STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB VOORHEES EAST	**113 SOUTH ROUTE 73 VOORHEES, NJ 08043**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey: 2/26/21 CENSUS: 95 SAMPLE: 19 + 14 = 33 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be out of compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. COMPLAINT #: NJ000145015 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		7/20/21

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

Electronically Signed | 07/03/2021

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F 623	Continued From page 1 representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 623		

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F 623	Continued From page 2 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

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F 623	Continued From page 3 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide written notification for an unplanned transfer to the hospital for 1 of 1 residents, (Resident #Executive) reviewed for written notification of transfer. The deficient practice was evidenced by the following: On 06/08/21 at 12:00 PM, the Licensed Nursing Home Administrator (LNHA) stated the facility did not send any written notification to the resident/resident representative regarding Resident #Executive's transfer to the hospital on Executive Order 26, 4.b. Upon surveyor inquiry, the facility was further unable to provide any written notification. The surveyor reviewed the medical record for Resident #Executive. Review of the Admission Record Report revealed Resident #Executive was admitted to the facility in Executive Order 26, 4.b. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated Executive Order 26, 4.b., revealed the resident had a Brief Interview for Mental Status (BIMS) Executive Order 26, 4.b. which indicated the resident was Executive Order 26, 4.b.. A	F 623	1. Written Notification for the unplanned transfer to the hospital submitted to resident #Executive and their responsible party. 2. All patients with unplanned transfers to the hospital have the potential to be effected by this deficient practice. Process: 3. Social Services department was in serviced on section 483.15 (C)(3) notice before transfer. Social Services will submit written notification to the patient and their representative within 7 days after any and all unplanned transfers to the hospital. A copy of all written notifications will be kept in a binder in the Social Services office and will be reconciled daily(Monday-Friday) by reviewing the 24-hour summary and notating any and all unplanned transfers to the hospital. On Mondays, Social Services will review the 72-hour summary report, highlighting any and all unplanned transfers to the hospital that occurred over the weekend. This will ensure that written notifications were submitted to all patients and/or representatives for any and all unplanned hospitalizations. 4. All findings will be presented by the Social Services Director and reviewed at	

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F 623	Continued From page 4 further review of the resident's MDS - Section [Executive Order 26] discharge plan indicated that the resident was planned to be discharged back into the community after his/her stay at the facility. Review of the Progress Notes dated [Executive Order 26, 4.b], revealed Resident [Executive Order] had an [Executive Order 26, 4.b] [redacted] The Progress Notes further stated that the resident was sent to and admitted to the hospital. Review of the facility provided policy, "Discharge and Transfer", revision date of 02/01/19, revealed Policy - Transfer and discharge includes movement of a patient to a bed outside the certified center whether that bed is in the same physical plant or not. A Center must immediately inform the patient/resident representative, consult with the patient's physician, and notify when there is a decision to transfer or discharge the patient from the Center. The patient and resident representative must be notified in writing and in a language and manner they understand. 5) For patients transferred to a hospital: 5.1 for unplanned, acute transfers where it is planned for the patient to return to the Center, the patient and/or resident representative will be notified verbally followed by written notification. NJAC 8:39-4.1(a)	F 623	the monthly QAPI meetings by the Care Delivery Team.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		7/20/21

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F 689	Continued From page 5 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # NJ00145015 Based on interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to ensure: a.) the facility policy for the management of residents at risk for falls was followed, b.) a resident admitted to the facility with a known history Executive Order 26, 4.b. c.) staff developed a care plan (CP) for falls and implemented interventions to reduce the Executive Order 2 falls. This deficient practice was identified for 1 of 1 residents reviewed for accidents (Resident # Executive O, who fell on Executive Order 26, 4.b. Executive Order 26, 4.b.. The resident had a subsequent fall on Executive Order 26, 4 at Executive Order 26, 4.b. and sustained a Executive Order 26, 4.b.. The resident was then transferred to the emergency room on Executive Order 26, 4 at approximately Executive Order 26, and was diagnosed with an Executive Order 26, 4.b. Executive Order 26, 4.b. This deficient practice was evidenced by the following: The surveyor reviewed the medical record for Resident Executive Or which revealed the following: According to the Admission Record Report	F 689	1.) Resident # Executive was discharged from center 2.) All patients have the potential to be affected by this deficient practice. An audit was completed for patients admitted within the last 30 days to ensure a fall risk assessment was completed, and a risk fall care plan initiated. An audit was conducted to identify patients who had falls in the last 30 days to review for post fall interventions. 3.) Licensed nurses were in-serviced on falls management process of assessing patients for fall risk on admission, implementing a fall care plan on admission, and implementing post fall interventions. The supervisor or designee on each shift will review new admissions to ensure implementation of fall risk assessment and fall risk care plan were implemented by nurse. 4.) The Clinical Director or designee will randomly audit 5 patients charts to ensure fall risk assessment and care plan are implemented, and audit patient post fall for updated fall interventions on each unit daily x5 weekly 3 and monthly x2. The results will be reported to the quality assurance committee x 3 months.	

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F 689	Continued From page 6	F 689		

(ARR), Resident #[redacted] was admitted to the facility with a diagnosis of[redacted] resulted from a fall at home. The Diagnosis Sheet reflected Resident [redacted] had an [redacted] of the [redacted]

The Progress Note (PN) dated [redacted] at 14:11 (2:11 PM) revealed, No Indication of [redacted] and was based on the following questions/results: There was no evidence of an acute change in mental status and behavior did not fluctuate during the day. The patient did not have difficulty focusing attention. The patient's thinking was not disorganized or incoherent and overall, the level of consciousness appeared alert.

The Admission/Re-Admission Evaluation (AE) dated [redacted] at [redacted] indicated that Resident #[redacted] was admitted to the facility from an acute care hospital with [redacted] area. The AE indicated that the resident was oriented to situation, place, person, and time and was able to understand verbal content and express ideas and wants. It also indicated that Resident [redacted] pupils were equal and reactive; the resident had [redacted] and was unable to determine standing balance. The AE clinical evaluation of the musculoskeletal system indicated that Resident [redacted] had an [redacted]. There was no documentation on the AE that a fall risk assessment was performed.

Review of the initial admission Care Plan (CP) dated [redacted] revealed that the resident had

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F 689	Continued From page 7 alterations in: a.) The musculoskeletal system with Executive Order 26, 4.b. related to Executive Order 26, 4. b.) Executive Order 26, 4.b. caused by the resident wearing a Executive Order 26, 4.b. c.) Difficulty communicating due to Executive Order 26 Executive Order 26, 4.b. d.) Expressed wishes to discharge home. e.) Nutritional status Executive Order 26, f.) Executive Order 26, 4.b. The surveyor was unable to locate evidence in the resident's medical record that indicated Resident # Executive was assessed as a fall risk, or that a CP for falls was developed upon admission that included interventions implemented to reduce the risk for falls and injury for a resident who had a Executive Order 26, 4.b. The untimed History and Physical (H&P) dated Executive Order 26, 4, completed by the physician, indicated that Resident Executive Or had a past medical history of Executive Order 26, 4.b. who presented to the hospital after sustaining a fall at home. The H&P indicated that the resident had an Executive Order 26, 4.b. Executive Order 26, 4.b. The resident was evaluated by a and no surgical interventions were required at that time. The H&P indicated that the resident was transferred to the facility for subacute rehabilitation and medical	F 689		

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F 689	Continued From page 8 management. The surveyor reviewed the Occupational Therapy (OT) Initial Evaluation dated [redacted] and signed 4:46 PM, which indicated that Resident [redacted] was [redacted] and required [redacted]. The evaluation also reflected that the resident had [redacted] limits, however [redacted] and [redacted]. The surveyor reviewed an untimed Physical Therapy (PT) Initial Evaluation dated [redacted] that revealed an assessment summary. The summary indicated that Resident [redacted] required skilled therapy services to address the following functional areas to include: bed mobility, transfers, ambulation, and stair negotiation. The summary also indicated that these functional deficits were a result of the resident's [redacted] and [redacted] and due to the documented [redacted] and associated functional deficits, without skilled therapeutic interventions, "the resident was at risk for falls", decreased ability to return to prior living arrangements, decreased participation in functional task, hospitalization and inability to return home. 1. The general Progress Note (PN) dated [redacted]), indicated that the nurse heard Resident [redacted] calling out for help. The nurse found the resident lying on the floor, close to bathroom door, and the resident stated [redacted] The resident told the nurse that he/she had gone to the bathroom and was walking back to the bed when he/she fell. The	F 689		

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F 689	Continued From page 9	F 689		

nurse also documented that the resident told the nurse that Executive Order 26, 4.b. . The nurse documented that the resident had no bumps, lacerations, or bleeding, and a Executive Order 26, 4.b. (an assessment tool used to assess an individual's Executive Order 26, 4.b. and Executive Order 2). The documentation indicated that the resident was assisted off the floor with the help of staff into the bed. The note revealed that the resident was experiencing Executive Order 26, 4.b. Executive Order 26, 4.b. . The nurse then documented that Executive O medications were administered for Executive Ord

The surveyor reviewed the facility form titled, Incident Report-Patient Involved (IR) and dated Executive Order 26, 4.b. which reflected that Resident Executive Or had an unwitnessed fall at Executive Ord hours Executive Order 26, 4.b.). According to the report, the assigned nurse heard Resident # Executive calling out for help and observed the resident was on the floor. The nurse then interviewed Resident # Executive and the resident stated that he/she had gone to the bathroom and was walking back to the bed when he/she fell. The resident told the nurse that Executive Order 26, 4.b. No other injuries were noted. A Executive Orde was initiated, the family and the medical doctor (MD) were notified and the MD did not provide the reporting nurse with any new orders for Resident Executive Ord at that time. According to the report the resident was Executive Order 26, 4.b.

The surveyor reviewed LPN#1's undated written Witness Statement (WS) which was attached to the IR for the fall of Executive Order 26, 4.b. . The LPN #1's WS

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F 689	Continued From page 10 revealed that Resident #[redacted] was heard calling for help and was found lying on the floor close to the bathroom and when LPN #1 approached the resident the resident stated [redacted] LPN#1 was told by the resident that he/she had gone to the bathroom and was walking back to bed and fell and that Executive Order 26, 4.b. (WS did not specify where the resident [redacted]). LPN #1 documented that there were no bumps, lacerations or bleeding assessed and neuro-checks ([redacted] examination assesses motor and sensory skills, hearing and speech, vision, coordination, and balance) were initiated. LPN#1 also documented that the resident appeared to be Executive Order 26, 4.b. [redacted] The [redacted] dated [redacted] indicated that the initial [redacted] evaluation was performed and then was performed every 15 minutes for the first 2 hours, then every 30 minutes for 2 hours, then evaluate every 4 hours, and then every 8 hours. According to the [redacted] the resident was [redacted] Executive Order 26, 4.b., could follow [redacted] [redacted], Executive Order 26, 4.b. to Executive Order 26, 4.b. [redacted] The Situation Background Assessment Recommendation (SBAR) dated [redacted] and untimed, indicated that Resident [redacted] had a change in condition and was evaluated for falls. The SBAR Background area was blank for the Diagnosis, Medication Alert section which included Executive Order 26, 4.b.). The SBAR indicated that the resident had signs of Executive Order 26, 4.b.. Section ten under	F 689		

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F 689	Continued From page 11 Executive Order 26, 4.b. Evaluation indicated that the resident was Executive Order 26, 4.b. There was no documentation under the section Summarize your Observations and Evaluation and there were no new interventions listed for fall reduction or injury reduction documented on the SBAR Interventions section. The entire Intervention section was blank. The surveyor reviewed the Telehealth Evaluation (TE) dated Executive Order 26, 4.b. which revealed: Resident Executive Or was being evaluated for the Primary Chief Complaint: Executive Order 26, 4.b.. The Executive indicated that Resident Executive Ord was walking in the hallway with his/her four Executive Order 26, 4.b. and accidentally tripped while walking. When he/she fell he/she Executive Order 26, 4.b. without (w/o) Executive Order 26, 4.b.). The TE indicated that the resident did not have Executive Or was Executive Order 2 Executive Order 26, 4.b. , and had no Executive Order 26, 4.b. with normal ROM and was without deficits. The TE Diagnosis and Assessment/Plan indicated that the resident had a history Executive Order and had a Executive Order 26, 4.b. without change in Executive O. The TE further revealed that staff were to continue with fall precautions, Executive Order 26, 4.b. and the resident was advised to call for assistance when getting out of bed. The surveyor reviewed the clinical medical record and could not locate documentation regarding the development of a CP which included fall prevention interventions after Resident Executive Or sustained a Executive Order 26, 4.b. Executiv. 2. According to a PN dated Executive Order 26, 4.b.	F 689		

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F 689	Continued From page 12 Executive Order 26, 4.b. Resident Executive Order was heard calling for help and was found lying on the floor near the bathroom. The resident told the nurse Executive Order The PN indicated that Resident Executive Order was not able to verbalize what transpired before the fall and during the assessment the Resident was noted to have a Executive Order 26, 4.b.. No other injuries were documented on the PN. The PN further indicated that the resident was not able to state if he/she Executive Order 26, 4.b. Executive Order 26, 4.b. were initiated and the Executive Order 26, 4.b. Executive Order 26, 4.b. was covered with a dressing. Resident # Executive was provided with first aid at that time. The surveyor reviewed the IR dated Executive Order 26, 4 at Executive Order 26, 4.b. and according to the IR report, Resident # Executive was heard calling for help and was found on the floor near the bathroom. The resident was unable to verbalize where he/she was going. Resident # Executive was assessed and was noted to have a Executive Order 26, 4.b. . According to the IR the resident denied hitting his/her Executive Order The IR also indicated that the Resident did not have any other injuries and that a Executive Order 26, 4.b. was initiated. The IR indicated that the resident was seen by the Nurse Practitioner (NP) and was ordered a treatment for the Executive Order 26, 4.b.. The IR reflected that the responsible party for Resident Executive Order was notified and requested that the resident was sent to the emergency room for an evaluation. The untimed WS, dated Executive Order 26, 4 , and was attached to the IR was written by a Registered Nurse (RN #2). The WS revealed that Resident # Executive had no complaints of Executive Order after the fall and was able to ambulate with a walker without	F 689		

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	315513	A. BUILDING _____ B. WING _____	C 06/10/2021

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F 689	Continued From page 13	F 689		

difficulty.

The WS dated Executive Order 26, 4.b. was written by a Certified Nursing Assistant (CNA #1), indicated that that she observed Resident Executive Or ten minutes prior to the fall and the resident was sitting in a chair and looking outside the window.

The WS dated Executive Order 26, 4 at Executive Order 26, 4.b. PM) and written by LPN#1, indicated that she heard the resident calling for help and found the resident on the floor near the bathroom. The resident was unable to verbalize why he/she fell. An assessment showed that Resident Executive Or sustained a Executive Order 26, 4.b. and no other injuries. No head injuries or bumps were noted, and Executive Order 26, 4.b. were initiated.

The undated and untimed WS written by RN#2 and attached to the IR dated Executive Order 26, 4 , indicated that Resident # Executive sustained a Executive Order 26, 4.b. on the Executive Order 26, 4.b. and first aid was applied. The MD and family were notified of the fall and that Resident Executive Or had ROM to Executive Order 26, 4.b. and Executive Order 26, 4.b. and the resident had no complaints of Executive P after the fall and was able to ambulate with a walker without difficulty.

The nurse put the bed in a low position and the call bell was put within the resident reach. This intervention was not added to the CP to ensure consistent implementation.

The Executive Orde dated Executive Order 26, 4.b. reflected that a Executive Order 26, 4.b. checks initial evaluation was performed and then was performed every 15 minutes for the first 2 hours.

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F 689	Continued From page 14 The [redacted] indicated that Resident #[redacted] was alert, oriented to person, could follow simple commands, normal response to pain, pupils were equal and reactive to light, and was able to move all extremities with equal strength. The resident's vital signs were within normal limits up to [redacted] and then the resident was sent to the hospital emergency room (ER) for evaluation. The untimed SBAR dated [redacted], indicated that Resident [redacted] was being evaluated for falls. There was documentation on the SBAR that revealed Resident #[redacted] was on an [redacted] medication and had signs and symptoms of [redacted] Under section 10 "[redacted] Evaluation", there was a check mark that indicated, "Not clinically applicable to the change in condition being reported." There were no new interventions for fall reduction documented in the "Intervention section" of the SBAR for this [redacted] fall. The PN dated [redacted] revealed that Resident #[redacted] had a obtained a "[redacted]" on the [redacted] after a fall. The PN reflected that the Nurse Practitioner (NP) was made aware and ordered the LPN #1 to cleanse the [redacted] and cover with a clean, dry dressing (CDD) daily until resolved. The PN also indicated that the responsible party requested to have a "one-on-one" aid put in place for Resident #[redacted] and the administrator had denied the request. Per the PN the responsible party then requested that the resident be sent to the hospital for evaluation and was then "approved by the NP".	F 689		

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According to the CP initiated after the [redacted] fall on [redacted], the resident was noted to be at risk for falls due to a [redacted], had [redacted] Executive Order 26, 4.b. . Interventions included:

1.) Bed in low position.
2.) Encourage to transfer and change positions slowly.
3.) Low bed.

The NP PN dated [redacted] and signed at [redacted], indicated that the NP examined Resident #[redacted] after sustaining [redacted]. The NP documentation revealed that the resident was [redacted], denied having a [redacted] The PN also indicated that Resident #[redacted] was on a [redacted] for [redacted] Executive Order 26, 4.b. (action taken to prevent disease) and complained of [redacted] at a [redacted] on the [redacted]. The PN also indicated that the resident's family requested that the resident be sent to hospital for evaluation.

On 06/03/21 at 11:40 AM the surveyor conducted a telephone interview with the Registered Nurse (RN #3) who signed and prepared the IR dated Executive Order 26, 4.b. for a fall that occurred at [redacted]. The RN #3 stated that she did not remember any details of the incident and was not able to speak any further.

On 06/03/21 at 11:21 AM, the surveyor interviewed the Registered Nurse Care Manager (RN CM #1) for the [redacted] 3:00 PM - 11:00 PM

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F 689	Continued From page 16 shift. The RN CM #1 stated that she could not recall the fall incidents that occurred on Executive Order 26, 4 and Executive Order 26, 4 and would like to review Resident Executive Order clinical medical record prior to being interviewed. RM CM #1 was not able to be contacted after the initial interview. On 06/03/21 at 11:33 AM, the surveyor conducted a telephone interview with an agency Licensed Practical Nurse (LPN#1), who was assigned to Resident # Executive on Executive Order 26, 4 and Executive Order 26, 4, and found Resident Executive O lying on the floor after both falls. LPN#1 stated that she did not know all the details of the events because she worked at many different places. LPN #1 stated that she was unaware if the facility had a policy regarding residents who had an unwitnessed fall, Executive Order 26, 4.b. and were also on Executive Order 26, 4.b. medications. LPN #1 stated that if a resident hit their head and was on Executive Order 26, 4.b. medication, then the resident would not automatically go to the hospital. She stated Executive Order checks would be completed and the nurse would then call the MD. LPN #1 then stated the MD would evaluate the resident via telehealth (internet video) and then the MD would make the determination if the resident needed to be sent to the hospital. She further stated that when Resident # Executive Executive Order 26, 4.b. Executive Order 26 and was seen by the MD on telehealth and the MD made the determination that the resident did not need to be examined at the hospital because the Executive Order checks were within normal limits (WNL) and there was no change in mental status. LPN #1 stated to the surveyor to refer to her witness statement (WS) that she wrote and that was included in the IR for any further information.	F 689		

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F 689	Continued From page 17 On 06/03/21 at 12:30 PM the surveyor requested to interview the NP that examined Resident #[redacted] on [redacted] and the NP was not available for an interview. On 06/03/21 at 12:23 PM the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team. The DON stated that Resident [redacted] had a fall prior to admission to the facility and had [redacted]. The DON stated that she did not know if a fall risk assessment needed to be completed upon admission and the facility treated all the residents as if they were at risk for falls. The DON stated that she did not know why the nurses did not add fall prevention interventions to the CP for Resident #[redacted] at the time of admission, or after the resident fell on [redacted] The DON stated if a resident had a fall, interventions should be added to the resident's care plan to reduce the risk for falls or injury. The DON also explained that the facility did not have a specific policy for nurses to follow regarding falls for the residents taking [redacted] medications. On 06/04/21 at 10:22 AM the DON stated, in the presence of the survey team, that the fall risk assessment was part of the CP process. The DON confirmed that this was not completed for Resident #[redacted] at the time of admission, or after the resident's first fall on [redacted] She further stated the resident should have been assessed for falls at the time of admission and a "CP should have been initiated with interventions to reduce risk for falls". The DON stated this was especially important after the first fall and interventions should have been put in place to	F 689		

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F 689	Continued From page 18 prevent additional falls. On 06/04/21 at 11:06 AM the surveyor interviewed a Registered Nurse (RN #4) about the admission process. RN #4 stated she has been employed with the facility for [redacted] years. RN #4 explained the admission process to the surveyor and stated when residents were admitted to the facility that the resident's vital signs (VS) were taken and an admission assessment was performed. She added that staff were provided with an intake sheet or report from the hospital which explained why the resident was being admitted including the diagnoses and that helped to prepare the facility for the admission. She stated that the facility was made aware that any resident was a fall risk even before admission, because it was usually written on the hospital report. RN#4 added that if the resident was a fall risk, fall precautions would be implemented and a CP would be formulated with interventions to prevent falls. RN#4 revealed that when a resident had a fall in the facility an incident report was completed, [redacted] checks were completed, the MD and family were notified, and employee statements were obtained. RN #4 stated the CP would also be updated to include new interventions to reduce the risk for falls. RN#4 also stated, if a resident was on [redacted] and fell, and hit their [redacted] we would let the MD know and then monitor the resident for bleeding. She stated the MD would then make the determination if a resident needed to be sent to the hospital or not. On 06/04/21 at 11:16 AM the surveyor interviewed CNA #1 who was employed in the facility for [redacted] years and provided care for Resident	F 689		

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F 689	Continued From page 19 #[redacted]. CNA #1 stated she took care of Resident #[redacted] on [redacted] night [redacted] (3:00 PM - 11:00 PM) and [redacted] (7:00 AM-3:00 PM), and on [redacted] (7:00 AM - 3:00 PM). CNA #1 explained to the surveyor that Resident #[redacted] was [redacted], and she had thought he/she was at risk for falls and [redacted]. CNA #1 explained that the resident had a [redacted] status upon admission, and this was unchanged during the resident's time at the facility. CNA #1 stated that she told one of the nurses at the nurse station that Resident #[redacted] [redacted] because he/she was at risk for falls and was unsteady at times. She further stated that "the facility did not have CNA care plans and the CNA's obtained report from the nurses and that was how they knew what care the residents required. CNA#1 added that she did not remember any fall interventions that were in place for Resident #[redacted] and she did not witness the fall. She also added that she did not remember if the resident had any [redacted] injuries or complaints of [redacted] in any extremities. On 06/04/21 at 11:45 AM the surveyor interviewed the Director of Rehabilitation (DOR) who confirmed to the surveyor that during the initial PT evaluation for Resident #[redacted] that the therapist identified Resident #[redacted] was at risk for falls related to reduced dynamic balance, decreased strength and limited painful movements. The DOR stated that Resident # [redacted] was also evaluated by OT on [redacted], and the resident had function ROM WNL of bilateral upper extremities, but strength was weak and "was at a risk for falls." On 06/07/21 at 9:27 AM, the surveyor	F 689		

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interviewed the Physical Therapy Assistant (PTA) who treated Resident [redacted] on [redacted], after the resident's [redacted] fall. The PTA explained that the resident "was a fall risk" and the he/she complained of [redacted] The PTA added that she notified the nurse about the resident's complaint of pain but was unable to provide the nurse's name. The PTA stated, if she noticed any [redacted] of the resident's [redacted] or complaints of [redacted] in any of the resident's extremities, she would have documented that in the treatment note. The PTA then added that if she did not document it, then she did not see it. The PTA added that she always documented anything that was unusual going on with the resident and that she did not notice anything unusual in Resident [redacted]s upper and lower body extremity movements. She stated to the surveyor that she did not observed any [redacted] on the resident's [redacted].

On 06/08/21 at 10:01 AM, the surveyor interviewed the Administrator who stated that if a resident was admitted to the facility with a history [redacted] then the staff "should have implemented interventions on the CP" to reduce the risk for falls/injury and a "CP should have been initiated." He added that if a resident fall after admission in the facility then the nurses should have developed a CP for falls with interventions to reduce the risk for falls. He admitted that the staff should have followed the facility policy for "Falls Management" and initiated a CP with fall reduction interventions for Resident #[redacted] on admission and after the [redacted] on [redacted] at [redacted].

On 06/10/21 at 08:47 AM, the surveyor

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F 689	Continued From page 21 interviewed the Administrator and DON who agreed that Resident #[redacted] should have had a CP developed on admission and after fall of [redacted], which included interventions to reduce the risk for falls. Resident #[redacted] sustained a fall at the facility on [redacted]. The resident had a subsequent fall on [redacted] and was transferred to the hospital for evaluation. The hospital records were reviewed and reflected that Executive Order 26, 4.b. [redacted] was performed of Resident [redacted] on Executive Order 26, 4.b. and the resident was diagnosed with an [redacted]. The facility policy titled, "Falls Management" with a revision date of 11/01/19, revealed that policies and procedures are guidelines and are not intended to replace the informed judgement and professional discretion of individual clinicians, nor are they intended to establish the standard of care applicable to the assessment or treatment of any particular condition and unique needs of each patient. The policy indicated that patients will be assessed for falls risk and will receive appropriate interventions to reduce risk and minimize injury. The purpose of the policy was to reduce risk for falls and minimize the actual occurrence of falls. The policy by addressed the "Practice Standards" to identify the patient's fall risk by reviewing the Nursing Assessment, Fall Risk Evaluation, Communicate the patient's fall risk, develop an individualized plan of care and Review the Care Plan regularly. The policy indicated that "if a resident falls" the Care Plan should be updated to reflect a new intervention.	F 689		

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F 689	Continued From page 22 The facility policy titled, "Falls Care Delivery Process" dated 07/25/16, revealed that the process was designed to assist the nursing staff in: Recognizing patients at risk for falls, Identifying appropriate interventions to reduce risk and minimize injury and initiating appropriate care and investigating the cause for patients that experience a fall. a.) Problem Management: 1.) Document the Care Plan focus. 2.) Develop a plan of care including general and specific interventions to address all areas of risk. Ensure that patient and family expectations and wishes are compatible with plan of care. 3.) Refer to following tools to develop an individualized plan of care which addresses environmental modifications, sensory capacity, functional deficits, orthostatic hypotension, and medications that affect balance or level of consciousness, and appropriate restorative/rehabilitation services. b.) Response to a patient Fall: 1.) Evaluate and monitor the resident for 72 hours after a fall and perform [redacted] assessment for all unwitnessed falls and witnessed fall with a [redacted] injury complete change in condition note and review the residents medical record and assessments to identify any causes that may have contributed to the fall. 2.) Investigate. 3.) Implement new interventions immediately after the fall. 4.) Notify physician and family. 5.) Update the care plan with new interventions and communicate interventions to the staff. 6.) Monitor the resident's response.	F 689		

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F 689	Continued From page 23 NJAC 8:39-27.1(a)	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure a.) the dish machine temperature gauge functioned in a manner to ensure proper operating temperatures, b.) the kitchen environment, ice machine and food service equipment was maintained in a clean and sanitary manner, c.) refrigerated food items were labeled and dated with a use by date, d.) staff utilized appropriate facial hair restraints, and e.) staff utilized the appropriate method to clean a thermometer probe to prevent potential food	F 812	I. 1. A beard restraint was properly adorned. 2. Fresh Mozzarella has been discarded 3. Fans in Walk-in Refrigerator Dirty/Debris has been cleaned accordingly. 4. The plastic bag of kale was discarded. 5. The ice machine was thoroughly cleaned accordingly. 6. Ice Scoop Holder for Ice Machine Scoop Dirty/Debris (mounting adhesive residue) has been cleaned accordingly.	7/20/21

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F 812	Continued From page 24 contamination. The deficient practice was evidenced by the following: On 06/02/21 from 9:40 AM through 10:30 AM, the surveyor conducted an initial tour the kitchen, in the presence of the Food Service Director (FSD) and observed the following: 1. The FSD was observed with facial hair and was wearing a beard restraint over his chin area with a surgical mask underneath the beard restraint. Both coverings did not fully cover his facial hair. The surveyor inquired to the FSD the purpose of the beard restraint. The FSD stated it was used to cover excess hair. 2. A five-pound package of shredded mozzarella cheese was opened and was not sealed. The package had a manufactured date of April 10, 2021 stamped on the outside of the package. The package was not labeled with a date the package was opened or a use by date. The FSD stated the process was to label and date the item when it was opened, and he confirmed it was not labeled or dated. 3. The fans located inside of the walk-in refrigerator had a build-up of a dark substance on the grates and around the fans. The FSD was interviewed at that time regarding the substance and he confirmed the surveyor's observation. 4. A sealed plastic bag of kale was located on a shelf in the walk-in refrigerator. The kale did not contain a use by date. The FSD stated the the perishables were not dated. 5. The baffle inside of the ice machine had areas	F 812	7. The blender has been cleaned accordingly. 8. Clear-Cover Knife Holder Dirty/Debris has been cleaned accordingly. 9. Base Boards Dirty/Debris have been cleaned accordingly. 10. Dish Machine Temperature Gauge has been replaced and repaired 11. Ceiling Tile in Dish Room Leaking Water has been repaired. Pictures have been emailed to Executive Order 26, 4.b.. The booster pump has been adjusted to increase water temperature above 150 degrees Fahrenheit. The sanitizer wipes have been discarded. II. All patients have the potential to be affected by these cited, deficient practices. 1. Daily Label & Dating Audits being completed. Corrective Action for items not in compliance. 2. Daily Sanitation Audits have been completed. Corrective action for items not in compliance. 3. Walk-in Refrigerator inspected Daily for proper/secure storage of all food and non-food products. Corrective Action for items not in compliance. 4. Daily Hair Restraint & Beard Guard Audits have been completed. Corrective Action for items not in compliance. 1. All dining services staff were	

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F 812	Continued From page 25 of a dark substance affixed to it. The FSD stated the maintenance department was responsible to clean it and stated, "it looks like it could be cleaner". The FSD proceeded to take a paper towel and wipe the baffle. The FSD showed the surveyor the paper towel which had dark spots on it. 6. An ice scoop was observed affixed to the side of the ice machine in an open metal holder. Debris was observed stuck to the metal holder. 7. A covered blender was stored the on the metal counter next to the ice machine. The FSD removed the lid and showed the surveyor the inside of the blender which was visibly wet with pooled liquid inside. The FSD stated the blender should not have been stored that way. 8. Two knife holders were affixed to a wall in the kitchen. Both holders contained large knives and were enclosed in a clear plastic type cover. The interior of both knife holders had crumb type debris throughout the bottom. The surveyor inquired to the FSD when the holders were cleaned. The FSD stated the holders looked like they needed to be cleaned. The surveyor reviewed the weekly cleaning schedule with the FSD who stated the knives were not listed on the schedule. 9. The baseboards throughout the kitchen were noted to have dark colored debris in the corners where the wall met the floor. The FSD stated that cleaning the baseboards was not on the cleaning schedule. The FSD explained that he and the kitchen staff were part of a management company and the kitchen staff were responsible	F 812	in-serviced on the procedure to properly label food items with the corrective action to take when food exceeds its□ used by date. 2. All dining services staff were in-serviced on proper storage of food items in walk-in refrigerator. 3. All dining services staff were in-serviced on proper wearing of hair restraints, and beard guards. 4. All Dining Services Managers were in-serviced on how to input repair/work orders for correction. 5. All dining services staff were in-serviced on properly following and completing Daily/Weekly Sanitation Schedules. 6. All dining services staff were in-serviced on how to properly clean/store equipment. (i.e. blender) 7. All dining services staff were in-serviced on how to properly record temperature of Dish Machine on Low-Temp Cycle. 8. All dining services staff were in-serviced on how to properly take Food Temperatures using Thermometer Probe and appropriate Alcohol-Based Sanitizing Wipes. IV. 1. The monitoring of all food storage locations will be completed by the FSD/designee during the opening and closing inspections. The monitoring of food storage will be completed during the weekly sanitation inspection by the	

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F 812	Continued From page 26 to only sweep and mop the floor. The FSD stated any deep cleaning was the responsibility of the facility. The FSD stated the floor baseboards should be cleaned once per month. 10. At 10:17 AM, the dish machine was observed in operation and a ceiling vent in the area of the dish machine had a copious build-up of black debris on the vent. A ceiling tile located next to the dish machine was dripping a fluid. The FSD stated maintenance was responsible for fixing the leaking ceiling tile. The FSD then showed the surveyor the dish machine temperature gauge which was located under the machine. The surveyor attempted to read the gauge and was unable to do so due to a build up of caked on debris. The surveyor used a paper towel and scraped off the debris and showed the paper towel to the FSD and he acknowledged it was soiled and did not offer any explanation as to how the temperature was recorded if the thermometer could not be read. The FSD then stated the dish machine temperature should be 120 degrees Fahrenheit (F) and that the temperatures varied due to the booster. At that time the dish machine temperature log was reviewed with the FSD and the documented dish machine temperature for 06/02/21 at 7:00 AM was 150 degrees F. The FSD then stated the air conditioner line that leaked had affected the dish machine temperatures and if the dish machine temperature was between 100-115 degrees F the dish machine could not be used. At that time the surveyor observed the dish machine temperature at 117 degrees F. 11. At 10:27, AM the Maintenance Director (MD) entered the kitchen and he informed the surveyor	F 812	FSD/District Manager. Unit inspections will be reported to the administrator and reviewed at the monthly QAPI meeting by the interdisciplinary team. 2. The monitoring of all hair restraints and Beard Guards will be completed by the FSD/designee at the beginning and end of every shift, as well as the start of every Meal Service. Unit inspections will be reported to the administrator and reviewed at the monthly QAPI meeting by the interdisciplinary team. 3. The monitoring of all label and dating procedures will be completed by the FSD/designee during opening and closing inspections. The monitoring of label and dating will be completed during Daily RD audits and Weekly District Manager audits. Unit inspections will be reported to the administrator and reviewed at the monthly QAPI meeting by the interdisciplinary team. 4. The monitoring of all sanitation procedures will be completed by the FSD/designee during opening and closing inspections. Ceiling Vents and Refrigeration Fans in need of cleaning will be reported to facility maintenance utilizing facility protocol to ensure the safety of Dining Staff employees who are not permitted to utilize equipment such as a ladder to access ceiling vents and tiles. Unit inspections will be reported to the administrator and reviewed at the monthly	

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F 812	Continued From page 27 the leaking ceiling was a condensate leak due to the air conditioner and the line needed to be flushed. The MD stated he was responsible for housekeeping, maintenance and laundry and that those departments were not responsible for doing any cleaning the kitchen. At 12:52 PM, the surveyor interviewed the District Manager (DM) for the food service management company in the presence of the facility Administrator (LHNA). The DM stated the dish machine was not a high temperature dish machine and that the temperature was not something that was regularly checked. The DM stated that test strips were used instead to test the chemical, therefore the temperature gauge would not be used and the booster was something that was used for an old dish machine. The LHNA stated he was unsure why the FSD referenced the dish machine booster and could not speak to the temperature of the dish machine. On 06/04/21 9:49 AM, the LHNA provided a Regular Service Call document, dated 06/02/21 at 3:36 PM, and completed by the dish machine maintenance company. The document revealed that under Machine Condition: Issue Found, Comments: Machine tank thermometer replaced. Under Chemical Sanitation, Comments: booster thermostat turned up. The LHNA also provided the specifications for the operation of the dish machine which revealed the minimum wash and sanitizing rinse temperature was 120 degrees F. On 06/07/21 at 11:02 AM, the surveyor conducted a telephone interview with the service technician (ST) who completed the 06/02/21	F 812	QAPI meeting by the interdisciplinary team. 5. The monitoring of all Dish Machine temperature cycles will be recorded by the FSD/designee at the beginning and end of every Meal Service. Daily check will be conducted by Registered Dietitian during walk-thru, and the District Manager during Unit Inspections. Unit inspections will be reported to the administrator and reviewed at the monthly QAPI meeting by the interdisciplinary team.	

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service call for the dish machine. The ST confirmed the gauge the surveyor observed was broken and he replaced it on 06/02/21. The ST stated the temperature on the gauge should not read less then 120 degrees F to properly clean dishes and he also increased the booster temperature during the service call on 06/02/21. He stated the final rinse temperature needed to increase and that is why the booster temperature was increased.

On 06/08/21 at 8:34 AM, the surveyor interviewed the MD regarding any preventative maintenance for the kitchen. He stated he cleaned the vents and flushed out the condensation line and if something was leaking he should have been notified. He further stated that the kitchen can contact him at any time for any maintenance issues.

On 06/08/21 at 8:54 AM, the surveyor interviewed the facility Registered Nurse/Infection Preventionist (RN/IP) regarding the cleanliness of the ice machine. The RN/IP stated if the ice machine was not maintained, particles could get into the ice.

On 06/08/21 at 11:46 AM, during the meal preparation, the surveyor inquired to the FSD regarding the food temperatures of the cold salads in an open service station. At 11:48 AM the FSD, in the presence of the surveyor, removed a packet from a clear bin located on in the steam table area, opened the packet and used the enclosed wipe to wipe the thermometer probe. The surveyor observed the package of the wipe was labeled, "Hand Sanitizing". The surveyor inquired to the product that the FSD

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used and the FSD stated that was what was used regularly to sanitize the thermometer probe. The surveyor asked the FSD to read the package, and the FSD stated the wipe was for hand sanitizing. The FSD then went into the same plastic bin and removed another type of wipe. The FSD proceeded to wipe the thermometer probe with the wipe. The wipe was labeled, "Obstetrical Cleansing Towelette". The thermometer did not touch the food and the surveyor requested additional information from the FSD.

On 06/08/21 at 12:06 PM, the surveyor informed the LHNA about the products utilized by the FSD to clean the thermometer probe. The LHNA acknowledged the products were not intended for cleaning thermometer probes.

On 06/09/21 at 8:52 AM, the LHNA provided the Safety Data Sheet (SDS) for the Hand Sanitizing Wipe and the Obstetrical Cleansing Towelettes. The SDS for the Hand Sanitizing Wipe revealed the recommended use was Hand Sanitizer. The SDS for the Obstetrical Cleansing Towelettes revealed the recommended use was for cleansing the intended area. Neither product was indicated for use of cleaning a thermometer probe. The LHNA also provided the surveyor with the SDS for the Thermometer Probe Wipes that he stated should have been used, which revealed the recommended use was to effectively cleanse food thermometers and meat probes. The LHNA could not provide information as to why the FSD utilized wipes that were not intended for food service use.

Review of the Staff Attire Policy #024, dated

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5/2014, revealed all staff members will have their hair off the shoulders, confined in a hair net or cap and facial hair properly restrained.

Review of the Food Preparation Policy #016, dated 5/2014, revealed dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological and chemical contamination, all utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use.

Review of the Environment Policy #028, dated 5/2014, revealed all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting and ventilation. All food contact surfaces will be cleaned and sanitized after each use and the Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.

Review of a Food Storage: Cold Foods Policy #019, dated 5/2014, revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

Review of 4.4 Machine Warewashing and Sanitizing Policy, dated 07/01/98, revealed for a low temperature machine, the minimum wash cycle temperature is 120 degrees F with 50 PPM of chlorine based chemical sanitizer. If temperatures fall below the standard for either

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F 812	Continued From page 31 wash or final rinse, or the chemical sanitizer does not test at the appropriate concentration, the Director of Dining Services or Maintenance Department is notified immediately. If the issue cannot be corrected by facility staff, the chemical supply service representative is notified and warewashing is discontinued until the issue is corrected. Review of undated Dining Services Director/Account Manager job description revealed under Job Function/Food Preparation and Safety: Ensures that established sanitation and safety standards are maintained. Review of the undated Food Storage and Retention Guide provided by the DM on 06/09/21 at 12:28 PM revealed Cheese, Shredded (mozzarella, cheddar) is stored at < 41 degrees F for one month. N.J.A.C. 8:39-17.2g	F 812		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency;	F 886		7/20/21

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F 886	Continued From page 32 (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who	F 886		

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F 886	Continued From page 33 refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to: a.) keep complete and accurate documentation of resident and staff rapid COVID-19 testing, and b.) re-test residents per facility policy and per the Center for Disease Control and Prevention (CDC) guidelines. This deficient practice was evidenced by the following: 1. On 06/07/21 at 10:50 AM, the Registered Nurse Infection Preventionist (RN/IP) stated the facility had a Licensed Practical Nurse (LPN) who had tested positive for COVID-19. The RN/IP stated that the LPN had informed the facility she was not feeling well on 04/20/21, and the RN/IP had the LPN come to the facility parking lot to perform a rapid COVID-19 test. The RN/IP stated the test was positive and the LPN had symptoms therefore, there were no additional COVID-19 tests performed on the LPN. The RN/IP further stated the LPN had last worked at the facility on 04/18/21 and that the facility then began rapid COVID-19 testing for all the residents and staff. The RN/IP stated all the residents and staff tested negative.	F 886	1.) Patient's covid records were reviewed for completion and accuracy. Covid 19 tracker documentation was updated in Covid 19 surveillance tracker system. 2.) All patients and staff were tested per CDC guidelines on June 18, 2021 and retested on June 24,2021 3.) The Quality Assurance Consultant will educate the Director of Nursing, Infection preventionist and nurse managers on utilization of the Covid-19 tracker and covid -19 testing requirements during outbreak per guidelines. 4.) The Director of Nursing or designee will audit the Covid 19 tracker daily x 5 weekly x3 and monthly x2. The results will be reported to quality assurance committee x 3 months.	

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F 886	Continued From page 34 The surveyor reviewed the, "Employee COVID-19 POC (Point of Care) Testing Log - BD Veritor" (A nasal swab test used for rapid detection of SARS-CoV-2 antigen tests that that detects proteins from the SARS-CoV-2 virus) and the "Patient/Resident COVID-19 POC Testing Log." Review of the facility on-going, "Patient/Resident COVID-19 POC Testing Log" revealed two different logs which included the following areas to be completed: DOB (date of birth); date; room; name; time of specimen collection; name of nurse collecting specimen; lot #/ expiration date of test card; time of test analysis; procedural controls validated " "; test result; name of card analyzer; test operator name. The surveyor reviewed 27 pages of the resident logs with 191 resident entries. The dates ranged from 04/19/21 through 05/06/21 and revealed the following missing or incomplete documentation: Date 187, time of specimen collection 142, name of nurse collecting specimen 148, test lot #/expiration date 150, time of test analysis 158, test results 21, test operator name 141. The resident logs consisted of five pages with 63 residents where the procedure control validation entries were required. Out of the 63 possible procedure control validation entries, 55 were either missing or incomplete. The surveyor reviewed 43 pages of the, "Employee COVID-19 POC Testing Log" with 289 employee entries that ranged from 04/16/21 through 05/19/21 and revealed the following	F 886		

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F 886	Continued From page 35 missing or incomplete documentation: Date 222, time of specimen collection 200, name of nurse collecting specimen 200, test log #/expiration date 231, time of test analysis 234, test results 34, name of card analyzer 196. Out of the 211 possible procedure control validation entries, 100 were either missing or incomplete. On 06/07/21 at 12:11 PM, the surveyor in the presence of the RN/IP reviewed the COVID-19 rapid testing logs for residents and employees. The RN/IP stated the testing log dates should have accurately specified the year, because it could have been last year, the log should always have the full name of the nurse collecting the specimen so the facility could ask questions if needed, that the time of the analysis test should be documented to specify AM or PM, the procedure control should always have a check mark to ensure it was performed, the test results should be "negative" or "positive" to negate any confusion, and the name of the card analyzer and test operator should have the full name so they can refer back to the staff member if needed. The RN/IP further stated she reviewed the logs when she entered the information into the computer, but she did not clarify the information and had made assumptions. The RN/IP further stated the facility testing logs needed to be done correctly because the information was also needed to conduct facility contact tracing. On 06/07/21 at 12:46 PM, the Director of Nursing (DON) reviewed the COVID-19 rapid testing logs with the surveyor. The DON stated the facility	F 886		

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PROMEDICA SKILLED NURSING & REHAB VOORHEES EAST	**113 SOUTH ROUTE 73 VOORHEES, NJ 08043**

(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 886	Continued From page 36	F 886		

had a schedule to review the COVID-19 test logs for results. The DON stated the logs should reflect the complete date which included the month, day, and year for accurate documentation; the name should include first and last name in case of a similar or same name; the time of specimen collection should have AM or PM indicated; the nurse obtaining the specimen should document their first and last name so the facility would know who collected it; the lot/expiration date would be important; the time of analysis should be in AM or PM; the procedures control "v" needs to have that check mark filled out entirely, the test results should indicate "neg" (negative) or "pos" (positive). The DON further stated that she wanted the staff to write out "neg" or "pos" to avoid confusion; and the name of the staff who read/interpreted the test should have documented their full name.

The DON further stated the information would be entered into the system, should be documented completely, and if there were gaps, the gaps should have been questioned. The DON stated she would be the one person responsible to review the logs but did not think to question the gaps.

The facility could not provide a procedure that indicated how to fill out the COVID-19 Testing Logs.

2. On 06/08/21 at 9:41 AM, the surveyors conducted an interview with the RN/IP and DON. The RN/IP stated the facility had tested all staff and residents after the LPN tested COVID-19 positive on 04/20/21. The RN/IP further stated she had only retested the staff and not the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING _____ B. WING _____	C 06/10/2021

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PROMEDICA SKILLED NURSING & REHAB VOORHEES EAST	**113 SOUTH ROUTE 73 VOORHEES, NJ 08043**

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F 886	Continued From page 37	F 886		

residents after the initial test. The RN/IP stated the staff were retested because they could still test positive after being exposed. The DON stated that when the LPN worked on 04/18/21, the resident's that she cared for were all on full Transmission-Based Precautions and the LPN was wearing a N95 mask, eye protection, a gown, gloves, and performed appropriate infection control practices according to CDC guidelines when she provided care to the resident's on her assignment.

On 06/09/21 at 10:58 AM, the DON stated the facility retested the residents as they were supposed to be retested based on guidance from the local health department and CDC guidelines.

On 06/09/21 at 11:34 AM, the DON then clarified to the survey team that the residents who were initially tested related to the positive staff member had not been retested.

Review of the facility provided, "Understanding and Managing COVID-19, COVID-19 Testing Plan", dated 05/12/21, revealed upon identification of a single new case in any staff or patient, all staff and patients will be tested. Staff and patients who test negative will be retested every 3-7 days until testing identified no new cases of COVID-19 among staff or patients for a period of at least 14 days since the most recent positive test.

Review of the Center for Disease Control and Prevention (CDC) COVID-19, "Interim Infection and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated 03/29/2021 indicated that when there was a new

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	315513	A. BUILDING _____ B. WING _____	C 06/10/2021

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F 886	Continued From page 38 infection in healthcare personnel or resident in a long term care facility, "continue repeat viral testing of all previously negative residents in addition to testing of HCP [healthcare personnel], generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result." Review of the CDC COVID-19, "Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination" updated 04/27/2021 indicated in regard to SARS-CoV-2 Testing, "Asymptomatic HCP with a higher-risk exposure and patients or residents with prolonged close contact with someone with a SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5 - 7 days after exposure." NJAC 8:39-19.4(a),(d),(e),(g)	F 886		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315513 Y1	A. Building B. Wing Y2	8/13/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB VOORHEES EAST	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

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 F0623	Correction	ID Prefix F0689	Correction	ID Prefix F0812	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	07/20/2021	LSC	07/20/2021	LSC	07/20/2021
ID Prefix F0886	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80 (h)(1)-(6)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/20/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/10/2021	☐ YES ☐ NO