STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING ______ B. WING ______	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 000	INITIAL COMMENTS Standard Survey COMPLAINT #'S NJ00155140, NJ 00158266, NJ00159718, NJ00159855, NJ00161775 Census: 95 Sample Size: 19 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		5/31/23

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

Electronically Signed | | 05/15/2023

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

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F 582	Continued From page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview it was determined that the facility failed to issue the required beneficiary notices for residents discharged from Medicare Part A services with Medicare A time remaining, to include residents discharged to the community and those residents who remained in the facility. This deficient practice was evidenced by the following: During the entrance conference on 04/12/2023 at 09:42 AM, the surveyor requested a list of all	F 582	SPECIFIC RESIDENTS NOMNC and SNFABN letters can not be issued to any specific residents that should have received them previously as they have already timed out. IDENTIFICATION OF OTHER RESIDENTS A 100% review of all residents who are	

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F 582	Continued From page 2 residents who were discharged from Medicare Part A service with Medicare time remaining who were discharged to home or remained in the facility. During an interview with the surveyor on 04/13/2023 at 01:18 PM, the Vice President of Clinical Services (VPCS) said, "I don't think we give out Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) or the Notice of Medicare Non-coverage (NOMNC). In fact I know we don't" When asked if the Social Worker (SW) gave them out, the VPCS replied, "No, but he should be the one that gives them out." During an interview with the surveyor on 04/13/2023 at 01:30 PM, the SW told the surveyor I do assessments, discharge planning, order medical equipment for residents discharged home, handle insurance cut letters for Medicare A or managed Medicare. He further explained, "I think I have done 1-2 NOMNC since I have been here." The SW went on to say if Medicare part A is cut we are supposed to give the letter 48 hours ahead for the last day of Medicare and either the resident goes home the next day or transitions to long term care. The SW further explained that most residents are managed Medicaid. I give the NOMNC if needed I do it. When asked what about a SNFABN the SW replied "I never heard of that." The SW said he was a hospital SW for past 8 years and had never heard of the SNFABN. During an interview with the surveyor on 04/14/2023 at 10:57 AM, the Licensed Nursing Home Administrator (LNHA) said he (the SW) hasn't been giving cut letters to residents so I	F 582	entitled to receive NOMNC and SNFABN letters as of 5/1/23 will be conducted. Any resident who should have received a letter but didn't will be provided with one. SYSTEMIC CHANGE The Director of Social Services has been inserviced on the importance of issuing both NOMNC and SNFABN letters as required by regulation and facility policy. The Director of Social Services will write up all NOMNC and SNFABN letters at the facility's weekly UR meeting upon being notified of a resident's last covered day under Medicare. The Administrator will receive a copy at that time and the Director of Social Services will issue the letter to the resident after the meeting with a copy signed by the resident also being provided to the Administrator. MONITORING The Dir of Social Services will submit a weekly report to the facility's weekly QAPI Committee.	

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F 582	Continued From page 3 have nothing to give you when asked for a list of all residents who were discharged from Medicare Part A service with Medicare A time remaining that discharged to home or remained in the facility. The facility was unable to provide a list of residents who were discharged to home or remained in the facility with Medicare A time remaining from October 2022 up to April 14, 2023.	F 582		
F 584 SS=E	NJAC 8:39-4.1(a)(8) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		6/9/23

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F 584	Continued From page 4 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: Based on observation, interview, and other facility documentation, it was determined that the facility failed to maintain housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. The deficient practice was observed on 2 of 2 units (East Wing and West Wing). The deficient practice was evident by the following: On 4/12/2023 at 9:45 AM during the initial tour, Surveyor #1 was in Room Ex.Order 26 on East Wing. Room Ex.Order 26 was occupied by a resident. Surveyor #1 observed the bathroom within the room. No toilet paper was observed in the bathroom. On the same date at 10:09 AM, Surveyor #1 was in Room 14 on East Wing. Room 14 was	F 584	SPECIFIC CONCERNS Toilet paper was provided to Room 1, and the Housekeeper later cleaned Room 14. The trash can without the lid was emptied and removed from the unit. The hall ceiling vent by Room 1 was cleaned and a new air filter installed. The floor in the West Wing Lounge was also cleaned. The towels, soap bottle, soap boxes, shower chair and garbage can were removed from the Shower Room area and toilet paper was added and the tub cleaned. The hair/threads around the wheels of the high side East Wing medication cart were removed and the low side East Wing medication cart was cleaned. A new low side East Wing medication cart will be requested from the Pharmacy if it can not	

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occupied by a resident. Surveyor #1 observed food debris, medicine cups, and stains on the floor within the room.

On the same date at 10:23 AM, Surveyor #1 was in the East Wing hallway near Room 01. At this time time, Surveyor #1 observed a trash can filled with garbage that was over the brim of the can. No lid was in place.

On the same date at 10:24 AM, Surveyor #1 was in the East Wing hallway near Room 01. At this time, Surveyor #1 observed a ceiling vent. Within the vent was a air filter that was covered in dust and dark in color.

On the same date at 10:48 AM, Surveyor #1 was in the West Wing lounge. At this time, Surveyor #1 observed a brown substance smeared on the floor. Dried, brown liquid stains were observed on the floor tiles next to the vending machine.

On 4/14/23 at 9:22 AM, Surveyor #1 was in the East Wing shower room. At this time, Surveyor #1 observed unfolded towels on the floor outside and inside the shower. Surveyor #1 also observed an uncapped soap bottle on the floor. Also within the shower room, was a broken shower chair and garbage can blocking access to the sink. Surveyor #1 observed that there was no toilet paper available in the toilet area. Surveyor #1 observed discarded soap boxes and an unidentifiable brown and gray, formed substance within the whirlpool tub.

04/14/23 at 12:16 PM, Surveyor #2 was on East Wing observing medication carts. The medication cart on the high side of East Wing had entangled hair and threads in the wheels. The medication

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be repaired. The door frame on the door to the West Wing Lounge will be repaired/repainted and the door was cleaned. The plywood box containing the microwave has been cleaned. The baseboard vent in the West Wing Lounge was cleaned and the cover replaced. The carpets in this area will be replaced. The West Shower Room by 28-40 has been cleaned and repairs made to the noted items. The ceiling fans in the hallway by Rooms 28-40 were cleaned. The water pitcher in Ex.Order was replaced. The walls on A Wing will be dusted. The West Wing juice cart has been cleaned. The hole behind the door in Room Ex.Ord has been repaired. Room Ex.Order has been cleaned and noted items repaired. The food cart has been cleaned. The cart on the East Wing Medication Room has also been cleaned and the cabinet repaired.

IDENTIFICATION OF SIMILAR CONCERNS

All residents have the potential to be affected by the deficient practice.

SYSTEMIC CHANGE

All Housekeeping and Maintenance staff will be inserviced on ensuring all common areas are appropriately cleaned and well maintained. 100% rounds of all common areas will be conducted by the Administrator. Any additional Housekeeping and Maintenance concerns will be addressed. Thereafter, the Administrator will be conducting weekly

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cart on the low side of East Wing had dried, orange stains and a brown stain along with chipped edges along the base of the cart.

On 4/24/2023 at 10:00 AM, during an interview with Surveyor #1, the Supervisor of Housekeeping (SHK) said resident rooms are checked everyday. The SHK also said that shower rooms are cleaned three times a day and that there are no shower rooms that are not cleaned.

A review of the facility policy titled, "Housekeeping - Resident Rooms" under section, "Policy" revealed, "The Housekeeping Department coordinates the daily cleaning of all resident rooms."

FACILITY

On 4/12/2023 at 09:54 AM during the initial tour of the facility surveyor #3 observed the entry door to the West Lounge had peeled paint and gauges on the door frame. The door also had unidentified black stains on a white door and the door window was severely smudged.

On 4/12/2023 at 10:19 AM surveyor #3 observed that the West Lounge floor adjacent to the Pepsi machine was filthy with unidentified and dried brown stains. Residents had reported that there was previously fecal matter on the floor. In addition a plywood box that contained a

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rounds in common areas.

MONITORING

Weekly environmental rounds will be conducted by the Administrator and/or the Dir of Housekeeping in all common areas. The rounds will identify both concerns noted as well as date corrected. The Administrator will submit a report to the facility's weekly QAPI Committee.

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microwave oven was stained on the outside with an unidentifiable, dried, brown substance.

On 4/12/2023 at 11:29 AM Resident #47 asked surveyor #3 to come to the West Lounge to inspect the microwave oven. The microwave was inside a plywood box with a door that wood open on the front of the box with a numerical key pad lock. The surveyor was able to open the plywood door and access the microwave oven. Surveyor #3 opened the microwave door and the interior of the microwave was covered with an unidentified brown substance on the base of the microwave. Resident #47 reported to surveyor #3 that the microwave had been like this for "a long time."

On 4/13/2023 at 08:52 AM Surveyor #3 observed the West Lounge. The baseboard heat vent against the wall to the door that leads to the smoking area was covered in an unidentifiable black/gray dusty substance. The front cover of the baseboard heater is partially torn off and exposed the internal contents of the heater. The surveyor also observed several brown stains on the floor, as previously observed, under the microwave oven. Carpets in the West Lounge remained littered with unidentified debris and the carpets rubber edges were torn.

On 4/14/2023 at 10:59 AM surveyor #3 entered the West Resident Bath for rooms 28-40. The following was observed: A bag of towels in a clear plastic bag was on the floor in a corner upon entry to the room. The tile floor immediately in front of the entry door and throughout the room was covered in black, unidentifiable stains. A black plastic trash can had no liner and contained an empty milk carton, 2 plastic cups with an unidentifiable brown substance inside, 2 plastic

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spoons, and unidentifiable debris on the bottom of the trash can. The baseboard moulding to the left side of the hand washing sink is partially torn from the wall. A section of an unlit cigarette was observed in the sink. A cigarette butt was observed on the floor of the shower to the right side of the room when entering. The shower on the opposite side has tile missing from the front wall. The structure is exposed and has allowed what appears to be water from the shower to puddle between the floor tile and the structure of the shower wall. The water was gray in color and appeared to also have toilet tissue in the accumulated water. Bed linens were observed on the floor and were not bagged.

On 4/19/2023 at 09:08 AM surveyor #3 entered the West lounge and was able to observe the ceiling fans in the room # 28-40 hallway. The fans were not in operation and were observed to have a substantial buildup of a black/gray dust-like substance on the tops of the fan blades. Resident #47 stated to surveyor #3, "That's been like that forever."

On 4/20/2023 at 12:59 PM In the West Lounge surveyor #3 observed that the baseboard heating unit had been repaired, however the unit remained dirty on the outside surface and covered in a black unidentified dust-like substance. The floor remained stained under the microwave area with an unidentified brownish substance.

On 4/24/2023 at 10:07 AM the surveyors interviewed the facility Director of Housekeeping (DOH). Surveyor #3 asked the DOH who was responsible for the cleaning of ceiling fans throughout the facility. The DOH said porters are

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responsible for cleaning the ceiling fans in the hallways. The DOH went on to say that showers are cleaned three times a day. They are cleaned at 7 AM, 12 PM, and 2 PM.

On 04/13/2023 at 11:49 AM during a tour of the West Wing A Hall, Surveyor #4 entered Room [Ex.Ord] B which was occupied by a resident. A water pitcher was observed on the over bed table. The water pitcher lid contained brown residue on the underside. The occupant of Room [Ex.Ord] B stated that he/she uses the pitcher for water to drink.

On the same date at 12:13 PM, Surveyor #4 observed a buildup of dust on various parts of the bilateral walls located on the A Wing.

On 04/14/2023 at 12:25 PM Surveyor #4 observed chipped paint on the door and door frame in front of the nurses station leading into the West Wing Lounge.

On the same date and time, Surveyor #4 observed a buildup of brown residue and dust-like particles on the West Wing Lounge floor. In addition, A 3- tier cart containing a large orange container of fluids for the residents, was noted with brown stains/residue on multiple areas on the cart.

On 04/14/2203 at 12:30 PM Surveyor #4 returned to Room [Ex.Order] to observe dining. During that time a hole approximately the size of a half dollar was noted in the wall behind the door. The baseboard heater and trimming along the wall were noted with a thick layer of dust. The rubber wall base trimming was noted peeling off the wall.

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F 584	Continued From page 10 On 04/14/2023 at 12:32 PM during a dining observation, Surveyor #4 observed stains/residue on multiple areas of the food cart used to transport the resident's food from the kitchen to the unit. On 04/17/2023 at 12:08 PM, in the East Wing medication room, a cart containing intravenous (IV) supplies had brownish residue in the drawers and on top of the cart. In addition, a broken cabinet near the sink was also noted during that time. Surveyor #4 was able to partially see under the sink through the cracked cabinet. During an interview with Surveyor #4 on 04/20/2023 at 10:18 AM, the Housekeeper (HK) replied, "I wipe everything down" when asked what duties are performed in the resident rooms. The HK also stated that he/she wipes down the baseboards in the resident rooms daily. On 04/24/2023 at 12:39 PM during an interview with Surveyor #4, the Licensed Nursing Home Administrator (LNHA) replied "the housekeepers" when asked who is responsible to clean the walls in the halls. The LNHA also stated that if the housekeepers see an issue, it should be addressed.	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		5/31/23

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F 625	Continued From page 11 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical record and other facility documentation, it was determined that the facility failed to provide a bed-hold and return policy to a resident representative. This deficient practice was identified for 1 of 2 residents (Resident #6) reviewed for Ex.Order 26.4(b)(1) and was evidenced by the following: According to Resident #6's Admission Record, Resident #11 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1	F 625	SPECIFIC RESIDENT The Director of Admissions was inserviced on ensuring Bed Hold Notices are issued to all residents, including resident #6, whenever a resident is transferred to the Ex.Order 26.4(b l or goes on therapeutic leave. IDENTIFICATION OF SIMILAR RESIDENTS All residents have the potential to be affected by the deficient practice.	

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F 625	Continued From page 12 EX Order 26 § 4b1. A review of the comprehensive Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated 3/10/2023, revealed Resident #6 had a Brief Interview for Mental Status score of EX Ord, indicating Ex.Order 26.4(b)(1) . On 04/14/2023 at 12:56 PM, the surveyor reviewed the medical record (MR) (paper/electronic). A progress note dated 01/16/2023 at 01:30 PM, revealed that Resident #6 was EX Order 26 § 4b1. Vital signs (VS) were completed. Ex.Order 26.4(b)(1) performed and received Ex.Order 26.4(b)(1 result. Nurse Practitioner (NP) was made aware and ordered resident to be sent out to acute care for Ex.Order 26.4(b)(1) Family notified via phone call. Resident #6 was admitted per progress note, dated 1/17/2023 at 6 AM for Ex.Order 26.4(b)(1) Resident was returned to facility on Ex.Order 26.4(b)(1). According to a progress note dated 01/19/2023 at 11:30 AM, Resident #6 was noted to be Ex.Order 26.4(b)(1 and complained of a Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1). Resident was assessed and VS were taken. Resident #6 was started on EX Order 26 § 4b1 . Ex.Order 26.4 were assessed and Ex.Order 26.4(b)(1) heard. MD (medical doctor) was notified and ordered Resident #6 to be sent to EX Order 26 care for evaluation. Family notified via telephone. Resident #6 was returned to facility on EX Order 26 § 4b1. On 04/19/2023 at 12:45 PM, the surveyor reviewed the MR. On 01/23/2023 a Physician's Order indicated to "EX Order 26 § 4b1	F 625	SYSTEMIC CHANGE Residents or Responsible Party's will be notified of the facility's Bed Hold Policy upon transfer to the Ex.Order 26.4(b l or therapeutic leave. The facility will review all Ex.Order 26.4(b)(transfers/therapeutic leaves as of 5/1/23 to ensure all residents/Responsible Party's receive the facility's Bed Hold Policy. Ex.Order 26.4(b)(transfers/therapeutic leaves will be discussed at daily Clinical Meeting. MONITORING The Director of Admissions will provide a weekly report regarding the status of issuing Bed Hold Notices as required to the facility's weekly QAPI Committee Meeting.	

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F 625	Continued From page 13 EX Order 26 § 4b1 EX Order 26 § 4b1 ." In addition, a second physician order dated 01/24/2023 read: EX Order 26 § 4b1 Resident #6 was provided EX Order 26 § 4b1 EX Ord was present and ordered to be sent out 911. Family notified via telephone. Resident #6 was admitted to the Ex.Order 26.4(b) l with diagnosis of EX Order 26 § 4b1 Resident #6 was readmitted to the facility on EX Order 26 § 4b1 A further review of the medical record revealed that Resident #6 was discharged from the facility to the Ex.Order 26.4(b)(1 on EX Order 26 § 4b1 Resident #6 was re-admitted to facility on EX Order 26 § 4b1 On 04/20/2023 at 09:03 AM, the surveyor interviewed the facility social worker (SW). The SW revealed to the surveyor that he had been employed at the facility since 12/06/2022. The surveyor asked the SW if he had provided bed-hold notices to Resident #6 or their representative prior to the previous mentioned hospitalization dates. The SW stated, "I've never been asked to issue a bed hold notice to a resident when they are transferred to the Ex.Order 26.4(b)(1 . That would be admissions. The surveyor confirmed that the SW did not issue bed-hold notices to resident or their representatives on transfer to the Ex.Order 26.4(b)(and the SW said, "Yeah,	F 625		

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F 625	Continued From page 14 that would be the admissions department." On 04/20/2023 at 10:01 AM, the surveyor interviewed the facility Admissions Director (AD), who identified that she had been employed at the facility for approximately 4 months. The surveyor asked the AD if she was the person responsible in the facility to issue bed hold notices when a resident is transferred to a Ex.Order 26.4(b)(1 or takes a therapeutic leave. The AD responded, "No, I'm not aware that we are providing a bed hold policy for residents that are discharged. I do send a list of discharges to the ombudsmen at the end of the month, and I also include the administrator on the email." The surveyor questioned the AD if a bed hold policy is included in the new admission packet. The AD stated, "There is no bed hold policy in our admission packet." The surveyor questioned the AD if she provides a bed hold notice to residents or their responsible party upon transfer to Ex.Order 26.4(b)(or therapeutic leave. The AD said, No, I do not provide a copy of the bed hold to the resident or responsible party when a resident is discharged from the facility to the Ex.Order 26.4(b)(." Upon further interview the facility Clinical Liaison was able to provide a copy of the facility bed hold policy that they issued as only part of the admission packet. On 04/20/2023 at 10:15 AM, the surveyor interviewed the facility Licensed Nursing Home Administrator (LNHA). The surveyor asked the LNHA if the facility provided a copy of the bed hold notice to residents upon transfer from the facility to the Ex.Order 26.4(b)(or therapeutic leave. The LNHA stated, "I'm not sure if admissions are doing that or not. I can find out." On 04/20/2023 at 11:05 AM, the LNHA told the surveyor that he was able to find a copy of the bed hold policy that	F 625		

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F 625	Continued From page 15 we provide upon admission. and said we provide it as part of our admission packet. The surveyor asked the LNHA if they are also providing residents or responsible party a bed hold policy upon resident transfer from the facility to Ex.Order 26.4(b)(1) or therapeutic leave. The LNHA responded, "We provide a copy at admission. Should we also provide it when they leave the facility on transfer. I'm not sure we are doing that. I would have to ask admissions?" A review of the facility policy under Section 3. DISCHARGE AND TRANSFER did not indicate when a bed-hold should be issued to residents. N.J.A.C. 8:39-4.1 (a)(31)(i-iv)	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure an accurate Minimum Data Set (MDS), an assessment tool, was completed. This was identified for 3 of 19 sampled residents (Resident #13, Resident #71 and Resident #19). This deficient practice was evidenced by the following: A.) According to the Admission Record, Resident #13 was admitted to the facility with diagnoses including but not limited to: Ex.Order 26.4(b)(1)	F 641	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident #13; Resident #71; and Resident #19 were all re-educated on the EX Order 26 § 4b1. Residents were advised of the risks versus benefits. The EX Order 26 § 4b1 consents were completed accurately. All residents identified had their EX Order 26 § 4b1 consents reviewed and completed accurately and	5/31/23

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F 641	Continued From page 16 levels of Ex.Order 26.4(b)(1) A review of the most recent Minimum Data Set (MD'S) an assessment tool used to facilitate care, dated 02/22/2023 revealed a Brief Interview for Mental Status (BIMS) score of EX O /15, indicating Resident #13 was EX Order 26 § 4b1 . Under section O the MDS indicated that EX Order 26 § 4b1 was offered and declined. A review of a EX Order 26 § 4b1 having been administered. A review of Ex.Order 26.4(b)(1) Immunization Informed Consent did not include documentation that Resident #13 was offered the EX Order 26 § 4b1 and whether the resident accepted or declined the EX Order 26 § 4b1 . B.) According to the Admission Record, Resident #71 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 . A review of the most recent MDS dated 03/09/2023 revealed a BIMS score of EX O /15 indicating Resident #71 was EX Order 26 § 4b1 . Section O of the MDS revealed that the EX Order 26 § 4b1 was offered and declined. A review of a 'EX Order 26 § 4b1 Record did not include of a EX Order 26 § 4b1 having been administered.	F 641	correctly. Minimum Data Set for residents identified was corrected and updated. - Staff Development Coordinator educated the Minimum Data Set Coordinator, facility and agency staff nurses on the facility protocol regarding Immunizations, specifically the EX Order 26 § 4b1 , informed consents, and administration of the EX Order 26 § 4b1 with proper documentation. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents have the potential to be affected by the same issue being addressed. - All residents□ charts were reviewed for EX Order 26 § 4b1 administration (if applicable). Consents were completed accurately and the Minimum Data Set for each resident was updated accordingly. - Staff Development Coordinator/Minimum Data Set (MDS) Coordinator/Designee will educate and in-service facility and agency staff nurses on the facility protocol regarding Immunizations, specifically the EX Order 26 § 4b1 informed consents, and the process for administration of the EX Order 26 § 4b1 with proper documentation in the residents□ electronic medical records.	

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F 641	Continued From page 17 A review of Ex.Order 26.4(b)(1) Immunization Informed Consent did not include documentation that Resident #71 was offered the EX Order 26 § 4b and whether the resident accepted or declined the EX Order 26 § 4b1 . During an interview with the surveyor on 04/20/2023 at 12:27 PM, the Interim Director of Nursing (IDON) was asked what the process was for EX Order 26 § 4b1 . The IDON said the consent is in admission packet and the nurse is to ask if they (resident) would like to have EX O . During a follow-up interview with the surveyor on 04/20/23 at 01:04 PM, the IDON said if under resident is 65 years of age, and has co-morbities yes we should offer the EX Order 26 § 4b1 and get consent signed. The documentation of either receiving or declining EX Order 26 § 4b1 , it would be in the physical chart. The surveyor reviewed with IDON consents not signed for EX Order 26 § 4b1 yet MDS indicates it was offered and declined. The surveyors requested any documentation pertaining to the EX Order 26 § 4b1 and the IDON said the only place the information would be is on consent form. When asked where did you get the information from for the MDS. The IDON replied "I did all the MDS's so it was me and it was a guess. There is no concrete information for EX Order 26 § 4b1 ." C.) A review of of the admission MDS; dated 12/25/2022 revealed a BIMS score of EX O /15, indicating Resident #19 was EX Order 26 § 4b1 . Under section O, the MDS indicated that the EX Order 26 § 4b1 was up to date.	F 641	- Staff Development Coordinator/Designee will educate all new hires during the orientation process regarding the facility□s protocol regarding Ex.Order 26.4(b)(1), specifically the Ex.Order 26.4(b)(1) informed consents, and the process for administration of the vaccine with proper documentation. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Staff Development Coordinator/Unit Manager/Designee will review charts of all new and readmissions during daily clinical meetings to ensure proper documentation and completion of the influenza and Ex.Order 26.4(b)(1) consents and documentation of administration if applicable, in the residents□ electronic medical records and that the Minimum Data Set reflects correctly based upon the vaccination consents. - Staff Development Coordinator/Designee will educate all new hires during the orientation process regarding the facility□s protocol regarding Immunizations, specifically th Ex.Order 26.4(b)(1) , informed consents, and the process for administration of the vaccine with proper documentation. 4)Indicate how the facility plans to monitor	

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A review of the most recent quarterly MDS dated 3/27/2023 revealed a BIMS score of EX O /15, indicating Resident #19 was EX Order 26 § 4b1 . Under section O, the MDS indicated that the EX Order 26 § 4b1 was offered and declined.

A review of Resident #19's electronic medical record (EMR) under EX Order 26 § 4b1

A review of Resident #19's paper medical record revealed a form titled EX Order 26 § 4b1 Informed Consent. The form revealed a marked check box and statement that the resident gave the facility permission to administer the EX Order 26 § 4b1 and that the resident has been educated on the risks and benefits of the EX Order 26 § 4b1. Below the statement was a line for a signature from the resident or legal representative that was blank. Also, the date was not written adjacent to the signature line.

On 04/20/2023 at 12:27 PM during an interview with the surveyors, the interim Director of Nursing (IDON/MDS) who also completes the MDS, said that consents for EX Order 26 § 4b1 are part of the admission packet. She said further that the documentation should be in the chart.

On 04/24/2023 at 12:38 PM during an interview with the surveyors, when asked what is the process for EX Order 26 § 4b1 consents, the Vice President of Clinical Services (VPCS) said when a resident comes in if they are eligible we offer the EX Order 26 § 4b1 . If refused they sign that they decline. The surveyor asked who is responsible to ensure the consents are

F 641

its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness.

- DON/Designee will conduct weekly audits of all new and readmissions to ensure proper documentation and completion of the EX Order 26 § 4b1 consents and documentation of administration if applicable, in the residents□ electronic medical records and on the residents□ Minimum Data Sets x8 weeks; then twice monthly x2, then monthly until compliance is maintained x2 months with reports being submitted to the facility's weekly QAPI Committee Meeting.

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F 641	Continued From page 19 completed accurately, the VPCS said "It will be the staff educator, Infection Preventionist and Director of Nursing to make sure they are done." The VPCS stated, "I can't answer why." when asked why Resident #19's EX Order 26 § 4b1 Informed Consent is marked without a date or signature that the resident gave permission to administer the EX Order 26 § 4b1 and that the resident has been educated on the risks and benefits of the EX Order 26 § 4b1. The VPCS replied, "No." when asked by the surveyors if a blank consent should be documented as "offered and declined". NJAC 8:39-11.2	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		5/31/23

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F 656	Continued From page 20 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review and review of other facility documentation, it was determined that the facility failed to to develop a person-centered comprehensive care plan to address the use of EX Order 26 § 4b1 for 1 of 5 Residents (Resident #13) reviewed for unnecessary medication. This deficient practice was evidenced by the following: According to the Admission Record, Resident #13 was admitted to the facility with diagnoses	F 656	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident #13□s care plan was updated regarding EX Order 26 § 4b1 use. - Staff Development Coordinator/Unit Manager/Designee educated and in-serviced nurses immediately on initiating and updating person-centered	

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F 656	Continued From page 21 including but not limited to: EX Order 26 § 4b1 A review of the most recent Minimum Data Set (MD'S) an assessment tool used to facilitate care, dated 02/22/2023 revealed a Brief Interview for Mental status score of EX O /15, indicating Resident #13 was EX Order 26 § 4b1. Section N indicated Resident #13 received EX Order 26 § 4b1 A review of the current Clinical Physician Orders revealed a physician order for EX Order 26 § 4b1 at bedtime for DM. A review of the April 2023 Medication Administration Record revealed the resident received EX Order 26 § as ordered except for April 8 through April 10, 2023 when the resident was Ex.Order 26.4(b)(1) A review of Resident #13's Care Plan revealed there was no care plan in place regarding Resident #13's EX Order 26 § 4b1 use. On 04/20/2023 at 10:52 AM, the surveyor requested copy of Electronic Medical Record care plan. The Interim Director of Nursing said that is correct this is the current care plan and this is the only care plan we would be using to provide residents care, when she gave the surveyor the care plan. During an interview with the surveyor on	F 656	comprehensive care plans on residents with Ex.Order 26.4(b)(1) use. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - An audit of all residents with diagnosis of Ex.Order 26.4(b)(1) use will be conducted. A Person-centered comprehensive care plans for each resident identified will be established and complete according to facility protocol. - Staff Development Coordinator/Unit Manager (UM)/Designee will educate and in-service facility and agency staff nurses on initiating and updating person-centered comprehensive care plans on all residents identified with Ex.Order 26.4(b)(1) use. - Staff Development Coordinator/Designee will educate all new hires on the facility process and policy regarding initiating and updating person-centered comprehensive care plans on all residents. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Staff Development Coordinator/Unit Manager/Designee will complete weekly random audits of all new admission/readmission residents who are	

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04/24/2023 at 11:16 AM, the Registered Nurse Unit Manager (RNUM) said the Minimum Data Set (MDS) coordinator and I can do the care plans but she has the most knowledge and responsibility. When asked what is expected to be on a care plan, RNUM responded ADL's (Activities of daily living), fall risk, if Stroke to keep safe with interventions, oxygen, use of anticoagulant, and yes diabetes. The surveyor requested RNUM to review Resident #13's care plan on the computer and asked RNUM does the resident have care plan for EX Order 26 § 4b1. RNUM said "no, and I believe Ex.Order should."

During an interview with the surveyor on 04/24/2023 at 12:52 PM, the Vice President of Clinical Services (VPCS) was asked what is expected to be on a residents care plan. The VPCS responded whatever is needed to help direct or address concerns or potential concerns and help with daily plan of care. VPCS said "yes, fall risk, anticoagulant use, and yes, would expect a care plan for diabetes." When asked who is responsible to do care plan the VPCS said nurses and MDS are responsible.

A review of a facility policy titled Care Plans, Comprehensive Person Centered with revised date of December 2016 revealed under the Policy and Interpretation section
8. The comprehensive person-centered care plan will:
a. include measurable goals, b. describe services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing. g. Incorporate identified problem areas h. incorporate high risk factors associated with identified problems o. reflect currently recognized standards of practice

F 656

identified as EX Order 26 § 4b1 and who use EX Order 26 § for EX Order 26 § 4b1 to ensure a person-centered comprehensive care plan is completed within 7 days of admission.

- Staff Development Coordinator/Designee will educate all new hires on the facility process and policy regarding initiating and updating person-centered comprehensive care plans on all residents.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness.

- Director of Nursing/Designee will complete weekly random audits of all new admission/readmission residents who are identified as Ex.Order 26.4(b)(1) and who use Ex.Order 26.4(b) for diagnosis of Ex.Order 26.4(b)(1) to ensure a person-centered comprehensive care plan is completed within 7 days of admission for a period of 8 weeks; then twice monthly x2; then once monthly until compliance is maintained x2 months during Quality Assurance Process Improvement meeting. The Director of Nursing will submit reports to the facility's weekly QAPI Committee Meeting.

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	315149	A. BUILDING ______ B. WING ______	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	**794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052**

(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 656	Continued From page 23 for problem areas and conditions. NJAC 8:39-11.2(e) (1,2)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review and review of other facility documentation, it was determined that the facility failed to a) maintain a detailed record of receipts and accurate reconciliation of controlled medications, b) provide necessary treatment services, consistent with professional standards of clinical practice by not providing EX Order 26 § 4b1 boots as ordered by the physician and c) ensure that the incoming and outgoing nurses reconciled controlled substances at the change of each shift. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing	F 658	1)Specific Residents DEA 222 form #211510990 written on 10/3/2022 was not filled out completely or accurately as per the instructions on the DEA 222 form: was missing the number of medications received and the date medications were received. DEA 222 form #211510991 written on 12/19/2022 was not filled out completely or accurately as per the instructions on the DEA 222 form: was missing the date received and the number of packages received. Electronic medical record for Resident #22 reflected a physician's order dated 3/10/2023 for Ex.Order 26.4(b)(1) (Lifetime Use) to be used while in bed as tolerated every shift. Observation of Resident #22 indicated that Resident #22 did not have Ex.Order 26.4(b)(1) available as ordered. Review of Backup EX Order 26 § 4b1, Abuse Drug Count Log in the Medication Backup Storage Room found multiple	5/31/23

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F 658

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medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:"

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

a) Surveyor #1 requested all Drug Enforcement Administration (DEA) 222 forms (a form used for ordering controlled substances) for the last 6 months from the Vice President of Clinical Services (VPCS). The surveyor was provided with two (2) DEA 222 forms. The surveyor reviewed the facility's DEA 222 forms and found two of two forms were not completed and accurately documented as follows:

1. The DEA 222 form # 211510990 was written on 10/3/2022 and contained an order for 1 package of 60 Oxycodone 5 milligrams, 1 package Oxycodone 10 milligrams, 1 package of 60 Oxycodone APAP (Acetaminophen) 5/535, 1 package of 2 Fentanyl 50 micrograms/hour transdermal, and 1 package of 2 Fentanyl 25 micrograms/hour transdermal . The DEA 222 form was missing the number received and date received.
The printed instructions on the DEA 222 form indicated: "To BE FILLED IN BY PURCHASER, number of packages received and date received."

F 658

signatures missing of the incoming nurse and outgoing nurse for multiple days and times.
Address how corrective action will be accomplished for resident(s) found to have been affected:

- a. No residents found to be affected
- b. Provider made aware that Ex.Order 26.4(b)(1) was still not available for resident #22's use per physician orders. Order was received from provider to utilize EX Order 26 § 4b1 as tolerated until device was obtained. Order was placed with corporate supply company for EX Order 26 § 4b1 for Resident #22. No direct harm has resulted to resident #22 as a result of not having device available as ordered in a timely manner. Resident #22 was assessed and no current signs or symptoms of EX Order 26 at this time.
- c. No residents found to be affected

- Staff Development Coordinator educated and in-serviced the facility and agency staff nurses on the facility protocol regarding following physician orders and following up on treatments, devices, or products ordered for residents, in a timely manner.

- Staff Development Coordinator educated and in-serviced the facility and agency staff nurse supervisors on the facility's daily process for completing shift change narcotic back up box count and signature of incoming nurse and outgoing

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F 658	Continued From page 25 2. The DEA 222 form # 211510991, was written on 12/19/2022 and contained an order for 1 packages of 1 Fentanyl 25 micrograms/hour transdermal, 1 package of 30 Hydromorphone 2 milligrams tab, 1 package of 5 Morphine Sulfate Sol (solution) 10/0.5 milligrams/milliliter , 1 package of 60 Oxycodone 5 milligrams, 1 package of 60 Oxycodone 10 milligrams, and 1 package of Oxycotin 10 milligrams. The DEA 222 form was missing the date received and the number of packages received. The printed instructions on the DEA 222 form indicated: "To BE FILLED IN BY PURCHASER, number of packages received and date received." During an interview with Surveyor #1 on 04/19/2023 at 09:25 AM, the VPCS stated "yes", when asked should the number of medications received and date received be filled in. The VPCS confirmed the sheets were not filled in as per the printed instructions. b) A review of the electronic medical record (EMR) for Resident #22 reflected that Resident #22 had a diagnosis that included, EX Order 26 § 4b1 A review of the Physician Order Summary dated 4/16/2023, reflected an order dated 3/10/2023, for a EX Order 26 § 4b1 On 04/14/2023 at 01:40 PM, Surveyor #2 observed Resident #22 in his/her room lying in a	F 658	nurse. - VP of Clinical Services reviewed with Director of Nursing the necessity on accurately and completely filling out DEA 222 forms as per form instructions. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents have the potential to be affected by the same issue being addressed. - All residents' charts will be reviewed for orders for Ex.Order 26.4(b)(1) and other ancillary devices ordered by physicians to ensure product receipt. - Staff Development Coordinator/Unit Manager/Designee will educate and in-service the facility and agency staff nurses on the facility protocol regarding following physician orders and following up on treatments, devices, and receipt of products ordered for residents, in a timely manner. - Staff Development Coordinator/Unit Manager/Designee will educate and in-service the facility and agency staff nurse supervisors on the facility's daily process for completing shift change narcotic back up box count reconciliation and signature of incoming nurse and outgoing nurse.	

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F 658	Continued From page 26 EX Order 26 § 4b1. Resident #22 did not have the ordered EX Order 26 § 4b1 in place. On 04/14/2023 at 02:16 PM, Surveyor #2 interviewed the Registered NurseUnit Manager (RNUM) of the East Side Unit. RNUM confirmed that Resident #22 did not have EX Order 26 § 4b1 and was unable to offer any additional information. On 04/17/2023 at 08:04 AM, during an interview Resident #22 stated that he/she has not had the EX Order 26 § 4b1 and that they were ordered over a month ago. A review of the Treatment Administration Record (TAR) for the period of0 3/11/ 2023 through 03/31/2023, the nursing staff documented in the progress notes: "Note Text: Ex.Order 26.4(b)(1) as tolerated every shift;" 7 day shifts, 7 evening shifts, and 4 night shifts. There was no documentation indicating that the device was not available nor that the ordering physician was notified. The surveyor reviewed the April TAR from 4/1/2023 through 4/23/2023, that revealed in the corresponding progress notes," The Ex.Order 26.4(b)(1) -Not Available:" 10 days shifts, 11 evening shifts, and 10 night shifts. There was no progress note indicating that the device was not available nor that the ordering physican had been notified. During an interview with the survey team on 04/24/2023 at 01:02 PM, Surveyor #2 questioned the Licensed Nursing Home Administrator (LNHA) and the VPCS as to Resident #22's order	F 658	3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Unit Manager/Shift Supervisor/Designee will review charts daily during 24-hour chart check for new orders regarding ordering of new devices for residents. - Unit Manager/Designee will review and audit all new physician orders during daily clinical meeting to determine if any new devices for residents were ordered and will follow up in 48 hours to check receipt of item(s). - Staff Development Coordinator/Designee will educate all new nursing hires and agency nurses during the orientation process regarding the facility's protocol regarding following physician orders and following up on treatments, devices, and receipt of products ordered for residents' use, in a timely manner. - Staff Development Coordinator/Unit Manager/Designee will educate all new nursing supervisors and agency staff nurse supervisors on the facility's daily process for completing shift change narcotic back up box count reconciliation and signature of incoming nurse and outgoing nurse. 4)Indicate how the facility plans to monitor	

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F 658	Continued From page 27 for the Ex.Order 26.4(b)(1) . The VPCS and LNHA stated that they were not aware that a physician order from 3/10/23 was not followed and that Resident #22 did not have the ordered equipment. A review of an undated facility policy titled, Physician Orders-Medical Record Manual-General, indicated under section VIII: "Whenever possible, the Licensed Nurse receiving the order will be responsible for documentation and implementing the order c) On 04/17/2023 at 10:32 AM, Surveyor #2 reviewed the "Record of Narcotic, Barbiturate, Abuse Drug Count" log in the Medication Backup Storage Room in the presence of the VPCS and found multiple signatures missing of the incoming nurse and outgoing nurse for the following days/times: 04/2/2023 11 PM Incoming and Outgoing nurse 04/3/2023 3 PM Incoming and Outgoing nurse 04/3/2023 11PM Outgoing nurse 04/4/2023 7AM Incoming and Outgoing nurse 04/4/2023 3 PM Incoming and Outgoing nurse 04/4/2023 11 PM Outgoing nurse 04/5/2023 3 PM Outgoing nurse 04/5/2023 11 PM Incoming and Outgoing nurse 04/6/2023 7 AM Incoming and Outgoing nurse 04/6/2023 3 PM Incoming and Outgoing nurse 04/6/2023 11 PM Outgoing nurse 04/7/2023 7 AM Incoming and Outgoing nurse 04/7/2023 3 PM Incoming and Outgoing nurse 04/7/2023 11 PM Outgoing nurse 04/8/2023 7 AM Outgoing nurse 04/8/2023 3 PM Incoming nurse 04/8/2023 11 PM Outgoing nurse 04/9/2023 7 AM Incoming and Outgoing nurse	F 658	its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - DON/Designee will conduct weekly random audits for orders for resident ancillary devices and receipt of item(s) within 48 hours of order x8 weeks; then twice monthly x2; then monthly until compliance is maintained x2 months during QAPI Committee Meetings.	

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04/9/2023 3 PM Incoming and Outgoing nurse
04/9/2023 11 PM Outgoing nurse
04/10/2023 7 AM Incoming and Outgoing nurse
04/10/2023 3 PM Incoming and Outgoing nurse
04/10/2023 11 Pm Outgoing nurse
04/11/2023 3 PM Incoming and Outgoing nurse
04/11/2023 11 PM Incoming and Outgoing nurse
04/12/2023 3 PM Incoming and Outgoing nurse
04/12/2023 11 PM Incoming and Outgoing nurse
04/13/2023 3 PM Incoming and Outgoing nurse
04/13/2023 11 PM Incoming and Outgoing nurse
04/14/2023 11 PM Incoming and Outgoing nurse
04/15/2023 7 AM Incoming and Outgoing nurse
04/15/2023 3 PM Incoming and Outgoing nurse
04/15/2023 11 PM Incoming and Outgoing nurse
04/16/2023 11 PM Incoming and Outgoing nurse
04/17/2023 7 AM Outgoing nurse
04/17/2023 3 PM Incoming and Outgoing nurse
04/17/2023 11 PM Outgoing nurse

When the VPCS was questioned as to the policy and procedure regarding the Narcotic Reconciliation log, she stated that each shift on each day should be signed by 2 nurses.

On 04/18/2023 at 01:12 PM, the Licensed Nursing Home Administrator (LNHA) provided a policy from their pharmacy [Pharmacy Name], titled, "4.0 Schedule II Controlled Substance Medication:" that revealed under #6; "An inventory count of all CDS medications stored on each nursing unit will be performed at each change of each shift by the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form."

On 04/19/2023 at 01:54 PM, the VPCS advised Surveyor #2 that the facility did not have a written

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F 658	Continued From page 29 policy for the narcotic storage reconciliation log. She stated that it is general practice that two nurses must sign off on each shift after reconciling the narcotic count in the locked storage box. The VPCS acknowledged that there is a concern regarding the noncompliance. On 04/24/2023 at 01:00 PM, in the presence of the survey team, the LNHA and the VPCS both acknowledged that they were aware of the issue and that they are addressing it now. NJAC 8:39-29.3 and 29.4(h) NJAC 8:39-29.7 NJAC 8:39-27.1 (a)	F 658		
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 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	F 661		6/9/23

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F 661	Continued From page 30 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: Based on interview, record review and review of other facility documentation, it was determined that the attending physician failed to document a summary of a resident's stay and course of treatment while at the facility for 1 of 2 residents reviewed for closed records, (Resident #99). This deficient practice was evidenced by the following: On 04/19/2023 at 10:14 AM, a review of the closed medical record for Resident #99 was completed. The review revealed that there was no documented physician discharge summary. A request was made to the Licensed Nursing Home Administrator (LNHA) for the discharge summary for Resident #99. During an interview on 04/19/2023 at 01:30 PM, the LNHA stated that the facility could not find the discharge summary. During an interview on 04/24/2023 at 12:39 PM, the Vice President of Clinical Services (VPCS) stated, the discharge summary should have been in the medical record, when asked should there have been a discharge summary in the medical record.	F 661	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident #99 was discharged from the facility – survey review was of a closed medical record. - Facility medical providers educated and in-serviced on the facility policy requiring a discharge summary on every resident discharged/transferred from the facility 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents have the potential to be affected by the same issue. - Staff Development Coordinator/Director of Nursing will in-service and educate facility medical providers/physicians of the facilities policy regarding required discharge summary for all residents discharged or transferred	

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F 661	Continued From page 31 A review of a facility policy titled Medical Record Content, revised on October 1, 2017, revealed, "Policy The Facility will maintain a medical record for each resident admitted to the facility that will contain sufficient information to identify the resident, support the diagnosis, justify the medical necessity for treatment, and facilitate continuity of care among health care providers. Procedure I. The medical record will be accurate, timely and complete..." NJAC 8:39-35.2(e)	F 661	from the facility. - Unit Manager/Charge Nurse/Designee will notify provider/physician of residents' anticipated discharge date in advance (when able to do so) or circumstance that would warrant an unplanned discharge, to allow provider/physician adequate time to prepare for residents' discharge summaries. - Interdisciplinary Team will discuss pending and potential resident discharges weekly during Utilization Review meeting. Unit Manager will be provided with a list of residents with pending and/or potential discharges will be provided by Therapy department, Admissions Department, or Social Services Department and given to the provider/physician. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Social Worker/Designee will complete a weekly audit of all residents identified in weekly Utilization Review Meeting and unplanned for discharge for discharge summaries completed by provider/physician. - Unit Manager/Designee will complete a weekly random audit of residents discharged from the facility to identify if a discharge summary was completed by the provider/physician.	

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F 661	Continued From page 32	F 661	4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - Staff Development Coordinator/DON/Designee will complete weekly random audits of all discharged residents to identify if a discharge summary was completed by the provider x 8 weeks; then twice monthly; then monthly until compliance is maintained x2 during facility's weekly QAPI meeting.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based observation, interview, record review and review of other facility documentation, it was determined that the facility failed to perform quarterly [EX Order 26 § 4b1] assessments according to facility policy for a supervised [EX Order 26 § 4b]. This deficient practice occurred for 1 of 1 residents (Resident #6) reviewed for [EX Order 26 § 4b1]. This deficient practice was evidenced by the following:	F 689	Specific Resident 1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident # 6 Quarterly assessment immediately completed	5/31/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33 On 04/12/2023 at 10:13 AM, the surveyor observed the facility designated EX Order 26 § 4b1 area. The surveyor asked staff present at the time if Resident #6 was present and EX Order 26 § 4b1. A staff replied to the surveyor and said Resident #6 is a "supervised" EX Order 26 § 4b. Staff assigned to EX Order 26 § 4b1 area stated resident #6 has specified times to EX Order 26 § and must be supervised. Staff confirmed that Resident #6 was not present on this observation. According to the Admission Record Resident #6 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 A review of the Medicare 5-day Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated 03/23/2023 revealed that Resident #6 had a Brief Interview for Mental Status score of EX O/15, indicating EX Order 26 § 4b1. Section G revealed that Resident #6 was required Ex.Order 26.4(b)(1) with all activities of daily living. Section N revealed that Resident #6 received EX Order 26 § 4b1 A review of the Order Summary Report did not reveal any physician associated orders for Resident #6. A review of Resident #6's comprehensive care	F 689	- Staff Development Coordinator educated and in-serviced the Minimum Data Set Coordinator and facility/agency nurses, in addition to Unit Managers, on the facility policy for completing quarterly Ex.Order 26.4(b)(1) assessments for residents identified as EX Order 26 § 4b1. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents identified as a Ex.Order 26.4(b)((independent and supervised) have the potential to be affected by the same issue needing to be addressed. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Staff Development Coordinator/Unit Manager/Designee will complete a weekly audit of all new and readmissions, as well as current residents, identified as Ex.Order 26.4(b)(1 to ensure initial and quarterly Ex.Order 26.4(b)(1 assessments are completed per facility policy. - Staff Development Coordinator will educate all new hire nursing staff and agency staff on the facility policy of completing initial and quarterly Ex.Order 26.4(b)(1 assessments. An audit of all residents who Ex.Order 26.4(b) will	

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plan revealed a Focus: The resident is a [Ex.Order 26.4(b)(1)]. Date Initiated: 03/08/2023. The following were observed under Goal: Resident will adhere to facility [EX Order 26 § 4b1] policy through the review date; the resident will not [EX Order 26 §] without supervision through the review date; and the resident will not suffer injury from unsafe [EX Order 26 § 4b1] through the review date. Interventions, Date Initiated: 03/08/2023 included but were not limited to: Instruct resident about the facility policy on [Ex.Order 26.4(b)(1)]: locations, times, safety concerns, the resident requires SUPERVISION while [EX Order 26 § 4b1], the resident's [Ex.Order 26.4(b)(1)] supplies are stored by [Ex.Order 26.4(] aid, notify charge nurse immediately if it is suspected resident has violated facility [Ex.Order 26.4(b)(1)] policy.

On 04/13/2023 at 12:07 PM, the surveyor reviewed Resident #6's medical record (MR). The surveyor observed a [facility name] Resident [Ex.Order 26.4(b)(1)] assessment in the resident's physical medical record. The original assessment was dated on 9/2/21. A 1st Quarter RE-Assessment was completed on 2/1/21. A 2nd Quarter RE-Assessment was completed on 3/2/21 (error should have read 22') and a 3rd Quarter RE-Assessment was completed on 6/3/22. The original and quarterly assessments all identified Resident #6 as a "supervised" [Ex.Order 26.4(b)(1)] The agreement also identified that the agreement/assessment was "Completed by Nursing upon resident admission, re-admission, and quarterly."

On 04/24/2023 at 09:38 AM, the surveyor reviewed the MR for Resident #6, both electronic and physical record. The surveyor was unable to locate a [facility name] Resident [EX Order 26 § 4b1] Agreement for Resident #6 dated after 6/3/2022.

F 689

be conducted to ensure initial and quarterly [EX Order 26 § 4b1] assessments are completed.

- Staff Development Coordinator/Unit Manager/Designee will in-service and educate facility and agency nurses on the facility policy for completing initial and quarterly [EX Order 26 § 4b1] assessments for residents identified as [Ex.Order 26.4(b)(1)].

4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness.

- Staff Development Coordinator/DON/Designee will complete weekly random audits of residents identified as [Ex.Order 26.4(b)(1)] to ensure initial and quarterly [Ex.Order 26.4(b)(1)] assessments were completed per facility protocol x8 weeks; then twice monthly x2; then monthly until compliance is maintained x2. Reports will be submitted to the facility's weekly QAPI Committee meetings.

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The surveyor spoke with the facility Activities Director as to where the facility Ex.Order 26.4(b)(1 binder was located, as the facility EX Order 26 § 4b1 Policy Contract revealed that a EX Order 26 § 4b1 binder will be maintained with a list of all EX Order 26 § 4b1 residents' assessments, safety devices, EX Order 26 § 4b1 violations, and premium EX Order 26 § 4b1 inventory. The AD stated that she would find out and get back to the surveyor. The AD then reported to the surveyor that EX Order 26 § 4b1 assessments and agreements were located either in the resident's medical binder or in the Electronic Medical Record.

On 04/24/2023 at 09:45 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) how often EX Order 26 § 4b1 assessments are completed for facility residents who EX Order 26 §. The LNHA stated that he was not sure but believed that Ex.Order 26.4(b)(1) assessments were to be completed quarterly. The surveyor made the LNHA aware that he could not find any completed assessments for Resident #6 since 6/3/22. The LNHA then said he would check into it and get back to the surveyor.

On 04/24/2023 at 10:52 AM the LNHA told the surveyor, "I was unable to find a Ex.Order 26.4(b)(1) assessment for Resident #6 other than the one last completed on 6/3/2022. According to our policy they are to be completed quarterly. We put activities in charge of doing the initial assessment for new residents within 14 days and nursing is responsible for the quarterly assessments.

On 4/24/2023 at 01:32 PM, during a meeting with the facility administration, the Vice President of Clinical Services and LNHA explained, "EX Order 26 § 4b1 assessments are to be conducted on a quarterly basis. Activity aides and the activity director are

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F 689	Continued From page 36 responsible for doing the initial EX Order 26 § 4b1 assessment. Nursing is responsible for the quarterly assessments." The surveyor reviewed the facility provided policy titled EX Order 26 § 4b1, undated. The contract revealed the following: "Any resident who wishes to EX Order 26 § 4b will be evaluated by the Interdisciplinary Team within fourteen (14) days of admission, and quarterly to determine whether they are responsible and/or independent enough to Ex.Order 26.4(b on their own and maintain their own Ex.Order 26.4(b)(1 materials. A EX Order 26 § 4b1 binder will be maintained with a list of all EX Order 26 § 4b1 residents' assessments, safety devices, EX Order 26 § 4b1 violations, and EX Order 26 § 4b1." NJAC 8:39-31.6(e)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a physician order to administer medication in accordance with the facilities policy and professional standards of nursing practice. This	F 695	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - A physician/provider□s order for Ex.Order 26.4(b)(was obtained for Resident #22	6/9/23

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F 695	Continued From page 37 deficient practice was identified for 1 of 3 residents reviewed for EX Order 26 § 4b (Resident #22) and was evidenced by the following: On 04/14/2023 at 01:40 PM, the surveyor observed Resident #22 lying in his/her EX Order 26 § 4b1 bed. The resident had a EX Order 26 § 4b1 in place administering EX Order 26 § 4b1 per minute. The EX Order 26 § 4b1 was dated 4/13/2023. The resident stated that he/she uses EX Ord at all times. A review of the electronic medical record (EMR) reflected that Resident #22 had a diagnosis that included but not limited to: EX Order 26 § 4b1 A review of the most recent Minimum Data Set (MDS) dated 3/20/23, indicated Resident #22 was on EX Order 26 § 4b1 while not a resident at facility as well as while a resident at the facility. A review of the Physician Order Summary (POS) with date of 4/16/2023, did not include a physician order for Ex.Order The POS did reveal an order for a "EX Order 26 § 4b1 " A review of the Care Plan included: The resident has Ex.Order 26.4(b)(1) r/t ineffective Ex.Order 26.4(b)(1); date initiated 3/21/2023. EX Order 26 § 4b1 During a meeting with the survey team on 04/24/2023 at 12:37 PM, in the presence of the	F 695	- Staff Development Coordinator educated and in-serviced facility and agency nurses on the facility policy for obtaining a physician/provider□s order for the use of EX Order 26 § 4b. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents have the potential to be affected by this deficient practice. - An audit will be conducted of all resident orders for the use of EX Order 26 § 4b and Ex.Order 26.4(b)(1) equipment, for appropriate orders in accordance with facility policy. Orders will be reviewed to ensure accuracy. - Staff Development Coordinator/Unit Manager/Designee will in-service and educate the facility and agency nurses on the facility policy for obtaining a physician/provider□s order for the use of Ex.Order 26.4(b)(3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Staff Development Coordinator/Unit Manager/Designee will complete a weekly audit of all new and readmissions, as well as current residents, identified as requiring the use of EX Order 26 § 4b to ensure that	

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F 695	Continued From page 38 Licensed Nursing Home Administrator, Vice President of Clinical Services (VPCS) stated that there should be a physician order for Ex.Order 26.4(b)(prior to administration unless it is an emergency situation. A review of a facility policy titled "Ex.Order 26.4(b)(Administration," with a revised date of 8/1/2017, revealed under #1 Initiation of Ex.Order 26.4(b)(; "A physician's order is required to initiate Ex.Order 26.4(b) therapy, except in an emergency situation." The order shall include: 1. Ex.Order 26.4(b)(flow rate 2. Method of administration (e.g. nasal cannula) 3. Usage of therapy (continuous or prn) 4. Titration instructions (if indicated) 5. Indication for use NJAC 8:39-27.1 (a)	F 695	a physician or provider□s order has been obtained in accordance with facility policy. - Staff Development Coordinator will educate all new hire facility staff and agency nurses on obtaining orders for residents identified as needing or having Ex.Order 26.4(b)(according to facility policy. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - Staff Development Coordinator/DON/Designee will complete weekly random audits of residents identified as requiring/wearing Ex.Order 26.4(b)(to ensure a physician/provider□s order has been obtained in accordance with facility policy x8 weeks; then twice monthly x2; then monthly until compliance is maintained x2 and identified during facility's QAPI Committee meetings.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		5/31/23

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F 756	Continued From page 39 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to respond to the monthly Consultant Pharmacist (CP) recommendations. This deficient practice was identified for 2 of 5 residents reviewed for unnecessary medications (Resident #13, Resident # 71), and was evidenced by the	F 756	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident #13 had consultant pharmacist outstanding recommendations corrected. .- Resident # 71 had consultant	

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F 756	Continued From page 40 following: On 04/14/2023 at 10:30 AM, the surveyor requested the CP reports and follow-up on any recommendations for past 6 months for Resident #13 and Resident #71. A.) A review of the Admission Record revealed Resident #13 was admitted to the facility with diagnoses including but not limited to: Ex.Order 26.4(b)(1) A review of the Electronic Medical Record (EMR) revealed Clinical Physician Orders as follows: EX Order 26 § 4b1 On 04/17/2023 at 10:23 AM, a review of the CP reports for past 6 months for Resident #13 revealed the following: "On Feb 27, 2023, assigned to nursing the CP recommended to 1. EX Order 26 § 4b1	F 756	pharmacist outstanding recommendations corrected. - Staff Development Coordinator educated and in-serviced facility Unit Managers and shift supervisors on the facility policy and process for completing consultant pharmacist recommendations in a timely manner 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents have the potential to be affected by the same issue needing to be addressed. - Staff Development Coordinator/Director of Nursing/Designee will in-service and educate unit managers and shift supervisors on completing and following up on consultant pharmacist's recommendations according to facility policy. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Staff Development Coordinator/Designee will complete a monthly audit of the consultant pharmacist's monthly recommendations to ensure that action has been taken on all recommendations of the prior month in efforts to be in compliance with the facility	

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F 756	Continued From page 41 Feb 27, 2023 Nursing: Separate Ex.Order 26.4(b)(1) by 2 hours as should not be given at same time as reduces absorption. Both of these must be separate from Ex.Order 26.4(b)(1) by 4 hours. Note changing Ex.Order 26.4(b)(1) will correct this." A review of February 2023 and March 2023 Medication Administration Record (MAR) indicated the following; February Ex.Order 26.4(b)(1) was administered at 6:30 AM Ex.Order 26.4(b)(1) administered at 6:30 AM Ex.Order 26.4(b)(1)) was administered at 9 AM and 5 PM Ex.Order 26.4(b)(1) was administered at 9 AM and 5 PM. A review of the March 2023 CP recommendations which were bolded identified the same concerns indicated above from February 27, 2023. A review of the March 2023 and April 2023 MAR's revealed there was no change to the medication administration times as documented above and recommended by the CP. B.) According to the Admission Record Resident #71 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 On 04/14/2023 at 10:42 AM the surveyor reviewed the CP report for Resident #71 which included the following: On 10/13/2022 Assigned to:Nursing patient has all med's ordered EX Order 26 § 4b1	F 756	protocol. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - Director of Nursing/Designee will complete monthly random audits of recommendations made by the consultant pharmacists monthly until compliance is maintained x4 months and reviewed monthly during facility's QAPI Committee Meetings.	

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F 756	Continued From page 42 except for EX Order 26 § 4b1 A review of the Physician Order Form dated for November 2022, December 2022 and January 2023 revealed that the above medications are still ordered as EX Order 26 § 4b1. A review of the current Physician orders revealed that EX Order 26 § 4b1 On 02/27/2023, "Assigned to: Nursing the CP identified that all med's (medications) are ordered EX Order 26 § 4b1 EX Order 26 § 4b1 Verify dosing. Is patient to be receiving a 2 mg dose? please verify and correct. Must indicate amount of mls to give in the order. EX Order 26 § 4b1 A review of the MARS for February 2023 did not include a change for the EX Order 26 § 4b1 were indicated to be given by mouth and time for EX Order 26 § 4b1 was unchanged. A review of the March 2023 MARS indicated EX Order 26 § 4b1 was timed at 6 AM until 03/13/2023 then changed on 03/14/2023 to 5 AM. The EX Order 26 § 4b1 were ordered by mouth until 3/14/2023 when the order was changed to give via EX Order 26 § 4. The EX Order 26 § 4b1 order unchanged.	F 756		

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The CP report dated March 28, 2023, EX Order 26 § 4b1 "

A review of the April 2023 MAR revealed the EX Order 26 § 4b1 continue to be ordered by mouth and the EX Order 26 § 4 is timed at EX Order 26 § 4b1.

During an interview with the surveyor on 04/20/2023 at 09:49 AM, the Registered Nurse Unit Manager (RNUM) said she has worked at the facility for 6 weeks. RNUM went on to say she is not familiar with the CP process or them (CP) coming in to do the Medication Regime Review.

During an interview with the surveyor on 04/20/2023 at 10:52 AM, the Interim DON (IDON) was asked what is the process for the CP. The IDON said the CP comes in and reviews all charts. The CP makes recommendations and then the Unit Manager (UM) reviews the recommendations and if needed will call the physician or will change medication times if recommended. There is no west wing UM so I am going to help with the CP report. The IDON went on to say I will get the report then give to east wing UM and I will do west wing. It would be immediately to do the report. This is new to me

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but I have seen them. I can't give an answer on how long we have to complete/follow-up on recommendations. The IDON said Yes, we would have our own policy for this.

During an interview with the surveyor on 04/24/2023 at 12:50 PM, the Vice President of Clinical Services (VPCS) said the process for the CP is that he write his findings and emails to DON and UM's and Licensed Nursing Home Administrator. I have asked for copy as well. VPCS went on to say that the UM is to correct recommendations he has made. When asked how long does the facility have to respond to the report, the VPCS said this needs to be done in timely manner.

A review of a facility policy titled Drug Regimen Review with revised date of November 01, 2017, revealed under the Policy section II. The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

NJAC 8:39-29.3(a)(1)

F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/9/23

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;

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(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for

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F 758	Continued From page 46 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow facility-established stop order policies for Ex.Order 26.4(b)(1) drugs (drugs that affect a person's Ex.Order 26.4(b)(1)) and PRN (as-needed) EX Order 26 § 4b1 medication ordered for longer than 14 days, without a documented rationale for continued use. The deficient practice was identified for 1 of 5 residents (Resident #19) investigated for Unnecessary Medications/PRN Use. The deficient practice was evidenced by the following: A review of Resident #19's diagnoses located in the Electronic Medical Record (EMR) revealed that he/she was diagnosed with EX Order 26 § 4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 03/27/2023 located in the EMR revealed that Resident #19 received EX Order 26 § 4b1 A review of the Physician's Orders located in the EMR revealed that Resident #19 had orders for the following medications:	F 758	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident # 19 had medication ordered re-evaluated and adjusted. EX Order 26 § 4b1 was discontinued after 7 days on 5/2/23 due to no symptoms or need at this time. EX Order 26 § 4b1 order was evaluated and placed on 7-day re-evaluation for Ex.Order 26.4(b)(Medication was discontinued on 5/2/23, however was re-ordered again on 5/4/23 for 7 days then evaluate need. - Staff Development Coordinator/designee educated and in-serviced the facility/agency nurses, in addition to Unit Managers, via face to face discussions on the facility policy for Ex.Order 26.4(b)(1) Management which includes ensuring Ex.Order 26.4(b)(1) medications are limited to 14 days until physician renewal. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents identified as having orders for Ex.Order 26.4(b)(1) orders will have stop dates implemented after speaking with provider. Any resident identified with PRN Ex.Order 26.4(b)(1) medication orders will have stop dates with evaluations put in place in	

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EX Order 26 § 4b1 A 14 day stop order was not documented in the physician's orders.

A review of the Consultant Pharmacist Summary Report dated 12/28/2022, revealed that the Pharmacist recommended to discontinue EX Order 26 § 4b1 as needed for EX Order 26 § 4b1. The Pharmacist also documented that current as needed EX Order 26 § 4b1 medication orders also must have a 14 day stop order at which point requires in person physician evaluation to renew, justifying continued need and duration of therapy.

A review of the same Consultant Pharmacists Summary Report dated 12/28/2022, further revealed that the Pharmacist recommended to review the order for EX Order 26 § 4b1 and add a 14 day stop date. The Pharmacist documented further that as per new CMS requirement for initial EX Order 26 § 4b1 PRN medication, orders are to be limited to 14 days. The same recommendation was documented by the Pharmacist on 01/24/2023 and 02/27/2023 on the Consultant Pharmacists Summary Report.

On 04/20/2023 at 12:27 PM, during an interview with the surveyor, the Interim Director of Nursing said that a EX Order 26 § 4b1 as needed order needs to be renewed after 14 days.

On the same date at 12:43 PM during an interview with the surveyor, the Registered Nurse Unit Manager said she is not aware of 14 day stop date.

On 04/24/2023 at 12:38 PM, during an interview

F 758

accordance to facility policy Ex.Order 26.4(b)(1) Drug Management.

- Staff Development Coordinator/Unit Manager/Designee will in-service and educate facility and agency nurses, via face to face discussions, on the facility policy regarding PRN orders for EX Order 26 § 4b1 medications and management which includes ensuring EX Order 26 § 4b1 medications are limited to 14 days until physician renewal.

3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future:

- Staff Development Coordinator/Unit Manager/Designee will review new orders and new/readmission orders for any EX Order 26 § 4b1 medications to ensure the order does not extend beyond 14 days if ordered PRN.

- Staff Development Coordinator will educate all new hire nursing staff and agency staff, via face to face discussions, on the facility policy regarding orders of PRN EX Order 26 § 4b1 Drug Management which includes ensuring EX Order 26 § 4b1 medications are limited to 14 days until physician renewal.

4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction

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F 758	Continued From page 48 with the surveyor, the Vice President of Clinical Services confirmed that an as needed Ex.Order 26.4(b)(1) medication must be limited to 14 days until physician renewal. A review of an undated facility policy titled, "Psychotherapeutic Drug Management" revealed under, "Procedure" letter "I(i)", "PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order." A review of the same policy revealed under letter "I(ii)" that, "PRN orders or anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident, in person, for the appropriateness of that medication." N.J.A.C. 8:39-29.2 (d)	F 758	is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - Director Of Nursing/Designee will complete weekly random audits x8 of residents identified as having been prescribed Ex.Order 26.4(b)(1) medications, to ensure that all Ex.Order 26.4(b)(1) medications that are ordered as PRN, are limited to 14 days with re-evaluation if warranted. Audit x8 weeks; then monthly x2 until compliance is maintained x3 months will be submitted to the facility's weekly QAPI Committee Meetings.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		5/31/23

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F 761	Continued From page 49 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to detect and remove expired biologicals and medications in a storage room identified by the facility as 1 of 1 Medication Backup Storage Rooms. This deficient practice was evidenced by the following: A) On 04/17/2023 at 10:32 AM, Surveyor #1, in the presence of the Vice President of Clinical Services (VPCS), and another surveyor, inspected the Medication Backup Storage Room on the West Wing Unit, which included a locked medication refrigerator. In the medication refrigerator, Surveyor #1 found 1 vial of Covid 19 [pharmaceutical company name] vaccine with an expiration date of 07/2022. When interviewed at that time, the VPCS confirmed the vaccine was expired and should be returned to the pharmacy. B) On 04/17/2023 at 10:33 AM, surveyor #2 in	F 761	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - All vials of expired medications were properly disposed of into the sharps containers per facility protocol regarding glass vials and sharps. - No resident or facility staff received any doses of the expired medications and were not harmed or affected. - Staff Development Coordinator educated and in-serviced facility Unit Managers, shift supervisors, and facility/agency nurses of the facility policy regarding removal of discontinued or expired medications. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue	

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F 761	Continued From page 50 the presence of the VPCS, and another surveyor, inspected the IV (Intravenous) Backup Box in the Medication Backup Storage Room. The Backup Box contained 1 vial of Vancomycin Hydrochloride for injection with an expiration date of 03/1/2021 and 9 vials of Teflaro for injection 600 milligrams/vial with expiration date of 09/2021. During an interview upon the discovery, the VPCS stated, "we pulled that out to be destroyed" it is not usually in that box. She continued to state that the medications were found last week behind a cabinet when the office was being cleaned. The VPCS confirmed that the medications were expired and added that she was unsure how the expired medications ended up in the IV Back Up box. A review of a facility policy titled, "6.0 Medication Storage, Policy," with a revised date of 09/2020, revealed under Procedure F: "Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy." NJAC-8:39-29.4(h)	F 761	needing to be addressed: - All residents have the potential to be affected by the same issue needing to be addressed. - Staff Development Coordinator educated and in-serviced facility Unit Managers, shift supervisors, and facility/agency nurses regarding the facility policy for proper removal of discontinued or expired medications by May 31, 2023. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Unit Manager/Shift Supervisors/Designee will audit the Medication refrigerators and back up box daily. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - Staff Development Coordinator/Designee will submit a weekly audit of the Back-up medication storage room to the Director of Nursing to ensure expired and discontinued medications are disposed of according to the facility policy x8 weeks, then monthly until compliance is maintained x3 months. The Director of	

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F 761	Continued From page 51	F 761	Nursing will submit the reports weekly/monthly per above schedule to the facility's QAPI Committee.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 04/12/2023 from 09:01 to 09:48 AM, the surveyor, accompanied by the Dietary Director (DD), observed the following in the kitchen:	F 812	SPECIFIC CONCERNS All Cooks responsible to log temperatures for freezers #2 and #3 were re-inserviced on the importance of doing so. All undated food items in the walk-in refrigerator and freezer #2 were immediately discarded. The floor to freezer #2 was cleaned. The broken trash can was replaced. The Dietary aide will be re-inserviced on wearing a hair net. The fan in the	5/31/23

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F 812	Continued From page 52 1. Reach in Freezer #2 and Freezer #3 temperature monitoring logs had no temperatures recorded for the following dates: Freezer 2: 04/05/2023 at breakfast, lunch, and dinner; 04/08/2023 at breakfast and lunch; 04/09/2023 at dinner; and 04/10/2023 at dinner. Freezer #3: 04/08/2023 at breakfast and lunch and 04/09/2023 at dinner. The DD told the surveyor that the cooks were responsible for recording temperatures at the breakfast, lunch, and dinner meal periods. 2. On a top shelf in the walk-in refrigerator a box labeled stick butter had an opened can of soda inside the box. The DD removed the can to the trash. On a shelf below a Styrofoam container with a plastic lid contained an unknown food item. The container had no dates. On an upper shelf an opened plastic bag of shredded mozzarella cheese had no dates. The bag was opened, and the cheese was exposed to the air. The bag was dated "3/23." A metal pan with clear plastic wrap contained sliced ham. The pan had no dates. On a lower shelf a third pan was covered with foil wrap. The pan had no dates, A 1/4 pan covered with clear plastic wrap contained tomato wedges. The pan had no dates. A multi-tiered wheeled cart contained a tray of peanut butter and jelly sandwiches on white bread. The tray of sandwiches had no cover, and the sandwiches were exposed. On a rack above the sandwiches a chef's salad covered in plastic wrap had no dates. A clear plastic bag on a rear middle shelf contained an unidentified food. The bag had no dates and had a foul odor. On a lower shelf on the right side of the walk-in a metal sheet tray contained (2) bags of pork and (1) bag of an unidentified food product. The DD stated that they were in the refrigerator to defrost. The surveyor	F 812	dishwashing area and floor of freezer #2 were cleaned and added to the department's cleaning schedule. The employees who "nested" the pans and didnt return the dented cans to the appropriate area were re-inserviced. Resident #44 refrigerator will be cleaned and the Housekeeper responsible to take the temperature will be re-inserviced. A temperature log was added to room 21 refrigerator. IDENTIFICATION OF SIMILAR CONCERNS All residents have the potential to be affected by the deficient practices. SYSTEMIC CHANGES The Dir of Dietary or the Cooks will review food dating, staff wearing hair nets and temperature logs daily for compliance and a form developed for this purpose. The Dir of Dietary will ensure all items requiring cleaning are included on the department's cleaning schedule. The Dir of Housekeeping will oversee staff compliance regarding all resident refrigerators. The Dietary Director will review all refrigerators and freezers to ensure temperatures are appropriately logged, food is dated, and they are clean. Any other broken trash cans in the department will be replaced. All Dietary staff will be re-inserviced on dating food,documenting temperatures,wearing hair nets, logging broken items in the Maintenance Log, not nesting pans,	

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F 812 Continued From page 53

checked the dates and the (1) bag of pork was labeled 033023. The DD stated, "Oh, I'll get rid of that." The bottom of the tray was covered in blood and produced a foul odor.

3. Observation of Freezer 2 noted that the bottom of the freezer was littered with unidentified food debris and what appeared to be unidentified food spills. The surveyor asked the DD when the last time the freezer was cleaned and sanitized. The DD stated, "We did a deep clean on Sunday." The surveyor asked if it should be cleaned as necessary and the DD stated, "Yes." On a middle shelf an opened package of hot dogs was wrapped in plastic wrap. The hot dogs had no dates. In addition, a plastic bag contained an unidentified food item. The bag was previously opened and had no dates. On a bottom shelf a plastic bag contained frozen diced chicken. The bag had no dates. The DD removed the products to the trash in the presence of the surveyor.

4. The surveyor performed hand hygiene at the designated hand washing sink after assessing Freezer 2. Upon completion of performing hand hygiene the surveyor grabbed a hand towel to dry their hands. The surveyor dried their hands and went to throw the hand towel into the designated waste receptacle. The lid to the waste receptacle was observed to be only partially covering the waste receptacle and was not able to be moved without the surveyor using their sanitized hands to access the waste receptacle. The surveyor asked the DD if there was a trash receptacle available to throw the wet hand towel into. The DD stated, "Right here and pointed to the broken trash can." The waste receptacle had a foot pedal used to open the lid so that staff do not have to use their clean hands to access. The foot pedal

F 812

removing dented cans to the appropriate area, and cleaning all fans. All Housekeepers will be re-inserviced on cleaning and documenting on cleaning and documenting temperatures on all resident refrigerators. Residents will be asked to date food items with the date they placed them in the refrigerator and Housekeepers will be inserviced to monitor this as well as discarding items per facility policy. The Director of Dietary will ensure all fans in the department are clean.

MONITORING

The Dir of Dietary will submit a daily report to the Administrator regarding food dating, refrigerator/freezer temperatures and hair nets. The Administrator will submit a weekly report to the facility's weekly QAPI Committee on these issues. The Dir of Dietary will submit a weekly report regarding Cleaning Schedule Compliance to the facility's weekly QAPI Committee. The Administrator will submit a separate monthly Dietary Sanitation Audit to the facility's weekly QAPI Committee.
The Dir of Housekeeping will submit a weekly report regarding resident refrigerators to the facility's weekly QAPI Committee.

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F 812	Continued From page 54	F 812		

was broken, and the trash lid could only be removed by hand. The surveyor stated to the DD, "Do you want me to remove the dirty lid with my clean hands to throw away my hand towel. The DD said that he would get the trash can fixed.

On 04/20/2023 from 09:13 AM to 09:47 AM, the surveyor, accompanied by the DD, observed the following in the kitchen:

1. Upon entry to the kitchen the surveyor observed a female dietary aide (DA) with lengthy hair in a pony tail. The DA had no hair net, and their hair was exposed. When the surveyor questioned the DA where their hairnet was the DA walked away and proceeded to obtain a hair net from the basket attached to the wall inside the entry door to the kitchen.

2. A wall mounted fan above the low temperature dish machine was observed to have a substantial build-up of a black/gray dust-like substance on the fan blades and fan guard. The DD stated that staff had recently cleaned the fan but that they could not reach the top of the fan to clean it properly.

3. A stack of 8 deep 1/2 pans were observed on an upper shelf of the pot/pan storage rack. The pans were in the inverted position and stacked on top of each other. The surveyor used their finger on the lower outside edge of the top pan to move in an upward manner. The 1/2 pan below was observed to have a water-like substance on the bottom of the external surface (wet nesting). Further removal of pans below also demonstrated wet nesting. A DA identified the substance as water. The DD stated, "They should be air dried before stacking." The DD removed the pans to be

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F 812	Continued From page 55 rewashed and sanitized and air dried. 4. In the dry storage room on a middle shelf of the first of several can storage racks, a can of beef stew had a significant dent on the bottom seam of the can. On an upper shelf a can of unsweetened apple sauce had a significant dent on the upper seam and side of the can. On a middle shelf a can of tropical fruit salad had a significant dent on the upper seam. The DD removed the dented cans to the designated dented can area. On 04/14/2023 at 08:35 AM, Resident #44 was observed seated in their EX Order 26 § 4b1 eating their breakfast meal. The surveyor asked Resident #44 if the personal refrigerator in the room belonged to them. Resident #44 responded, "Yes, its dirty." The surveyor asked if he/she would like their refrigerator to be clean. Resident #44 stated that they would like it to be cleaned and authorized the surveyor to examine the contents of the refrigerator. The surveyor observed a facility provided plastic dessert bowl with a plastic lid. The contents of the dish were unknown, and the dish had no dates. In addition, a small, round Styrofoam container with a plastic lid had unknown contents and the container had no dates. Several 4 oz orange juice containers were inside the refrigerator and had no dates. The inside of the bottom of the refrigerator was covered with unidentified spills and food debris, as well as the upper shelf of the refrigerator. The temperature monitoring log attached to the front door of the refrigerator in a clear plastic protector was undated for the month/year and no temperatures had been recorded. The temperature monitoring sheet was blank.	F 812		

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On 4/14/2023 at 11:13 AM a small personal refrigerator was observed in room Ex.Ord on the East Wing. The surveyor did not observed a temperature monitoring log attached to the refrigerator or anywher in the room.

On 04/17/2023 at 01:20 PM, the surveyor observed the temperature log on the door of Resident #44's personal refrigerator. The temp log had temps recorded for Day 1, Day 2, and Day 4. The temperature log is not dated for month and those temps were not documented on the surveyor's previous observation on 04/14/2023. Resident #44's personal refrigerator remained with the same stains and undated foods as previously observed on 04/14/2023.

On 04/24/2023 at 10:05 AM, the surveyor observed the personal refrigerator in Resident #44's room. The Temperature Log was only dated for three days, as previously observed on 04/17/2023. Temperatures were recorded for Day 1, Day 2, and Day 4. The surveyor opened the refrigerator and observed a brownish/orange unidentified substance. This same substance was also observed on the 1st, 2nd, and 3rd shelves of the refrigerator. During an interview with the facility Director of Housekeeping (DOH) the DOH stated that she was not sure who in the facility was responsible for the sanitation of personal refrigerators in the facility. The DOH stated that she believed that the facility Licensed Nursing Home Administrator (LNHA) was responsible for recording and monitoring temperatures of personal refrigerators in the facility.

On 04/24/2023 at 01:10 PM, during an interview with the facility LNHA explained to the surveyor that "the housekeeper assigned to the room is

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responsible for monitoring refrigerator temperatures on the personal refrigerators and we have not worked out who is responsible for the sanitation of the refrigerators at this point."

The surveyor reviewed the facility policy titled Food Storage Policy No. - DS - 52, Date Revised: August 01, 2017. The following was revealed under Procedure:

II. Frozen Meat/Poultry and Food Guidelines

C. (i) Label and date all food items.

D. (i) Date meat when taken out of freezer and with date of meal service.

VIII. Canned Fruit Storage Guidelines

C. Dented or bulging cans should be placed in separate storage area and returned for credit.

The surveyor reviewed the 03/27/2023 - 04/1/2023 and 04/2/2023 - 04/8/2023 Dietary Aides and Cook Weekly/Daily Cleaning Schedule. Upon review of the schedules neither Freezer 2 or the wall mounted fan over the dish machine were included on the weekly/daily cleaning schedules to be completed either by the cooks or dietary aides.

The surveyor reviewed the facility policy titled Refrigerator/Freezer Temperature Records, Policy No. - DS - 53, Date Revised: August 01, 2017. The policy revealed the following under Policy: A daily temperature record is to be kept for refrigerated and frozen food storage areas. The following was revealed under Procedure:

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F 812	Continued From page 58 I. The Dietary Manager or designee is to record daily all refrigerator and freezer temperatures on DS - 53 - Form A - Refrigerator/Freezer Log during AM and PM shifts. The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, Revised October 2017. The following was revealed under Policy Interpretation and Implementation: 5. All personnel involved in preparing, handling, serving, or assisting the resident with meals or snacks will be trained in safe food handling practices. 7. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. b. Perishable foods must be stored in re-sealable containers with tight fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. N.J.A.C. 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		6/9/23

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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F 842	Continued From page 60 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 19 sampled residents, (Resident #253) and was evidenced by the following: Resident #253 was discharged on Ex.Order 26.4(b)(1) On 04/14/2023 at approximately 01:45 PM, the surveyor requested the closed medical record for Resident #253. During an interview with the surveyor on 04/17/2023 at 09:30 AM, the Vice President of Clinical Services (VPCS) stated that she was still working on getting the medical records and all she could find was the hospital records. During an interview with the surveyor on 04/17/2023 at 01:15 PM, the Licensed Nursing	F 842	SPECIFIC RESIDENT Resident #253 medical record could not be located. IDENTIFICATION OF SIMILAR RESIDENTS All residents have the potential to be affected by this deficient practice. The facility will conduct a retroactive audit to 8/1/22 when the current company took over management operations through 2/1/23 when the facility converted to an EMR system, to ensure all medical records for discharged residents are accounted for. SYSTEMIC CHANGE Facility is now on an EMR system	

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F 842	Continued From page 61 Home Administrator (LNHA) handed the surveyor a manila file folder containing a hospital record for Resident #253 and stated that the hospital record was the only thing he could find. The LNHA was unable to provide the surveyor with Resident #253's clinical record. During an interview with the surveyor on 04/24/2023 at 12:39 PM, the LNHA replied 10 years when asked how long should the clinical record be maintained. A review of the facility policy titled Medical Records dated August 1, 2017, revealed under "Policy" Clinical records, paper or electronic, will be kept for each resident admitted for care. Content will be in compliance with licensing and certifying governmental agency requirements and professional standards. Procedure I. Records will be maintained in a permanent form, typewritten or legibly written in ink and are capable of being photocopied. ...III. Generally, records are retained for a period of 10 years from the date of the last discharge, after which time they may be destroyed. NJAC 8:39-35.2(K)	F 842	MONTORING The Medical Records Designee will submit a weekly report on the status of all discharged residents medical records to the facility's weekly QAPI Committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/31/23

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F 880	Continued From page 62 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 63 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, and review of other facility documentation, it was determined that the facility failed to a.) implement infection control practices for the handling and storage or EX Order 26 § 4b1 equipment for 2 of 2 residents reviewed for EX Order 26 § 4b (Resident #30 and Resident #7) and b.) failed to implement infection control practices for the changing of a EX Order 26 § 4b1 set for 1 of 1 residents reviewed for EX Order 26 § 4b1 (Resident #71). This deficient practice was evidenced by the following: This is a cited at E level as this is a repeat deficiency from the recertification survey conducted on 2/3/2022. 1.) On 04/12/2023 at 10:27 AM, Surveyor #1 entered Resident #30's room after gaining resident permission. Upon entering the room,	F 880	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - The EX Order 26 mask for Resident #30 was cleaned and securely placed in a bag to prevent contamination. The EX Order 26 § 4b typing EX Order 26 § 4b1 for Resident #7 changed and then was placed in a bag to prevent contamination while not in use. - The EX Order 26 § 4b1 set used for Resident#71 was immediately discarded and replaced with a new one. - Infection Preventionist/Staff Development Coordinator educated and in-serviced facility and agency nurses on the recommended practices of preventing contamination when storing Ex.Order 26.4(b)(1)	

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F 880	Continued From page 64 Surveyor #1 observed Resident #30's EX Order 26 § 4b1 was placed on top of the EX Order 26 § 4b1 The mask was in the upright position exposing the portion of the mask that would cover the face when in use. The EX Order 26 § mask was uncovered when not in use and was exposed to contamination. According to the Admission Record Resident #30 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 According to the comprehensive Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated 03/10/2023, Resident #30 had a Brief Interview for Mental Status (BIMS) score of EX O /15, indicating EX Order 26 § 4b1. Section G of the MDS revealed that Resident #30 was Ex.Order 26.4(b)(1) in all activities of daily living. According to Section O of the MDS Resident #30 received EX Order 26 § 4b1 while a resident at the facility. A review of the Order Summary Report, dated 04/25/2023, indicated that Resident #30 had the following physician's order: EX Order 26 § 4b1 A review of the comprehensive care plan	F 880	items not in use and irrigation sets when not in use. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents with and requiring Ex.Order 26.4(b)(1) n kits have the potential to be affected by the same issue needing to be addressed. - Infection Preventionist will conduct an audit of all residents with use of Ex.Order 26.4(b) and Ex.Order 26.4(b)(1) equipment, for appropriate storage of Ex.Order 26.4(b)(1) supplies and items when not in use to prevent contamination. - Infection Preventionist/Staff Development Coordinator/Designee will in-service and educate the facility and agency nurses on the recommended practices for storing residents' Ex.Order 26.4(b)(1) supplies when not in use. - Infection Preventionist/Staff Development Coordinator/Designee will in-service and educate the facility and agency nurses on the recommended practices for storing residents' Ex.Order 26.4(when not in use. 3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: - Infection Preventionist/Director of	

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F 880	Continued From page 65 revealed that Resident #30 had a care plan with a Focus of: Resident has Ex.Order 26.4(b)(1) (related to) EX Order 26 § 4b1 Date Initiated: 03/15/2023. The following was listed under Interventions: EX Order 26 § EX Or at bedtime and remove in the AM. Date Initiated: 3/15/2023. According to a review of the Treatment Administration Record (TAR), dated 4/1/2023-4/30/2023, Resident #30 was documented to have had EX Order 26 § in use during the evening and night shift on the following dates of the survey: 4/11/2023, 4/14/2023, 4/15/2023, 4/16/2023, 4/17/2023, 4/18/2023, 4/19/2023, 4/23/2023, and 4/24/2023. According to the documentation on the TAR, Resident #30 did not wear the EX Order 26 § 4b1 on the evening shift (3 PM-11 PM) on 4/13/2023, 4/21/2023, and 4/22/2023, however the TAR revealed that Resident #30 did wear the EX Order 26 § 4b1 the night shift (11 PM-7 AM) on those dates. On 04/14/2023 at 08:24 AM, Resident #30 was observed seated on the bedside with EX Order 26 § 4b1 No complaints were offered, and Resident #30 stated he/she only used the EX Order 26 § at night while sleeping. The EX Order 26 § 4b1 was lying on top of the EX Order 26 § 4b1. The EX Order 26 was uncovered and exposed with the part of the EX Order 26 that covers the mouth and nose facing upward. On 04/19/2023 at 09:27 AM, Resident #30 was observed sitting up in bed with EX Ord via N/C in place. The BiPap was not in use on this observation. The EX Order 26 was uncovered and set	F 880	Nursing will write and implement an infection control policy regarding the storage of Ex.Order 26.4(b)(1) supplies and Ex.Order 26.4(b)(1), when not in use by the resident to prevent contamination. - Infection Preventionist/Staff Development Coordinator will complete a weekly audit of all residents requiring the use of Ex.Order 26.4(b)(1) supplies EX Order 26 § 4b1 to ensure Ex.Order 26.4(is changed and dated weekly and stored properly when not in use. - Infection Preventionist/Staff Development Coordinator will complete a daily audit of all residents requiring the use of Ex.Order 26.4(b)(1) to ensure Ex.Order 26.4(b)(1) is changed and dated daily and stored properly when not in use. - Staff Development Coordinator will educate all new hire facility staff and agency nurses on facility policy and recommended practices for storage of Ex.Order 26.4(b)(1)y supplies not in use by the resident to prevent contamination. - Staff Development Coordinator will educate all new hire facility staff and agency nurses on facility policy and recommended practices for storage of Ex.Order 26.4(b)(1) not in use by the resident to prevent contamination. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction	

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F 880	Continued From page 66 on top of the EX Order 26 § EX Order 26 § 4b1 on the bedside table. The part of the mask that covers the mouth and nose was exposed. Resident #30 stated to the surveyor that he/she had used the mask to sleep with but removed it when they woke up today after the Surveyor #1 had asked when the EX Order 26 § had last been used by the resident. On 04/20/2023 at 09:07 AM, Resident #30 was observed lying in bed with EX Order 26 § 4b1. The EX Order 26 § was not in use and the EX Order 26 § 4b1 was observed on top on top of the EX Order 26 § 4b1 on the bedside table. The EX Order 26 was uncovered while not in use and the part of the EX Order 26 that covers the mouth and nose was exposed. On 04/20/2023 at 10:46 AM, the Surveyor #1 asked the Licensed Practical Nurse (LPN #1) assigned to Resident #30 for that shift to enter Resident #30's room. The EX Order 26 § 4b1 was observed to be in the same position and uncovered as mentioned previously. The Surveyor #1 asked LPN #1 what the facility practice was for the EX Order 26 § 4b1 when not in use. LPN #1 told Surveyor #1, "The EX Order 26 § 4b1 should be covered when not in use. It should be in a bag. Especially when it's face up." On 04/24/2023 at 01:13 PM, during an interview with the facility administration the Surveyor #1 asked the Vice President of Clinical Services (VPCS) what the facility practice was for EX Order 26 § when not in use. The VPCS replied, "The EX Order 26 § 4b1 is to be covered when not in use." 2.) On 04/12/2023 at 10:25 AM, Resident #7 was observed lying in bed sleeping. Surveyor #2 observed an EX Order 26 § 4b1 at the bed side that was not in use. The EX Order 26 § 4b1 was	F 880	is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - Director of Nursing/Designee will complete weekly random audits of residents identified as requiring/wearing Ex.Order 26.4(b) or Ex.Order 26.4(b)(1) kits to ensure infection control practices are being maintained. Audits will be conducted weekly x8 weeks, then monthly until compliance is maintained x 3 months and will be submitted to the facility's QAPI Committee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 67 hanging on top of the concentrator uncovered, exposed, and undated. On 04/13/2023 at 08:50 AM, Resident #7 was observed EX Order 26 § 4b1 The EX Order 26 § 4b1 was uncovered and exposed. According to the Admission Record Resident #7 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 A review of the most recent MDS dated 1/21/23, revealed Resident #7 had Ex.Order 26.4(b)(1) Section O of the MDS was checked to indicate that Resident #7 used EX Order 26 § 4b while a resident in the facility. A review of the Clinical Physician Orders revealed an order for EX Order 26 § 4b1 continuously with a discontinued date of 3/1/23. During an interview with Surveyor #2 on 04/19/2023 at 09:40 AM, Registered Nurse/Unit Manager (RN/UM) said she has been at the facility for 6 weeks. RN/UM was asked what the facility EX Order 26 § 4b policy was and she responded, "No smoking in the room, if on continuous EX Order 26 § 4b, change the EX Order 26 § 4b1 once a week, but no set day." The surveyor asked the RN/UM how the EX Order 26 § 4b1 should be stored when not in use. The RN/UM replied, "EX Order 26 § 4b1	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING ______ B. WING ______	C 04/25/2023

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F 880	Continued From page 68	F 880		

On 04/19/2023 at 09:44 AM, Surveyor #2 and the RN/UM went to Resident #7's room to observe the EX Order 26 § 4b1 . The RN/UM said the Ex.Order 26.4(b) draped over the concentrator was not appropriate and was uncovered and exposed.

During an interview with Surveyor #2 on 04/24/23 at 12:48 PM, the VPCS was asked how Ex.Order 26.4(b)(1) s to be stored when not in use. The VPCS replied, EX Order 26 § 4b1

A review of the facility provided policy titled Oxygen Administration Policy No. - NP- 243, Date Revised: August 01, 2017, revealed the following under III. Infection Control:

B. EX Order 26 § 4b items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use.

3.) On 04/12/2023 at 10:53 AM, during the initial tour, Resident #71 was observed lying in bed sleeping. Surveyor #2 observed a EX Order 26 § 4b1 at bedside dated 4/11/23 and timed at 7 AM.

On 04/13/2023 at 08:41 AM, Resident #71 was observed lying in bed sleeping and no EX Order 26 § EX Order 26 § 4b1 or container was observed at this time.

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F 880	Continued From page 69	F 880		

On 04/18/2023 at 09:53 AM, Surveyor #2 observed a EX Order 26 § 4b1 at the bed side of Resident #71. The EX Order 26 § 4b1 was on the table in a plastic bag dated "4/13."

According to the Admission Record Resident #71 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1

A review of the most recent MDS dated 3/9/23 revealed a BIMS score of EX O /15, indicating Resident #71 was EX Order 26 § 4b1. The MDS also indicated under section K, that Resident #71 had Ex.Order 26.4(b)(1) and no EX Order 26 § 4b1. Section K further revealed Resident #71 had a EX Order 26 § 4b1 and receives 51% or more of total calories via EX Order 26 § 4b1, and 501cc (cubic centimeters)/day or more of fluids via EX Order 2 .

A review of the Clinical Physician Orders revealed a physician order dated 1/24/23, for three times a day for EX Order 26 § 4b1 A further review of the physician orders revealed three times a day EX Order 26 § 4b1

A review of Resident #71's comprehensive care plan did not address the use of a piston EX Order 26 § 4b1.

During an interview with Surveyor #2 on

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F 880	Continued From page 70 04/20/2023 at 12:34 PM, the Interim Director of Nursing (IDON) was asked what the facility policy was regarding the use of Ex.Order 26.4(b)(1) e. The IDON said that every 24 hours the Ex.Order 26.4(b)(1) gets changed it is not documented as order in chart. The IDON further explained, "It is just common knowledge and we don't have a policy that says that per se. It should have a date on there so we know the last time it was changed." During an interview with Surveyor #2 on 04/24/2023 at 01:20 PM, the VPCS was asked what is the facility policy for the use of Ex.Order 26.4 . The VPCS responded, "It should be changed every 24 hours." The facility was unable to provide a policy for the use of Ex.Order 26.4(b)(1) . N.J.A.C 8:39-27.1(a)	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		5/31/23

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F 883	Continued From page 71	F 883		

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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F 883	Continued From page 72 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to ensure documentation in the resident's medical record of the information provided regarding the benefits and risks of immunization and the administration or the refusal of the vaccine, specifically the pneumococcal vaccination (vaccine used to prevent pneumonia). The deficient practice was identified for 2 of 5 resident's reviewed for immunizations, (Resident #13, Resident #19). This deficient practice was evidenced by the following: A.) According to the Admission Record, Resident #13 was admitted to the facility with diagnoses including but not limited to: EX Order 26 § 4b1 Resident #13 is over the age of EX O. A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care, dated 02/22/2023 revealed a Brief Interview for Mental status score of EX O/15, indicating Resident #13 was EX Order 26 § 4b1. Section "O0300" indicated Resident #13's EX Order 26 § 4b1 is not up to date. The MDS further revealed that Resident #13 was offered and declined the EX Order 26 § 4b1 A review of a EX Order 26 § 4b1 , which are on the back side of the EX Order 26 § 4b1 consent, were blank for 2019,	F 883	1)Address how corrective action will be accomplished for resident(s) found to have been affected: - Resident #13 was offered and administered the EX Order 26 § 4b1 ☐ EX Order 26 § 4b1 after being educated on the benefits and risks of the EX Order 26 § 4b - Resident #19 was offered and declined the EX Order 26 § 4b1 after being educated on the benefits and risks of the EX Order 26 § 4b - The Staff Development Coordinator will educate and in-service the facility and agency nurses on the facility policy for educating, offering, and providing the EX Order 26 § 4b1 to all new and readmissions. Additionally, residents will be offered th EX Order 26 § 4b1 season if they previously declined. 2)Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: - All residents have the potential to be affected by the same issue being addressed. Residents identified as candidates with underlying medical conditions that would benefit from the vaccine who were eligible, a recommendation of the EX Order 26 § 4b1 will be offered and given the EX Order 26 § 4b1 if they consent	

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F 883

Continued From page 73

2020 and 2022. There was no documentation of the resident being offered and declination of the EX Order 26 § 4b1.
During an interview with the surveyor on 04/18/2023 at 12:34 PM, Resident #13 said "EX Orde

B.) A review of Resident #19's electronic medical record (EMR) under "EX Order 26 § 4b1" did not yield any information that Resident #19 received the EX Order 26 § 4b1.

A review of Resident #19's quarterly MDS dated 3/27/2023, revealed under section "O0300" that Resident #19's EX Order 26 § 4b1 is not up to date. Further, it revealed that the EX Order 26 § 4b1 was offered and declined.

A review of Resident #19's paper medical record revealed a form titled, The form revealed a marked check box and statement that the resident gave the facility permission to administer the EX Order 26 § 4b1 and that the resident has been educated on the risks and benefits of the EX Order 26 § 4b. Below the statement was a line for a signature from the resident or legal representative that was blank. Also, the date was not written adjacent to the signature line.

On 04/20/2023 at 12:27 PM during an interview with the surveyors, the interim Director of Nursing (IDON/MDS) who also completes the MDS, said that consents for EX Order 26 § 4b1 are part of the admission packet. She said further that the documentation should be in the chart.

F 883

to receiving the EX Order 26 § 4b

- A total of 43 out of 93 residents were identified as eligible that gave consent and receive the EX Order 26 § 4b1 .

- Minimum Data Set (MDS) Coordinator will audit all residents charts for the EX Order 26 § 4b1 for accurate completion and administration of EX Order 26 § 4b1 in accordance to facility policy.

3)Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future:

- Staff Development Coordinator/Unit Manager/Designee will educate and in-service the facility and agency staff nurses on the facility protocol regarding the EX Order 26 § 4b1 process and protocol for residents admitted to the facility.

- Staff Development Coordinator/Designee will educate all new nursing hires and agency nurses during the orientation process regarding the facilitys protocol regarding the EX Order 26 § 4b1 process and protocol for residents admitted to the facility within 48 hours of admission to facility.

- Staff Development Coordinator/Unit

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F 883	Continued From page 74 On 04/24/2023 at 12:38 PM during an interview with the surveyors, when asked what is the process for vaccine consents, the Vice President of Clinical Services (VPCS) said when a resident comes in if they are eligible we offer the pneumococcal vaccine. If refused they sign that they decline. The surveyor asked who s responsible to ensure the consents are completed accurately, the VPCS said "It will be the staff educator, Infection Preventionist and Director of Nursing to make sure they are done." The VPCS stated, "I can't answer why." when asked why Resident #19's Pneumococcal Immunization Informed Consent is marked without a date or signature that the resident gave permission to administer the pneumococcal vaccination and that the resident has been educated on the risks and benefits of the vaccine. The VPCS replied, "No." when asked by the surveyors if a blank consent should be documented as "offered and declined". A review of a facility policy titled Pneumococcal Vaccine Policy and Procedure with TT/2018, revealed under the Policy section All residents will be offered pneumococcal vaccines to aid in the preventing pneumonia/pneumococcal infections. Under the Procedure section included 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. 3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine....5. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident;s medical record	F 883	Manager/Designee will conduct daily audits during clinical meetings to ensure residents admitted to the facility are educated on the Ex.Order 26.4(b)(1) facility protocol and that consent forms are completed accurately and completely within 48 hours of admission or readmission to the facility. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. - DON/Designee will conduct weekly random audits to ensure residents admitted to the facility are educated on the Ex.Order 26.4(b)(1) facility protocol and that consent forms are completed accurately and completely within 48 hours of admission or readmission to the facility x8 weeks; then twice monthly x2; then monthly until compliance is maintained x2 months during facility's weekly QAPI Committee Meetings.	

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F 883	Continued From page 75 indicating the date of the refusal of the pneumococcal vaccination. N.J.A.C. 8:39-19.4 (i)	F 883		

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S 000	Initial Comments COMPLAINT #'S NJ00155140, NJ 00158266, NJ00159718, NJ00159855, NJ00161775 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident 5 of 14 days shifts and 1 of 14 overnight shifts, b.) Maintain a record of influenza vaccinations for all facility employees, and contract employees as required for compliance with N.J.S.A 26:2H-18.79- Influenza vaccination in health care facilities. c.) to train the facility staff within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender	S 560	SPECIFIC CONCERNS The facility experienced call-outs on the noted shifts that the facility was not able to replace. Due to interruption in the IP/Staff Development position, the facility was not able to provide the flu vaccine to all employees and contracted personnel by the end of the flu season. Regarding LGTBQ + training, the facility had 2 Managers certified as required, however, 1 manager left. Additionally, due to interruption of the IP/Staff Development	5/31/23

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S 560	Continued From page 1	S 560		

identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program.

This deficient practice was evidenced by the following:

A.) 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. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021:

One 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.

position, all staff was not trained in this area.

IDENTIFICATION OF SIMILAR CONCERNS

The facility will review 100% of all call-outs 4/1-4/30 and issue disciplinary actions for any staff who is excessively absent per facility policy. The facility will do a 100% audit of all in- house staff to determine who has completed LGBTQ+ training, and training will be provided to all employees who have not received it.

SYSTEMIC CHANGE

The facility has implemented a Staffing Committee that will meet weekly to the fullest extent possible. The Committee, which will consist at a minimum of the DON, Dir of HR/Staffing and the Administrator, will review and implement strategies geared towards recruitment, retention, as well as other policies that impact staffing including monitoring of absenteeism. The facility now has a FT Dir of IP/Staff Development that will ensure all vaccines, including the flu vaccine, are provided as required, and all staff receive LGBTQ+ training a minimum of upon hire and annually.

MONITORING
The HR/Staffing Coordinator will provide a copy of the facility's Daily Nursing Staffing Sheet for the prior and current day, on a daily basis, to the DON and Administrator at the facility's daily Operational Meeting. The Administrator and DON will continue

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As per the "Nurse Staffing Report" completed by the facility for the weeks of 03/26/2023 to 04/01/2023 and 04/02/2023 to 04/08/2023 the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA (Certified Nurse Aide) to 8 residents for the day shift and one direct care staff member to every 14 residents for the night shift are documented below:

-03/28/23 had 11 CNAs for 95 residents on the day shift, required 12 CNAs.
-03/29/23 had 11 CNAs for 93 residents on the day shift, required 12 CNAs.
-03/29/23 had 6 total staff for 93 residents on the overnight shift, required 7 total staff.
-04/01/23 had 11 CNAs for 93 residents on the day shift, required 12 CNAs.
-04/02/23 had 10 CNAs for 93 residents on the day shift, required 12 CNAs.
-04/03/23 had 10 CNAs for 91 residents on the day shift, required 11 CNAs.

On 4/24/2023 at 12:38 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) said that the facility is aware of the New Jersey staffing mandate. Further, the LNHA responded, "We don't consistently, not every day." when the surveyor asked if the facility is meeting the staffing mandate.

B.) Findings include:
1. Reference: On January 13, 2020, Governor Murphy signed P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute"). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and

Provider's plan of correction (continued):

to coordinate daily to attempt to meet the required staffing minimums.The Administrator will provide a weekly report to the facility's QAPI Committee. The Dir of IP/Staff Development will provide a weekly report regarding the status of staff LGBTQ+ training to the facility's QAPI Committee Meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 04/25/2023
NAME OF PROVIDER OR SUPPLIER: **STERLING MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE: **794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052**		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3	S 560		

designate a medical exemption form to be distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as "facility" or "facilities," in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking.

Covered Employees
All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated.

Record Keeping
Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department.

During entrance conference on 04/12/2023, the surveyor requested a list of all staff documentation for the 2022-2023 Influenza season.

During an interview with the surveyoron 04/14/2023 at 01:13 PM, the Infection Preventionist (IP) provided the surveyor with "all the Influenza and vaccine information she could find." The IP stated that the records provided to the surveyor were indeed incomplete and that she was unable to find any additional documentation left behind from the previous IP nurse. The

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	060312	A. BUILDING: ______ B. WING ______	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Employee Flu Vaccine Line List included 29 out of 96 staff members that received the Influenza vaccine.

On 4/18/2023 at 1:36 PM, the Licensed Nursing Home Administrator (LNHA), admitted that the facility did not properly maintain a record of Influenza Vaccine records for staff or contractors and that they are not in compliance. The LNHA was unable to provide a policy for the Influenza Vaccine.

C.) Findings include:

Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking.

Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities").

The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status.

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S 560	Continued From page 5	S 560		

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Prohibited Actions
The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:

1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility;

2. Denying a request by residents to share a room;

3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5);

4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;

5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice;

6. Denying a resident from wearing preferred

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S 560	Continued From page 6	S 560		

Continued From page 6

clothing, accessories, or cosmetics, or participating in grooming practices;

7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;

8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and

9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6).

Resident Records
Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality
The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.

Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or

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S 560	Continued From page 7 accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated	S 560		

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S 560	Continued From page 8	S 560		

expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.

The required training shall address:
1. Caring for LGBTQI+ seniors and seniors living with HIV;

2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status;

3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV;

4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns;

5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community;

6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and

7. An overview of the provisions of LGBTQI+ Law.
Facilities are responsible for maintaining records

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S 560	Continued From page 9 documenting the completion of the training, as well as the cost of providing the training. During entrance conference on 04/12/2023 at 09:42 AM, the surveyor requested the certifications of the 2 staff members who were trained in LGBTQI+. A review of the certificates revealed the Interim Director of Nursing and the Infection Preventionist completed LGBTQI+ training. During an interview with the surveyor on 04/13/2023 at 11:42 AM, the Vice President of Clinical Services (VPCS) said I don't think they trained the staff on LGBTQI+. Only new employee in orientation but not the other staff. During an interview with the surveyor on 04/17/2023 at 09:00 AM, the Infection Preventionist said I am only doing the new orientation LGBTQI+ training. During an interview with the surveyor on 04/24/2023 at 01:27 PM, the Licensed Nursing Home Administrator and the VPCS said that the LGBTQI training, not that I am aware of, has the staff been trained. Surveyor: Leonard, Daniel	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed	S1405		6/9/23

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S1405	Continued From page 10 physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of 5 recently hired employee files, it was determined that the facility failed to ensure that 4 of 5 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: On 04/19/2023 at 12:19 PM, the surveyor reviewed the employee files of five random and recently hired employees. Employee # 1's "Employee's Health Questionnaire" document dated 03/06/2023 was not complete. The document section titled; "Employee Health Examination" was blank	S1405	SPECIFIC CONCERNS The 4 noted new hires will have Health Questionnaires and Examinations completed IDENTIFICATION OF SIMILAR CONCERNS The facility will audit 100% of newly hired employee files from 4/1-present to ensure all have completed Health Questionnaires and Examinations, and if not, they will be completed. SYSTEMIC CHANGES The facility had an employment gap in the IP/Staff Development position who was responsible for employee health, but a FT	

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S1405	Continued From page 11 including the date, address, and signature of the Physician. Employee # 2's "Employee's Health Questionnaire" document dated 03/20/2023 was not complete. The document section titled; "Employee Health Examination" was blank including the date, address, and signature of the Physician. Employee # 3's "Employee's Health Questionnaire" document dated 01/12/2023 was not complete. The document section titled; "Employee Health Examination" was blank including the date, address, and signature of the Physician. Employee # 4's "Employee's Health Questionnaire" document dated 02/27/2023 was not complete. The document section titled; "Employee Health Examination" was blank including the date, address, and signature of the Physician. On 04/24/2023 at 12:38 PM, during an interview with the surveyor, the Vice President of Clinical Services replied, "Not sure of the time frame" when asked by the surveyor when does a newly hired employee have to obtain a health assessment from a physician. A review of the facility policy "Employee Health Records" with a revised date of November 2011 under the section titled, "Policy Interpretation and Implementation" section 1 revealed, "A health record for each employee will contain, at a minimum: "i. A copy of any results of examinations, medical testing, and follow-up procedures related to employee health and infection control issues ..."	S1405	person has been hired. MONITORING The Dir of IP/Staff Development will submit a weekly report regarding the status of Health Questionnaires and Examinations for all new hires for a period of 8 weeks; then twice monthly x2; then once monthly until compliance is maintained x2 months during facility's weekly QAPI Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the EX Order 26 § 4b1 skin test result is less than 10 millimeters of induration, the second step of the two-step EX Order 26 § 4b1 test shall be administered one to three weeks later. Ex. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that a new employee received the Mantoux EX Order 26 § 4b1 as required. This deficient practice was identified for 1 of 5 new employee files reviewed.	S1410	SPECIFIC CONCERN The 1 noted newly hired employee will be provided with the 2-step EX Order 26 § 4b1 skin test as required. IDENTIFICATION OF SIMILAR CONCERNS	6/9/23

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
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S1410	Continued From page 13 The deficient practice is evidenced by: On 04/19/2023 at 12:19 PM, during a review of new employee files, it was determined that 1 of 5 newly hired employees had not received the first and second step of the 2-step EX Order 26 § 4b1 test. A review of Employee #1's document titled, EX Order 26 "Step 1 Results" and "Step 2." On 04/24/2023 at 12:38 PM, during an interview with the surveyor, the Vice President of Clinical Services replied, "Not sure, they should be doing it unless they come in with recent proof for the six months, otherwise they should have it repeated" when asked by the surveyor if there was a reason Employee #1's "Initial EX Order 26 § 4b1 Skin Test Report Form" was not completed. A review of the facility policy titled, "Employee Health Records" revised November 2011 under section, "Policy Interpretation and Implementation" revealed, "1. A health record for each employee will contain, at a minimum:" letter c., "Associate TB Screening Record ..."	S1410	The facility will audit 100% of newly hired employee files from 4/1-present to ensure all have been provided with the required EX Order 26 § 4b1 test, and if not, they will be provided with it. SYSTEMIC CHANGES The facility had an employment gap in the IP/Staff Development position who was responsible for employee health, but a FT person has been hired. MONITORING The Dir of IP/Staff Development will submit a weekly report to the DON and Administrator regarding the status of the required Mantoux test for all new hires for a period of 8 weeks; then twice monthly x2; then once monthly until compliance is maintained x2 months during Quality Assurance Process Improvement meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315149	A. Building B. Wing	6/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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 F0582 Reg. # 483.10(g)(17)(18)(i)-(v) LSC	Correction Completed 05/31/2023	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 06/09/2023	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 05/31/2023
ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 05/31/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 05/31/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/31/2023
ID Prefix F0661 Reg. # 483.21(c)(2)(i)-(iv) LSC	Correction Completed 06/09/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 05/31/2023	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 06/09/2023
ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 05/31/2023	ID Prefix F0758 Reg. # 483.45(c)(3)(e)(1)-(5) LSC	Correction Completed 06/09/2023	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 05/31/2023
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 05/31/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 06/09/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 05/31/2023

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315149 (Y1)	A. Building B. Wing (Y2)	6/22/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0883 Reg. # 483.80(d)(1)(2) LSC	Correction Completed 05/31/2023				

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	
4/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
060312 Y1	Y2	6/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
4/25/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060312 (Y1)	A. Building B. Wing (Y2)	6/22/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2023	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 06/09/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 06/09/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING **01** B. WING ______	C **04/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	**794 N FORKLANDING ROAD** **MAPLE SHADE, NJ 08052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/17/2023 and 04/18/2023 and Sterling Manor 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 Occupancies. Sterling Manor is a single (1) story, Type V Protected building that was built in January 1977. The facility is divided into 7 smoke zones.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 04/17/2023 and 04/18/2023 in the presence of facility management, it was determined that the facility failed to provide a stable/suitable walking surface for evacuation at 1 of 11 designated exit discharges that would serve residents in an evacuation. This deficient practice was evidenced by the following:	K 271	Specific Concern The exit leading from the West Wing courtyard will be re-designed by 6/16/23 so that it has a hard-packed all-weather travel surface free of obstructions. Identification of Similar Concerns	6/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/11/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING 01 B. WING ___	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 271	Continued From page 1 On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms, smoke compartments. A review of the facility provided lay-out identified the building is a single story building with a eleven (11) designated exit discharge (illuminated exit signs) doors in the facility. Starting at approximately 9:19 AM on 04/17/2023 and continued on 04/18/2023, in the presence of the facility's MD a tour of the building was performed. Along the two day tour the surveyor observed the following, 1. On 04/17/2023 at approximately 11:12 AM, during an inspection of the West wing resident vending machine room had one designated exit (illuminated exit sign above the door) discharge door that lead to the outside fenced-in Resident smoking area. The surveyor observed an approximately forty five (45') unleveled grassy/dirt path to reach the designated exit discharge gate. The surveyor also observed outside the gate an approximately seven (7') unleveled, grassy path to reach a public-way. A review of an emergency evaluation diagram posted inside the building identified the exit discharge as the primary and or secondary exit discharge to reach a public-way. The MD confirmed the finding at the time of observation. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately	K 271	All other exit discharges have been evaluated and determined to be in compliance with this regulation. Systemic Changes The exit leading from the West Wing courtyard will be re-designed so that it has a hard-packed all-weather travel surface free of obstructions. Monitoring The Administrator will review all exit discharges on a monthly basis to ensure the surfaces remain in-tact and free of obstructions and submit a monthly report to the facility's weekly QAPI Meeting. Reports will be submitted to QAPI for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING **01** B. WING ______	C **04/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 271	Continued From page 2 12:56 PM PM. Life Safety Code 101 - 18.2.7 NJAC 8:39-31.2(e)	K 271		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility	K 321	Specific Concern	6/16/23

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K 321	Continued From page 3 documentation on 04/17/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms, smoke compartments and how many resident sleeping rooms are in the facility. A review of the facility provided lay-out identified the building as a single story building with a basement in the facility. Starting at approximately 9:19 AM on 04/17/2023, in the presence of the facility's MD, a tour of the building was performed. 1, At approximately 10:25 AM, an inspection of the basement level Commercial laundry room was performed. During a closure test of the corridor door leading into the Commercial laundry room the door did not self-close into its frame. The surveyor observed the door hit a pallet filled with products, this left a 3 inch opening. With this corridor door not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.	K 321	The pallet has been removed and the door will be adjusted so that it properly closes per this regulation. Identification of Similar Concerns A 100% audit of all smoke doors will be conducted by the Maintenance Director or designee to ensure they close properly and no obstructions are preventing them from doing so. Systemic Change All smoke doors will be placed on a monthly audit to ensure they close properly and no obstructions are preventing them from doing so. Monitoring The Dir of Maintenance or designee will submit the monthly audit to the facility's weekly QAPI Committee	

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K 321	Continued From page 4 The MD confirmed the finding at the time of observation. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 04/17/2023 and 04/18/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as	K 351	Specific Problem The ceiling tiles in the Maintenance Shop and by exit door #6 were replaced.	6/16/23

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K 351	Continued From page 5 required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms, smoke compartments. A review of the facility provided lay-out identified the building is a single story building with a basement. Starting at approximately 9:19 AM on 04/17/2023 and continued on 04/18/2023, in the presence of the facility's MD a tour of the building was performed. Along the two day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 04/17/2023: 1.) At approximately 10:25 AM, the surveyor observed inside the basement level Maintenance shop two (2) 2' by 4' ceiling tiles missing an approximately 2' by 2' section of each tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.	K 351	Identification of Similar Problems A 100% audit of all ceiling tiles will be conducted by the Maintenance Director or designee to ensure any missing ones are replaced. Systemic Change All ceiling tiles will be placed on a monthly audit to ensure any missing or stained ones are replaced. Monitoring The Dir of Maintenance or designee will submit the Monthly audit to the facility's weekly QAPI Committee	

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K 351	Continued From page 6 On 04/18/2023: 2) At approximately 9:23 AM, the surveyor observed by the designated exit discharge door #6, one ceiling tile missing an approximately 12" by 4" section. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. The MD confirmed the finding at the time of observations. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ____ b) Who provided system test ____ c) Water system supply source ____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		6/16/23

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K 353	Continued From page 7 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility was cited K-353 sprinkler Maintenance and Testing during the 11/02/2020 and re-cited during the 02/18/2022 recertification surveys. The Facility has a Time Limited Waiver granted by CMS until December 30, 2023. Based on observation, interview, and record review on 10/29/20 in the presence of the facility Regional Maintenance Director, Administrator and Facility Owner, it was determined that the facility failed to maintain the sprinkler system in operating condition according to NFPA 25/13 regulations. This deficient practice was evidenced by the following: 1.) At 10:45 AM, the surveyor reviewed the provided fire sprinkler quarterly documentation from the facility vendor. The documents reviewed were dated: 10/22/20, (7/7/2020 annual Inspection), and 4/6/2020 in which all the inspection reports from 4/29/2016 to the current report dated 10/22/2020 indicated that: *Copper Pipe throughout attics shows signs of corrosion/mechanical patches (found during the Annual Inspection). A document from the facility vendor dated 2/13/2020 indicated that The Maple Shade Fire Department (Authority having Jurisdiction) is requiring that the leaks in the system be fixed permanently (no repair clamps) and a 200 psi for 2-hour hydrostatic test be performed with no leaks. The most current fire sprinkler vendor document dated 10/22/2020 indicated on page 2. under:	K 353	Specific Concern The Administrator will request the Sprinkler Contractor to conduct a current quarterly inspection. The facility will ensure any penetrations around the closet sprinkler heads in rooms 27,37,38 and 39 are appropriately sealed. Regarding the sprinkler system replacement, all drawings, calculations and specifications have been approved by the engineers and have been submitted to the town and DCA for review. The facility has a CMA approved waiver through 12/31/23. Identification of Similar Concerns The Administrator will request the Sprinkler Contractor to conduct a current quarterly inspection. Regarding the sprinkler system replacement, all drawings, calculations and specifications have been approved by the engineers and have been submitted to the town and DCA for review. Systemic Change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 8 Pipes and Fittings (visible): NO: 1. in good condition and no external corrosion NO: 2. no leaks or mechanical damage NO: 3. correct alignment- no external loads Building: NO: 4. wet piping not exposed to freezing temperatures In an interview with the Facility owner on 10/29/20 at 11:13 A.M. he stated that currently there is no documentation indicating that the pipe was fixed permanently and a 200 psi for 2-hour hydrostatic test was performed. 2. While touring the building on 10/29/20 from 9:10 AM to 11:15 AM the surveyor, Regional Maintenance Director, Administrator, and Facility Owner observed fire sprinkler heads with escutcheon plates that were not in the proper position along with ceiling tiles with bad cuts around the fire sprinkler heads in the following areas of the facility: Resident Rooms: 27, 37, 38, and 39- 2- (interior closets) An interview was conducted with the Regional Maintenance Director during the observations and he agreed and stated that the ceiling tiles and escutcheon plates must be in the proper position and the ceiling tiles must have better cuts around the fire sprinkler heads in the facility.	K 353	The Administrator will ensure required quarterly sprinkler inspections occur prior to, during and after the sprinkler system is replaced. Monitoring The Administrator will submit a monthly report regarding quarterly sprinkler compliance and the status of the sprinkler system installation to the facility's weekly QAPI Committee.	

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K 353	Continued From page 9 The ceiling tile is an integral part of the sprinkler system. When fire occurs the smoke and heat rises until it meets the ceiling, then the smoke and heat travels horizontally until it encounters a smoke detector or a sprinkler head. If there is a gap greater than 1/8 inch from a missing and/or an escutcheon plate not in proper position and/or a broken ceiling tile, the sprinkler head function is now impaired. The smoke and heat would rise up through the hole where the tile was located and fill up the space above the ceiling before it attempts to activate the sprinkler head and fire alarm detection system. On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the Administrator and Maintenance Director (MD) to provide all mandatory inspections from 01/01/2022 through 04/16/2023 for review later. The surveyor also asked if the facility had any waivers for the facility. The Administrator told the surveyor, yes we have a waiver for the fire sprinkler system. The sprinkler system is going to be replaced. Later a review of the mandatory quarterly (every 3 months) sprinkler inspection was performed. The facility conducted the following quarterly sprinkler inspections with the following results, 1) Annual inspection 06/24/2022 reads in part: "Antifreeze Tested +10 at test point (during annual inspection)- Basement Hot Water Room - Controls (2) heads under canopy at back door (Antifreeze requires replacement)- (same as 2021) (tested during annual inspections)." "Copper Pipe throughout attics shows signs of corrosions/mechanical patches (found during	K 353		

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K 353	Continued From page 10 annual inspection)." "Miscellaneous missing sprinkler escutcheon plates throughout (holes for sprinklers in sheet-rock will require patching)." 2) Quarterly inspection 02/15/2023 reads in part: "Antifreeze Tested +10 at test point (during annual inspection) - Basement Hot Water Room - Controls (2) heads under canopy at back door (Antifreeze requires replacement)- (same as 2021) (tested during annual inspections)." "Copper Pipe throughout attics shows signs of corrosion/ mechanical patches (found during annual inspection)." "Miscellaneous missing sprinkler escutcheon plates throughout (holes for sprinklers in sheet-rock will require patching)." The facility conducted two Quarterly (every 3 months) sprinkler inspections during the requested 01/01/2022 through 04/16/2023 (16 months) window of mandatory inspections. The MD confirmed the finding at the time of review. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. NJAC 8:39-31.2(c) NJAC 8:39-31.2(e) NFPA 13, 25	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		6/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING **01** B. WING ______	C **04/25/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	**794 N FORKLANDING ROAD** **MAPLE SHADE, NJ 08052**

(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 355	Continued From page 11 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 04/17/2023 and 04/18/2023 in the presence of facility management, it was determined that the facility failed to: 1.) Perform a monthly examination for 1 of 22 portable fire extinguishers, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 4-3, 4- 3.1, 4- 3.3 and 4- 3.4 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency: Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.	K 355	Specific Concern This extinguisher was missed when they all were signed monthly. It has been signed for April. All maintenance staff were re-inserviced to ensure all fire extinguishers are visually inspected and signed monthly. Identification of Similar Concerns A 100% check of all fire extinguishers was conducted and all others were signed current through April. Systemic Change All maintenance staff were re-inserviced to ensure all fire extinguishers are visually inspected and signed monthly. Monitoring The Dir of Maintenance or designee will submit a monthly report to the facilitys weekly QAPI Committee regarding the status of the visual inspections/signing of all fire extinguishers.	

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K 355	Continued From page 12 The findings include the following, On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM, a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:19 AM on 04/17/2023 and continued on 04/18/2023, in the presence of the facility's MD a tour of the building was performed. Along the two-day tour of the facility the surveyor observed and inspected twenty two (22) portable fire extinguishers that were last annually inspected July 2022 in various locations with the following issues identified: 1.) At approximately 10:37 AM, one class "K-Wet" Chemical Type fire extinguisher in the kitchen was last annually inspected July 2022 was missing monthly visual examination performed and documented for February and March 2023. The MD confirmed the finding at the time of observations. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		6/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 13 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY, from re-certification	K 363	Specific Concerns	

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K 363	Continued From page 14 survey of 02/18/2022. Based on observation on 04/17/2023 and 04/18/2023, in the presence of facility management, it was determined that the facility failed to ensure that 5 of 35 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM a request was made to the Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms, smoke compartments, and how many resident sleeping rooms are in the facility. The MD told the surveyor, there are 52 resident sleeping rooms and several offices in the facility. A review of the facility provided lay-out identified the building was a single story building with a basement in the facility. Starting at approximately 9:19 AM on 04/17/2023 and continued on 04/18/2023, in the presence of the facility's MD, a tour of the building was performed. During the tour the surveyor performed closure tests of the thirty five (35) doors in the corridors with the following results, On 04/17/2023: 1. At approximately 11:18 AM, the surveyor observed the corridor door leading into the West Wing residents lounge had a 1/2" gap along the top of the door and a 1/4" gap along the latching edge.	K 363	The corridor doors to Room 7 and 18, the East Wing Shower Room door, the West Wing Lounge door, and the Staffing Coordinator's Office door will be repaired or replaced so they meet the required specifications of this regulation. Identification of Similar Concerns A 100% audit of all corridor doors will be inspected to ensure they meet the required specifications of this regulation and, any doors that do not, will be repaired or replaced. Systemic Change All corridor doors will be inspected by the Dir of Maintenance or designee on a monthly basis to ensure they meet the required specifications of this regulation. Monitoring The Dir of Maintenance or designee will submit a monthly report to the facility's weekly QAPI Committee.	

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K 363	Continued From page 15 This is the same corridor door cited during the 02/18 /2022 survey. On 04/18/2023: 2. At approximately 9:57 AM, the surveyor observed that during a closure test of Resident room #7 corridor door, the door did not latch into its frame. the door left a 13 inch opening. This test was repeated two additional times with the same results. 3. At approximately 10:03 AM, the surveyor observed the East wing Resident shower room corridor door had a 3/8" gap along the top. 4. At approximately 10:15 AM, the surveyor observed the staffing office corridor door had a 1/3 inch gap along the top edge. 5. At approximately 10:19 AM, the surveyor observed Resident room #18 corridor door when in the closed position had a 1/2 inch gap running up from the bottom edge along the latching edge. This would allow fire, smoke, and poisonous gases to pass into the exit access corridor in the event of a fire. Review of facility posted emergency evacuation diagrams in the areas identify that you would need to pass these rooms as the primary and/ or secondary exit access route to reach an exit. The MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. NJAC 8:39-31.1(c), 31.2(e)	K 363		

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K 363	Continued From page 16 NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 04/17/2023 and 04/18/2023, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for one (1) of six (6) smoke barrier walls as evidenced by the following: On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the building was a single story building divided into seven (7) smoke compartments with six (6) smoke barrier walls.	K 372	Specific Concern The penetrations above the ceiling tiles by the smoke barrier door near Room 41 will be repaired so that its integrity is in accordance with this regulation. Identification of Similar Concerns A 100% inspection of the area above the ceiling tiles by all double smoke barrier doors will be conducted by the Dir of Maintenance or designee. Systemic Change A monthly audit of the area above the	6/16/23

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K 372	Continued From page 17 Starting at approximately 9:19 AM on 04/17/2023 and continued on 04/18/2023, in the presence of the facility's MD, a tour of the building was performed. On 04/17/2023 along the tour at approximately 10:58 AM, the surveyor observed above the ceiling tiles by the double smoke barrier doors next to Resident room #41 that the barrier wall had an approximately eight (8) inch by eight (8) inch section of wall board missing from the barrier wall. There was an approximately one (1) inch in diameter hole with a pipe running through the penetration. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment. The MD confirmed the finding at the time. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372	ceiling tiles by all double smoke barrier doors will be conducted by the Dir of Maintenance or designee. Monitoring The monthly audit will be submitted by the Dir of Maintenance or designee to the facility's weekly QAPI Committee.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374		6/16/23

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K 374	Continued From page 18 are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 04/17/2023 and 04/18/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 6 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms, smoke compartments in the facility. A review of the facility provided lay-out identified the building was a single story building, divided into 7 smoke zones with five (5) sets of corridor double smoke doors and two (2) single smoke doors in the facility.	K 374	Specific Concerns The smoke door in the Main Dining Room will be repaired or replaced so it meets the required specifications of this regulation. Identification of Similar Concerns A 100% audit of all corridor doors will be inspected to ensure they meet the required specifications of this regulation and, any doors that do not, will be repaired or replaced. Systemic Change All corridor doors will be inspected by the Dir of Maintenance or designee on a monthly basis to ensure they meet the required specifications of this regulation. Monitoring The Dir of Maintenance or designee will submit a monthly report to the facility's weekly QAPI Committee.	

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K 374	Continued From page 19 Starting at approximately 9:19 AM on 04/17/2023 and continued on 04/18/2023, in the presence of the facility's MD, a tour of the building was performed. Along the two day tour the surveyor performed closure tests of the five (5) sets of double smoke barrier doors and two (2) single smoke doors in the corridors with the following results, 1. On 04/18/2023 at approximately 9:45 AM, during a closure test of one single smoke door in the main dining room leading to the East wing when the door was released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 3/16 of an inch gap along the edge of the door. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The MD confirmed the finding at the time of observation. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. N.B. 8:39-31.1(c), 31.2(e)	K 374		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		6/16/23

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K 918	Continued From page 20 criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 04/17/2023 and 04/18/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to: a.) Ensure a remote manual stop station on 1 of 1 of generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and	K 918	Specific Concerns The facility will install a manual stop station for the generator and ensure that an appropriate monthly load test will be conducted correctly. The Dir of Maintenance was inserviced on the proper way to do a generator load test.	

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K 918	Continued From page 21 5.6.5.6.1. b.) The facility failed to ensure the generator was exercised under load for 30 minutes, 12 times a year in 20-40 day intervals. The deficient practice could affect all residents and was evidenced on 12 of 12 monthly load test's for 2022 and 2023 on the provided log and by the following: On 04/17/2023 (day one of survey) during the survey entrance at approximately 9:01 AM a request was made to the Administrator and Maintenance Director (MD) to provide all mandatory inspections from 01/01/2022 through 04/16/2023 for review. The surveyor also asked if the facility had an emergency generator and how often do they run the generator under a load. A). At approximately 10:15 AM, the surveyor and MD, observed in the basement level the Natural gas generator. There was no remote manual stop station. At this time the surveyor asked the MD, "Do you have a remote emergency stop for the generator." The MD told the surveyor, no. B). At approximately 12:30 PM, the surveyor observed the monthly emergency generator tour log report provided by the MD. The report indicated the following months: November, December 2022 and January, February and March 2023 that the run times were 15 minute under load and not the required 30 minutes. Later during an interview with the MD the surveyor asked the MD how long do you run the generator under load monthly. The MD told the surveyor, "15 minutes." The facility could not provide January through	K 918	Identification of Similar Concerns The Dir of Maintenance conducted an appropriate generator load test for April Systemic Change The facility will install a manual stop station for the generator. The Dir of Maintenance was inserviced on the proper way to do a generator load test. Monitoring The Administrator will ensure the generator manual stop station is installed and the Dir of Maintenance will provide a copy of the monthly generator load test to the facility's weekly QAPI Committee.	

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K 918	Continued From page 22 October 2022 generator monthly load date logs. The MD confirmed the findings. The Administrator was informed of the deficiency at the survey exit on 04/18/2023 at approximately 12:56 PM PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315149	A. Building 01 - MAIN BUILDING 01 B. Wing	6/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0271	Correction Completed 06/16/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 06/16/2023	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 06/16/2023
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 06/16/2023	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 06/16/2023	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 06/16/2023
ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 06/16/2023	ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 06/16/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 06/16/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
4/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO