to resident incidents were not reported to the NJDOH because there were [redacted] and did not pose an imminent threat. The DON added that she would report a resident to resident altercaton to the NJDOH if there was an injury or escalation of threat to the safety of the others which would be determined by the physician. During an interview with the surveyor on 03/31/23 at 11:55 AM, the LNHA stated that he or the DON was responsible for reporting to the NJDOH. The LNHA added that they follow the regulation of the NJDOH to their understanding. During an interview with the surveyor on 03/31/23 01:00 PM, the COO stated there was no additional information. The COO added that	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 609	Continued From page 6 they reviewed the resident to resident incidents, determined it was not abuse, and an incident report was completed. Review of the facility's policy titled, "Abuse Identification and Prevention Program," with a reviewed date of 07/22, indicated under the Reporting section that, "All alleged or suspected incidents of abuse, neglect or mistreatment shall be reported promptly to the New Jersey Department of Health and Senior Services," and, "The Administrator/ Director of Nursing/ designee will notify the Department of Health and the Ombudsman of the alleged abuse by telephone 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 or abuse and do not result in serious bodily injury. Notification will include the details known up to this point in time, and that the investigation has been started." Review of the facility's "Incident Reporting for Residents and Visitors" policy, reviewed 01/23, indicated that "5. The Administrator [LNHA], Director of Nursing, or designee must notify the appropriate state agency within the required State and Federal regulations."	F 609		
F 658 SS=D	NJAC 8:39-9.4(f) 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,	F 658		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 658	Continued From page 7 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to transcribe a current Physician's Order for a resident's diet for 1 of 5 residents (Resident #36) reviewed for [redacted] This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 03/22/23 at 11:41 AM, the surveyor interviewed Resident #36 in their room. The resident stated that the food [redacted]" because it is [redacted]. The resident further explained he/she has been receiving [redacted] for at least [redacted] months. According to the Admission Record, Resident #36 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]	F 658	1. The diet order for resident #36 was corrected on 2/10/23. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. An audit of all current residents' diet orders has been completed to assure that all diet orders have been reconciled with the physician order in the electronic medical record and the diet tray card. The facility policy and procedure titled "Dietary Alert" has been revised to include the responsibility of the licensed nurse to obtain and enter the diet orders. 3. All licensed nurses have been educated on the revised Dietary Alert policy. The Dietitian will audit all resident's diet orders monthly x 12 months. 4. The results of these audits will be submitted to the Administrator monthly and reviewed at the Quarterly Quality Assurance Meeting to assure compliance and to identify any trends or patterns requiring corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 658	Continued From page 8	F 658		

[redacted].

A review of the resident's March 2023 Physician Orders (PO) revealed an order with a start date of [redacted] for: NJ Exec. Order 26:4.b.1

NJ Exec. Order 26:4.b.1

On 03/27/23 at 9:43 AM, the surveyor reviewed Resident #36's Electronic Medical Record (EMR). Review of Resident #36's Progress Notes revealed a note written by the Registered Dietitian (RD), dated 11/25/2022 at 10:07 AM, which included, [redacted]. Recommended SLP [Speech Language Pathology] consult, at this time recommend downgrade diet to [redacted] NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4 until evaluated. Recommendation placed in chart for nursing." Further review of the Progress Notes included a nurse's note completed on the same day at 1:58 PM which revealed, "MD called, recommendation approved."

On 03/27/23 at 10:41 AM, the surveyor reviewed Resident # 36 physical/paper chart. Review of the paper Physician's Orders (Yellow Sheet) revealed there weren't any diet change orders related to the 11/25/22 RD note. Further review of the paper chart revealed a paper titled "Dietary Alert Sheet" and under the action to be taken section, it included "Downgrade diet texture to NJ Exec. Order 26:4.b.1 Also included in the paper chart was a "change of diet" slip dated 11/25/22 signed by the LPN, with a new diet order of: NJ Exec. Order 26:4.b.1 texture.

During an interview with the surveyor on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 658	Continued From page 9 03/27/23 at 11:13 AM, the 200-Unit Unit Manager (UM) stated for a diet change, we alert the doctor and get their approval. Once we get the approval the nurse will enter the diet order in the EMR under the PO section and also fill out a paper 'change of diet' slip. The UM further stated one copy of the form stays in the chart and the other is sent to the dietary office. The surveyor and UM reviewed the POs and the UM stated, "I don't see an order for a diet change on 11/25/2022, but the diet was correctly entered on 02/10/2023." The UM stated that the expectation would be for the nurse to enter the PO in EMR on the day it was ordered. Review of the facility's Entering of Pharmacy Orders in EMAR policy from included a purpose "To identify a procedure to ensure the accuracy and completeness of transcriptions of medication and treatment orders received by Licensed Personnel." Further review of the policy included, "When a physician's order is placed verbally or by telephone, the receiving nurse shall enter the order that was received in the EMAR."	F 658		
F 695 SS=D	NJAC 8:39-19.4 (a)(1) 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	F 695		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 10 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that a resident received [redacted] as prescribed by the physician for 1 of 1 resident (Resident #3) reviewed for [redacted] The deficient practice was evidenced by the following: On 03/22/23 at 11:35 AM, the surveyor observed Resident #3 in bed wearing a [redacted]. The surveyor observed that the [redacted] was connected to an [redacted] that was set to [redacted]. The resident stated that they usually receive [redacted]. On 03/24/23 at 10:10 AM, the surveyor observed Resident #3 sitting in their wheelchair in their room. The surveyor observed that the resident was wearing the [redacted] and that the NJ Exec. Order 26:4.b.1 was set to [redacted]. The resident stated that they do not touch the [redacted] and that only the nurses adjust it. On 03/27/23 at 9:50 AM, the surveyor observed Resident #3 in bed with their eyes closed. The surveyor observed that the resident was wearing the [redacted] and that their [redacted] concentrator was set to [redacted] During an interview with the surveyor on	F 695	F 695 1. Resident #3 was reassessed by the physician for [redacted] usage. The resident's [redacted] usage is being maintained as per physician order. Licensed Nurses assigned to resident #3 were re-educated regarding the reading of, documenting and maintaining of [redacted] flow level according to the physician order. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. An audit was conducted on all residents who are receiving [redacted] therapy to assure they are receiving [redacted] care according to the physician order and professional standards of practice. The facility policy on NJ Exec. Order 26:4.b.1 was reviewed and updated. 3. The facility licensed nursing staff were re-educated on [redacted] care consistent with professional standards with an emphasis on maintaining the proper [redacted] flow rate as per physician order. The Nursing Manger/ designee will audit all residents with [redacted] orders 3 times a week x 1 month, weekly x 5 months and monthly x 6 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 11 03/27/23 at 10:06 AM, the Certified Nursing Assistant (CNA) #1 stated that Resident #3 was on [redacted] continuously. CNA #1 stated that she must adjust the [redacted] when the resident goes to the [redacted] but that otherwise she does not touch the [redacted]. During an interview with the surveyor on 03/27/23 at 10:10 AM, the Licensed Practical Nurse (LPN) #1 stated that Resident #3's [redacted] is "routine" and that it should be set to [redacted] LPN #1 stated that she checks that the rate of [redacted] correct every shift. At this time the surveyor and LPN #1 went to Resident #3's room together. LPN #1 acknowledged that the [redacted] was set to [redacted] LPM. LPN #1 stated that she checked that the [redacted] was set to [redacted] when she came in. The surveyor stated that she observed that the [redacted] was set to [redacted] on three different days. LPN #1 stated that the nurses should check every shift. During an interview with the surveyor on 03/28/23 at 10:24 AM, the LPN/ Unit Manager (LPN/UM) stated that Resident #3 receives [redacted] of [redacted] continuously and that the [redacted] should be set to [redacted] because that is what is ordered by the physician. She stated that if the resident is not maintaining a good [redacted] (the amount of [redacted] that is circulating in the blood) on [redacted] then the nurse should call the doctor to get a new order. The LPN/UM stated that she expected that the nurses would check the [redacted] at least once every shift. On 03/28/23 at 10:58 AM, the surveyor observed Resident #3 sitting in their wheelchair. The	F 695	4. The results of the audits will be reviewed monthly by the Administrator/ Director of Nursing monthly and at the quarterly Quality Assurance meeting to ensure compliance and to identify any trends or patterns requiring further corrective action. Date of Completion:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 12 surveyor observed the [NJ Exec. Order 26:4.b.1] on the ground, not connected to the [redacted] concentrator. The surveyor immediately informed the LPN/UM that the resident was not connected to any [redacted]. The LPN/UM went into Resident #3's room and confirmed that the [redacted] was no [redacted] concentrator. Resident #3 stated that they did not feel the air coming through the prongs of the [redacted]. The LPN/UM plugged the [redacted] into the [redacted] and stated that she checked this morning and the resident was [redacted] to the [redacted] at that time. During a follow up interview with the surveyor on 03/28/23 at 11:07 AM, Resident #3 stated that the [redacted] must have been disconnected when their aide got them out of bed and into their wheelchair. During a follow up interview with the surveyor on 03/28/23 at 11:27 AM, CNA #1 stated that she got Resident #3 out of bed around 9:30 or 10:00 AM. CNA #1 stated that she usually checks [redacted] when she transfers residents to make sure that it is not tangled and that it is connected. The CNA stated that when she got Resident #3 out of bed and into the chair, the [redacted] was connected. The CNA stated that maybe the resident moved and disconnected the [redacted] themselves. During a follow up interview with the surveyor on 03/28/23 at 12:27 PM, LPN #1 stated that she saw the resident around 9:30 AM and that they were in bed and were [redacted] to the [redacted] at that time. LPN #1 stated that she instructed the CNAs that if they take residents	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 13 out of bed that they can switch their [redacted] to portable [redacted]. LPN #1 stated that CNA #1 took the resident to be weighed and that she might have disconnected the resident at that time. LPN #1 stated that residents sometimes are disconnected from their [redacted] when they get out of bed to use the bathroom but acknowledged that Resident #3's [redacted] should have been connected to the [redacted] According to the Admission Record, Resident #3 was admitted to the facility with diagnoses which included, but were not limited to [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated that Resident #3 had a Brief Interview for [redacted] Status score of [redacted] which indicated that the resident had [redacted]. The MDS also revealed that Resident #3 used [redacted], that they needed limited assistance from one staff member to transfer (from the bed to a wheelchair) and move about their room, and that they did not walk in their room during the assessment window of the MDS. Review of the Order Summary Report indicated that Resident #3 had an active physician order for [redacted] continuously, dated [redacted] Review of the Care Plan indicated that Resident #3 had a focus, dated 04/23/21, of [redacted] Therapy related to [redacted] with an intervention to have the [redacted]	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 14 delivered via [redacted] a [redacted] continuously. Review of the March 2023 Medication Administration Record (MAR) revealed that nurses signed every shift from 03/22/23 to 03/28/23 that Resident #3 received [redacted] of [redacted] continuously. On 03/30/23 at 2:01 PM, the surveyor notifed the Licensed Nursing Home Administrator, Director of Nursing, Director of Operations, and Chief Operating Officer (COO) of the above concern. During an interview with the surveyor on 3/31/23 at 10:05 AM, the COO acknowledged that [redacted] should be set to the rate ordered by the physician. The facility policy, "Respiratory Therapy Administration and Equipment Policy and Procedure" with a reviewed date of 01/23 indicated under Preparation to "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for [redacted] administration." NJAC 8:39-27.1 (a) NJAC 8:39-29.2 (d)	F 695		
F 698 SS=D	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	F 698		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 698	Continued From page 15 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to consistently assess and monitor the [redacted] access site for any complications before and after [redacted] treatments for 1 of 1 resident (Resident #26) reviewed for [redacted] care This deficient practice was evidenced by the following: According to the Admission Record, Resident #26 was admitted with diagnoses which included, but were not limited to, [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the managment of care, dated [redacted], revealed that Resident #26 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident had [redacted]. Further review of the MDS, Section O - Special Treatment and Procedures, included that the resident received [redacted] services (a process of [redacted]. Review of the Nurses Notes in the electronic Progress Notes (PN), dated [redacted], revealed that Resident #26 had an [redacted] nt) on his/her	F 698	1. Resident #26 physician orders were updated on [redacted] to include an assessment of the [redacted] every shift. Resident #26 was discharged from the facility on [redacted] 2. The facility recognizes that all residents on [redacted] have the potential to be affected by this deficient practice. There are no residents at the facility currently receiving [redacted]. The facility policy on caring for residents with [redacted] has been revised to include assessment of the [redacted] every shift. 3. All licensed nurses have been in-service on the revised facility policy on caring for a resident with [redacted] to include assessments of [redacted] The Unit Manager/designee will audit all [redacted] residents' physician orders on admission/readmission and then monthly to maintain compliance. 4. The results of these audits will be reviewed by the Director of Nursing/designee monthly and at the quarterly Quality Assurance meeting to identify trends or patterns that require further corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 698	Continued From page 16 Review of the Order Summary Report (OSR) revealed a Physician's Order (PO) dated 03/13/23 for "Dialysis at [name redacted] every Tuesday, Thursday, and Saturday..." Further review of the OSR revealed no documented evidence of a PO to check the AV shunt for bruit and thrill (a sound and sensation test to identify how well the dialysis access is functioning). Review of the resident's Dialysis Communication Log (a form that the facility used to communicate with the [NJ Exec. Order 26:4.b.] center for each of the resident's [NJ Exec. Order 26:4.] sessions) book reflected that the resident had [NJ Exec. Order 26:4.] sessions on the following dates: [redacted] Further review of the resident's Dialysis Communication Log revealed no documented evidence that Resident #26's [redacted] was assessed prior to dialysis and upon return from [redacted] treatments on the dates mentioned above. Review of the electronic PN revealed no documented evidence that Resident #26's [redacted] was assessed prior to and upon return from [redacted] on the dates mentioned above, except upon return to the facility on [redacted] Review of the resident's hybrid medical records revealed no documented evidence that Resident's #26's [redacted] was assessed	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 698	Continued From page 17 prior to and upon return from [NJ Exec. Order 26:4.b.1] treatments on the dates mentioned above, except upon return to the facility on 03/28/23. During an interview with the surveyor on 03/27/23 at 12:37 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the resident had [NJ Exec. Order 26:4.] on Tuesdays, Thursdays, and Saturdays. She stated that the facility did not have a policy and the resident did not have a PO for assessment of the [redacted] She further stated, "personally, it needs a doctor's order to check for [redacted] On 03/27/23 at 1:29 PM, the surveyor observed the resident lying in bed awake and responded to the surveyor's inquiry, but with eyes closed. The surveyor observed the resident with an intact dressing on his/he [redacted]. The surveyor was unable to complete the interview due to the resident's refusal to continue. On 03/30/23 at 2:29 PM, the surveyor informed the Chief Operating Officer (COO), Director of Operations (DO), Administrator (LNHA), and the Director of Nursing (DON) of the above concern in the presence of the survey team. The COO acknowledged that the facility did not have a policy for [NJ Exec. Order 26:4.b.1] She further stated that there should have been a PO for an [redacted] site assessment for [redacted] for Resident #26, so they can be consistently recorded in the resident's electronic medical records. On 03/31/23 at 1:03 PM, the survey team met with the COO, DO, LNHA, and DON. There was no additional information provided by the facility.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 698	Continued From page 18 NJAC 8:39 - 27.1(a)	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 19 by: COMPLAINT # NJ00160909 Based on interview, record review, and review of facility documents, it was determined that the facility failed to a.) notify the physician when a medication became unavailable and b.) maintain an accurate record of a [redacted] for 1 of 3 residents (Resident #138) reviewed for [redacted] management. This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #138 had diagnoses that included, but were not limited to, [redacted] Review of Resident #138's Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed the resident was [redacted] for daily decision making. Further review of the MDS included the resident received a scheduled [redacted] medication regimen. Review of Resident #138's Care Plan, initiated 10/29/19, included a focus that "[Resident #138] has [redacted], and is now on [redacted]." Interventions for this focus included "Administer [redacted] as per orders." Further review of the Care Plan included a focus of [redacted]," and with an intervention to [redacted] as ordered."	F 755	1. Resident #138 [redacted] on [redacted] prior to survey so no corrected actions could be completed. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. An audit was conducted of all [redacted] declining inventory sheets for accuracy and to verify the medication is available as ordered. The policy and procedures for Medication Administration and [redacted] Control were updated to meet these standards. 3. Licensed nurses were educated on the policy and procedures ordering narcotic medication from the pharmacy and documentation of [redacted] administration by the pharmacy provider representative. The Nurse Manager/designee will conduct weekly audits x4 then monthly x 3 months to assure compliance. The pharmacy consultant will also conduct random observations of the administration of NJ Exec. Order 26:4.b.1 onthly to ensure the accuracy of the [redacted] inventory and the availability of [redacted]. 4. These audits will be submitted to the Administrator/Director of Nursing monthly and reviewed at the quarterly Quality Assurance meeting to identify trends or patterns and implement appropriate interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 20 Review of Resident #138's January 2023 Medication Administration Record (MAR) included a physician's order for [redacted] every [redacted] hours [redacted]" with administration times of 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Starting on the 01/17/23 [redacted] through the [redacted], the [redacted] order was not coded as administered and instead coded as [redacted] indicating "Other/See Nurse Notes" for 10 doses. Further review of the [redacted] MAR revealed the resident did not have [redacted] from [redacted] Review of Resident #138's Progress Notes revealed the corresponding eMAR (electronic MAR) notes for the aforementioned [redacted] order: [redacted] Further review of the Progress Notes revealed a note written by the Advanced Nurse Practitioner (ANP), dated [redacted], which	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 21	F 755		

included, "[he/she] is using [his/her] [redacted] routinely every [redacted] hours for [redacted] as per [redacted] recommendations. [He/She] needs new Rx [prescription] for every [redacted] for SOB [redacted] and every 6 hours routinely for [redacted]. Rx written and faxed to pharmacy." There were no progress notes prior to the ANP's note that indicated the nursing staff had notified the physician or ANP of the resident's [redacted] NJ Exec. Order 26:4.b.1 being unavailable, and therefore not administered, starting on [redacted].

Review of the declining record for Resident #138's [redacted] revealed the resident received the last dose signed out from one bottle on [redacted] and the following dose was not signed out until [redacted] from a new bottle of [redacted] received by the facility on [redacted]

During an interview with the surveyor on 03/30/23 at 10:06 AM, the Licensed Practical Nurse (LPN) stated that if a resident's medication was unavailable, the nurse should call the pharmacy to check the status of the medication and notify the physician because the physician may want to order an alternative medication or place the medication on hold. The LPN also stated that the nurse on the following shift should follow up if the medication was still unavailable. The LPN added that it is important to notify the physician if a resident's medication is unavailable because there could be consequences for the resident depending on the medication.

During an interview with the surveyor on 03/30/23 at 10:29 AM, the LPN/Unit Manager (LPN/UM) stated that if a medication is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 22	F 755		

unavailable, the nurse should contact the pharmacy to check how soon the medication could be delivered and notify the physician to check if an alternative medication could be given. The LPN/UM also stated that the nurse on the following shift should continue to follow up on the unavailable medication. The LPN/UM added that it is important to notify the physician if a resident's medication is unavailable to ensure the resident is receiving what they need. In reference to Resident #138, the LPN/UM stated she called the pharmacy and they informed her the resident needed a new prescription for the [redacted] and the LPN/UM realized the physician did not send one. The LPN/UM further stated that the pharmacy contacted the physician for a prescription and that to the LPN/UM's knowledge, the resident only missed two doses of [redacted] The LPN/UM also stated that the nurse on 01/17/23 should have notified the pharmacy and physician of the unavailable medication because then the nurse would have known the pharmacy needed a new prescription for the morphine and could have followed up with the physician at that time.

During an interview with the surveyor on 03/30/23 at 10:45 AM, the Director of Nursing (DON) stated that if a medication is unavailable, the nurse needs to notify the physician and follow up with the pharmacy on the status of the medication. In reference to Resident #138, the DON stated the nurse should have notified the physician on [redacted] when the [redacted] became unavailable and called the pharmacy to have the medication delivered stat to the facility.

Review of the facility's Medication Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 23 Policy and Procedure, revised 01/2023, included, "If a medication is unavailable the pharmacy will be contacted for the medication to be received on the next scheduled delivery. The primary MD [physician] will be notified of the unavailable medication and orders obtained as needed." 2. Further review of the declining record for Resident #138's [redacted] revealed the medication was destroyed on [redacted] by two nurses and there was a line with the word "destroyed" indicating the last dose of [redacted] was given on 01/17/23 at 12:00 PM. However, there were two doses signed out after 01/17/23 which included 01/18/23 at 6:00 PM and 01/19/23 at 6:00 AM and were written through the line that had the word "destroyed" on it. During an interview with the surveyor on 03/31/23 at 10:00 AM, the DON stated she was unsure which nurse signed out the 01/18/23 and 01/19/23 doses of [redacted] During an interview with the surveyor on 03/31/23 at 1:02 PM, the Chief Operating Officer (COO) provided a written statement from one of the nurses who destroyed the [redacted] on 01/17/23 verifying the medication was destroyed on that date. The COO then stated that a nurse should not have signed out the [redacted] on 01/18/23 and 01/19/23 after the medication was already destroyed. Review of the facility's [redacted] Declining Balance Sheet Monitoring and Destruction Policy and Procedure, revised 03/23, included, "The medication once verified to be accurate, is	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 24 poured and is immediately signed for on the declining inventory sheet," and, [NJ Exec. Order 26:4.b.1] destruction will be performed by two licensed nurses using RX destroyer located on the medication cart and documented on the declining inventory sheet." NJAC 8:39-27.1(a) NJAC 8:39-29.7(c)	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 756	Continued From page 25 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to respond in a timely manner to the Consultant Pharmacist's (CP) monthly recommendations for 1 of 6 residents (Resident #5) reviewed for unnecessary medications. The deficient practice was evidenced by the following: On 03/27/23 at 10:30 AM, the surveyor observed Resident #5 in bed. The resident stated that he/she slept well but was [redacted] Resident #5 informed the surveyor that he/she didn't want to get out of bed. According to the Admission Record, Resident #5 was admitted to the facility with diagnoses that included, but were not limited, to unspecified [redacted]	F 756	[redacted]. Resident #5 recommendations from the pharmacy consultant were reviewed by the Nurse Manager and orders obtained from the attending physician. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. An audit has been completed of the past 3 months of the pharmacy consultant recommendations to assure the recommendations have been reviewed and addressed accordingly. The facility policy on the pharmacy consultant monthly report has been reviewed and revised. 3. Nurse managers were educated on the monthly pharmacy consultant reports and responding to their recommendations by the pharmacy consultant. The Director of Nursing/designee will review the pharmacy consultant report monthly to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 756	Continued From page 26 Review of Resident #5's Physician Order Sheet (POS), dated [redacted], revealed that the Resident was treated wit [redacted] All these medications were active physician orders noted since the resident's admission in [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had [redacted]. Review of Resident #5's Care Plan, initiated on 04/30/2021, included, "Resident #5 uses [redacted] In addition, the Care Plan included an intervention to, "Monitor/record occurrence of for target [redacted] symptoms [redacted] and document per facility protocol." Review of Resident #5's Behavior Monitoring Sheets from [redacted] revealed that there were, [redacted] During an interview with the surveyor on 03/30/23 at 11:35 AM, the Licensed Practical Nurse (LPN) that cared for Resident #5 stated that Resident #5 had nc [redacted] during the day. The LPN added that Resident #5 had	F 756	assure the facility is acting upon the consultant's recommendations. 4. The results of the Pharmacy Consultant recommendations will be reviewed at the Quarterly Quality Assurance meeting to ensure compliance and to identify any trends or patterns requiring further corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 756	Continued From page 27 NJ Exec. Order 26:4.b.1 in the evening such as talking nonstop, asking questions to other residents, and being very loud. The LPN further explained that Resident #5 was hard to redirect. During an interview with the surveyor on 03/30/23 at 11:40 AM, the LPN/Unit Manager (UM) identified the documented behaviors for Resident #5's, as listed on the NJ Exec. Order 26:4.b.1 Tab of the Electronic Medical Record, as [redacted]. Review of CP Evaluations from [redacted] revealed the following recommendations to the Physician related to requests to identify the behaviors being monitored for [redacted] [redacted] Identify and monitor the NJ Exec. Order 26:4.b.1 being exhibited for [redacted]. Please clarify and update the diagnosis for [redacted]: Please clarify and update the diagnosis for [redacted] On 03/30/23 at 2:20 PM, the surveyor met with the facility Licensed Nursing Home Administrator, Director of Nursing, Chief Operations Officer (COO), and Director of Operations to discuss the absence of the indication of use for [redacted] and the response time for the CP recommendations. The COO stated that the facility should respond to the CP recommendations before the CP's next monthly visit. During an interview with the surveyor on 03/31/23 at 11:22 AM, the Consultant Pharmacist Director of Operations stated that [redacted] should be evaluated periodically when a resident	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 756	Continued From page 28 was treated with an [redacted]. He further stated that the CP (who was not available to be interviewed) reviewed the resident's charts monthly and evaluated the [redacted], requesting that the diagnosis be updated more than once. During an interview with the surveyor on 03/31/23 at 12:42 PM, the COO and the LPN/UM stated that CP recommendations should be responded to before their next monthly visit. No further information was provided by the facility.	F 756		
F 758 SS=D	NJAC 8:39- 11.2 (d) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 758	Continued From page 29 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure a PRN (as needed) [redacted] NJ Exec. Order 26:4.b.1 medication was ordered for a 14-day period for 1 of 5 residents (Resident #81) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 03/24/23 at 12:17 PM, the surveyor observed	F 758	1. Resident #81 has been reevaluated for the appropriate use of [redacted] medications and the physician orders for the use of [redacted] medications have been revised. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. An audit was completed on all current residents' on [redacted] to assure that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 758	Continued From page 30 Resident #81 sitting at a table during the lunch meal service. The resident was [redacted] According to the Admission Record, Resident #81 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] Review of the Order Summary Report, order date range [redacted] revealed a physician order (order), dated [redacted] for [redacted] The order did not contain a [redacted]-day duration. Review of the [redacted] Medication Administration Records (MAR) included the aforementioned order for [redacted] dated [redacted] The order did not contain a [redacted]-day duration and had been discontinued on [redacted] The MARS reflected the medication was administered on the following dates and times: [redacted] During an interview with the surveyor on 03/29/23 at 12:37 PM, the Licensed Practical Nurse (LPN) stated that [redacted] orders were initially ordered for [redacted] days. The LPN added that	F 758	[redacted] prn medication orders did not exceed 14 days without the appropriate rationale and duration of treatment documented by the physician/designee. The facility policy on [redacted] Medication use has been reviewed. 3. Licensed nurses have also been inserviced on the use of the [redacted] medications by the consultant pharmacist. The consultant pharmacist will review all residents on [redacted] medication drug regimens monthly x 12 months to assure that the residents' [redacted] drug regime is compliant with this standard and make recommendations as needed. The Nurse Manager will review and address these recommendations monthly. 4. The results of the audits will be submitted monthly to the Director of Nursing and reviewed at the quarterly Quality Assurance meeting to ensure compliance and to identify any trends or patterns requiring further corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 758	Continued From page 31 the order would then be re-evaluated and the physician would need to send another order/prescription to the pharmacy if the medication was to be continued. During an interview with the surveyor on 03/30/23 at 1:01 PM, the LPN/Unit Manager (LPN/UM) stated that [redacted] medications were ordered for a duration of [redacted] days and sometimes 30 days depending on the physician order. The initial order should automatically disappear after 14 days and then be re-evaluated by the physician. The LPN/UM further stated that [redacted] orders without a duration should be clarified with the physician and that the nurses knew that any [redacted] medication should have a stop date. During an interview with the surveyor on 03/30/23 at 1:41 PM, the Director of Nursing (DON) stated tha [redacted] orders should be for [redacted] days and then re-evaluated by the physician. The DON added that she expected nurses to clarify a [redacted] medication order with no duration with the physician. During an interview with the surveyor on 03/31/23 at 1:00 PM, the Chief Operating Officer stated there was no additional information in reference to Resident #81's [redacted] order and that it should have been discontinued after [redacted] days and reordered if necessary. Review of the facility's "Psychotropic Medication Use Policy and Procedure," reviewed 01/23, indicated that "PRN orders for [redacted] NJ Exec. Order 26:4.b.1 medications were limited to 14 days." The policy revealed that the physician would document a	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 758	Continued From page 32 rationale and include a duration for extending the use of the prn NJ Exec. Order 26:4.b.1 medication. NJAC 8:39 - 29.3(a)(4)	F 758		
F 812 SS=E	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 review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following: On 03/22/23 at 12:03 PM, the surveyor, in the presence of the Food Service Director (FSD),	F 812	1. The chicken soup mix in the dry storage room was discarded. The dented can of applesauce was moved to the dented can area. The 7 cups of Pineapple were discarded. The cups of pudding were discarded. The box of undated mighty shakes in the walk-in refrigerator were discarded. The trays of undated mighty shakes in the	5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 812	Continued From page 33 observed the following during the kitchen tour: 1. In the dry storage room, an opened an undated package of chicken soup mix powder wrapped in plastic was stored on a shelf. When interviewed, the FSD stated the container should have been dated when opened. 2. In the dry storage room, a dented can of applesauce was stored on a shelf alongside undented cans. When interviewed, the FSD stated the can should not have been on the rack and should have been placed in the designated dented can area. 3. In the dessert refrigerator, a tray dated 03/21 containing seven cups of pineapples was stored on a shelf. The pineapple cups were uncovered and exposed. 4. In the dessert refrigerator, a tray containing pudding was stored on a shelf. The cups of pudding were uncovered and exposed. When interviewed, the FSD stated the pineapples were from last night's meal and that they normally stored the aforementioned items uncovered in the refrigerator. 5. In the walk-in refrigerator, a box containing 10 undated vanilla mighty shakes (MS) and one chocolate MS, was stored on a multitiered shelf. A second box containing 34 undated strawberry MS, was stored on a multitiered shelf. 6. In the walk-in refrigerator, the surveyor observed multiple trays stored on a multitiered cart. The first tray contained three undated vanilla MS, one undated strawberry MS and one	F 812	walk-in refrigerator were discarded. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. A kitchen sanitation audit was completed by Dietitian to identify and correct any additional areas of non-compliance. The facility policies titled “Food Storage Policy” and “Mighty Shakes Storage Policy and Procedure” were reviewed and updated. 3. Dietary staff were re-educated on the facility policies on food storage which included basics for handling food safety and the revised policy on the Mighty Shakes Storage Policy and Procedure. Kitchen Sanitation audits will be conducted by the Dietitian weekly x 4 weeks and monthly x 12 months to ensure ongoing compliance with sanitation and food storage procedures. 4. The results of these audits will be reviewed monthly by the Administrator and reviewed at the quarterly Quality Assurance meeting to identify trends or patterns and implement appropriate interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD HOPE, NJ 07844**

(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 812	Continued From page 34 undated chocolate MS. A second tray contained three undated vanilla MS and one undated chocolate MS . When questioned about the pull dates for the MS, the FSD could not provide a date and asked the surveyor was if she supposed to date them when pulled. Review of the facility's "Food Storage Policy and Procedure," reviewed 01/23, indicated that prepared foods stored in the refrigerator should be dated with an expiration date and stored tightly sealed with plastic wrap, foil, or a lid. Review of the facility's "Mighty Shake Storage Policy and Procedure," reviewed 01/23, indicated that MS placed in refrigerator would be labeled with "pull date." The policy further indicated the MS had a 14-day shelf life from the "pull date" and must be used or discarded by date on label. NJAC 8:38-17.2 (g)	F 812		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315224 Y1	A. Building B. Wing Y2	5/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	05/03/2023	LSC	05/03/2023	LSC	05/03/2023
ID Prefix F0698	Correction	ID Prefix F0755	Correction	ID Prefix F0756	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed
LSC	05/03/2023	LSC	05/03/2023	LSC	05/03/2023
ID Prefix F0758	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	05/03/2023	LSC	05/03/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315224	A. Building B. Wing	5/5/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 05/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062103	A. BUILDING: _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents, it was determined that the facility failed to ensure that all newly hired employees had completed the required physical examination (PE) by the physician or advanced practice nurse within two weeks prior to the first day of employement or upon employment for 4 of 5 newly hired employees whose personnel records were reviewed. This deficient practice was evidenced by the following: On 03/22/23 at 10:50 AM, the surveyor reviewed	S1405	1. Employees #1, #2, #3 and # 4 noted with this deficient practice have had physical exams in accordance with the guidelines outlined in 8:39-19.5 (a) Mandatory Infection Control and Sanitation. 2. All new employees have the potential to be affected by this deficient practice. The facility policy and procedure for employee physicals has been reviewed and revised to meet the above standards. 3. All Department Managers have been	5/3/23

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

Electronically Signed | 04/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062103	A. BUILDING: _____ B. WING _____	C 03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	Continued From page 1 the health records for 5 employees hired within the last 4 months which revealed the following information: 1.) Employee #1 was a Registered Nurse with a date of hire of [redacted] The PE was performed on [redacted] 2.) Employee #2 was a Certified Nursing Assistant with a date of hire of [redacted]. The PE was performed on [redacted]. 3.) Employee #3 was a Licensed Practical Nurse with a date of hire of [redacted] The PE was performed on 1[redacted] 4.) Employee #4 was a Licensed Practical Nurse with a date of hire of [redacted] The PE was performed on [redacted]. On 03/23/23 at 1:58 PM, the survey team met with the facility's Licensed Nursing Home Administrator, Director of Nursing, Director of Operations, and Chief Operating Officer and discussed the above concerns. No further information was provided.	S1405	re-educated on this policy and procedure. All new hire employees' health files will be audited monthly by the Human Resource Representative/designee X 12 months to assure compliance. 4. These monthly audits will be submitted to the Administrator and at the quarterly Quality Assurance meeting to identify trends or patterns and implement appropriate interventions.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062103 (Y1)	A. Building B. Wing (Y2)	5/5/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 05/03/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING **02** B. WING _____	**03/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD** **HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 03/22/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/22/23 and was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Forest Manor Health Care Center is a one story building that was built in the 2000's. It is composed of Type II protected construction. The facility is divided into five smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 86 of 120. .	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		5/3/23

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

Electronically Signed | 04/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING **02** B. WING _____	**03/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD** **HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 1 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the Electrical/Fire Pump Room was rated for one-hour with a listed 45-minute fire rated door and frame in accordance with NFPA 20 Standard for the Installation of Stationary Pumps for Fire Protection (2010 Edition) Section 4.12.1.1.2. This deficient practice had the potential to affect all 86 residents.	K 321	1. The door leading from the Electrical/Fire Pump Room to the exit access corridor will be replaced with the required 45-minute fire rated door. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. An audit of all the doors in Hazardous areas was completed by the Maintenance Director and Administrator to ensure that they	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING **02** B. WING _____	**03/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD** **HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 Findings include: An observation of the facility's combined Electrical/Fire Pump Room on 03/22/23 from 12:50 PM revealed the door leading from the Electrical/Fire Pump Room to the exit access corridor was 20-minute fire rated and not the required 45-minute fire rated. The Maintenance Director and the Administrator were present at the time of the observation and confirmed the door was 20-minute fire rated. NJAC 8:39-31.2(e) NFPA 20 .	K 321	meet the 45-minute fire rated requirement. 3. Maintenance staff were educated on fire rated doors within the Hazardous areas. Monthly audits will be completed x 12 months by the Maintenance Director of all hazardous areas to ensure that the doors in the area are fire rated for 45 minutes. 4. Results of the Hazardous area audits will be submitted to the Administrator monthly and submitted to QAPI quarterly.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: .	K 761	1. Fire doors inspections were	5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING **02** B. WING _____	**03/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD** **HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 3 Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 86 residents. Findings include: An observation of the facility's fire doors on 03/22/23 from 12:06 PM to 1:25 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The Maintenance Director and the Administrator were present at the time of the observation and confirmed the doors were not inspected. NJAC 8:39-31.2(e) NFPA 80 .	K 761	completed, and the doors tagged as required. 2. The facility recognizes that all residents have the potential to be affected by the deficient practice. The Fire door inspection tool was initiated in accordance with S&C 17-38-LSC which includes the tagging of doors. 3. Maintenance staff were re-educated on how to perform Fire door inspections and use of the Fire door inspection tool including the use of inspection tags. Fire Door inspections were added to the Life Safety Code documentation review spreadsheet to be completed monthly by the Maintenance Director. 4. The Life Safety Code Review spreadsheet will be submitted to the Administrator monthly and to the QAPI Committee quarterly.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING **02** B. WING _____	**03/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD** **HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 4 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the three year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 86 residents. Findings include: A document review of the generator reports for 2021 and 2022 provided by the Maintenance Director revealed a three year load bank test	K 918	1. The 3-year load bank generator test is scheduled to be completed on April 25,2023. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. The facilities Life Safety Code Review spreadsheet was revised to include the 3-year load bank generator test. 3. The Maintenance Director was re-educated on the requirement of completing a load bank test on the generator every 3 years. The Life Safety Code documentation review spreadsheet	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING **02** B. WING _____	**03/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	**145 STATE PARK ROAD** **HOPE, NJ 07844**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 5 had not been completed for the emergency generator. During an interview with the Maintenance Director at 12:20 PM on 03/22/23, it was confirmed that the three year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e) NFPA 99, 110 .	K 918	will be completed monthly by the Maintenance Director. 4. The Life Safety Documentation spreadsheet will be submitted to the Administrator monthly and the QAPI committee quarterly.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315224	A. Building 02 - NEW BUILDING B. Wing	5/5/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 05/03/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 05/03/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 05/03/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO