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	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

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COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD BURLINGTON, NJ 08016**

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F 000	INITIAL COMMENTS Complaint NJ #s: 149879, 150570, 151052, 151398, 151707, 152112, 152420, 153704 Survey Date: 12/13/23 Census: 148 Sample: 29 + 17 = 46 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. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		1/26/24

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

Electronically Signed | 01/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint #NJ 152052, NJ 152420, NJ 153704 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner. This deficient practice was evidenced on 2 of 3 resident Wings (Wing [redacted]) and was evidenced by the following: Interviews and observations of Surveyor #2 were	F 584	Residents affected by deficient practice: The facility failed to maintain the resident environment, equipment and living areas in a safe, sanitary, and homelike manner. This deficient practice was evidenced on 2 of 3 resident Wings (Wing [redacted]). Identify those individuals who could be affected by the deficient practice: • All Residents have the potential to be affected by the deficient practice. • No adverse effects of the deficient practices were noted in any of the residents.	

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F 584	Continued From page 2 as follows: On 11/28/23 at 09:23 AM, upon entrance to the facility, the Director of Nursing (DON) stated that the facility had 3 wings which consisted of Wing [redacted] which was the Ex Order 26. 4B1 Unit and had 50 beds, [redacted] Wing had 59 beds and [redacted] Wing had 50 beds. On 11/28/23 at 9:45 AM, an unsampled resident on [redacted] wing informed the surveyor the heat in his/her room had been broken for 4 days. The resident stated that they had been unable to sleep because of the cold. At that time, the Registered Nurse Unit Manager (RN UM) confirmed the head had not been working and that maintenance was made aware. On 11/28/23 at 10:00 AM, a maintenance worker confirmed that the heat had not been working, and he was not the maintenance director, and he did not work on the weekends. On 11/28/23 at 12:19 PM, Surveyor #2 interviewed the housekeeper (HK) for Unit [redacted] who stated that she was the only housekeeper for the unit with a census of 37 residents. The HK stated that she would go from room to room to clean but not in any specific order. She stated she would wait until the nurses have completed care in a room and then she would clean it. On 11/28/23 at 12:40 PM, while observing the lunch meal delivery, the surveyor interviewed two unsampled residents in room [redacted]. The unsampled resident in the door bed of Room [redacted] stated "they haven't cleaned our room yet." The unsampled resident near the window bed stated" she (the HK) just came in an emptied our trash. I can't remember when our room and bathroom were	F 584	What corrective action will be accomplished for those residents affected by the deficient practice: • Maintenance ensured the heater in unsampled resident's room was functioning properly. • Room [redacted] was cleaned. • The yellow and black stains in the [redacted] wing shower room cleaned. • Resident rooms Ex Order 26. 4B1 moldings have all been replaced and privacy curtains have been cleaned. • [redacted] bathroom has been cleaned and debris thrown in the trash. • The air conditioner covers of Rooms Ex Order 26. 4B1 have all been affixed to their units. • The wall near room [redacted] was repaired. • The thermostat case near room [redacted] was replaced. • The door protective material in room [redacted] was repaired. • The AC unit in room [redacted] was repaired and the bed's foot board was reinstalled. • The floor in Resident room [redacted] was cleaned. • All Maintenance and Housekeeping Staff re-educated regarding maintaining the facility as a homelike environment, proper cleaning practices and schedules, and daily rounding to ensure all issues are addressed timely. • All Nursing and Department Manager staff re-educated regarding what to look for regarding Homelike Environment in Resident Rooms, Dining Rooms, Resident Common Areas and Hallways during rounds and how to report deficient areas	

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F 584	Continued From page 3 last cleaned. They empty the trash, but they do not clean the rooms." On 11/29/23 at 11:31 AM, Surveyor #2 interviewed the unsampled resident in the door bed of Room [redacted] who stated that the HK did clean his/her room yesterday but there was still white debris under her bed. "They did not clean under my bed." On 11/29/23 at 11:55 AM, Surveyor #2 observed yellow and black stains on the bottom tiles of the [redacted] wing shower. Interviews and Observations of Surveyor #1 were as follows: On 11/29/23 at 11:08 AM, Surveyor #1 observed in Room [redacted] that the heating /air conditioner (AC) unit had a paper towel wedged inside the unit. On 11/29/23 at 11:54 AM, Surveyor #1 observed that in Rooms *Ex Order 26. 4B1* , there was peeling molding in the rooms and stained resident privacy curtains. Surveyor #1 observed debris on the floor in the bathroom of [redacted]. The surveyor observed that in rooms *Ex Order 26. 4B1* , the air conditioner covers were broken . On 11/29/23 at 11:35 AM, Surveyor #1 and Surveyor #4, in the presence of the Unit Manager (UM), went to Rooms *Ex Order 26. 4B1* . The UM stated that she conducted daily rounds on the residents in their rooms, but was not aware of the conditions of the rooms. The surveyors and the UM observed the following: [redacted] door bed the wall was crumbling; outside of room [redacted] the thermostat case was missing; [redacted] the lower protective covering of the door was broken and	F 584	in the facility electronic work-order system in a timely manner. Measures or systemic changes to ensure that the deficiencies will not recur: • Housekeeping Director/designee to conduct environmental audits regarding ensuring facility is kept clean. • Maintenance Director/Designee to conduct resident room and equipment repair audits to ensure all equipment is in proper working order and resident rooms are maintained in good repair. • The duration of all audits will consist of auditing five different resident rooms two-times per week x4 weeks then one-time per week x2 months and ongoing to ensure future compliance. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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peeling away; [redacted] the AC unit was disassembled in areas and the bed foot board was apart; and [redacted] resident room floor was visibly soiled. The UM stated that any maintenance requests would be put in the computer system and the Maintenance Director (MD) will then address the issues. The UM was unable to provide the surveyor with any computer maintenance requests for the month of November 2023.

On 11/30/23 at 9:13 AM, Surveyor #1 interviewed the housekeeping Director (HD) who stated that he did not have enough staff to clean. He stated that he usually had three (3) housekeepers/porters for day shift, one for each unit ([redacted]) and one porter for the 3-11 shift. The HD further stated that if the housekeeping staffing was bad, he would then cover for the housekeepers. Surveyor #1 had observed an unsampled resident's wheelchair with large amounts of food debris on the wheelchair. The HD stated that he had a cleaning schedule for the wheelchairs which was completed in November. The housekeepers were to clean seven wheelchairs per unit every day, but the HD stated that it "had not been done." The HD further stated that the privacy curtains were to be cleaned during a deep cleaning of the resident rooms which consisted of one room per day.

On 11/30/23 at 9:29 AM, the HD stated that he worked for a contracted agency, but the housekeeping staff were employed by the facility. He stated that he had discussed the staffing concerns with the contracted agency and the Licensed Nursing Home Administrator (LNHA).

On 11/30/23 at 10:30 AM, Surveyor #4 conducted a resident council meeting with five current

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residents. Three of five residents expressed concerns that their rooms and the facility in general was not always kept clean.

On 12/05/23 at 9:23 AM, Surveyor #2 interviewed the HK on [redacted] wing who stated that she was the only housekeeper on the unit and "could not get to clean all the resident's rooms every day". The HK stated, "I usually will do the worst rooms first."

On 12/08/23 at 9:14 AM, Surveyor #2 interviewed the HD who stated that he was responsible for both the housekeeping and the laundry department. He stated that the porters were responsible for taking the trash and the linen out from the units and their focus was primarily on the non-resident areas such as the hallways, dining/day rooms, medication rooms and common areas. The expectations of the housekeepers were to clean every room every day which included removing the trash, sweeping the rooms, and sanitizing the rooms. He further stated that, "When we are short staffed like we are today (one housekeeper only for day shift) I would get staff from other building, and I will then clean the rooms too." He stated that he would usually have a housekeeper for each wing ([redacted]) and at least 2 porters per day. "I don't expect one housekeeper to be able to clean 60 rooms. We have been doing the best that we can."

On 12/08/23 at 9:41 AM, Surveyor #2 interviewed the Infection preventionist (IP) who stated that housekeeping should clean the residents' rooms every day which included the bathrooms, toilet, sink, floor, and high touch areas such as doorknobs, overbed table, bedside table." The IP stated it was important for resident's rooms to be

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cleaned because this is their home and for infection control purposes. The IP stated she did not follow up to check that the rooms were cleaned and that she would rely on the HD to make sure all the rooms were cleaned.

On 12/9/23 at 10:03 AM, the contracted Account Manager (AM) for housekeeping from another building was cleaning rooms on the [redacted] wing. The AM stated that he was at the facility helping and was the housekeeper for [redacted] wing. The AM stated that when he cleaned a room, he cleaned all "the touch points such as the faucet, overbed table, sinks, and remotes." He stated anything that can be touched and that all rooms should be cleaned daily. He further stated at his facility, he used a quality control checklist and made rounds to make sure all the rooms were cleaned every day.

On 12/12/23 at 12:20 PM, the survey team reviewed the above findings to the Previous LNHA (PLNHA), the current LNHA, the Vice President of Clinical Services and the Director of Nursing. The PLNHA stated that housekeeping had been short staffed. The facility was unable to provide any quality control inspection checklists or audits that were completed to verify that high touch areas and residents' rooms were cleaned daily.

A review of the facility's provided procedure titled, "Housekeeping Procedures", dated 06/2016, revealed a 5 step daily room cleaning method which included to: 1) empty trash, 2) damp mop floors, 3) horizontal cleaning- disinfect all flat surfaces, 4) spot clean-disinfect all vertical areas, and 5) dust mop the floor.

NJAC 8:39-4.1 (a)11; 31.2(e)

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F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		1/26/24

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completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 9 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Complaint # NJ 151052 Based on closed record review and review of facility documentation, it was determined that the facility failed to follow their "Resident and Family Concerns and Grievances" policy and procedure by failing to conduct a formal investigation of a grievance filed by a resident regarding care to determine if abuse had occurred. This deficient practice was identified for 1 of 1 residents (Resident #159) reviewed for a grievance and was evidenced as follows: A review of the closed record revealed that Resident #159 was admitted to the facility with diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of the Admission Minimum Data Set (MDS) an assessment tool used to facilitate resident care dated [redacted], included but was not limited to; a Brief Interview for Mental Status (BIMS) of [redacted]/15 which indicated [redacted]	F 585	Residents affected by deficient practice. Facility failed to follow their "Resident and Family Concerns and Grievances" policy and procedure by failing to conduct a formal investigation of a grievance filed by a resident regarding care to determine if abuse had occurred. This deficient practice was identified for 1 of 1 resident (Resident #159). Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by the deficient practice. " Resident #159 was discharged in [redacted]. What corrective action will be accomplished for those residents affected by the deficient practice: " The Management Team re-educated on Grievance policy and procedure and investigations, including interviewing staff and residents.	

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F 585	Continued From page 10 Ex Order 26. 4B1. Section [redacted] documented the resident required Ex Order 26. 4B1 of at least one staff member for toileting. Section [redacted] documented that the admission performance of toilet transfer was coded "[redacted]" as Ex.Order 26.4(b)(1) [redacted]. A review of the resident centered ongoing care plan included but was not limited to; a focus area of limited Ex Order 26. 4B1 [redacted] with interventions which included Ex.Order 26.4(b)(1) [redacted]. A review of the facility provided, "Grievance Form" dated 1/6/22, included but was not limited to the following; the Social Worker (SW) filled out the grievance form after being contacted by the resident's caseworker. The resident contacted his/her caseworker requesting to be transferred to another facility. The grievance form documented that the resident reported that on 1/5/22, on the 3:00 PM to 11:00 PM shift, he/she had used the call bell to request assistance to be toileted. The resident's spouse was present in the room at the time. When "nobody came", the resident phoned a family member who then phoned the facility requesting someone assist the resident. The family member called the resident back and with the family member on the phone and the spouse present in the room, a Certified Nursing Assistant (CNA) entered the room and stated, "you need to have patience" with what was reported "as an attitude". The resident, resident's spouse, and family member all heard	F 585	" All staff re-educated on Abuse policy emphasizing using proper tone when speaking with residents. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee will conduct compliance audits on Grievances/Concerns and Grievance/Concern log. " The duration of all audits will be conducted one-time weekly x4 weeks and then two-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion 1/26/24	

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the comment and were not pleased. It was at that time the resident phoned his/her caseworker and requested to be transferred to another facility where he/she "can get the care he/she needs". The grievance form further documented that the SW informed the Unit Manager (UM). The SW apologized and empathized with the resident and acknowledged that what happened was unacceptable. The UM also apologized for the "aforementioned incident" regarding the CNA. The resident was informed an "in-service" would be done with the CNA. The grievance form documented that the grievance was resolved, but the resident declined to continue her rehabilitation stay at the facility and wanted to leave. The Grievance Form included an area for "Administrator Review" which had not been signed or dated. An in-service sheet attached had a handwritten topic of "customer service", dated 1/6/22. The form had no legible staff name where the form indicated to "Print Name (Neatly)", no legible signature, and failed to provide the educational content provided to the CNA.

On 12/05/23 at 12:07 PM, the Director of Nursing (DON) in the presence of the survey team stated that the types of abuse were physical, sexual, and verbal. She stated that as soon as staff heard anything regarding abuse, they would report that to their supervisor, the DON, or the Licensed Nursing Home Administrator (LNHA). The DON stated *Ex Order 26. 4B1* would require the start of an investigation to determine what happened. She further stated examples of verbal abuse would be resident to resident or staff to resident by using "foul language", a "tone of voice" or if a resident claimed staff were *Ex Order 26. 4B* ". The DON stated if staff were nasty or loud to a resident, the facility

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would start an investigation, interview the staff member, and remove the CNA from care. She stated it was important to collect statements from the resident, nurse, any other person involved, other residents that were on the staff members assignment, and the family member if they overheard the conversation. The DON stated the facility would document the date, time, and what happened. The DON stated the IDT (Interdisciplinary Team) would review the investigation and would have a written conclusion by the fifth day. She stated *Ex Order 26. 4B1* would be reported to the Department of Health (DOH) within two hours and a written report would be sent to the DOH regarding whether the investigation was substantiated or not substantiated. The DON stated that all grievances would be reviewed with the interdisciplinary team (IDT) the next morning.

On 12/06/23 at 8:41 AM, a CNA on the [redacted] unit stated that she received training on abuse. The CNA stated that abuse could be things like "talking bad with a resident, yelling at a resident or not bringing their food". She stated that if she heard a staff talking like that, she would tell the nurse, but get the resident away from that staff member first of all to keep the resident safe.

On 12/06/23 at 8:45 AM, during an interview with the surveyor, a Licensed Practical Nurse (LPN) stated she had been trained on abuse. The LPN stated that abuse could be verbal, mental, or physical. She stated that if she heard a staff member being loud or rude, she would protect the resident first and report what happened.

On 12/06/23 at 10:37 AM, the DON in the presence of three surveyors, read the facility

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provided grievance form with the statement, "you need to have patience, with an attitude". The DON stated that was totally unacceptable because "not putting a resident in the bathroom was a kind of abuse and the resident's needs were not being met in a timely manner". The DON stated the CNA would immediately be educated about answering call bells in a timely manner of "3-5 minutes but that 5 minutes is even too long".

On 12/06/23 at 10:51 AM, the SW in the presence of four surveyors, stated she received abuse training yearly. The SW stated abuse could be physical, emotional, psychological, sexual, or financial. When asked about verbal abuse or staff being verbally rude to a resident, the SW stated she would assess the resident, have that staff member step away, and follow the process to report what happened. She stated she handled the grievance forms and would "ask the resident if they feel they were abused" and would go from there. She stated she would document the resident's answer on a resident statement form and not on the grievance form and that it would be attached with the incident. The SW was provided the Grievance Form of 1/6/22 to review. The SW stated she interviewed the resident who did not appreciate the attitude and requested to be transferred to another facility. She stated the resident would have been asked if he/she felt abused and see "how did the staff say it". The SW acknowledged there was no documentation that the resident was asked, "so, it was not done". The SW further stated that knowing that we are discussing this, "yes" there should have been an investigation. She further stated that grievances were discussed in morning meeting, but she was "not sure if this grievance was taken to morning

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meeting". The SW stated that reading the grievance, the education to the staff had no content attached and she could not say what the CNA was educated about.

On 12/06/23 at 11:33 AM, the LNHA stated the CNA still worked at the facility but that the name on the Grievance Form was not her real name, it was name she preferred to be called.

On 12/06/23 at 2:36 PM, the SW stated she started a grievance form because the resident's caseworker informed her the next day that the resident wanted to leave the facility. The SW stated the resident reported his/her spouse was in the room, but she did not get a statement from the spouse. The SW stated there was no investigation completed. The SW acknowledged that there was no signature that the form was reviewed by the LNHA. The SW stated that the resident reported to her it "was more how she (CNA) responded when she came in". The SW stated she documented when the resident informed her that the "staff talked to him/her with an attitude" but that she wasn't there to hear the CNA. The SW further stated the resident wanted to be transferred because he/she was not toileted and reported it was because of "care". The SW stated, "yes I should have taken a statement from the family and the CNA." The SW further stated that "saying something harsh" to anyone could cause mental stress and should be investigated. When asked, the SW stated she had not interviewed or taken a statement from the front desk staff member who would have taken the phone call from the family member, had not interviewed or taken a statement from any of the family members and did not take a statement from the CNA. The SW stated she should have

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obtained statements. The SW stated she spoke to the resident the following day after the incident and the resident "was not as upset". The SW again stated that the resident reported "staff talked to him/her with an attitude but I wasn't there to hear it". The SW stated verbal abuse was saying something "harsh" to anyone that would cause mental stress. The SW stated the grievance should have been investigated.

On 12/07/23 at 9:23 AM, the surveyor attempted to phone the CNA but was unable to reach her to be interviewed.

A review of the facility provided, "Quality of Life-Dignity", policy and procedure, updated 10/2019 and reviewed 1/2023, included but was not limited to; each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 1. Residents shall be treated with dignity and respect at all times. 7. Staff shall speak respectfully to residents at all times ... The facility failed to follow their Qualify of Life-Dignity policy and procedure.

A review of the facility provided, "Resident and Family Concerns and Grievances" policy and procedure, 2020, included but was not limited to; Purpose: ... prompt resolution of grievances, in accordance with applicable federal and state statues and regulations. Policy: the facility is committed to providing its residents with exceptional care and services. Procedure: I. Filing of Grievances. II. Documentation of Grievances. III. Investigation of Grievances. a. The management or supervisory staff will commence a formal investigation of the grievance as soon as is practicable. IV. d. the facility will

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provide the resident with a written Grievance Decision, which shall include: i. the date the grievance was received; ii. a summary statement of the resident's grievance; iii. the steps taken to investigate the grievance; iv. a summary of the pertinent findings or conclusions regarding the resident's concern(s); v. a statement as to whether the grievance was confirmed or not confirmed; vi. any corrective action taken or to be taken by the facility as a result of the grievance; and vii. the date the written decision was issued. The facility failed to follow their Resident and Family Concerns and Grievances policy and procedure by not commencing a formal investigation.

A review of the facility provided, "Abuse and Neglect-Clinical Protocol", revised 3/2018 and updated 1/2023, included but was not limited to; 1. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 2. Neglect is defined as the failure of the facility .... To provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 4. Willful is defined as the individual must have acted deliberately, not that the individual had intended to inflict injury or harm. Recognition 4. The .... Staff will help identify risk factors for abuse ... for example, ... Performance that might affect resident care. 5. 1. The staff, ... will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Monitoring and Follow-Up 2. The medical director will advise the facility about

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ways to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable conditions affecting the function and quality of life are addressed appropriately. The facility failed to follow their Abuse and Neglect-Clinical Protocol and did not investigate the grievance.

A review of the facility provided, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" policy and procedure, revised 4/2021 and reviewed 5/2023, included but was not limited to; 3. Ensure adequate staffing and oversight/support to prevent burnout, stressful working situations ... 5. Establish and maintain a culture of compassion and caring for all residents .... 8. Identify and investigate all possible incidents of abuse, neglect .... 9. Investigate any allegations within timeframe required by federal requirements. The facility failed to follow their Abuse, Neglect, Exploitation and Misappropriation Prevention Program.

A review of the facility provided, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating", policy and procedure, 2001 and updated 5/2023, included but was not limited to; all reports of abuse .... Neglect ... are thoroughly investigated by facility management. 6. Upon receiving any allegations of abuse, neglect ..... the administrator is responsible for determining what actions are needed to protect the residents. Investigating Allegation 1. All allegations are thoroughly investigated. 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence. C. observes the alleged victim, including interactions with staff and other residents. D. interviews the person(s) reporting the incident. E. interviews and

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F 585	Continued From page 18 witnesses to the incident. F. interviews the resident or the resident's representative. H. interviews staff members who have had contact with the resident during the period of the alleged incident. i. interviews the resident's roommate, family members, and visitors. J. interviews other residents to whom the accused employee provides care or services. K. reviews all events leading up to the alleged incident. L. documents the investigation completely and thoroughly. 8. Guidelines when conducting interviews: a. each interview is conducted separately and in a private location. D. witness statements are obtained in writing, signed, and dated. The facility failed to follow their Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy and procedure. The above information was discussed with the administration team on 12/12/23. The facility had no additional information or documentation to provide. NJAC 8:39-4.1(a)5, 12; 13.2(c); 27.1(a)	F 585		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		1/26/24

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F 661	Continued From page 19 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Complaint # NJ 149879 Based on interview, record review and review of pertinent documents it was determined that the facility failed to ensure a resident was provided with a discharge summary at the time of discharge, including a documented mediation reconciliation and post discharge instructions per the facility policy. The deficient practice occurred for 1 of 1 closed records reviewed (Resident #157) for appropriate discharge and was evidenced by the following: On 12/02/23 at 8:49 AM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #157 which revealed a Physician Progress Note, titled "Discharge Summary", Signed by a Nurse Practitioner on Ex Order 26. 4B1 at 9:04 PM. The note revealed that Resident #157 was being discharged home with a family	F 661	F661 - Discharge Summary Residents affected by deficient practice: The facility failed to ensure a resident was provided with a discharge summary at the time of discharge, including a documented medication reconciliation and post discharge instructions per the facility policy. The deficient practice occurred for 1 of 1 closed record reviewed (Resident #157) for appropriate discharge. Identify those individuals who could be affected by the deficient practice: " All discharged residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected	

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F 661	Continued From page 20 member on Ex.Order 26.4(b)(1) The EMR revealed a "General" type of progress note signed by a Licensed Practical Nurse (LPN), Effective Date: Ex.Order 26.4(b)(1) 1 at 19:07 [7:07 PM]. The note revealed, "*Ex Order 26. 4B1* [redacted]". There was a Social Services, Activities and Dietary section and the document was not signed off as reviewed with the resident/family regarding any post discharge instructions. On 12/07/23 at 10:00 AM, the surveyor reviewed the paper closed medical record for Resident #157 and reviewed the hand-written "Discharge Summary", which revealed a Nursing section, signed Ex Order 26. 4B1, and documented that Resident admitted *Ex Order 26. 4B1* with meeting goals with *Ex Order 26. 4B1*. Resident discharged home with home health services in place. The note did not indicate if any medications were dispensed at discharge per the LPN note, and if any medication reconciliation or instructions upon discharge were provided to the resident/family. An additional "Discharge Summary" dated Ex Order 26. 4B1 and signed by a Physician revealed that the Reason for Admission and *Ex Order 26. 4B1* and *Ex Order 26. 4B1* section was left blank. The Course and Treatment in Facility Section revealed Ex.Order 26.4(b)(1) [redacted] There were no specifics regarding mediation or other treatments while admitted to facility. Instructions revealed "follow up with family doctor". There were no documented specifics regarding any discharge instructions regarding medication or post discharge care. On 12/07/23 at 12:35 PM, the surveyor	F 661	by the deficient practice: " All nursing staff re-educated on the policy for Nursing Discharge Procedure and Discharge Summary and Plan and the importance of obtaining a signature on the discharge instructions. The education of all existing nurse staff is immediate and will be ongoing with all new hires. Measures or systemic changes to ensure that the deficiencies will not recur: " Compliance audits of discharged residents initiated. " The duration of all audits will consist of completion of three-times weekly audits x4 weeks then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/2024	

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interviewed the Director of Nursing (DON), in the presence of the survey team, regarding what the process was for providing discharge instructions to a resident. The DON stated that written discharge instructions would be provided to a resident and also signed by a resident to confirm receipt. The surveyor asked about providing medications to a resident per the documentation and the DON stated all medications are returned to the pharmacy and are not provided to the residents. The DON stated that she reviewed the EMR and paper medical record for Resident #157 and there was no discharge recapulation or mention of review of medications.

On 12/07/23 at 1:21 PM, the surveyor interviewed the DON regarding any additional information to provide regarding Resident #157's discharge. The DON stated there was "nothing in the chart and they did not mention which medications were provided".

On 12/13/23 at 9:16 AM, during an exit conference held with the facility administration. The DON stated that staff must provide a medication reconciliation upon discharging a resident.

A review of the "Discharge Summary and Plan" Policy, updated 01/2023, revealed the following: Policy Statement: When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge; 2. As part of the discharge summary, the nurse reconciled all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation is documented; 6. The resident/representative is involved in the

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F 661	Continued From page 22 post-discharge planning process and informed of the final post-discharge plan; 11. A member of the interdisciplinary team reviews the post-discharge plan with the resident and family at least twenty-four hours before the discharge is to take place; 12 A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post discharge plan; and c. the discharge summary. NJAC 8:39-36.1(b)	F 661		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint NJ# 151052, NJ #152112 Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to consistently provide appropriate Activities of Daily Living (ADLs) care, for residents who were dependent on staff assistance for care, by failing to provide: a) nail care, and b) *Ex Order 26. 4B1* . This deficient practice was identified for 5 of 5 dependent residents (Resident # 20, 76, #101, #106 and Resident #116) reviewed for assistance with *Ex Order 26. 4B1* . Findings included: On 11/28/23 at 9:40 AM, during the initial tour of the [redacted] Unit, a strong [redacted] odor was noted in the	F 677	Residents affected by deficient practice: The facility failed to consistently provide appropriate Activities of Daily Living (ADLs) care, for residents who were dependent on staff assistance for care, by failing to provide: a) nail care, and b) *Ex Order 26. 4B1* . This deficient practice was identified for 5 of 5 Ex.Order 26.4(b)(1) residents (Resident #20, 76, #101, #106, and Resident #116) reviewed for assistance with Ex.Order 26.4(b)(1) Identify those individuals who could be affected by the deficient practice: • All residents have the potential to be affected by the deficient practice.	1/26/24

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F 677	Continued From page 23 hallway. 1. On 11/28/23 at 10:03 AM, the surveyor observed Resident #20 lying in bed in their room. The resident was alert and informed the surveyor that he/she Ex.Order 26.4(b)(1). He/she could not find the call light to alert the staff, and stated, " Ex. Order 26. 4B1 " The surveyor left the room and informed the nurse of the resident's request. The resident informed the nurse that she needed to be changed. An interview with the resident at 10:15 AM, revealed that staff would take time to answer the call light and sometimes he/she could not locate the call light. The surveyor continued the tour and returned to the nursing station at approximately 12:00 PM. A strong odor of Ex. Order 26. 4 was permeated in the hallway at the nursing station adjacent to Resident #20's room. The surveyor attempted to enter the room and was informed by the nurse that Resident #20 was being changed. An interview was conducted on 11/28/23 at 12:23 PM, with the Certified Nursing Assistant (CNA) who cared for Resident #20. The CNA acknowledged that she checked the resident at 7:00 AM, then placed the breakfast tray in the room at 8:30 AM. The CNA failed to check the resident to see if he/she needed Ex. Order 26. 4B1 , or if the Ex. Order 26. 4B1 needed to be changed prior to providing the resident with the breakfast meal. The CNA stated, "I was informed by the nurse that the resident needed help. I was not informed that the resident was Ex.Order 26.4(b)(1) Ex. Order 26. 4 ." The CNA confirmed she provided Ex.Order 26.4(b)(1) around 12:00 PM and that the resident was Ex.Order 26.4(b)(1) Ex. Order 26. 4 . The CNA explained that she was in another room providing	F 677	• The residents affected were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: • Resident # 76 had nails trimmed and filed smoothly immediately; no ill effects noted. • Resident #s 20, 101, 106, 116 Ex Order 26. 4B1 immediately provided; no ill effects noted. • All affected residents' care plans reviewed updated. • All nursing staff re-educated on facility policy for 'Ex Order 26. 4B1 Support", "Ex Order 26. 4B1 ", " Ex. Order 26. 4B1 – clinical protocol" and the importance of single use of briefs, and Ex Order 26. 4B1 . Measures or systemic changes to ensure that the deficiencies will not recur: The DON/Unit Manger/Designee will conduct audits of 6 random residents that require Ex. Order 26. care with an emphasis on nail care and Ex Order 26. 4B1 . Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action. Date of Completion: 1/26/2024	

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	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

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care when the nurse informed her that Resident #20 needed assistance. The nurse did not inform her that Resident #20 needed Ex Order 26. 4B1 . When inquired regarding the call light that was not accessible, the CNA stated that it was her responsibility to ensure the call light was accessible but this morning she did not check the call light.

2. On 11/28/23 at 12:09 PM, the surveyor observed Resident #76 in bed. The Ex.Order 26.4(b)(1) and an Ex Order 26. 4B1 Ex.Order 26.4(b)(1) was noted inside the resident's Ex Order 26. 4B1 . The Ex Order 26. 4B1 were long Ex.Order 26.4(b)(1)

On 11/29/23 at 11:21 AM, the surveyor observed Resident #76 in bed. The resident was awake, alert and agreed to be interviewed. The resident's Ex Order 26. 4B1 were still Ex.Order 26.4(b)(1). Upon inquiry, the resident stated that he/she would like their Ex Order 26. 4B1 to be trimmed. Resident #76 stated, "Ex Order 26. 4B1 " The resident acknowledged being provided with Ex Order 26. 4B1 four times in 24 hours period.

The surveyor left the room and asked the Registered Nurse Unit Manager (RN/UM) who was responsible to provide Ex Order 26. 4B1 care. The RN/UM stated that the CNAs were responsible to provide Ex Order 26. 4B1 care. The surveyor then accompanied the RN/UM to the room where we both observed Resident #76 in bed with his/her Ex Order 26. 4B1 Ex.Order 26.4(b)(1) . When interviewed by the RN/UM regarding Ex Order 26. 4B1 care, the resident stated that the Ex Order 26. 4B1 visited three weeks ago. When asked if the RN/UM made rounds and observed care, the

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F 677	Continued From page 25 RN/UM informed the surveyor that she made rounds daily to ensure that the residents were safe. The RN/UM stated she was not aware of the resident's Ex Order 26. 4B1 condition. On 11/29/23 at 12:24 PM, the surveyor observed a CNA at Resident #76's bedside providing care. When the surveyor inquired regarding the resident's Ex Order 26. 4B1, the CNA stated, "I was not here yesterday." She declined to comment further. Resident #76's electronic medical record revealed: the resident was admitted to the facility with diagnoses which included but were not limited to; Ex Order 26. 4B1 . A review of Resident #76's most recent quarterly Minimum Data Set (MDS) an assessment tool to facilitate resident care, dated 1 Ex.Order 26.4(b)(1) documented the resident required Ex Order 26. 4B1 with most Ex Order 26. 4B1 including Ex Order 26. 4B1 . Resident #76 scored Ex Ord out of 15 on the Brief Interview for Mental Status (BIMS) which revealed that Resident #76 had Ex Order 26. 4B1. The resident was Ex Order 26. 4B1 and required Ex Order 26. 4B1 . Review of Resident #76's care plan dated Ex.Order 26.4(b)(1), revealed he/she was care planned for Ex Order 26 /self-care performance deficit related to Ex Order 26. 4B1 . The goal was for the resident to improve current level of function in: bathing, grooming/personal hygiene, dressing, and toileting by the next review as evidenced by improved ADL scores. The interventions included: Monitor conditions that may contribute to ADL decline, monitor for decline	F 677		

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F 677	Continued From page 26 in ADL function. Provide Resident with total assist for personal hygiene. On 11/30/23 at 10:30 AM, Surveyor #4 conducted a resident council meeting with five residents who reside at the facility. Five of the five residents expressed concern with the amount of time it took staff to answer a call bell for them to get assistance with ADLs or care. Examples included but were not limited to; one resident stated he/she personally waited an hour after ringing the call bell for assistance. A second resident stated he/she witnessed their roommate use the call bell and it took close to an hour for someone to respond. The second resident also added that their roommate was unable to get out of bed his/herself and needed staff assistance. 3. On 12/01/23 at 7:00 AM, the surveyor entered the [redacted] Unit to observe medication pass administration. The surveyor observed two residents in the dayroom. Resident #101 was wrapped in a blanket and resting in a recliner chair. The surveyor approached the resident and observed their eyes were closed. A strong [redacted] odor permeated at the corner where the resident was positioned. The surveyor observed a CNA also sitting in the dayroom. The surveyor inquired about the resident being placed in the dayroom and was wrapped in a blanket. The CNA informed the surveyor that she worked the 11:00 PM -7:00 AM shift and was ready to exit the facility and provided not further details On 12/01/23 at 8:25 AM, the surveyor observed a CNA wheel Resident #101 to their room. The surveyor followed the CNA to the room. The CNA used a [redacted] to transfer Resident #101 to the bed. While on the [redacted], the	F 677		

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F 677	Continued From page 27 surveyor along with the two CNAs who were executing the transfer, observed [redacted] dripping on the resident's bed during the transfer and while in the *Ex Order 26. 4B1* over the bed and Resident #101 was wearing two [redacted] *Ex Order 26. 4B1* [redacted]. [redacted] continued to drip all over the the resident's blanket. An interview on 12/01/23 at 9:00 AM, with the two CNAs that provided the observed *Ex Order 26. 4B1* [redacted], revealed Resident #101's [redacted] with [redacted], and some of the inside material of the *Ex Order 26. 4B1* balled up and was stuck to the resident's back and a strong odor of [redacted] was observed when the [redacted] was opened. Resident #101 was also [redacted] with [redacted]. The surveyor summoned the RN/UM to the room where the RN/UM confirmed that *Ex Order 26. 4B1* was not provided to Resident #101 during the 11:00 PM- 7:00 AM shift. The RN/UM observed, who observed the condition of the resident, stated that the resident should not have had been wearing two *Ex Order 26. 4B1*. On 12/01/23 at 10:15 AM, the surveyor interviewed the CNA who stated that she was responsible for taking care of Resident #101 during the 7:00 AM to 3:00 PM shift on 12/01/23. The CNA stated her shift began at 7:00 AM, but she had not provided Resident #101 with any care during her shift. She stated she would have to find someone to help her with care for Resident #101 and would change the resident when another staff was available to assist. The CNA stated the resident required [redacted] and provide *Ex Order 26. 4B1*.	F 677		

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F 677	Continued From page 28 Review of Resident #101's electronic medical record revealed: the resident was admitted to the facility with diagnoses which included but were not limited to; Ex Order 26. 4B1 [redacted]. A review of Resident #101's Ex Order 26. 4B1 assessment dated Ex.Order 26.4(b)(1), revealed that Resident #101 scored [redacted]/15 on the [redacted] and was Ex Order 26. 4B1 [redacted]. Resident #101 was documented as requiring Ex Order 26. 4B1 [redacted] with all [redacted] including Ex Order 26. 4B1 [redacted]. A review of the Ex Order 26. 4B1 [redacted] revealed that the resident had Ex Order 26. 4B1 [redacted]. The goal was for staff to anticipate all needs. Resident #101's Care Plan had a focus area for [redacted] initiated Ex.Order 26.4(b)(1) related to Ex Order 26. 4B1 [redacted]. The goal was for Resident #101 to maintain the highest capable level of [redacted] ability throughout the next review period. Initiated Ex.Order 26.4(b)(1) and last revised Ex.Order 26.4(b)(1). The interventions included: Monitor conditions that may contribute to [redacted] decline, and monitor for decline in [redacted] function. Provide Resident with Ex.Order 26.4(b)(1) (staff) for Ex Order 26. 4B1. Provide the resident with Ex.Order 26.4(b)(1) (staff) for Ex Order 26. 4B1. Provide the resident with [redacted] for personal hygiene. Initiated Ex.Order 26.4(b)(1). 4. On 12/04/23 at 8:45 AM, the surveyor observed Resident #106 in bed. A care tour	F 677		

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completed with the CNA assigned to Resident #101 at that time revealed that Resident #106 was wearing an *Ex Order 26. 4B1* which was Ex.Order 26.4(b)(1) with Ex Order 26. . Inside the *Ex Order 26. 4B1* the surveyor observed a sanitary-type pad that was also Ex.Order 26.4(b)(with Ex Order 26. , the *Ex Order 26. 4B1* was also Ex.Order 26.4(b)(1) with Ex Order 26. and was Ex.Order 26.4(b) The surveyor inquired regarding the last time that *Ex Order 26. 4B1* had been provided to the Resident. The CNA stated that she had not provided care yet to Resident #106. The CNA further stated that all Ex.Order 26.4(b)(1)" wore *Ex Order 26. 4B1* inside the *Ex Order 26. 4B1*. The CNA added that the facility provided the *Ex Order 26. 4B1* .

Review of Resident #106's electronic medical record revealed: the resident was admitted to the facility with diagnoses which included but were not limited to; *Ex Order 26. 4B1* . A review of the Annual MDS Assessment dated Ex.Order 26.4(b)(1) , reflected that Resident #106 was *Ex Order 26. 4B1* . Resident #106 scored Ex Ord out of 15 on the Ex Order 26. 4 . The resident was *Ex Order 26. 4B1* and required *Ex Order 26. 4B1* . A review of the *Ex Order 26. 4B1* dated Ex.Order 26.4(b)(1) , had a focus for Ex Order 26 self-care performance deficit related to *Ex Order 26. 4B1* for *Ex Order 26. 4B1* status Ex.Order 26.4(b)(1) . The goal was for Resident #101 to maintain current level of functioning in all Ex Order 26. 4 through the review date. Initiated Ex.Order 26.4(b)(1) 1 and last revised Ex.Order 26.4(b)(1) . Interventions included: The resident required Ex.Order 26 assist for *Ex Order 26. 4B1* . The care plan did not specify the frequency for *Ex Order 26. 4B1* .

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F 677	Continued From page 30 5. On 12/01/23 at 9:00 AM, the surveyor performed a care tour with the CNA who cared for Resident #116. The surveyor observed Resident #116 in bed. Resident #116 was wearing an *Ex Order 26. 4B1* which was Ex.Order 26.4(b)(1) with Ex Order 26. . Inside the *Ex Order 26. 4B1* the surveyor observed three *Ex Order 26. 4B1* Ex.Order 26.4(b)(1) with Ex Order 26. . The *Ex Order 26. 4B1* was also Ex.Order 26.4(b)(1) with Ex Order 26. and Ex.Order 26.4(b)(1) . The surveyor accompanied the RN/UM to the room where we all observed that Resident #116's *Ex Order 26. 4B1* along with the three Ex.Order 26.4(b)(1) with Ex Order 26. and was Ex Order 26. 4B stained. During an interview with the CNA at 11:30 AM, she stated that the 11:00 PM -7:00 AM shift staff left Resident #116 with three *Ex Order 26. 4B1* inside of the *Ex Order 26. 4B1* . She stated that Resident #116 was a "*Ex Order 26. 4B1* ." On 12/04/23 at 10:30 AM, the surveyor interview the Director of Nursing (DON) regarding the above concerns with *Ex Order 26. 4B1* . The DON stated that *Ex Order 26. 4B1* was to be provided every 2-3 hours and as needed, and " Ex Order 26. 4B [redacted] " were to be changed more frequently. The DON added that double *Ex Order 26. 4B1* could be used upon request. When inquired regarding a policy for utilizing Ex.Order 26.4(b)(1) and multiple *Ex Order 26. 4B1* " inside of the Ex.Order 26.4 the DON stated there was "no policy." The DON stated that two residents on the unit requested double *Ex Order 26. 4B1* and they had been care planned to have *Ex Order 26. 4B1* . The DON then clearly stated , "This had to do more with skin integrity, and this was not a standard of practice." The DON acknowledge that she had been aware that the staff were placing two *Ex Order 26. 4B1* of the residents, and three weeks ago, the staff	F 677		

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were in-serviced regarding not placing Ex Order 26. 4B1 [redacted] on the residents.

On 12/04/23 at 10:39 AM, the DON stated that the Ex Order 26. 4B1 [redacted] were provided for alert residents and to be used inside of "regular underwear and not inside of Ex Order 26. 4B1 [redacted]." The DON stated it was not the facility protocol to put Ex.Order 26.4([redacted] inside of Ex Order 26. 4B1 [redacted]. The DON stated that the residents must be checked for Ex Order 26. 4B1 [redacted] prior to breakfast and she would provide the policy for Ex Order 26. 4B1 [redacted].

On 12/05/23 the surveyor reviewed Resident #116 medical record. The Admission Face Sheet (an admission summary), reflected that Resident #116 was admitted to the facility with diagnoses which included but were not limited to; Ex Order 26. 4B1 [redacted]. The Ex Order 26. 4B1 [redacted] dated Ex.Order 26.4(b)(1) [redacted], reflected that Resident #116 was Ex Order 26. 4B1 [redacted]. Resident #116 scored Ex Ord [redacted] out of 15 on the Ex Order 26. 4 [redacted]).

Review of Resident #116's Comprehensive Care plan provided by the facility on Ex.Order 26.4(b)(1) [redacted] revealed: A focus area for Ex Order 26 [redacted] self care performance deficit related to Ex Order 26. 4B1 [redacted]. Initiated Ex.Order 26.4(b)(1) [redacted]. The goal was Resident #116 will maintain current level of Ex Order 26 [redacted] function in bathing/showering, dressing, eating, personal hygiene and toileting through the review date. The interventions included: Resident #116 required Ex Order 26. 4B1 [redacted] by one staff with personal hygiene. Resident #116 was Ex.Order 26.4([redacted]. The Care Plan did not include directive to the direct care staff regarding the frequency of Ex Order 26. 4B1 [redacted].

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On 12/06/23 at 8:19 AM, the surveyor interviewed the RN assigned to the 11:00 PM-7:00 AM shift. She stated that she was aware, and the night supervisors were also aware that the CNAs were using double Ex Order 26. 4B1 and Ex Order 26. 4B1 on some of the residents. When asked to comment on how the facility handled the above concerns with Ex Order 26. 4B1, the RN stated the CNAs were reminded verbally not to use double Ex Order 26. 4B1 on the residents. Upon further inquiry, the RN informed the surveyor that no formal education was provided to the staff.

On 12/13/23 at 9:09 AM, during the exit conference with the survey team, the DON, Liscensed Nursing Home Administrator and Corporate Administation, the DON stated, "I don't know what the Ex Order 26. 4B1 were". The DON stated that Ex Order 26. 4B1 could only be used inside of underwear and not inside of Ex Order 26. 4B1 .

A review of the facility's policy titled, "Activities of Daily Living (ADLs) Supporting updated 1/2023,revealed the following:
Policy Statement
Residents will be provided with care and services as appropriate to maintain or improve their ability carry out activities of daily living (ADLs).
Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.
The Policy for "Urinary Incontinence -Clinical Protocol revealed under "Treatment" /Management #4
As appropriate, based on assessment of the category and causes of incontinence, the staff will

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F 677	Continued From page 33 provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status. All 5 residents were assessed to be Ex.Order 26.4(b)(1) on staff for Ex Order 26. 4 care. The residents were observed with Ex.Order 26.4(b)(1) *Ex Order 26. 4B1* and did not received the care needed based on their assessments. Since the initial tour of the survey the Ex Order 26. odor was noted on the unit and shared with the staff.	F 677		
F 686 SS=E	NJAC 8:39-27.1 (a) 2 (g) (h) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint # NJ 151052 Based on observations, interviews, record review, and review of facility documentation, it was determined that the facility failed to follow the	F 686	Residents affected by deficient practice: The facility failed to follow the facility policy to ensure that residents who were admitted without a Ex.Order 26.4(b)(1) and identified at Ex.Order 26.4(b)(1) for developing	1/26/24

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F 686	Continued From page 34 facility policy to ensure that residents who were admitted without a pressure ulcer (PU) and was identified at "Mild" risk for developing pressure ulcers, and a resident admitted without a PU and was identified as "completely limited" in ability to respond to pressure-related discomfort, were provided with care and services to prevent worsening, or development of a pressure ulcer by failing to ensure: a) comprehensive skin assessments were accurately documented for a pressure ulcer and interventions were implemented to prevent further skin breakdown and promote healing, b) a resident was kept clean and free of exposure to Ex Order 26. and Ex Order 26. matter, and c) a resident was evaluated for nutritional status to determine if interventions to increase calories and protein were needed to assist with Ex Order 26. 4B1. This deficient practice occurred for 1 of 3 residents reviewed (Resident #20), and for 1 of 2 closed records reviewed (Resident #159) for Ex Order 26. 4B1. The deficient practice was evidenced by the following: a) On 11/28/23 at 10:03 AM, Surveyor #1 observed Resident #20 lying in bed in his/her room. The resident's feet were rested directly on the mattress. The resident was alert and informed the surveyor that he/she was Ex.Order 26.4(b) He/she stated he/she could not find the call light to alert the staff and stated to the surveyor "please help". Surveyor #1 exited the room and alerted the nurse who was in the hallway of the resident's request. The surveyor followed the nurse to the room and noted that the call light was not attached to the bed. The Licensed Practical Nurse (LPN) could not locate the call light. Upon inquiry, the LPN stated that the call light should be accessible.	F 686	Ex.Order 26.4(b)(1), and a resident admitted with Ex.Order 26.4(b)(1) was identified as Ex.Order 26.4(b)(1) [redacted], were provided with care and services to prevent worsening, or development of a Ex Order 26. 4B1 [redacted] by failing to ensure. A) Comprehensive skin assessments were accurately documented for a Ex Order 26. 4B1 [redacted] and interventions were implemented to prevent further Ex.Order 26.4(b)(1) and promote healing. B) A resident was kept clean and free of exposure to Ex Order 26. and Ex Order 26. matter, and C) A resident was evaluated for Ex.Order 26.4(b)(1) status to determine if interventions to increase calories and protein were needed to assist with Ex Order 26. 4B1. This deficient practice occurred with 2 residents reviewed (Resident #20) and (Resident #159). Identify those individuals who could be affected by the deficient practice: • All residents with actual Ex Order 26. 4B1 [redacted] and at risk for Ex Order 26. 4B1 and skin impairments have the potential to be affected. • The affected resident received a nutrition assessment with emphasis on nutritional status. Resident #159 was discharged. • Resident #20 received a comprehensive assessment by Ex Order 26. 4B1 on 11/30/2023 and treatment an intervention ordered and implemented. Resident #159 was discharged. • Resident #20 provided Ex Order 26. 4B1 [redacted] immediately resident #159 was	

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F 686	Continued From page 35 On 11/28/23 at 10:15 AM, Surveyor #1 interviewed the resident who stated that he/she had been a resident at the facility for [redacted]", sometimes staff would take time to answer the call light, and that his/her [redacted] were [redacted]. The surveyor continued the facility tour and returned to the nursing station around 12:10 PM. A strong odor of [redacted] permeated in the hallway adjacent to the resident's room. The nurse informed the surveyor that staff was in the room assisting Resident #20 with care. The resident stated that he/she needed to be changed at approximately 10:00 AM, and the resident had not been provided with *Ex Order 26. 4B1* until after 12:00 PM [two-hours later]. On 11/28/23 at 12:15 PM, an interview with the Certified Nursing Assistant (CNA) who cared for Resident #20 revealed that she was not informed that Resident #20 needed to be changed. The CNA further stated that while she was providing care to another resident, the nurse informed her that Resident #20 needed assistance. She reported to the room after taking care of the other resident only to observe that Resident #20 was [redacted] with [redacted]. When asked if she had provided *Ex Order 26. 4B1* to the resident that morning, the CNA stated "no". She informed the surveyor that around 8:30 AM, she delivered the breakfast tray and left the room and did not elaborate on why she failed to provide any *Ex Order 26. 4B1* to the resident and could not state if she had provided any *Ex Order 26. 4B1* to the resident. The surveyor reviewed the medical record for	F 686	discharged. What corrective action will be accomplished for those residents affected by the deficient practice: • Residents at risk were reviewed for timely assessment and treatment with no concerns noted. • All residents at risk reviewed for evaluation of nutrition status and assessment completed. • All nurses were re-educated on the policy for "Prevention of [redacted] /Injuries" and "*Ex Order 26. 4B1*" and the importance of identifying at risk patients, completing comprehensive skin assessments, limiting exposure to [redacted] and [redacted] matter, and initiating a dietary consult to determine nutritional status and need for interventions to increase calories and protein to assist in *Ex Order 26. 4B1*. The education of all existing nurse staff is immediate and will be ongoing with all new hires. Measures or systemic changes to ensure that the deficiencies will not recur: The DON/Unit Manger/Designee will conduct compliance audits of 6 random residents *Ex Order 26. 4B1* , prevention of [redacted] and nutritional assessment completion . The duration of all audits will occur weekly X4 and then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Date of Completion:	

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F 686	Continued From page 36 Resident #20 which revealed: The Admission Record face sheet (an admission summary) reflected that Resident #20 was admitted with diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1), reflected that the resident had a *Ex Order 26. 4B1* score of [redacted] out of 15, indicating a *Ex Order 26. 4B1* [redacted]. The assessment reflected that the resident did not Ex.Order 26.4(b)(1) that would interfere with treatment goals in the last seven-day look-back period. The resident required Ex.Order 26.4(b)(1) with *Ex Order 26. 4B1* and transfers, and that he/she was admitted without any *Ex Order 26. 4B1* [redacted]. There was no evidence that the resident had a [redacted] upon admission per review of the Admission Nursing History and Assessment, the individualized Comprehensive Care Plan, the admission Physician's Orders sheet, the admission Skilled Nurses Notes, the Physician progress notes, or the Treatment Administration Record for Ex.Order 26.4(b)(1). A review of the Admission Nursing History and Assessment form dated Ex.Order 26.4(b)(1) reflected that Resident #20 was [redacted] and Ex.Order 26.4(b)(1) and had Ex.Order 26.4(b)(1). The assessment did not reflect evidence that the resident was admitted with a *Ex Order 26. 4B1*. On admission the resident received a score of [redacted] on the *Ex Order 26. 4B1*	F 686	1/26/24	

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indicated that he/she was [redacted].

A review of the admission Physician Order's Sheet (POS) dated [redacted] reflected an order to perform a weekly [redacted] check by a nurse on Tuesday and Friday. Use the weekly [redacted] assessment to document findings. Schedule on bath day and time ordered was in the morning every Tuesday, and Friday for the [redacted] assessment.

A review of the *Ex Order 26. 4B1* [redacted] Risk assessment dated upon admission on [redacted], reflected the resident was [redacted]" for developing a *Ex Order 26. 4B1*. The assessment had a total score of [redacted]. A score of [redacted] reflected [redacted]" for developing a *Ex Order 26. 4B1*. The scale further revealed:
Moderate risk 13-14
High risk 10-12
Very high risk 9 or below.

A review of the resident's individualized, Interdisciplinary Plan of Care dated [redacted], reflected that the resident was [redacted] for *Ex Order 26. 4B1* [redacted] due to a decreased activity. The goal indicated that Resident #20 will not show signs of Ex.Order 26.4(b)(1) days. Interventions included to provide [redacted] care i.e., lotions, *Ex Order 26. 4B1* as ordered, Initiated [redacted]; Observe [redacted] signs and symptoms of Ex.Order 26.4(b)(1) [redacted], Initiated [redacted]3; Observe for verbal and nonverbal signs of [redacted] related to *Ex Order 26. 4B1* [redacted] and medication as ordered, Initiated [redacted]; Weekly [redacted] by license nurse, Initiated [redacted]

A review of a Nursing Admission Note dated

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Ex.Order 26.4(b)(1)3 timed 14:20 [4:20 PM] revealed that Resident #20 was 'Ex.Order 26.4(b)(1) . Verbally appropriate, Ex.Order 26.4(b)(1) normal, Ex.Order 2 temperature warm." *Ex Order 26. 4B1* . The notes revealed that Resident #20 did not have Ex.Order 26.4(b)(1) or any type of Ex.Order 2 or Ex Order 26. 4B1 to the *Ex Order 26. 4B1* .

A review of the Nutrition Quarterly review dated Ex.Order 26.4(b)(1) at 20:58 [8:58 PM] revealed: Routine *Ex Order 26. 4B1* report with a collection date of Ex.Order 26.4(b)(1), which reflected the resident had an *Ex Order 26. 4B1* level of *Ex Order 26. 4B1* . The Registered Dietitian (RD) did not make any recommendations. The RD indicated that the *Ex Order 26. 4B1* was resolved. The RD did not indicate in his note that Resident #20 had a *Ex Order 26. 4B1* to the Ex Order 26. 4B1 .

On 11/29/23 at 11:30 AM, Surveyor #1 interviewed the RD in the presence of the survey team. The RD revealed that he was not made aware of Resident #20 having a Ex Order 26. 4B1. The RD further added that all Ex Order 26. 4B1 were to be discussed and addressed in the morning meeting. Surveyor #1 interviewed the RD regarding the Ex Order 26. 4B1 identified on Ex.Order 26.4(b)(1) to the *Ex Order 26. 4B1* . The RD confirmed that he was not made aware that Resident #20 had developed a Ex Order 26. 4B1 to the *Ex Order 26. 4B1* on Ex.Order 26.4(b)(1)

A review of the *Ex Order 26. 4B1* report collected Ex.Order 26.4(b)(1) and reported Ex.Order 26.4(b)(1), reflected some critical lab values. Ex Order 26. 4B1 was *Ex Order 26. 4B1* . *Ex Order 26. 4B1* . On Ex.Order 26.4(b)(1), the RD forwarded a note to the

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F 686	Continued From page 39 physician which revealed that Resident #20 was at risk for Ex Order 26. 4B1. A review of the Treatment Administration Record (TAR) for November 2023 reflected weekly Ex.Order 2 for 7:00 AM to 12:00 PM shift plotted to be performed on Tuesdays and Fridays on 11/03, 11/07, 11/10 and 11/14, 11/17, 11/21, 11/24, and 11/28, signed by the Registered Nurse/Charge Nurse. Resident #20 had a change in condition for Ex Order 2 identified on Ex.Order 26.4(b)(1), however the weekly Ex.Order 26.4(b)(1) dated Ex.Order 26.4(b)(1) indicated that Resident #20 had "Ex Order 26. 4B1". A review of the resident's Interdisciplinary Comprehensive Plan of Care revised on Ex.Order 26.4(b)(1), reflected that the Ex Order 26. 4B1 Ex Order 26. 4B1 was resolved on Ex.Order 26.4(b)(1). A review of the Ex Order 26 reflected that Resident #20 had another Ex Order 26. 4B1 to the Ex Order 26. 4B1 identified on Ex.Order 26.4(b)(1) that was resolved on 11/ Ex.Order 26.4(b However, there was a change in condition documented and dated that the change in condition was noted Ex.Order 26.4(b)(1). A review of the change in condition reflected the resident representative was informed of the change in Ex.Order 2 condition, but the physician was not notified. On 11/30/23 at 11:20 AM Surveyor #1 interviewed the Charge Nurse regarding the Ex Order 26. 4B1 dated Ex.Order 26.4(b)(3. The nurse stated that she informed the physician of the Ex Order 26. 4B1 and suggested that the Ex Order 26. 4B1 be treated with [name redacted] (a Ex.Order 26.4(b)(1) dressing) and [name redacted] (a Ex.Order 26.4(b)(1)). The Charge Nurse also stated that she did not review the Ex Order 26. 4B1 measurements with the physician. The surveyor	F 686		

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then asked the Charge Nurse what stage of Ex Order 26. 4B1 should be treated with [name redacted] Ex Order 26. 4B1 dressing and [name redacted] Ex.Order 26.4(b)(1), but she declined to comment.

A review of the POS for November 2023 did not reflect a physician order for the Ex Order 26. 4B1 identified on Ex.Order 26.4(b)(1)

A review of the Weekly Ex.Order 26.4(b)(1) dated Ex.Order 26.4(b)(1), reflected that Resident #20's Ex.Order 26 was Ex.Order 26.4(b)(1), the Weekly Ex.Order 26 Assessment indicated under Ex.Order 2 condition, "Pre-existing", but there was no corresponding documentation in the Ex Order 26. 4B1 to address what areas of the body had Ex.Order 26.4(b)(1), nor did the assessment address where on the body the Ex.Order 26.4(b)(1) was, and if there was a new finding.

A review of the Ex.Order 26.4(b) consult Visit Report dated Ex.Order 26.4(b)(1), and documented by the Ex Order 26. 4B1 reflected that Resident #20 had a Ex Order 26. 4B1 to the Ex Order 26. 4B1 and the measurements were 2.5 centimeters (cm) x 1.5 cm x 0.1 cm. A Timeline for the Ex Order 26. 4B1, dated Ex.Order 26.4(b)(1)3 revealed the Ex.Order 26.4(b)(1) consult was completed virtually, and was not in person.

The Ex Order 26. 4B1 recommended to apply a Ex Order 26. 4B1 and 1. [name redacted] agent used for Ex.Order 2 care Ex Order 26. 4B1 : 1. [name redacted] Ex Order 26. 4B1. There was no documented evidence for a Ex Order 26. 4B1 Risk assessment dated upon identification of the Ex Order 26. 4B1 on Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1), to determine the resident's new Ex Order 26. 4B1 risk.

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F 686	Continued From page 41 A review of the POS for November 2023 did not reflect evidence of a new physician order for the treatment of the Ex Order 26. 4B1 in accordance with the Ex Order 26. 4B1 recommendations made on Ex.Order 26.4(b)(1). The Daily Progress Notes dated Ex.Order 26.4(b)(1) timed 14:50 PM (2:50 PM) as a late entry created on Ex.Order 26.4(b)(1) timed 14:53 PM (2:53 PM), after the surveyor's inquiry, reflected that Resident #20 was noted with a Ex.Order 26.4(b)(which measured 2.5-centimeter (cm) x 1.8 x 0.1 cm. There was no documentation regarding the Ex.Order 26.4(b)(when the facility stated the Ex Order 26. 4B1 was identified on Ex.Order 26.4(b)(1). A review of the POS for November 30, 2023, reflected a telephone order from the Attending Physician to cleanse Ex Order 26. 4B1 with Ex Order 26. 4B1 and apply a [name redacted] Ex Order 26. 4B1, and [name redacted] Ex Order 26. 4B1, and cover with Ex Order 26. 4B1 daily every day shift for Ex Order 26. 4B1. A review of the TAR for November 2023, did not reflect evidence that a treatment to the Ex Order 26. 4B1 was implemented on Ex.Order 26.4(b)(1)3. The Ex Order 26 reflected that the Charge Nurse was signing for the Ex Order 26. 4B1 for the 7:00 AM -3:00 PM shift. On 11/30/23/23 at 12:15 PM, the surveyor interviewed both the LPN and the CNA assigned to Resident #20. The LPN informed Surveyor #1 that Resident #20 did not have a Ex Order 26. 4B1. The CNA confirmed that she did not observe a dressing on the resident's Ex Order 26. 4B1. The CNA informed the surveyor that she was provided with a Ex.Order 26.4(b [not a treatment] to apply to the	F 686		

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F 686	Continued From page 42 resident's [redacted]. There was no documented evidence in the medical record from the resident's attending physician that addressed the [redacted] to the [redacted] or evidence that it was examined by the attending physician or the [redacted] prior to [redacted]. A review of a follow-up [redacted] Visit Report dated [redacted], reflected that the [redacted] was not healed. The [redacted] measured 1.0 cm x 0.7 cm x 0.1 cm. A review of a follow-up Nutrition Assessment dated 1[redacted], which was 15 days after the identification of the [redacted] to the [redacted] facility-acquired [redacted], which time the RD indicated that Resident #20 was [redacted] for [redacted]. The RD initiated a [redacted]. The RD recommended to obtain weight weekly x 4 weeks, change the resident's diet to a [redacted] with double portions, add an ordered drink for [redacted], and an ordered liquid medication for [redacted]. On 11/30/23 at approximately 1:10 PM, the surveyor interviewed again the Charge Nurse assigned to do the treatments for the residents on the unit. The Charge Nurse was outside the resident's room with the treatment cart, and she stated that Resident #20 was awake, and she was about to do his/her [redacted] to the [redacted]. She stated that it was a newer [redacted] but could not speak to when it developed. The Charge Nurse stated that direct care staff did not report any change in [redacted] condition prior to [redacted].	F 686		

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F 686	Continued From page 43 On 11/30/23 at 1:30 PM, the surveyor conducted a phone interview with the APN/WC who stated that she comes every Wednesday to the facility and was not made aware of Resident #20's Ex Order 26. 4B1 identified on Ex.Order 26.4(b)(1). She stated that she was informed on Ex.Order 26.4(b)(1), regarding a Ex Order 26. 4B1 on the Ex Order 26. 4B1. The APN/WC stated she did a video call with the facility and changed the Ex Order 26. 4B1 at that time. The APN/WC stated the process was that she would come to the facility and complete Ex Order 26. 4B1 and if there was a Ex Order 26. 4B1, or a change in her recommendations that she would write the order for nurses to implement at that time. The APN/WC stated she documented the visit report, and the facility would receive it "within a day or so". When inquired about what type of Ex Order 26. 4B1 should be treated with [name redacted] Ex Order 26. 4B1 and [name redacted] Ex.Order 26.4(b)(1), she stated a stage 2 to stage 4 and if the Ex Order 26. 4B1 had a lot of drainage. The surveyor inquired why she recommended the [name redacted] particles used for Ex.Order 26 care for Resident #20, and the APN/WC stated that she recommended it to act as an Ex Order 26. 4B1 dressing so that the drainage of the Ex.Order 26.4(b)(1 did not Ex Order 26. 4B1 the edges of the Ex Order 26. 4B1. On 11/30/23 at 2:00 PM, the surveyor interviewed the CNA assigned to care for Resident #20. The CNA stated that she assisted the resident in getting him/her dressed and would apply Ex Order 26. 4B1 to the Ex Order 26. 4B1. The CNA was unsure about the Ex Order 26. 4B1 or any dressing that had been applied. On 12/01/23 at 8:21 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor copies of the facility policies on Prevention of Pressure Ulcers/Injuries updated	F 686		

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11/2018, and the Pressure Ulcer Investigation Form policy updated 2018. The LNHA was unable to provide any additional documentation to the survey team.

On 12/01/23 at 8:21 AM, the LNHA provide facility's policy titled, "Prevention of Pressure Ulcers/ Injuries", last revised 1/2023. No other document was provided regarding the Ex Order 26. 4B1 identified on Ex.Order 26.4(b)(1).

On 12/01/23 at 9:58 AM, Surveyor #1 interviewed the Unit Manager regarding the Ex.Order 26.4(b)(identified on Ex.Order 26.4(b)(1). The Unit Manager stated she could not speak to or provide any document regarding the resident's Ex Order 26. 4B1 and that the surveyor would need to speak to the Director of Nursing.

On 12/05/23 at approximately 10:00 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process when a Ex Order 26. 4B1 was identified. The DON stated that the nurse would inform the Ex Order 26. 4B1 care team who would provide directives on how to proceed with the Ex Order 26. 4B1. A change of condition would be completed and documented, and the *Ex Order 26. 4B1* would be made aware in the morning meeting. When asked to provide the documents for the Ex Order 26. 4B1 identified on Ex.Order 26.4(b)(1), the DON stated that she did not have any documentation regarding the Ex Order 26. 4B1 as she was not made aware.

There were no statements from the Primary Nurse, and/or statements from previous shifts from direct care staff. There was no investigation done to rule out if neglect been ruled out as a possible cause for the development of the *Ex Order 26. 4B1* on Ex.Order 26.4(b)(1) and again on Ex.Order 26.4(b)(1)

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	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

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COMPLETE CARE AT BURLINGTON WOODS, LLC	115 SUNSET ROAD BURLINGTON, NJ 08016

(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
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The DON added that the Charge Nurse did not follow the facility's protocol. The DON and surveyor reviewed the Progress notes together for Resident #20 and the DON could not speak to the timing, accuracy, and accountability questions the surveyor had regarding the resident's [redacted]. The DON acknowledged that there were discrepancies. The surveyor inquired how the resident developed a *Ex Order 26. 4B1* to the *Ex Order 26. 4B1* and the facility was not aware of any [redacted] condition prior to Ex.Order 26.4(b)(1), but the direct care staff had been providing *Ex Order 26. 4B1* on all 3 shifts. The DON stated she would need to get back to the surveyor.

On 12/06/23 at 10:30 AM, the DON stated that Resident #20 was assessed by nursing to only be "at risk" for developing a *Ex Order 26. 4B1* as per the *Ex Order 26. 4B1*. The facility was unable to provide documented evidence that the resident refused care or medications, had other behaviors that would impact interventions to prevent the *Ex Order 26. 4B1*. The facility was unable to speak to why there the care plan was not updated when the *Ex Order 26. 4B1* was identified.

b) A review of the hybrid closed medical record revealed that Resident #159 had been admitted with diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of the Admission MDS dated Ex.Order 26.4(b)(1), included but was not limited to a [redacted] of [redacted]/15 indicating the resident was *Ex Order 26. 4B1* [redacted]. Section *Ex Order 26. 4B1* revealed Resident #159 required the assistance of one staff for transferring between surfaces and [redacted] turning side to side. Section [redacted] further

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documented that the resident required two or more staff physical assistance to walk in the room and there was impairment of one side of the Ex Order 26. 4B1 . Section Ex Order documented the resident's admission performance as Ex Order 26. 4B1 from staff to roll left and right, sit to lying, lying to sitting on the side of the bed, and sit to stand. Section Ex O documented the only Ex.Order 26 problem as being a Ex Order 26. 4B1 . A review of the resident centered on-going Care Plan included but was not limited to; a focus area of a Ex Order 26. 4B1 , there were no goals or interventions to address skin integrity. A focus area of limited Ex Order 26. 4B1 , with a goal which included to remain free of complications including Ex.Order 26.4(b)(1), and interventions which included dependent on 1 staff for locomotion/transfer, assistance with Ex Order 26. 4B1 as needed. A review of the Order Recap Report included a physician's order dated Ex.Order 26.4(b)(for [name redacted] Ex Order 26. 4B1 apply to Ex.Order 26.4(b)( ] Ex Order 26. 4B1 every day shift for Ex Order 26. 4B1 cleanse area with Ex Order 26. 4B1 apply [name redacted] Ex Order 26. 4B1 and cover with a dry dressing.

A review of Resident #159's Ex.Order 26 assessments included but was not limited to the following;

Admission Assessment dated 1 Ex.Order 26.4(b)(1 , Section Ex O . Skin Integrity documented a Ex Order 26. 4B1 , a Ex Order 26. 4B1 , and Ex Orde . The assessment failed to document any measurements as indicated on the form. 12. Ex Order 26. 4B1 documented a. ability to respond meaningfully to Ex.Order 26.4(b)(1) Ex " completely limited Ex.Order 26.4(b)(1)

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Ex.Order 26.4(b)(1) [redacted] most of body surface. c. activity "[redacted]" walks occasionally. d. mobility "[redacted]" slightly limited. f. friction and sheet "[redacted]" no apparent problem.
A Weekly Skin Review dated Ex.Order 26.4(b)(1), documented pre-existing Ex Order 26. 4B1 to Ex Order 26. 4B1 intact.
A Weekly [redacted] Review dated [redacted] documented Ex.Order 26.4(b)(1)".
A Weekly [redacted] Review dated [redacted], documented "raised area to Ex Order 26. 4B1, Ex.Order 26.4(b)(1) [redacted]" (The [redacted] review did not identify Ex Order 26. 4B1 that necessitated the physician order dated [redacted]
A Discharge Instruction form dated [redacted] documented Nursing treatment instructions [name redacted] Ex Order 26. 4B1 apply to [redacted] Ex Order 26. 4B1 every day shift for Ex Order 26. 4B1 cleans area with Ex Order 26. 4B1 apply [name redacted] Ex Order 26. 4B1 and cover with a dry dressing.

A review of the electronic Progress Notes (PN) included but were not limited to; an entry dated [redacted] the activities department. The next entry was a PN dated [redacted] by the physician. There were no PNs dated [redacted] by nursing regarding the 'Ex Order 26. 4B1 [redacted], intact, [redacted]." with any measurements or assessments. The PNs failed to include an assessment of the facility acquired [redacted]

The DON at the time of Resident #159's stay at the facility, no longer worked at the facility and was unable to be interviewed.

A review of the facility provided, "Skin Integrity

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Program Policy", updated 10/2020, included but was not limited to;
Purpose: to provide information regarding identification of pressure ulcer/injury risk factors.
Preparation: Review the resident's care plan and identify the risks factors as well as interventions designed to reduce or eliminate those considered modifiable.
Prevention: Keep the skin clean and free of exposure to urine and fecal matter.
Mobility/ Repositioning: Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort.

(The policy was not being followed. Resident #20 was left lying in Ex Order 26. 4B1 for 2 hours before being changed on Ex.Order 26.4(b)(1). The care plan was not updated with the development of the Ex Order 26. 4B1 on Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1). The care plan for Resident #159 failed to document any goals or interventions to address Ex.Order 26.4(b)(1) or the facility acquired Ex Order 26. 4B1. The RD nor the Ex Order 26. 4B1 nurse were consulted when the resident developed a Ex Order 26. 4B1 on Ex.Order 26.4(b)(1).)

A review of the facility provided, "Care Plans, Comprehensive Person-Centered" policy and procedure reviewed 1/2023, included but was not limited to; ... includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation. 2. The care

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F 686	Continued From page 49 plan interventions are derived from a thorough analysis of the information gathered from the comprehensive assessment. 7. The care planning process will: b. include an assessment of the resident's strength and needs. 8. The comprehensive person-centered care plan will: b. describe the services to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being. g. incorporate identified problem areas. k. reflect treatment goals, timetables and objectives in measurable outcomes. k. identify the professional services that are responsible for each element of care. 13. Assessments are ongoing and care plans are revised as information about the resident's conditions change. A review of the facility provided, "Charting and Documentation" policy and procedure reviewed 1/2023, included but was not limited to; ... any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. 2. The following information is to be documented in the resident medical record: c. treatments or services performed. d. changes in the resident's condition. e. events, incidents or accidents involving the resident. f. progress toward or changes in the care plan goals and objectives. 3. documentation in the medical record will be ... complete, and accurate. On 12/13/23 during the exit conference, the facility did not provide any documentation to indicate that the *Ex Order 26. 4B1* was avoidable or not and what interventions should have been implemented to prevent recurrence. NJAC 8:39-25.2 (b)(c); 27.1 (a)(e)	F 686		

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure adequate supervision was provided to a resident to prevent falls, b) follow the facility accident policy to investigate falls, and consistently initiate new fall prevention interventions in response to falls, c) ensure current care plan interventions to prevent accidents were implemented. This deficient practice occurred for 1 of 1 resident reviewed (Resident #116) for Ex.Order 26.4(b)(1) who was identified as being at Ex.Order 26.4(b)(1), sustained multiple Ex.Order 26.4(b)(1) that required transfer to the *Ex Order 26. 4B1* which resulted in a *Ex Order 26. 4B1* and the *Ex Order 26. 4B1* , and required a *Ex Order 26. 4B1* . The deficient practice was evidenced by the following: On 11/28/23 at 11:44 AM, the surveyor toured the [redacted] Unit and observed Resident #116 seated in a wheelchair in the hallway and appeared [redacted] and was self-propelling back and forth.	F 689	Residents affected by deficient practice: The facility failed to: A) ensure adequate supervision was provided to a resident to prevent [redacted] B) follow the facility accident policy to Ex.Order 26.4(b)(1) and consistently initiate new Ex.Order 26.4(b)(1) interventions in response to [redacted], C) ensure current care plan interventions to prevent accidents were implemented. This deficient practice occurred for 1 of 1 resident #116 Identify those individuals who could be affected by the deficient practice: • All residents at risk for [redacted] have the potential to be affected by the deficient practice. • The affected resident's (Resident #116) care plan was reviewed and updated. What corrective action will be accomplished for those residents affected by the deficient practice: • Resident #116's care plan was reviewed and adjusted to ensure all interventions were in place and continued to be appropriate for current level of	1/5/24

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F 689	Continued From page 51 On 11/29/23 at 11:20 AM, the surveyor observed Resident #116 self-propelling from the dayroom to the hallway. There was no staff observed in the dayroom supervising the resident or at the nursing station. On 11/29/23 at 12:38 PM, the surveyor observed the resident in the dayroom, rummaging through a bookcase. Resident #116 appeared very [redacted], was wheeling back and forth in the wheelchair. There was no staff in attendance and six other residents were observed in the dayroom. On 11/30/23 at 8:30 AM, the surveyor observed the resident in the dayroom along with four other residents, there was no staff in attendance. On 12/05/23 the surveyor reviewed Resident #116 medical record. The admission face sheet (an admission summary) reflected that Resident #116 was admitted to the facility with diagnoses which included but were not limited to; [redacted]. The Quarterly Minimum Data Set (MDS) dated [redacted] an assessment tool used by the facility to prioritize care reflected that Resident #116 was [redacted]. Resident #116 scored [redacted]/15 on the [redacted] Normal Score (00-15). Review of Resident #116's Comprehensive Care plan provided by the facility on [redacted], revealed: A focus area: "Resident #116 is [redacted] for [redacted]. Initiated [redacted] and revised on [redacted] The goal was that Resident	F 689	function; to include close monitoring when noted in the day room. • All licensed nursing staff re-educated on facility policy for "Falls-Clinical Protocol" and Policy on "Accidents and Incidents Investigating and Reporting" with an emphasis on updating care plans for appropriate person-centered interventions. Measures or systemic changes to ensure that the deficiencies will not recur: The DON/Unit Manger/Designee will conduct compliance audits of 4 random residents risk management investigation for falls. The duration of all audits will occur weekly X4 and then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Date of Completion: 1/05/24	

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F 689	Continued From page 52 #116 will be Ex.Order 26.4(b)(1) through the review date of Ex.Order 26.4(b)(1) The interventions included: Anticipate and meets Resident #116's needs. Initiated Ex.Order 26.4(b)(1). Assure Resident #116's sneakers are on while ambulating. Be sure Resident#116's call light is within reach and encourage the resident to use it for assistance as needed. Ex Order 26. 4B1 to the wheelchair. Ensure by staff that Resident #116 can stay in dayroom or hallway in sight of staff. Ex.Order 26.4(b)(1). Educate Resident, family, and caregivers about safety reminders and what to do if a Ex.Order 26.4(b)(1). Initiated Ex.Order 26.4(b)(1) Encourage resident to engage in activities when in bed. Initiated Ex.Order 26.4(b)(1). Close observation by staff when entering to other residents' room. Initiated Ex.Order 26.4(b)(1). Evaluate and apply wheelchair anti-tippers by Ex Order 26. 4B1. Initiated Ex.Order 26.4(b)(1). The following incidents were documented in the Electronic Medical Record: The surveyor reviewed an Ex.Order 26.4(b)(1) nursing Progress note documented at 1:00 PM that indicated the following: Resident #116 was pacing around units when he/she tripped on the Ex Order 26. 4B1 in the hallway and Ex Orde face down. Ex Order 26. 4B1 noted to the Ex Order 26. 4B1. Treatment done to Ex Order 26. 4B1 site. Resident attempted to get up from the chair he/she was sitting but he/she could not. He/she walked few steps with unsteady gait pushing the chair and then sat down. The physician was notified and ordered Ex Order 26. 4B1	F 689		

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F 689	Continued From page 53 Ex Order 26. 4B1 done which were negative for Ex Order 26. 4B1 as per the progress notes dated Ex.Order 26.4(b)(1) and timed 21:00 [9:00 PM] . On 12/05/23 at 12:30 PM, the surveyor requested all investigations, Ex.Order 26.4(b)(1) Assessments for Resident #116, and a timeline for review from the Director of Nursing (DON). On 12/06/23 at 9:46 AM the following were provided by the DON: Ex.Order 26.4(b)(1) Assessment on admission dated Ex.Order 26.4(b)(1) reflected that the facility identified Resident #116 as a Ex Order 26. 4B1 risk. Resident #116 received a score of Ex Ord. -Ex.Order 26.4(b)(1) Assessment dated Ex.Order 26.4(b)(1) reflected that Resident #116 was at Ex Order 26. 4B1, Resident #116 received a score of Ex Ord. -Ex.Order 26.4(b)(1) Assessment dated 0 Ex.Order 26.4(b)(1) Resident #116 received a score of Ex Ord. Category: Ex Order 26. 4B1. Ex.Order 26.4(b)(1) Assessment dated Ex.Order 26.4(b)(1) Resident #116 scored Ex Ord. Category: Ex Order 26. 4B1. -Ex.Order 26.4(b)(1) Assessment dated Ex.Order 26.4(b)(1) Resident #116 received a score of Ex Ord and was still at Ex Order 26 for Ex.Order The following incidents were documented in the Electronic Medical Record. A review of the Progress Notes revealed that Resident #116 sustained Ex Order 2 on the following dates: 1. Ex.Order 26.4(b)(1), 9:44 AM, Late Entry: witnessed by CNA. Nurse called to room. Patient assessed by nursing for Ex.Order 26.4(b)(1) noted to Ex Order 26. 4B1. Patient complaint of Ex.Order 2 to Ex Order 26. 4B1 guarded actions as well as Ex Order 26. 4B1 Ex.Order 26. Patient assisted	F 689		

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F 689	Continued From page 54 back to bed via Ex Order 26. 4B1. MD [physician notified]. New orders for stat Ex Order 26. 4B to Ex Order 26. 4B1 . Ex Order 26. 4 positive for Ex Order 26. 4B1. Sent to Ex Order 26. 4B1 for evaluation and treatment. Resident #116 was diagnosed with Ex Order 26. 4B1 and Ex Order 26. 4B1 . Predisposing factor: "Ex.Order 26.4(b)(1)". There was no statements from the nurse or the CNAs attached to the incident report. The DON indicated that the Ex.Order was not investigated and there were no new interventions implemented. Ex.Order 26.4 assessment done upon return from the Ex Order 26. 4B1 revealed: Ex Order 26. 4B1 and Ex Order 26. 4B1 , Ex.Order 26.4(b)(1) Ex Order 26. 4B1 area, Ex Order 26. 4B1 Ex.Order 26.4(b)(1) noted Ex Order 26. 4B1 , Ex.Order 26.4(b)(1) noted Ex Order 26. 4B1 with small, Ex.Order 26.4(b)(1) area. According to the Incident report provided, the nurse was called to the room, resident was Ex Order 26. 4 on the floor. Per review of hospital records, Resident #116 Ex Order on Ex.Order 26.4(b) 2 and was transferred to the Ex Order 26. 4B1 and had Ex.Order 26.4(b)(1) to repair the Ex Order 26. 4B1. An Ex Order 26. 4B1 to repair the Ex Order 26. 4B1. The care plan was not revised after the Ex.Order of Ex.Order 26.4(b)(1) to include interventions and supervision that would prevent further Ex.Order 26. 2. Ex.Order 26.4(b)(1) at 6:42 AM, Resident #116 was found sitting on the floor. Interventions: to help prevent further occurrences, Resident #116 is to be reminded to raise bed before attempting to transfer out. Resident #116 Ex Order 26. 4 Score was Ex /15 which indicated the resident was Ex Order 26. 4B1	F 689		

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Ex Order 26. 4B1. The facility described the resident as being Ex.Order 26.4(b)(1). No specific interventions were implemented to prevent recurrence.

3. Ex.Order 26.4(b)(1) at 17:09 [5:09 PM], Ex Orde from wheelchair in hallway outside the dayroom. Intervention: Remind Resident #116 of safety awareness while ambulating. No specific interventions were implemented to prevent recurrence.

4. Ex.Order 26.4(b)(1) 12:06 PM, Nursing/Unit Clerk heard a sound coming from the direction of Resident #116's room. Resident #116 was noted on the floor near the door. Resident stated that Ex Order hit Ex Order head. When asked, the resident stated, "[redacted]". The physician was made aware and ordered to send the resident to the hospital for a Ex Order 26. 4B1 which was Ex.Order 26.4(b)(1)

There was no statement from the Unit Clerk who first went to the room and observed Resident #116 on the floor. An interview with the Unit Clerk on Ex.Order 26.4(b)(1) at 10:15 AM, revealed that she was not asked to provide a statement. As she could recall the incident, there was a CNA in the room at that time. No statement from the CNA was attached. The Supervisor nor the Director of Nursing signed the Accident/ Incident Report dated Ex.Order 26.4(b)(1).

5. Ex.Order 26.4(b)(1) at 11:20 PM, Observed Resident #116 sitting on the floor in front of the wheelchair facing the door. New Intervention: Ex Order 26. 4B1, culture, and sensitivity. Staff will offer toileting needs early morning before getting up from the bed. The Ex.Order was not documented in the Progress

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COMPLETE CARE AT BURLINGTON WOODS, LLC	115 SUNSET ROAD BURLINGTON, NJ 08016

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F 689	Continued From page 56 Notes. 6. Ex.Order 26.4(b)(1) timed 15:28 [5:28 PM], Resident tilted wheelchair backward, Ex Orde and Ex.Order 26.4(b)(1) Resident acquired a Ex Order 26. 4B1 on the Ex.Order 26.4(b)(1). Resident #116 was sent to the Ex Orde for evaluation. Ex Order 26. 4B1 was Ex.Order 26.4(b)(1). New Intervention: Evaluate and apply wheelchair anti tippers by Ex Order 26. 4B1 . The Ex.Order 26.4(b)(1) not documented in the progress notes. 7. Ex.Order 26.4(b)(1) 15:05 PM [5:05 PM], Unwitnessed Ex Orde. Resident #116 was noted to be in the lounge on the Ex Order floor pulling on the change machine located between the two-vending machine. The free-standing change machine tipped over and Ex Orde the resident in the Ex.Order 26.4 giving him/her a Ex Order 26. 4B1 to the Ex Order 26. 4B1 and Ex Orde on his/her Ex Order 26 where he/she sustained a Ex.Order 26.4(b) and a Ex Order 26 to the Ex Order 26. 4B1. Interventions: Redirect staff to observe closely when out from unit. Engage resident to activities according to resident need. Treatment as ordered to open Ex Order 26. 4B1. The nurse documented that she heard the resident crying out from the snack room, she ran out and observed the change machine on the floor. The Ex Orde was unwitnessed. There was no investigation to indicate when the resident was last observed. 8. Ex.Order 26.4(b)(1), 16:40 PM [6:40 PM], Unwitnessed Ex Orde. Resident lost his/her balance and Ex Orde to the floor in the dayroom. Wheelchair was on the other side of the dayroom unlocked. Resident might have attempted to ambulate but lost balance and Ex Orde. Resident complained of Ex Order 26. 4B1 Ex.Order 26 during assessment. Stat Ex Order 26. 4B1 of the Ex Orde ordered. Interventions: Involved resident in activities, offer naps after lunch or between late	F 689		

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F 689	Continued From page 57 afternoon. 9. Ex.Order 26.4(b)(1), 19:31 [7:31 PM] Unwitnessed Ex.Order 2 Resident #116 was Ex.Order 26. 4 on the floor, bent over in another resident's bathroom. A statement from the CNA revealed the following: "I was doing rounds and I heard a resident yelling that Resident #116 was on the Ex.Order 2 in the bathroom. I went to help, and I notified the nurse." There were no new interventions added to the care plan after this Ex.Order 2 10. 0 Ex.Order 26.4(b)(1) 7:53 PM. Unwitnessed Ex.Order 2 Another resident called for help. Resident #116 was found sitting on his/her Ex.Order 26. 4B1 in another resident's room. New intervention: Sleeping pattern to observe resident sleep. Encourage resident to go to bed for night sleep. The care plan did not include any specific interventions in response to this Ex.Order 26.4(b)(1), or to ensure Resident #116's safety in the event of further Ex.Order 26 11. Ex.Order 26.4(b)(1) 14:50 PM [4:50 PM] Unwitnessed Ex.Ord. Resident was in the dayroom. Resident was found lying on his/her back and stated, " Ex.Order 26. 4B1 ." There was no investigation to indicate who was monitored the dayroom. Intervention: Redirect staff to maintain close observation from nearby when resident is in the dayroom. On 12/06/23 at 9:42 AM, the surveyor interviewed the Registered Nurse/Unit Manage (RN/UM) regarding the facility's fall protocol. The RN/UM stated that all residents identified to be Ex.Order 26. 4B1 Ex.Order 26.4(b)(1, were to be closely monitored. When prompted regarding Resident #116's multiple Ex.Order 26 the RN/UM added that Ex.Order 26.4 s were discussed in the morning meeting and the care plan were revised after each Ex.Order 2 The surveyor	F 689		

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F 689	Continued From page 58 reviewed the Care Plan with the RN/UM and verified that the care plan was not updated after the [redacted]. The surveyor then asked the UM who was responsible to monitor the dayroom when residents were in attendance. The UM stated the CNA and the nurses should take turns to monitor the dayroom. The surveyor then escorted the UM to the dayroom and we both observed six residents were sitting in the dayroom unsupervised. There was no staff monitoring the residents as stated should have occurred per the RN/UM. On 12/06/23 at 11:01 AM, the surveyor interviewed the Director of nursing (DON) regarding Resident #116's [redacted]. The DON stated that Resident #116 needed constant [redacted] and was [redacted]. The DON added that [redacted] were discussed in the morning meeting. The DON further stated that she was not employed at the facility as the DON in 2022. When inquired regarding the process after [redacted], the DON stated, an Registered Nurse should complete an assessment after each fall. The physician and the resident representative should be notified. Pain assessment should be completed and if any injury was suspected, the resident would be sent to ER for evaluation and treatment. The nurse was to complete a fall assessment, obtain statements from all staff assigned to the unit to identify the causal factor and implement interventions to prevent recurrence. When inquired about the [redacted] where the resident sustained [redacted], the DON stated that the [redacted] should have been investigated and then confirmed that there was no investigation completed, and no specific interventions to prevent [redacted]	F 689		

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F 689	Continued From page 59 On 12/06/23 at 3:35 PM, the survey team reviewed with the DON the interventions on the care plan dated Ex.Order 26.4(b)(1) which included to remind the resident to raise the bed before transferring, and on Ex.Order 26.4(b)(1) to remind resident of safety awareness while ambulating. The DON stated, "there is Ex.Order 26.4(b)(1), how can you remind [him/her]." The DON then stated, "at that time I did not know [his/her] Ex.Order 26.4(b)(1) status. Interventions should be initiated right away. Resident #116 had a [redacted] of [redacted] and cannot Ex.Order 26.4(b)(1)." A review of Resident #116's Care Card [CNA tasks] revealed the following under safety: Ensure by staff that resident can stay in the dayroom or hallway in sight of staff. Close observation by staff when entering to other residents' room. Ensure/provide a safe environment: Call light in reach, adequate low glare light. Bed in lowest position and wheels locked, avoid isolation. Redirect staff to observe resident closely when out from unit. Engage resident to activities according to resident needs. On 12/12/23 at 12:18 PM, during a pre-exit meeting held with the survey team and current facility Licsensed Nursing Home Administrator (LNHA), the incoming LHNA, DON and Executive Nursing Managment, the surveyor reviewed the concerns regarding Resident #116's Ex.Order 26.4(b)(1) including Ex.Order 26.4(b)(1), multiple observations of resident not being supervised during survey, and the Comprehensive Care Plan not updated past Ex.Order 26.4(b)(1).	F 689		

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F 689	Continued From page 60 On 12/13/23 at 9:17 AM, during the facility exit conference, the DON informed the survey team that the Nurses and CNA's must follow the clinical protocol for falls and the all staff will be educated. A review of the facility's policy titled, "Accident/ Incident Report- Investigating and Reporting " dated 07/2017 updated 1/2023, revealed the following: Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data as applicable, shall be included on the Report of Incident/ Accident form: a. The date and time the accident or the incident took place. b. The nature of the injury/illness. c. The circumstances surrounding the incident. e. the name (s) of witnesses and their accounts of the incident or accident. i. The condition of the injured person, including his/her vital signs. j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, k. Any corrective action taken. Incident/ Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. The facility also provided a form titled, "Falls-	F 689		

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F 689	Continued From page 61 Clinical Protocol revised 3/2018 and updated 1/2023. Under Cause and Identification, it revealed: For an individual who has fallen, the staff and the practitioner will begin to try to identify possible causes within 24 hours of the fall. After a fall, Clinical staff should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. The staff will continue to collect and evaluate information until the cause of the fall-ing is identified, or it is determined that the cause cannot be found, or it is not correctable. Treatment /Management. Based on the preceding assessment, the clinical staff will identify pertinent interventions to try to prevent subsequent falls and address the risks of clinically consequences of falling. The policy was not being followed. Resident #116 sustained Ex.Order 26.4(b)(1) at the facility and the facility could not provide accountability that Resident # 116 was being supervised.	F 689		
F 691 SS=D	NJAC 8:39-27.1 (a) Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced	F 691		1/26/24

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F 691	Continued From page 62 by: Complaint # NJ 152112 Based on interview and document review it was determined that the facility failed to ensure that resident Ex Order 26. 4B1 was performed in accordance with physician orders for 1 of 1 closed medical records reviewed (Resident #354) for Ex Order 26. 4B1. On 12/07/23 at 9:33 AM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #354 which revealed Resident #354 had Medical Conditions which included, but were not limited to; Ex Order 26. 4B1 [redacted]. The Care Plan revealed a Focus area that the resident has an Ex Order 26. 4B1 status due to a Ex Order 26. 4B1, initiated Ex.Order 26.4(b)(1). The Goal was the resident will remain free from discomfort, complications or signs/symptoms related to Ex Order 26. 4B1 through review date, initiated Ex.Order 26.4(b)(1). A review of the Order Summary Report, dated Ex.Order 26.4(b)(1) revealed active physician orders dated Ex.Order 26.4(b)(1) which included: Ex Order 26. 4B1 change every day shift every 3 days. The Ex Order 26. 4B1, dated January 2022 revealed that the Ex Order 26. 4B1 Change was documented as completed on 01/01/22, 01/04/22, 01/10/22 (6 days later), 01/13/22, 01/16/22, 01/19/22, 01/22/22, 01/28/22 (6 days later), and 01/31/22. A review of the progress notes from 01/04/22 through 01/10/22 and 01/22/22 through 01/28/22 did not reveal that the Ex Order 26. 4B1 was changed and there were no refusals documented.	F 691	F691- Ex Order 26. 4B1 [redacted] Residents affected by deficient practice: The facility failed to ensure that resident Ex Order 26. 4B1 was performed in accordance with physician orders for 1 of 1 Ex Order 26. 4B1 reviewed (Resident #354) for Ex Order 26. 4B1. Identify those individuals who could be affected by the deficient practice: " All residents (1) who have a Ex Order 26. 4B1 have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: " All residents (1) with a Ex Order 26. 4B1 were reviewed for appropriate orders for care of the Ex Order 26. 4B1 with no concerns noted. " All nursing staff re-educated on facility policy for Ex Order 26. 4B1 and the importance of documentation of care. Measures or systemic changes to ensure that the deficiencies will not recur: " Compliance audits of Ex Order 26. 4B1 or ileostomy care initiated. " The duration of all audits will consist of completion three-times weekly x4 weeks then three- times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the	

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F 691	Continued From page 63 On 12/07/23 at 10:44 AM, the surveyor interviewed the Director of Nursing (DON) regarding what type of care is provided for residents who have a colostomy. The DON stated the colostomy bag would be emptied and changed daily or as needed, and the colostomy appliance would be changed every three days or as needed. The surveyor asked the DON how would you know if the staff changed the appliance or emptied the bag. The DON stated, "it is documented" on the TAR usually or on the Medication Administration Record. The surveyor asked the DON, referring to Resident #354, if the TAR was not signed off by a nurse what did that mean. The DON stated if the nurses are not initialing it, it means it "is not done". The DON stated "it has to be signed". The Colostomy/Ileostomy Care Policy updated 10/2019 revealed under Documenation: The fallowing information should be recorded in the resident's medical record: 1. The date and time the colostomy/ileostomy care was provided, 2. The name and title of the individual(s) who provided the colostomy/ileostomy care, 3. If the resident refused the procedure, the reason (s) who provided the colostomy/ileostomy care, 4. The signature and title of the person recording the data. NJAC 8:39-27.1(a)	F 691	duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		1/26/24

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F 725	Continued From page 64 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ 149879, NJ 151052, NJ 151398, NJ 152112, Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure sufficient staff were available to: a) provide timely and appropriate incontinence care for residents who were dependent on staff for Activities of Daily Living (ADLs) care, b) provide nail care for a resident who was dependent on staff for ADLs, and c) provide colostomy (a surgically created opening in the colon or large intestine) for a	F 725	Residents affected by deficient practice: Facility failed to ensure sufficient staff were available to: a) provide timely and appropriate *Ex Order 26. 4B1* for residents who were dependent on staff for *Ex Order 26. 4B1* care, b) provide nail care for a resident who was dependent on staff for *Ex Order 26. 4B1*, and c) provide *Ex Order 26. 4B1* for a resident dependent on staff for *Ex Order 26. 4B1*. This deficient practice was identified for 7 of 9 residents	

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F 725	Continued From page 65 resident dependent on staff for colostomy care. This deficient practice was identified for 7 of 9 residents reviewed for ADLs (Resident #20, #76, #101, #106, #116, #354, and closed record #159), and expressed by 5 of 5 residents who attended a resident council meeting and was evidenced by the following: Refer to 677E, 686E, 689G, and 691D. a) On 11/28/23 at 10:03 AM, Surveyor #1 observed Resident #20 lying in bed in his/her room. The resident was alert and informed the surveyor that he/she was Ex.Order 26.4(b). He/she stated he/she could not find the call light to alert the staff, and stated, "Please help." Surveyor #1 left the room and alerted the nurse in the hallway that the resident was requesting assistance. The surveyor and the Licensed Practical Nurse (LPN) went to Resident #20's room and the LPN eventually found the call light wrapped and placed on the wall out of the residents reach. On 11/28/23 at 10:15 AM, Surveyor #1 interviewed the resident sometimes staff would take time to answer the call light. At 12:10 PM, the surveyor noticed a strong Ex.Order 26 permeated in the hallway adjacent to the resident's room. The resident reported that he/she needed to be changed at approximately 10:03 AM, but the resident was not provided with Ex.Order 26.4(b)(1) until after 12:00 PM. On 11/28/23 at 12:15 PM, an interview with the Certified Nursing Assistant (CNA) who cared for the resident revealed that she was providing care	F 725	reviewed for Ex.Order 26.4 (Resident #20, #76, #101, #106, #116, #354, and closed record #159), and expressed by 5 of 5 residents who attended resident council meeting. Identify those individuals who could be affected by the deficient practice: " All Residents have the potential to be affected by this deficient practice. " All were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. " The facility will take the following measures to ensure this deficient practice does not occur. The facility will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff.	

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F 725	Continued From page 66 to another resident. When asked if she provided Ex.Order 26.4(b)(1) to the resident that morning, the CNA stated, no. She informed the surveyor that around 8:30 AM, she delivered the breakfast tray and left the room. On 12/01/23 at 8:25 AM, Surveyor #1 observed a CNA wheeling Resident #101 to their room. As the CNA transferred the resident to their bed, the surveyor observed Resident #101 was wearing two *Ex Order 26. 4B1* and the [redacted] was leaking out. The Unit Manager (UM) was present and acknowledged that the resident had two Ex.Order 26.4(b)(1) and was [redacted] with [redacted]. On 12/01/23 at 8:40 AM, Surveyor #1 observed Resident #116 in their room in the presence of the UM. The surveyor and UM observed the resident was wearing one *Ex Order 26. 4B1* that had three *Ex Order 26. 4B1* inside. On 12/04/23 at 8:45 AM, during a care tour with the CNA, the surveyor observed Resident #106. The resident was wearing an *Ex Order 26. 4B1* what was [redacted] with [redacted]. The surveyor further observed an Ex.Order 26.4(b)(1) with [redacted] inside the *Ex Order 26. 4B1*. A review of a facility provided Grievance Form, dated 01/06/22, included but was not limited to; a grievance filed by Resident #159 documented that on 01/05/22, on the 3 PM to 11 PM shift, the resident rang his/her call bell but no staff arrived. The resident had a family member call the facility to inform the staff that the resident needed assistance to be toileted. b) On 11/28/23 at12:09 PM, the surveyor	F 725	Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to conduct compliance audits on effectiveness of hiring strategies to include open CNA and Licensed Nurse positions, reporting on new hires, successful strategies-to-hire, and implementation of employee retention programs. " The duration of all audits will consist of completion one-time weekly x 4 weeks then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion 1/26/24	

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F 725	Continued From page 67 observed Resident #76 in bed and observed his/her Ex.Order 26.4(b)(1) with the Ex Order 26. 4B1 Ex.Order 26.4(b)(1). On 11/29/23 at 11:21 AM, a second observation of Resident #76 revealed his/her Ex Order 26. 4B1 were still Ex.Order 26.4(b)(1) and had not been addressed. Resident #76 stated that he/she would like to have his/her Ex Order 26. 4B1 trimmed. On 11/29/23 at 12:24 PM, the CNA was at Resident #76's bedside providing nail care. When inquired regarding the resident's nails, the CNA stated, "I was not here yesterday." c) On 12/07/23 at 9:33 AM, a surveyor reviewed the closed electronic medical record (EMR) for Resident #354. Resident #354 was documented as having a Ex Order 26. 4B1 . A review of a physician's order dated Ex.Order 26.4(b)(1), included Ex Order 26. 4B1 change every day shift every three days. The surveyor reviewed the Treatment Administration Record (TAR), for January 2022 included but was not limited to the following; a Ex Order 26. 4B1 change was completed on 01/01/22, 01/04/22, and 01/10/22 (6 days later); completed on 01/13/22, 01/16/22, 01/19/22, 01/22/22, and 01/28/22 (6 days later). The surveyor reviewed the nursing Progress Notes which failed to document that the Ex Order 26. 4B1 was changed during the dates of 01/07/22 and 01/25/22. d) On 11/30/23 at 10:30 AM, Surveyor 4 conducted a resident council meeting with five current residents of the facility. During the	F 725		

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F 725	Continued From page 68	F 725		

meeting, five of five residents expressed concerns with the facility being understaffed and having to wait a "long time" for care. One resident stated he/she had waited an hour for care. A second resident stated that he/she witnessed their roommate use the call bell and waited close to an hour.

On 12/07/23 at 8:55 AM, Surveyor 4 interviewed a CNA on the E wing. The CNA stated she had worked at the facility for 2 years and the staff would work short. The CNA gave an example of the day before, 12/6/23, the facility was short, and she had not time to document and less time to spend on resident care.

On 12/07/23 at 8:59 AM, a second CNA on [redacted] wing stated that when the facility had less than five CNAs on the unit, she found it hard to complete tasks such as resident hygiene and *Ex Order 26. 4B1* .

On 12/07/23 at 9:01 AM, a CNA on [redacted] win stated that she found it hard to provide "quality care" if there were less than 5 CNAs. She further stated it was too difficult to care for 15 residents and get "basic things" done.

On 12/07/23 at 9:02 AM, a second CNA on [redacted] wing stated that on 12/6/23, there were not enough staff, and it was "rough" and that things such as showers would "suffer".

Staffing had been calculated for the following time frames and revealed the following:

1. For the 2 weeks from 11/07/2021 to 11/20/2021, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as

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follows:

-11/07/21 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-11/10/21 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs.
-11/13/21 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs.

-11/14/21 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs.
-11/15/21 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs.
-11/19/21 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs.
-11/20/21 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs.

2. For the 2 weeks from 01/02/2022 to 01/15/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows:

-01/02/22 had 14 CNAs for 151 residents on the day shift, required at least 19 CNAs.
-01/02/22 had 14 total staff for 151 residents on the evening shift, required at least 15 total staff.
-01/02/22 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs.
-01/02/22 had 10 total staff for 151 residents on the overnight shift, required at least 11 total staff.
-01/03/22 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-01/04/22 had 13 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-01/05/22 had 15 CNAs for 150 residents on the

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day shift, required at least 19 CNAs.
-01/06/22 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-01/07/22 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs.
-01/08/22 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs.
-01/08/22 had 9 total staff for 149 residents on the overnight shift, required at least 11 total staff.
-01/09/22 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs.
-01/10/22 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-01/11/22 had 12 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-01/12/22 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-01/13/22 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-01/14/22 had 13 CNAs for 146 residents on the day shift, required at least 18 CNAs.
-01/15/22 had 9 CNAs for 144 residents on the day shift, required at least 18 CNAs. This equated to half of the required CNAs to provide the minimum resident care.

3. For the 2 weeks of staffing prior to survey from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows:

-11/12/23 had 10 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-11/13/23 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-11/14/23 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-11/16/23 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs.

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F 725	Continued From page 71 -11/17/23 had 16 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/18/23 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/19/23 had 10 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/20/23 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/21/23 had 18 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/22/23 had 18 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/23/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs. -11/24/23 had 13 CNAs for 148 residents on the day shift, required at least 18 CNAs.	F 725		
F 804 SS=D	NJAC 8:39-4.1(a)12; 27.1(a) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint # NJ 151052 Based on observation, interview, and review of pertinent facility provided documentation, it was determined that the facility failed to provide meals that were at acceptable temperatures for 5 of 5	F 804	Residents affected by deficient practice. The facility failed to provide meals that were at acceptable temperatures for 5 of 5 residents interviewed and one test tray and ensure palatable food for 6 of 6 residents interviewed.	1/26/24

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F 804	Continued From page 72 residents interviewed and one test tray and ensure palatable food for 6 of 6 residents interviewed. a) On 11/28/23 at 10:27 AM, the surveyor observed Resident #355 sitting at the bedside eating breakfast. When interviewed, Resident # 355 stated "the food tastes like prison food. It is bland and has no taste." On 11/29/23 at 12:39 PM, the surveyor observed Resident #355 eating his lunch. Resident # 355 stated "the pork chop was a little tough." b) On 11/30/23 at 10:30 AM, Surveyor #4 conducted a resident council meeting with five residents. During the resident council meeting, five of the five residents expressed concerns with the palatability and temperature of the food served at the facility. Examples provided included but were not limited to; the liquid eggs were being baked in a square pan and had "no flavor". The resident council participants prefer real eggs. A concern was that when provided with tomato soup, the taste was "like someone poured water or milk into spaghetti sauce and served that as tomato soup". The residents expressed the concern that the meals were "not being delivered fast enough and were cold or lukewarm" when they were finally able to eat. c) On 12/05/23 at 12:40 PM, the surveyor observed the meal cart brought to [redacted] wing. The meal trays were being distributed to the residents by the Certified Nursing Assistants (CNA) and Licensed Practical Nurses (LPN). The survey requested the CNA to save the last tray to check temperatures of the food items.	F 804	Identify those individuals who could be affected by the deficient practice: • All residents have the potential to be affected by this deficient practice. • All residents monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: • The Food Services District Manager re-educated the Food Services Director and all dietary staff on Policy and Procedures related to proper hot and cold food temperatures. • The Food Services Director re-educated the Dietary staff on proper use of facility base heater and plate warmer equipment prior to each meal service. • Director of Nursing educated all CNA and Nursing staff regarding the importance of delivering meal trays to residents as soon as the meal delivery cart is delivered to the unit. Measures or systemic changes to ensure that the deficiencies will not recur: • The Administrator/designee will conduct compliance audits on hot and cold food temps. • The duration of all audits will consist of the completion of auditing 5 trays for proper temperature and delivery time, two-times per week x4 weeks, and then two-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based	

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F 804	Continued From page 73 On 12/05/23 at 12:53 PM, the surveyor interviewed the Food Service Director (FSD) who stated the food should be palatable and it depends on the person. The FSD stated the hot food should be above 135 degrees Fahrenheit (F) and cold food should be below 41 degrees F. The surveyor and FSD proceeded to check the temperatures of the food items. The meal tray contained the main entrée that consisted of baked chicken thigh, roasted potatoes, and corn. The meal tray also had a chef salad that contained a hardboiled egg and a dessert cup of peaches. All food items on the tray were checked with a facility thermometer and a surveyor thermometer. The following temperatures were recorded with the facility thermometer. Baked chicken thigh 127 degrees F Roast potatoes 116 degrees F Corn 114 degrees F Chef Salad 46 degrees F Hardboiled Egg 52 degrees F Peaches 64 degrees F A review of the facility provided policy on Food Preparation revised on 9/2017, included but was not limited to; # 4 The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per state regulation. NJAC 8:39-17.4 (a)(2)	F 804	on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/26/24

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F 812	Continued From page 74 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure: a) potentially hazardous and perishable food items located in the refrigerator were labeled with a use by date and covered. b) staff restrained hair c) resident food storage areas were maintained in a clean and sanitary manner and food was appropriately labeled and dated with a use by date to prevent the potential for food borne illness. This deficient practice occurred in the main kitchen and 2 of 2 remote resident food pantries and was evidenced by the following: On 11/28/23 at 8:54 AM, the surveyor conducted a tour of the kitchen with Food Service Manager FSM and observed the following: 1) The walk-in refrigerator was observed with	F 812	Residents affected by deficient practice: The facility failed to ensure a) potentially hazardous and perishable food items located in the refrigerator were labeled with a use by date and covered. b) staff restrained hair c) resident food storage areas were maintained in a clean and sanitary manner and food was appropriately labeled and dated with a use by date to prevent the potential for food borne illness. This deficient practice occurred in the main kitchen and 2 of 2 remote resident food pantries. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by this deficient practice. " All residents were monitored for any adverse effects of the deficient practice	

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F 812	Continued From page 75 opened potentially hazardous food items that were not labeled with a used by date and expired dairy products. This included half a case of bacon stored in a box that was uncovered, exposed to air and was not labeled with a use by date, ham that was opened and exposed to the environment, located on a tray without use by date, and a bag of shredded cabbage that was in a box opened and was not labeled with a use by date. The FSM stated that the items in the refrigerator must be covered, labeled, and dated with use by dates. The walk-in refrigerator also included various items of expired dairy products, these items included half a crate of 8 oz of whole milk, 3/4 of a crate of 8oz 2 % milk and half a crate of 32oz of half and half. The expiration dates for these items varied from November 15th, 18th, 19th, and 20th. The milk crates were disorganized, and items were not rotated according to the dates of expiration. The FSM confirmed he was responsible to ensure the items were appropriately rotated and that expired items needed to be removed. 2) On 12/01/23 at 10:24 AM, the surveyor observed a Food Service Worker (FSW) in the kitchen washing and stacking dishes without wearing a hair restraint. When the FSW acknowledge the surveyor she proceeded to the doorway by the exit and obtained a hair net. The surveyor interviewed the FSW and stated that she had been educated on wearing a hair net and wearing proper Personal Protective Equipment (PPE) in the kitchen. The FSW also stated the propose of wearing a hair net is that hair did not get into the food. During this time the FSM was also present. The FSM stated the FSW had an emergency phone call and left the kitchen and upon return forgot to wear a hairnet. The FSM	F 812	with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " All dietary staff were re-educated on facility policy and procedure related to food labeling and dating. " All Nursing Unit Managers were re-educated on facility policy related to Food brought in by family members and the discarding of brought-in food 72-hours after being opened. " All dietary staff were re-educated on dietary staff attire policy related to hair and beard nets. " Half a case of bacon, ham, and the bag of shredded lettuce, located in the walk-in refrigerator, were immediately discarded. " The half a crate of 8 oz whole milk, ¿ of a case of 8 oz 2% milk, and the half a case of 32 oz of half and half immediately discarded. " The staff member washing dishes without a hairnet was immediately re-educated on facility policy and procedure related to hair nets. " The ice scoop holder mounted on the ice machine on [redacted] wing was cleaned immediately and corrected to ensure wet nesting would not occur on scoop or in holder. " The package of deli meat in the pantry refrigerator, the 6-count of bagels were discarded immediately. " The floor in the [redacted] wing pantry was immediately cleaned. " The ice scoop holder mounted on the ice machine on [redacted] wing was cleaned	

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F 812	Continued From page 76 acknowledged that it was not an excuse, and it is the policy and procedure to wear hairnets in the kitchen. 3) On 12/05/23 at 8:30 AM, the surveyor observed the food pantry on [redacted] wing with the Registered Nurse Unit Manager (RNUM). The ice scoop holder mounted to the ice machine was noted to have brown murky fluid with particles at the bottom of the scoop holder and the bottom edge of the scoop was in direct contact with the brown murky fluid. The surveyor interviewed the RNUM and she acknowledged the brown water nesting at the bottom of the ice scoop holder and without a means to drain. The resident refrigerator contained packaged lunch meat that was gray and appeared to have mold like cover on it and was dated 11/09/23, a 6 count of bagels that were unopened that contained mold like discolorations and a wrapped sandwich that was undated. The resident refrigerator had signage that was posted on the outside of the refrigerator that stated "WHEN PLACING ITEMS IN THE REFRIGERATOR ALL ITMES MUST HAVE: NAME & DATE MAX. HOLD DATE-2 DAYS. EVERY FRIDAY REFRIGERATOR WILL BE CLEANED OUT REMOVE YOUR STUFF!!". On 12/05/23 at 8: 40 AM, the surveyor observed the food pantry on [redacted] wing with the RNUM. The floors on [redacted] wing pantry were noted to be visibly soiled, the ice scoop holder was visibly soiled with dust and fluid was nesting at the bottom of the ice scoop holder with no means to drain. Upon opening of the refrigerator, a visibly soiled red sticky content on the inner top shelf was observed, there were numerous items undated and expired, which included a container with ham, beans and macaroni and cheese undated,	F 812	immediately and corrected to ensure wet nesting would not occur on scoop or in holder. " Refrigerators containing items requiring proper labeling, dating and Use-by Dates were immediately discarded. " All ice scoops checked to ensure they were mounted properly, proper drainage and no wet nesting of scoops and all refrigerators/freezers were inspected for cleanliness. " The red sticky spill located in the pantry refrigerator cleaned immediately. " Undated containers of ham, beans, macaroni & cheese, chocolate cake, apple pie, rice and thawed strawberries discarded immediately. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee will conduct compliance audits of all kitchen and pantry refrigerators for cleanliness, unlabeled and expired foods, and ice scoop holders. " The duration of all audits will consist of completion one-time weekly x4 and then two-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	

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	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

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F 812	Continued From page 77 chocolate cake with sell by date of 11/28/23, apple pie with sell by date of 11/24/23, container of rice undated, and completely thawed frozen strawberries undated. The RNUM stated the purpose of dating food is because it could have bacteria. The RNUM also acknowledged the water nesting in the ice scoop holder and said stagnant water can cause bacteria. On 12/05/23 at 9:15 AM, the surveyor interviewed the Director of Nursing (DON) with the concerns of the panties of Ex Order 26. 4B1 wing. The DON stated nursing department and housekeeping is to monitor the pantry, and expired items are to be removed daily. The DON stated the ice scoops should be cleaned and should have a means to drain and should not be sitting in stagnant water for infection control purposes. A review of the Food Brought by Family/Visitors Policy updated on 10/2019 number 7.) food brought by family/visitors that is left with the resident to consume later will labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. Part B) perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "us by" date. 8.) the nursing staff will discard perishable foods on or before the "use by" date. 9.) The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). A review of the Staff Attire policy updated on 9/2017 number 1.) All staff members will have their hair off the shoulders, confined in hair net or cap, and facial hair restrained.	F 812		

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F 812	Continued From page 78 A review of the Pantry Policy updated on 01/2023 states the facility will ensure Resident Pantries will always be maintained in a sanitary and organized condition. The Policy Explanation and Compliance Guidelines states expired food or food that has been in the refrigerator or freezer for greater than (>) 72 hours will be discarded. Ice Machine is clean and there is no standing water in the bottom of the Ice Scoop holder.	F 812		
F 865 SS=E	NJAC 8:39-17.2 (g) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		1/26/24

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F 865	Continued From page 79 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation	F 865		

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F 865	Continued From page 80 of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		

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F 865	Continued From page 81 Based on observation, interview and document review, it was determined that the quality assessment and assurance committee (QAPI) facility failed to ensure that the facility self-identified areas for improvement including environmental concerns, resident care related concerns and significant incidents. This deficient practice had the potential to affect all residents that resided in the facility and was evidenced by the following: Refer to F584E, F585D, F677E, F686, F689G, F924E On 11/28/23, during the initial tour of the facility, multiple surveyors observed the following: -9:40 AM: the [redacted] Unit had a strong odor of [redacted] throughout the Unit. -11:35 AM, two surveyors observed the condition of room on the [redacted] Unit which included: [redacted]- room and bathroom floor visibly soiled. [redacted]- the air conditioner unit and door appeared to be torn apart, the privacy curtain was stained and there was debris on the floor. On 11/28/23 at 12:40 PM, a surveyor interviewed two residents in their room on the [redacted] Unit *Ex Order 26. 4B1*. Lunch was delivered to the Room. The surveyor observed both Unsampled residents sitting in bed were eating lunch. One Unsampled Resident stated, "they haven't cleaned our room yet" and the other Unsampled Resident stated, "she just came in an emptied our trash." Both Unsampled Residents stated they could not remember when their room and bathroom was cleaned last and stated, they empty the trash but do not clean. At that time, the surveyor observed some small pieces of paper	F 865	Residents affected by deficient practice: The facility failed to ensure that the facility self-identified areas for improvement including environmental concerns, resident care related concerns and significant incidents. This deficient practice had the potential to affect all residents that resided in the facility and was evidenced by the following: Identify those individuals who could be affected by the deficient practice. o Resident #159 was discharged in [redacted]. o Resident # 76 had nails trimmed and filed smoothly immediately; no ill effects noted. o Resident #s 20, 101, 106, 116 *Ex Order 26. 4B1* immediately provided; no ill effects noted. o All affected residents' care plans reviewed updated. o The affected resident received a nutrition assessment with emphasis on nutritional status. Resident #159 was discharged. o Resident #20 received a comprehensive assessment by *Ex Order 26. 4B1* on 11/30/2023 and treatment an intervention ordered and implemented. Resident #159 was discharged. o Resident #20 provided *Ex Order 26. 4B1* [redacted] immediately resident #159 was discharged. o The affected resident's (Resident #116) care plan was reviewed and updated. o Resident #116's care plan was	

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F 865	Continued From page 82 on the floor. On 11/29/23 at 11:52 AM, a surveyor toured the [redacted] Unit and outside room [redacted] observed a handrail was falling off the wall. The handrail across from nurses' station by bathroom had broken end cap, and the handrail by door of unit day room was not secure. On 11/29/23 at 12:38 PM, a surveyor observed Resident #116 in the day room rummaging through books, pacing in the wheelchair and was unsupervised. A subsequent medical record review for Resident #116 revealed that on 06/14/23 the resident was observed in the [redacted] floor lounge and was pulling on the change machine located between two vending machines. The change machine tipped over and [redacted] which resulted in a [redacted], and a [redacted]. Resident #116 also sustained multiple [redacted], including a [redacted] with a [redacted] On 11/30/23 at 9:13 AM, a surveyor interviewed the Housekeeper Director (HD) about the cleaning process. The HD stated he had two weeks cleaning schedule. The surveyor asked the HD if he confirmed that the cleaning was being completed and he stated, "not often". The HD stated, "I do not have enough staff to clean, and I discussed it with the district manager." On 12/5/23 at 8:30 AM, a surveyor along with the Unit Manager for [redacted] Wing toured the unit pantry. Various food items that were stored in the refrigerator were either expired or not labeled with a use by date, including gray and a mold-like coated package of deli type meat. The ice scoop was nested in a holder with brown colored water	F 865	reviewed and adjusted to ensure all interventions were in place and continued to be appropriate for current level of function; to include close monitoring when noted in the day room. o The handrail outside of Room [redacted] was re-secured firmly to the wall by Maintenance staff. o The handrail across from the [redacted] Unit nurses station broken end cap was replaced with a new end cap. o The handrail by the entrance to the [redacted] Unit Day Room was re-secured firmly to the wall, handrails outside of rooms [redacted] were all re-secured firmly to the wall by the Maintenance staff. o The handrail leading to the door of [redacted] and [redacted] Units was firmly re-secured to the wall. " All residents have the potential to be affected by this deficient practice. " All residents monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " Administrator and Director of Nursing re-educated on facility QAPI policy, procedure, and practice by corporate Vice President of Clinical Services. " Management Team, and remaining staff re-educated on facility QAPI policy, procedure, and practice by Administrator and Director of Nursing. Measures or systemic changes to ensure	

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F 865	Continued From page 83 on the bottom. On 12/05/23 at 8:40 AM, a surveyor toured the [redacted] Wing unit pantry with the Unit Manager Registered Nurse. Floors were observed as visibly soiled, the ice scoop was nesting in water, many undated items that included, but was not limited to; an undated container of ham, beans and macaroni and cheese in the refrigerator. The UM stated the Housekeeping Department was responsible for cleaning the refrigerator and removing items. On 12/12/23 at 9:48 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, about the facility Quality Assurance and Performance Improvement (QAPI) process. The LNHA stated he was the LNHA of record from Ex.Order 26.4(b)(1) [redacted], as he was transferring to another facility. The LNHA stated the facility completed monthly QAPI meetings, and the quarterly QAPI meetings were the meeting that included the Medical Director (MD). 11/30/23 at 9:13 AM, a surveyor interviewed the Housekeeper Director (HD) about the cleaning process. The HD stated he two weeks cleaning schedule. The surveyor asked the HD if he confirmed that the cleaning was being completed and he stated, "not often". The HD stated, "I do not have enough staff to clean, and I discussed it with the district manager." On 12/12/23 at 9:48 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, about the facility Quality Assurance and	F 865	that the deficiencies will not recur: " Administrator/designee to conduct compliance audits related to tracking and measuring performance of environmental concerns, resident care related concerns and significant incidents; systematically analyzing underlying causes of system quality deficiencies and establishing goals and thresholds to be monitored ongoing or until compliance is met. " The duration of all audits will consist of monitoring all QAPIs, one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	

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F 865	Continued From page 84	F 865		

Performance Improvement (QAPI) process. The LNHA stated he was the LNHA of record from Ex.Order 26.4(b)(1) [redacted], as he was transferring to another facility. The LNHA stated the facility completed monthly QAPI meetings, and the quarterly QAPI meetings were the meeting that included the Medical Director (MD).

On 12/12/23 at 9:54 AM, the surveyor asked the LNHA what the QAPI process was. The LNHA stated, it was a way to see how all departments were doing as a building and it was an improvement plan to look at what needed to be focused on.

The LNHA stated the quarterly QAPI was a synopsis of what was being reviewed and the MD, along with others were present at that meeting. The LNHA confirmed that he was the facility QAPI Coordinator and he, along with the Director of Nursing was involved with QAPI and was ultimately responsible for the QAPI process.

12/12/23 at 9:56 AM, the surveyor requested the LNHA to list all the current QAPI plans that were in effect prior to the surveyors entering the building. The LNHA stated he did not have any minutes from the July to September 2023 QAPI meetings. The surveyor asked what the policy was for QAPI. The LNHA stated to identify a problem, identify the root cause, who was involved, set up a team, implement interventions and monitor outcomes. The LNHA stated the goal was always "100%"

On 12/12/23 at 9:58 AM, the LNHA stated the facility's current QAPI's included:

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F 865	Continued From page 85 1. The appropriate destruction of narcotics. 2. Antibiotic stewardship- proper use of antibiotics 3. Activity- Smoking appropriately, activity staff, working with nursing on having residents out of bed. 4. The Material Data Set form, section GG with the certified nursing assistants. 5. Therapy- adaptive equipment and splints appropriately. 6. Human Resources-staff retention and recruitment. 7. Central supply- housekeeping and personal protective equipment carts. 8. Maintenance-a lot of peeling bed boards and foot boards. 9. Dietitian-weight loss. 10. Food service- Residents are complaining that food is not hot enough and started 10/01/23 by the new food service director. It is between the kitchen and nursing and was related to a new insulated tray system that was now working and was specific for the temperatures in the kitchen only and to ensure the heating system for the trays was working. 11. Housekeeping- cleaning rooms. The LNHA stated "rooms I felt, are not clean the room", and stated the staffing is part of the challenges for housekeeping and maintenance, and other areas. 12. Admissions- involved with housekeeping for new admissions and all items in room. On 12/12/23 at 10:19 AM, the LNHA confirmed the facility did not have any QAPIs on abuse and also there were no QAPI's on significant events. On 12/12/23 at 10:26 AM, the surveyor asked the LNHA if there were any QAPI's in place related to the findings identified by the survey team, which included loose handrails. The LHNA stated,	F 865		

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F 865	Continued From page 86	F 865		

"maybe an earlier month" and confirmed that the status of the handrails was currently not part of the QAPI.

On 12/12/23 at 10:31 AM, the surveyor asked the LNHA about the unsecured cash machine that fell on a resident in June, 2023. The surveyor asked if that incident was reviewed in the QAPI. The LNHA stated, "I think it was just installed and wasn't secured, the vendor put it in and Maintenance found out after". The surveyor asked if that would be considered a significant event and the LNHA responded, "I would say it was significant, and maybe it should have been a QAPI" and stated that Maintenance went around the facility to ensure things were secured, and "I don't think Maintenance documented that they went around to ensure things were secured, I would have to ask". The surveyor asked the LNHA stated that "Maintenance can QAPI about forty things in this building", however did not provide a rationale for why the identified concerns were not part of the QAPI.

On 12/12/23 at 10:42 AM, another surveyor asked the LNHA about what about a QAPI for cleanliness or resident rooms. The LNHA stated, there are a lot of things to be done in the rooms and stated he will speak with maintenance, "it is endless what needs to get done". The LNHA confirmed that he was aware of the staffing deficit for the Housekeeping Department and when asked if the decrease in staffing was part of the QAPI, the LNHA stated the staffing concerns with the Housekeeping Department were not included in the QAPI process.

A review of the following policies revealed:

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F 865	Continued From page 87 Quality Assurance and Performance Improvement (QAPI) Program policy reviewed 5/2023 revealed: This facility shall develop, implement, and maintain and ongoing, facility-wide, data driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life., 2. Profice a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Implementation: 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance; b. Establishing goals and thresholds for performance measurements; c. Identifying and prioritizing quality deficiencies, d. Systematically analyzing underlying causes of systemic quality deficiencies, e. Developing and implementing corrective action or performance improvement activities, f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities. The Quality Assurance Performance Improvement (QAPI) Program Plan, Reviewed 5/2023 revealed: Purpose ... Focus areas include all systems, processes and outcomes that affect resident and family satisfaction, the quality of care and services provided, and the quality of life for persons living and working in our organization, as well as visitors to our facility. Scope ... The principles of QAPI are taught to all staff, volunteers ... Governance & Leadership ... Administration fosters a culture of quality within the facility, so staff embrace the principles of	F 865		

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	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

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F 865	Continued From page 88 QAPI and are comfortable identifying quality problems or areas for improvement. Engagement of staff, residents, families and visitors is a hallmark of the QAPI program. PIP (performance improvement projects) Identification ... The QAPI team monitors and analyzes data, and reviews feedback and input from residents, staff, families, volunteers, providers, and stakeholders to identify areas to improve the quality of life and quality of care and services ... The Quality Assurance and Performance Improvement (QAPI) Program - Feedback, Data and Monitoring Updated 5/2023 revealed the QAPI programs is based on the collection of information obtained from data, self-assessment and systems of feedback ... 1. Information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI committee in order to identify problems that are high risk, high volume or problem prone and to guide decisions regarding opportunities for improvement ... 2. The QAPI process focuses on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice or resident autonomy, and on making a good faith effort to correct or mitigate these outcomes. NJAC 8:39- 33.2 (a)(b)(c)12;13(d); 33.3, 34.1(a)(c)(d)	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		1/26/24

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F 867	Continued From page 89	F 867		

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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F 867	Continued From page 90 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance	F 867		

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F 867	Continued From page 91 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the quality assessment and assurance committee (QAPI) facility failed to ensure: a) written policies and procedures were followed to ensure all adverse events were identified and investigated, b) written procedures were followed to ensure the QAPI was consistently data driven and measurable to	F 867	Residents affected by deficient practice: The facility failed to ensure that the facility self-identified areas for improvement including environmental concerns, resident care related concerns and significant incidents. This deficient practice had the potential to affect all residents that resided in the facility and	

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F 867	Continued From page 92 ensure the effectiveness of the performance improvement initiative, and c) a mechanism was in place and consistently followed to obtain input from staff, residents/ resident representatives. The deficient practice had the potential to affect all residents that resided in the facility and was evidenced by the following: Refer to F584E, F585D, F677E, F686E, F689G, F924E On 11/28/23, during the initial tour of the facility, multiple surveyors observed the following: -9:40 AM: the [redacted] Unit had a strong odor of [redacted] throughout the Unit. -11:35 AM, two surveyors observed the condition of room on the [redacted] Unit which included: [redacted]- room and bathroom floor visibly soiled. [redacted]- the air conditioner unit and door appeared to be torn apart, the privacy curtain was stained and there was debris on the floor. On 11/28/23 at 12:40 PM, a surveyor interviewed two residents in their room on the [redacted] Unit ([redacted]). Lunch was delivered to Room [redacted]. Observed both Unsampled residents sitting in bed were eating lunch. One Unsampled Resident stated, "they haven't cleaned our room yet" and the other Unsampled Resident stated, "she just came in an emptied our trash." Both Unsampled Residents stated they could not remember when their room and bathroom was cleaned last and stated, they empty the trash but do not clean. At that time, the surveyor observed some small pieces of paper on the floor. On 11/29/23 at 11:52 AM, a surveyor toured the [redacted] Unit and outside room [redacted] observed a handrail was falling off the wall. The handrail across from	F 867	was evidenced by the following: Identify those individuals who could be affected by the deficient practice: • All residents have the potential to be affected by this deficient practice. • All residents monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: • Administrator and Director of Nursing re-educated on facility QAPI/QAA policy, procedure, and practice by corporate Vice President of Clinical Services. • Management Team, and remaining staff re-educated on facility QAPI/QAA policy, procedure, and practice by Administrator and Director of Nursing. • Administrator to ensure the QAPI program, per facility QAPI/QAA policy, tracks and measures the performance of environmental concerns, resident care related concerns and significant incidents and systematically analyze underlying causes of all self-identified areas of improvement of system quality deficiencies and establish goals and thresholds to be monitored by the QAPI/QAA Committee. Measures or systemic changes to ensure that the deficiencies will not recur: • Administrator/designee to conduct compliance audits related to tracking and measuring performance of environmental concerns, resident care related concerns and significant incidents; systematically analyzing underlying causes of system quality deficiencies and establishing goals	

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F 867	Continued From page 93 nurses' station by bathroom had broken end cap, and the handrail by door of unit day room was not secure. On 11/29/23 at 12:38 PM, a surveyor observed Resident #116 in the day room rummaging through books, pacing in the wheelchair and was unsupervised. A subsequent medical record review for Resident #116 revealed that on 06/14/23 the resident was observed in the Ex.Order floor lounge and was pulling on the change machine located between two vending machines. The change machine tipped over and Ex.Order 26.4(b) [redacted] which resulted in a Ex Order 26. 4B1, Ex.Order 26 e, and a Ex Order 26. 4B1. Resident #116 also sustained multiple Ex.Order 2, including a Ex.Orde with a Ex.Order 26.4(b)(1) 11/30/23 at 9:13 AM, a surveyor interviewed the Housekeeper Director (HD) about the cleaning process. The HD stated he had two weeks cleaning schedule. The surveyor asked the HD if he confirmed that the cleaning was being completed and he stated, "not often". The HD stated, "I do not have enough staff to clean, and I discussed it with the district manager." On 12/12/23 at 9:48 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, about the facility Quality Assurance and Performance Improvement (QAPI) process. The LNHA stated he was the LNHA of record from September 2022 through December 13, 2023, as he was transferring to another facility. The LNHA stated the facility completed monthly QAPI meetings, and the quarterly QAPI meetings were the meeting that included the Medical Director (MD).	F 867	and thresholds of all self-identified areas of improvement to be monitored ongoing or until compliance is met. • The duration of all audits will consist of monitoring all QAPIs/QAAs, one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	

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F 867	Continued From page 94 On 12/12/23 at 9:54 AM, the surveyor asked the LNHA what the QAPI process was. The LNHA stated, it was a way to see how all departments were doing as a building and it was an improvement plan to look at what needed to be focused on. The LNHA stated the quarterly QAPI was a synopsis of what was being reviewed and the MD, along with others were present at that meeting. The LNHA confirmed that he was the facility QAPI Coordinator and he, along with the Director of Nursing was involved with QAPI and was ultimately responsible for the QAPI process. 12/12/23 at 9:56 AM, the surveyor requested the LNHA to list all the current QAPI plans that were in effect prior to the surveyors entering the building. The LNHA stated he did not have any minutes from the July to September 2023 QAPI meetings. The surveyor asked what the policy was for QAPI. The LNHA stated to identify a problem, identify the root cause, who was involved, set up a team, implement interventions and monitor outcomes. The LNHA stated the goal was always "100%" On 12/12/23 at 9:58 AM, the LNHA stated the facility's current QAPI's included: 1. The appropriate destruction of narcotics. 2. Antibiotic stewardship- proper use of antibiotics 3. Activity- Smoking appropriately, activity staff, working with nursing on having residents out of bed. 4. The Material Data Set form, section GG with the certified nursing assistants. 5. Therapy- adaptive equipment and splints	F 867		

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appropriately.
6. Human Resources-staff retention and recruitment.
7. Central supply- housekeeping and personal protective equipment carts.
8. Maintenance-a lot of peeling bed boards and foot boards.
9. Dietitian-weight loss.
10. Food service- Residents are complaining that food is not hot enough and started 10/01/23 by the new food service director. It is between the kitchen and nursing and was related to a new insulated tray system that was now working and was specific for the temperatures in the kitchen only and to ensure the heating system for the trays was working.
11. Housekeeping- cleaning rooms. The LNHA stated "rooms I felt, are not clean the room", and stated the staffing is part of the challenges for housekeeping and maintenance, and other areas.
12. Admissions- involved with housekeeping for new admissions and all items in room.

On 12/12/23 at 10:12 AM, the surveyor asked what the mechanism was to identify areas for improvement to bring to the QAPI. The LNHA stated he would get information from the daily morning meeting which included department heads. The surveyor asked if resident families would provide a source of areas to be reviewed in the A from qapi- re: QAPI. The LNHA stated, "no", that if a family had a concern, it would be the grievance process. The surveyor asked if the grievances are incorporated into the QAPI process and the LNHA stated, "if there is a grievance that stands out", or keeps reappearing, "we may QAPI it". The LNHA stated, "I am not going to say a specific rule to see that they are part of the QAPI, I typically review every single

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grievance and sign off. The surveyor asked if there were any QAPI's related to abuse or falls and he stated, "no". The surveyor asked how the QAPI monitors significant events. The LNHA stated nursing would be responsible for that. The surveyor asked the LNHA if he could recall the last time a significant event occurred and he stated, it has been discussed but he was not sure when. The surveyor asked the LNHA if any front-line staff, like Certified Nursing Aides (CNA) or housekeeping, attended the QAPI, or were a part of the process. The LNHA stated "no" the front-line staff, per the policy, were not included in the QAPI. The LNHA stated each department was to themselves and may provide education of the staff and that would be completed with the department managers. The surveyor then referenced the facility QAPI policy regarding "Staff members are chosen from staff with direct care and/or service responsibilities, (i.e. other leadership members, nursing assistants, nurse, housekeeping aides, maintenance workers, and dietary aides) to participate in performance improvement projects (PIPs) ... The surveyor asked the LNHA if there was a mechanism to report any concerns to the QAPI. The LNHA stated he has an open-door policy and if the staff wanted to be confidential, they could go to Human Resources. The LNHA confirmed he did not have a process to solicit input for the QAPI from all staff.

The surveyor asked how the QAPI would monitor improvement. The LNHA stated the next month we would bring up the topic and hopefully see an improvement. The surveyor asked the LNHA if the QAPI process was measurable to determine if improvement occurred. The LNHA stated "some of it is data driven".

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F 867	Continued From page 97 On 12/12/23 at 10:54 AM, the surveyor interviewed the Corporate Nurse (CN) regarding the goals for the QAPI. The CN stated the goal should be specific and measurable and it was part of the QAPI process. On 12/12/23 at 10:56 AM, a surveyor interviewed a CNA #1 who was working on the [redacted] Wing and stated she has been employed since [redacted]. CAN #1 stated staffing was the biggest issue and she would go to her Union Representative. The surveyor asked CNA #1 about QAPI and she stated, "I don't know what QAPI is." On 12/12/23 at 11:09 AM, a surveyor interviewed CNA #2 who stated she has worked at the facility for [redacted] years. The surveyor asked about QAPI and she stated, "I don't know anything about that." CNA #2 stated staffing was an issue and there were issues with equipment and things get fixed and break again. On 12/12/25 at 11:25 AM, the DON provided the surveyor with a copy of three active QAPI plans which revealed: Problem Statement: Side rail assessments are not initiated quarterly/annually, Goal: All residents side rails assessments much be initiated quarterly/annually, Started 09/24/23. The Metric(s) section of the form was blank; Problem Statement: The injudicious use of antibiotics, Goal: To encourage judicious use of antibiotics, Started 07/21/22, The Metric(s) section of the form was blank; Problem Statement: Antibiotic Stewardship, Goal: To manage the use of and prevent the misuse of antibiotics, The Metric(s) section of the form was	F 867		

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F 867	Continued From page 98 blank. A review of the QAPI Meeting Minutes dated 07/10/23 revealed that the DON reported 5 reports of resident to resident abuse and 1 report of drug diversion. There were no documented QAPI plans related to abuse or drug diversion. A review of the following policies revealed: Quality Assurance and Performance Improvement (QAPI) Program policy reviewed 5/2023 revealed: This facility shall develop, implement, and maintain and ongoing, facility-wide, data driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life., 2. Profice a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Implementation: 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance; b. Establishing goals and thresholds for performance measurements; c. Identifying and prioritizing quality deficiencies, d. Systematically analyzing underlying causes of systemic quality deficiencies, e. Developing and implementing corrective action or performance improvement activities, f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities. The Quality Assurance Performance Improvement (QAPI) Program Plan, Reviewed	F 867		

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F 867	Continued From page 99 5/2023 revealed: Purpose ... Focus areas include all systems, processes and outcomes that affect resident and family satisfaction, the quality of care and services provided, and the quality of life for persons living and working in our organization, as well as visitors to our facility. Scope ... The principles of QAPI are taught to all staff, volunteers ... Governance & Leadership ... Administration fosters a culture of quality within the facility, so staff embrace the principles of QAPI and are comfortable identifying quality problems or areas for improvement. Engagement of staff, residents, families and visitors is a hallmark of the QAPI program. PIP (performance improvement projects) Identification ... The QAPI team monitors and analyzes data, and reviews feedback and input from residents, staff, families, volunteers, providers, and stakeholders to identify areas to improve the quality of life and quality of care and services ... The Quality Assurance and Performance Improvement (QAPI) Program - Feedback, Data and Monitoring Updated 5/2023 revealed the QAPI programs is based on the collection of information obtained from data, self-assessment and systems of feedback ... 1. Information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI committee in order to identify problems that are high risk, high volume or problem prone and to guide decisions regarding opportunities for improvement ... 2. The QAPI process focuses on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice or resident autonomy, and on making a good faith effort to correct or	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD BURLINGTON, NJ 08016**

(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 867	Continued From page 100 mitigate these outcomes. NJAC 8:39- 33.2 (a)(b)(c)12;13(d); 33.3, 34.1(a)(c)(d)	F 867		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least	F 868		1/26/24

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F 868	Continued From page 101 one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have the Director of Nursing (DON) present for one of four Quality Assurance and Performance Improvement (QAPI) meeting as evidenced by the following: On 12/12/23 at 12:20 PM, the surveyor reviewed the quarterly QAPI sign-in sheets for the last four quarterly QAPI meetings. The second quarter sign in sheet, dated 04/03/23, was missing the attendance signature of the Director of Nursing (DON). At that time, the DON stated she may have taken that day off but handed in her report for the meeting. A review of the Facility Assessment, dated 09/01/23, revealed that the QAPI committee included the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing. Infection Control Preventionist, MDS (Minimum Data Set), dietary representatives, pharmacy, social service, activities, environmental services, rehab/restorative, human resources, safety and records. NJAC 8:39-23.1(3)	F 868	Residents affected by deficient practice: The facility failed to ensure that the facility self-identified areas for improvement including environmental concerns, resident care related concerns and significant incidents. This deficient practice had the potential to affect all residents that resided in the facility and was evidenced by the following: Identify those individuals who could be affected by the deficient practice. • All residents have the potential to be affected by this deficient practice. • All residents monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: • Administrator and Director of Nursing re-educated on facility QAA Committee policy, procedure, and practice by corporate Vice President of Clinical Services. • Management Team, and remaining staff re-educated on facility QAA Committee policy, procedure, and practice by Administrator and Director of Nursing. • Administrator will ensure the facility maintains Quality Assessment and Assurance Committee (QAA Committee) consisting, at a minimum, the Director of Nursing, Medical Director, or his/her	

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F 868	Continued From page 102	F 868	designee, three members of the facility's staff, at least one of who must be the Administrator, owner or board member or other individual in a leadership role; and the *Ex Order 26. 4B1* . Measures or systemic changes to ensure that the deficiencies will not recur: • Administrator/designee to conduct compliance audits related to ensuring, at a minimum, the Director of Nursing, Medical Director, or his/her designee, three members of the facility's staff, at least one of who must be the Administrator, owner or board member or other individual in a leadership role; and the *Ex Order 26. 4B1* will attend all QAA Committee meetings. • The duration of all audits will consist of monitoring all QAA Committee meetings, one-time per month x3 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by:	F 924		1/26/24

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F 924	Continued From page 103 Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure handrails were secure and intact on 2 of 3 resident units. This deficient practice was evidenced by the following: On 11/29/23 at 11:52 AM, Surveyor #4 was on [redacted] unit and observed that outside of room [redacted], the handrail was not securely fastened to the wall and was slanting down on the left side. Surveyor #4 was able to physically move the handrail up and down. Surveyor #4 observed another handrail across from the [redacted] unit nurses station by the bathroom which had a broken jagged end cap. Surveyor #4 observed a handrail by the entrance door of the [redacted] unit day room which was visibly not secured to the wall. On 11/29/23 at 11:55 AM, the Registered Nurse Unit Manager (RN UM) on [redacted] wing was shown the handrails. The RN UM stated that handrails were for the safety of someone who ambulates. She stated when handrails were broken or loose, it would be "very unsafe". On 12/05/23 at 8:30 AM, Surveyor #1 observed the [redacted] unit. The handrails outside of rooms [redacted], were observed to be pulling away from the wall and not securely fastened. On 12/05/23 at 9:15 AM, Surveyor #4 observed the handrail leading to the door of the [redacted] unit and [redacted] unit shared activity room. The handrail was closer to the [redacted] unit side and was observed to be pulling away from the wall and not secure. On 12/05/23 at 9:15 AM, the Director of Nursing (DON) stated that the handrails should be secured for "resident safety" and that	F 924	Residents affected by deficient practice. The facility failed to ensure handrails were secure and intact on 2 of 3 resident units. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by this deficient practice. " All residents monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " All handrails were checked, and repaired as necessary, to ensure they were firmly secured to walls, not cracked, or had jagged endcaps. " The handrail outside of Room [redacted] was re-secured firmly to the wall by Maintenance staff. " The handrail across from the [redacted] Unit nurses station broken end cap was replaced with a new end cap. " The handrail by the entrance to the [redacted] Unit [redacted] Room was re-secured firmly to the wall, handrails outside of rooms [redacted] were all re-secured firmly to the wall by the Maintenance staff. " The handrail leading to the door of [redacted] and [redacted] Units was firmly re-secured to the wall. " The Administrator/designee re-educated the Maintenance staff on facility handrail policy to ensure all handrails are affixed firmly to walls and contain no non-smooth surfaces to ensure resident safety. Measures or systemic changes to ensure that the deficiencies will not recur:	

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	315050	A. BUILDING _____ B. WING _____	C 12/13/2023

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COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD BURLINGTON, NJ 08016**

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F 924	Continued From page 104 maintenance should check them. On 12/05/23 at 9:43 AM, the Maintenance Director (MD) in the presence of the survey team, stated that there was a computer program for handrail audits. The MD pulled out his work phone and showed the survey team the work orders the staff used to report concerns to the MD. The MD stated it would be everyone's responsibility to check and report if handrails were not secure. The MD further stated it was important for the handrails to be secure because residents "hold on to them" and that someone could be injured if the handrails were not secured. He stated a resident "could fall and break something". The MD was unable to provide any handrail audits to the survey team. On 12/05/23 at 10:56 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated the handrails may be loose but they "can hold 200 pounds". The LNHA further stated it was not acceptable for the handrails to be loose or broken. A review of the facility provided, "Handrail Policy", updated 2/2023, included but was not limited to the following; Policy Explanation and Compliance Guidelines 1. All handrails will be firmly secured. 2. Secured handrails means handrails that are firmly affixed to the wall. 3. Routine maintenance on handrails will be completed by the maintenance department. The facility failed to follow their policy. This concern was presented to the facility administration on 12/12/23. The facility had no additional documentation to provide the surveyors.	F 924	" The Administrator/designee to conduct compliance audits to ensure handrails are firmly secured to walls and contain no non-smooth surfaces. " The duration of all audits will consist of one-of-three Unit□s handrails checked to ensure they are firmly secured to walls and contain no non-smooth surfaces one-time weekly x4 weeks and then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	

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F 924	Continued From page 105 NJAC 8:39-31.2(e)	F 924		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060301	A. BUILDING: _____ B. WING _____	C 12/13/2023

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COMPLETE CARE AT BURLINGTON WOODS, I	115 SUNSET ROAD BURLINGTON, NJ 08016

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #s NJ 149879, NJ 1622113 Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey that from (a) from 11/07/21 to 11/20/21, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts (b) from 01/02/2022 to 01/15/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts and (c) from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S 560	Residents affected by deficient practice: The facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by this deficient practice. " All residents were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. " The facility will take the following measures to ensure this deficient practice does not occur. The facility will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with	1/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/01/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing as follows: 1. For the 2 weeks of Complaint staffing from 11/07/2021 to 11/20/2021, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -11/07/21 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/10/21 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -11/13/21 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. -11/14/21 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. -11/15/21 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. -11/19/21 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs. -11/20/21 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs.	S 560	Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to conduct compliance audits on effectiveness of hiring strategies to include open CNA and Licensed Nurse positions, reporting on new hires, successful strategies-to-hire, and implementation of employee retention programs. " The duration of all audits will consist of completion one-time weekly x 4 weeks then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion 1/26/24	

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S 560	Continued From page 2 2. For the 2 weeks of Complaint staffing from 01/02/2022 to 01/15/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -01/02/22 had 14 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/02/22 had 14 total staff for 151 residents on the evening shift, required at least 15 total staff. -01/02/22 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -01/02/22 had 10 total staff for 151 residents on the overnight shift, required at least 11 total staff. -01/03/22 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. -01/04/22 had 13 CNAs for 150 residents on the day shift, required at least 19 CNAs. -01/05/22 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -01/06/22 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. -01/07/22 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. -01/08/22 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/08/22 had 9 total staff for 149 residents on the overnight shift, required at least 11 total staff. -01/09/22 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/10/22 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs. -01/11/22 had 12 CNAs for 147 residents on the day shift, required at least 18 CNAs. -01/12/22 had 16 CNAs for 146 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 day shift, required at least 18 CNAs. -01/13/22 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. -01/14/22 had 13 CNAs for 146 residents on the day shift, required at least 18 CNAs. -01/15/22 had 9 CNAs for 144 residents on the day shift, required at least 18 CNAs. 3. For the 2 weeks of staffing prior to survey from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -11/12/23 had 10 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/13/23 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/14/23 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/16/23 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/17/23 had 16 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/18/23 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/19/23 had 10 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/20/23 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/21/23 had 18 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/22/23 had 18 CNAs for 152 residents on the day shift, required at least 19 CNAs. -11/23/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs. -11/24/23 had 13 CNAs for 148 residents on the day shift, required at least 18 CNAs. On 12/12/23 at 12:12 PM, the surveyor	S 560		

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S 560	Continued From page 4 interviewed the staffing coordinator who stated shew as aware of the state mandatory staffing ratios for CNA's as 1:8 day shift, 1:10 evening shift and 1:14 nights .	S 560		

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
315050 Y1	A. Building B. Wing Y2	1/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	115 SUNSET ROAD BURLINGTON, NJ 08016

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0585	Correction	ID Prefix F0661	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0677	Correction	ID Prefix F0686	Correction	ID Prefix F0689	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/05/2024
ID Prefix F0691	Correction	ID Prefix F0725	Correction	ID Prefix F0804	Correction
Reg. # 483.25(f)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0812	Correction	ID Prefix F0865	Correction	ID Prefix F0867	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0868	Correction	ID Prefix F0924	Correction	ID Prefix	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.90(i)(3)	Completed	Reg. #	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/13/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315050 Y1	A. Building B. Wing Y2	1/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	115 SUNSET ROAD BURLINGTON, NJ 08016

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
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Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0677	Correction	ID Prefix F0686	Correction	ID Prefix F0691	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(f)	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	01/26/2024
ID Prefix F0725	Correction	ID Prefix F0804	Correction	ID Prefix	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. #	Completed
LSC	01/26/2024	LSC	01/26/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/13/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060301 Y1	A. Building B. Wing Y2	1/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	115 SUNSET ROAD BURLINGTON, NJ 08016

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/26/2024	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 12/13/2023	☐ 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
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD** **BURLINGTON, NJ 08016**

(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 12/12/2023. 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 12/12/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Burlington Woods LLC is a two-story building that was built in 1966. It is composed of Type II protected construction. The facility is divided into 14 - smoke zones. The generator does approximately 70 % of the building as per the Maintenance Director. The current occupied beds are 157 of 237.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6	K 311		1/26/24

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

Electronically Signed | 01/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD** **BURLINGTON, NJ 08016**

(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 311	Continued From page 1 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware; and failed to ensure labels on fire doors were legible in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 157 residents who resided at the facility. Findings include: Observation on 12/12/23 from 12:13 PM to 3:30 PM revealed four of eight stairway exit doors, located on the second floor were equipped with panic hardware which violated the listing of the rated fire door assemblies. Additionally, one out of eight fire doors' label was able to be read. The fire door was near room A31. During an interview at the time of observations, the Maintenance Director confirmed the stairway exit doors were equipped with panic hardware. The Maintenance Director also confirmed the label on the stairway door located near room A31 was not legible. NJAC 8:39-31.2(e)	K 311	Residents affected by deficient practice: The facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware; and failed to ensure labels on fire doors were legible in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. Identify those individuals who could be affected by the deficient practice: " This deficient practice had the potential to affect all residents who resided at the facility. " All residents were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " Maintenance Director to purchase and install fire-rated panic hardware in accordance NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. " The Maintenance Director replaced the illegible fire door label with a new exit-instruction legible label near room A31. " The Maintenance Director was re-educated by Corporate Regional Maintenance Director regarding ensuring appropriate door hardware systems are in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD** **BURLINGTON, NJ 08016**

(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 311	Continued From page 2	K 311	" The Maintenance Director was re-educated by Corporate Regional Maintenance Director regarding ensuring that all fire rated doors have legible exit-instruction labels affixed. Measures or systemic changes to ensure that the deficiencies will not recur: " The Administrator/Designee to conduct compliance audits on fire-rated door assemblies and labels on fire doors are legible in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. " Administrator/designee will audit 5 fire doors one-time per week x4 weeks and then two-times per month x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 911		1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD** **BURLINGTON, NJ 08016**

(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 911	Continued From page 3 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure low voltage wiring below seven feet above the finished floor was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Section 760.53 (A) (1). This deficient practice had the potential to affect all 157 residents. Findings include: Observation on 12/12/23 at 12/23 PM revealed low voltage wiring below seven feet above the finished floor going to the sprinkler flow switch and the sprinkler tamper switch was not in conduit in the sprinkler riser. During an interview at 3:55 PM on 12/12/23, the Maintenance Director confirmed that the low voltage wiring was not in conduit. NJAC 8:39-31.2(e)	K 911	K911 - Electrical Systems-other Residents affected by deficient practice: The facility failed to ensure low voltage wiring below seven feet above the finished floor was in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Section 760.53 (A) (1). Identify those individuals who could be affected by the deficient practice: " This deficient practice had the potential to affect all residents who resided at the facility. " All residents were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The Maintenance Director corrected deficient practice by ensuring low voltage wiring placed in a conduit. " The Maintenance Director was re-educated by Corporate Regional Maintenance Director regarding low voltage wiring and to ensure wiring remains in conduit. Measures or systemic changes to ensure that the deficiencies will not recur: " The Maintenance Director/Designee to conduct compliance audits on ensure facility low voltage wiring is safe and is in conduit per NFPA 70 National Electrical Code (2011 Edition) Section 760.53 (A) (1). " The Maintenance Director/designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD** **BURLINGTON, NJ 08016**

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K 911	Continued From page 4	K 911	will audit facility low voltage wiring one-time weekly x4 weeks and then one-time monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect all 157 residents.	K 912	K912- Electrical Systems Receptacles. Residents affected by deficient practice: The facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3	1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

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K 912	Continued From page 5 Findings include: Document review of the "Fire Safety Folder for 2023," provided by the Maintenance Director, revealed the electrical outlet testing was not completed on the electrical outlets. During an interview on 12/12/23 at 3:55 PM, the Maintenance Director confirmed that the electrical outlet testing was not completed on the electrical system. NJAC 8:39-31.1(d)	K 912	Identify those individuals who could be affected by the deficient practice: " This deficient practice had the potential to affect all residents who resided at the facility. " All residents were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The Maintenance Director and staff completed the Annual Electrical Outlet Inspection. " Maintenance Director re-educated by Regional Maintenance Director regarding facility electrical outlets and to ensure that facilities outlet inspections are done in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to conduct compliance audits on ensuring facility will review the required inspection paperwork related to electrical outlet inspections to ensure the facility is accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. " The Administrator/designee will audit electrical outlet inspections one-time weekly x4 weeks and then one-time monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. BUILDING **01** B. WING _____	**12/13/2023**

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COMPLETE CARE AT BURLINGTON WOODS, LLC	**115 SUNSET ROAD** **BURLINGTON, NJ 08016**

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K 912	Continued From page 6	K 912	be made regarding the need for continued submission and reporting. Date of Completion: 1/26/24	

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
315050 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BURLINGTON WOODS, LLC	115 SUNSET ROAD BURLINGTON, NJ 08016

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 01/26/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 01/26/2024	ID Prefix Reg. # NFPA 101 LSC K0912	Correction Completed 01/26/2024
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

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FOLLOWUP TO SURVEY COMPLETED ON	
12/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO