STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	77 EAST 43RD STREET PATERSON, NJ 07514

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F 000	INITIAL COMMENTS STANDARD SURVEY: 2/23/22 CENSUS: 111 SAMPLE SIZE: 28 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	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, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		4/11/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/16/2022

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F 584	Continued From page 1 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, record review and review of other pertinent documentation, it was determined that the facility failed to maintain a residents EX Order 26 § 4b1 and cushion in a clean and homelike manner. This deficient practice was identified for 1 of 3 residents reviewed for care of equipment and maintenance, Resident #63 and was evidenced by the following: The surveyor toured the 400's Unit on 2/11/2022 at 11:30 AM and observed Resident #63 siting on the bed, he/she did not acknowledged the surveyor when the surveyor entered the room. Next to the bed the surveyor observed a ripped and torn EX Order 26 § 4b1 the cushion was torn in several places exposing the yellow foam. Some particles and food like debris were noted on the torn cushion. On 2/14/2022 at 11:45 AM, the surveyor observed Resident #63 sitting in the room, the EX Order 26 § 4b1 was noted at the bedside, ripped and torn in	F 584	1. Immediately once notified, Facility removed and replaced Resident #63 with a new EX Order 26 § 4b1 and cushion. 2. All Residents have the potential to be affected by this deficient practice. 3. Director of Maintenance/Designee immediately conducted a Facility wide audit regarding ripped EX Order 26 § 4b1. No other residents were affected. Additionally, ADON/Designee conducted a Facility-wide in-service on reporting any broken or damaged equipment. 4. Director of Maintenance/Designee to conduct a Facility wide audit weekly x4 weeks, monthly x2 months thereafter to ensure all EX Order 26 § 4b1 and cushions are not damaged or torn. Negative Findings to be corrected immediately and reported	

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F 584	Continued From page 2 different places. The cushion was ripped and also torn in different areas. The surveyor reviewed Resident #63's medical record on 2/26/2022. The Admission Face Sheet revealed that Resident #63 was admitted to the facility with diagnoses which included but not limited to EX Order 26 § 4b1 [redacted] A review of the Quarterly Minimum Data Set (MDS) an assessment tool used to prioritize care, dated 11/18/21, coded Resident #63 as being EX Order 26 § 4b1 with a score of [redacted] out of 15 on the Brief Interview for Mental Status (BIMS). On 2/15/22 at 11:05 AM, an interview with the Unit Manager Registered Nurse (UM/RN) revealed that housekeeping power washed the EX Order 26 § 4b1 every Monday but she was not aware that the EX Order 26 § 4b1 needed to be repaired. On 2/15/22 at 11:19 AM, the surveyor interviewed the Physical Therapy (PT) Director regarding Resident #63's EX Order 26 § 4b1 condition. He stated that he was not aware of the EX Order 26 § 4b1 condition. He stated that he attended daily morning meeting and was never informed of the EX Order 26 § 4b1 condition. The surveyor showed the EX Order 26 § 4b1 picture to the PT Director who stated that, it was unacceptable and that he would take care of it. On 2/16/2022 at 10:00 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for the resident. The CNA stated that	F 584	monthly in the QA/PI Meeting.	

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F 584	Continued From page 3 Resident #63 was able to assist with care and that he/she was able to use the EX Order 26 § 4b1 independently. The surveyor observed Resident #63's EX Order 26 § 4b1 and cushion still in the same condition. The EX Order 26 § 4b1 was ripped and torn in different parts. On 2/16/2022 at 11:55 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN) who stated that staff were supposed to inform maintenance and housekeeping if something was broken or needed cleaning. The LPN had no explanation for why this equipment was not brought to the attention of maintenance and housekeeping. During a pre-exit conference with the facility administrative staff on 2/23/2022 at 10:40 AM, the Director of Nursing (DON) indicated that the EX Order 26 § 4b1 cushion was immediately removed and the staff was in -serviced on reporting on any damaged/ broken equipment. On 2/16/2022 at 9:09 AM, the DON provided the policy titled, "Cleaning and Disinfection of Resident- Care Items and Equipment" The policy Statement indicated the following: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The policy did not addressed EX Order 26 § 4b1 replacement. NJAC 8: 39 -31.4 (c)	F 584		
F 636 SS=D	Comprehensive Assessments & Timing	F 636		4/11/22

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F 636	Continued From page 4 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 636		

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F 636	Continued From page 5 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility provided documentation, it was determined that the facility failed to complete a Comprehensive Admission 14-day Minimum Data Set (MDS) assessment or Comprehensive Annual MDS assessment as required according to the Resident Assessment Instrument (RAI) for 5 of 24 residents reviewed for MDS completion (Resident #2, #4, #5, #8 and #363). The deficient practice was evidenced by the following: Reference: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified	F 636	1. Immediately once notified, MDS Director/Designee completed all due assessments for Residents #2, #4, #5, #8, #363 and submitted. 2. All Residents have the potential to be affected by this deficient practice. 3. MDS Director/ Designee immediately conducted a Facility wide audit regarding incomplete MDS assessments, no other residents were affected. DON/Administrator conducted an in-service with MDS Director regarding timeliness, completion and accuracy of MDS assessments.	

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F 636	Continued From page 6 the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. On 2/15/22, the surveyor reviewed the MDS assessments, an assessment tool used to facilitate the management of care, for the timeliness of submission for 23 system-selected residents. Information provided by the facility revealed the following for the 5 residents: 1. Resident #2 had an Assessment Reference Date (ARD) of 12/8/21. The assessment was not completed until 2/9/22. 2. Resident #4 had an ARD of 12/29/21. The assessment was not completed until 2/14/22. 3. Resident #5 had an ARD of 12/19/21. The assessment was not completed until 2/14/22. 4. Resident #8 had an ARD of 12/29/21. The assessment was not completed until 2/14/22. 5. Resident #363 had an ARD of 1/20/22. The assessment was not completed until 2/15/22. On 2/15/22 at 10:31 AM, the surveyor interviewed the MDS Coordinator who stated that there was 14 days to complete the assessment after the ARD. She then confirmed that she had not completed the five MDS. She stated that she was	F 636	4.Director of Nursing/Designee to conduct weekly audit x4 weeks, monthly x2 months thereafter to ensure all MDS assessments are being completed in a accurate and timely manner. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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F 636	Continued From page 7	F 636		

trying to "catch up" with the assessments when she started in October after the last MDS coordinator left.

On 2/23/22 at 10:09 AM, during surveyor interview, the Director of Nursing (DON) confirmed that the MDS assessments were not done and that they should have been completed in 14 days.

A review of the facility provided policy titled, "Resident Assessment Policy and Procedure" dated 2020, included the following:
Purpose and Policy. To ensure that ...upon a resident's admission and periodically thereafter, conducts a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
Procedure ...
II. Comprehensive assessment/Resident assessment instrument.
A. The Facility shall make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS ....
B. Timeframe for conducting resident assessments. The Facility shall conduct comprehensive assessment of residents:
a. Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition ...
c. Not less often than once every 12 months.
d. The facility may be subject to additional state requirements and timelines.

N.J.A.C. 8:39-11.2

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F 638	Continued From page 8	F 638		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility provided documents, it was determined that the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment, a periodic and federally mandated, standardized assessment tool, within the required time frame, according to the Resident Assessment Instrument (RAI) for 15 of 24 residents reviewed for MDS completion (Resident #1, #3, #6, #7, #9, #10, #11, #19, #23, #25, #27, #28, #29, #30 and #50). The deficient practice was evidenced by the following: Reference: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and; 2). the completion date was no later than 14 days after the ARD.	F 638	1. Immediately once notified, MDS Director/Designee completed all due quarterly assessments for Residents #1 #3 #6 #7 #9 #10 #11 #19 #23 #25 #27 #28 #29 #30 #50 2. All Residents have the potential to be affected by this deficient practice. 3. MDS Director/Designee immediately conducted a Facility wide audit regarding incomplete MDS quarterly assessments, no other residents were affected. DON/Administrator conducted an in-service with MDS Director regarding timeliness, completion and accuracy of MDS quarterly assessments. 4.Director of Nursing/Designee to conduct weekly audit x4 weeks, monthly x2 months thereafter to ensure all MDS quarterly assessments are being completed in a accurate and timely manner. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	4/11/22

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F 638	Continued From page 9	F 638		

On 2/15/22, the surveyor reviewed the MDS's, an assessment tool used to facilitate the management of care, for the timeliness of completion for 1 new admission resident and 23 system-selected residents.

Information provided by the facility revealed the following for the 15 residents:

1. Resident #1 had an Assessment Reference Date (ARD) of 12/31/21. The assessment was not completed until 2/14/22.
2. Resident #3 had an ARD of 12/28/21. The assessment was not completed until 2/14/22.
3. Resident #6 had an ARD of 12/19/21. The assessment was not completed until 2/14/22.
4. Resident #7 had an ARD of 12/19/21. The assessment was not completed until 2/14/22.
5. Resident #9 had an ARD of 12/26/21. The assessment was not completed until 2/15/22.
6. Resident #10 had an ARD of 12/24/21. The assessment was not completed until 2/15/22.
7. Resident #11 had an ARD of 12/23/21. The assessment was not completed until 2/14/22.
8. Resident #19 had an ARD of 12/29/21. The assessment was not completed until 2/14/21.
9. Resident #23 had an ARD of 12/28/21. The assessment was not completed until 2/15/22.
10. Resident #25 had an ARD of 1/4/22. The assessment was not completed until 2/15/22.
11. Resident #27 had an ARD of 1/4/22. The assessment was not completed until 2/15/22.
12. Resident #28 had an ARD of 1/4/22. The assessment was not completed until 2/15/22.
13. Resident #29 had an ARD of 1/7/22. The assessment was not completed until 2/16/22.
14. Resident #30 had an ARD of 1/7/22. The assessment was not completed until 2/15/22.

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F 638	Continued From page 10 15. Resident #50 had an ARD of 1/9/22. The assessment was not completed until 2/15/22. On 2/15/22 at 10:31 AM, the surveyor interviewed the MDS Coordinator who stated that there was 14 days to complete the assessment after the ARD. She then confirmed that she did not complete the MDS. She stated that she was trying to "catch up" with the assessments when she started in October after the last MDS coordinator left. On 2/23/22 at 10:09 AM, during surveyor interview, the Director of Nursing confirmed that the MDS assessments were not done and that they should have been completed in 14 days. A review of the facility provided policy titled, "Resident Assessment Policy and Procedure" dated 2020, included the following: Purpose and Policy. To ensure that ...upon a resident's admission and periodically thereafter, conducts a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Procedure ... III. Quarterly review assessment. The Facility shall assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. N.J.A.C. 8:39-11.2	F 638		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		4/11/22

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F 658	Continued From page 11 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to 1) follow acceptable standards of practice for the administration of a controlled medication and 2) failed to maintain accurate accountability and documentation of a controlled medication for 1 of 23 Residents reviewed, Resident # 76, 3) clarifying a physician's medication order for 1 of 9 residents reviewed for medication administration Resident #37; 4) sign for the administration of medication that was not administered for 1 of 9 residents reviewed for medication administration Resident #37, 5) sign for behavior monitoring that was not completed for 3 of 9 residents (Resident #89, #84,and #39) reviewed for behavior logs, 6) use a facility approved blood pressure cuff for 1 of 2 nurses observed for medication administration pass; and 7) use the required method for disposing of unused or refused medications for 1 of 2 nurses observed for medication administration pass. These deficient practices were evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a 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,	F 658	F658 1. Resident #76 was not affected by the deficient practice of following acceptable standards of practice for administration of controlled medication. 2. All Residents have the potential to be affected by this deficient practice. 3. Immediately upon notification, Assistant Director of Nursing (ADON) conducted a Facility wide audit regarding Signing Individual Patient Controlled Substance Administration Record "IPCSAR", no other residents were affected. ADON in-serviced LPN #2 regarding IPCSAR. ADON/Designee conducted Nursing wide in-service on signing of IPCSAR. 4. Director of Nursing (DON)/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure IPCSAR is signed before administration of controlled substance. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. Resident #76 was not affected by the deficient practice of following acceptable standards of practice for administration of controlled medication. All Residents have the potential to be affected by this deficient practice.	

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F 658	Continued From page 12 and executing 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 states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, 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." This deficient practice was evidenced by the following: 1) The Surveyor #2 reviewed the medical record for Resident #76. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/4/22 reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated EX Order 26 § 4b1 [redacted]. A review of the resident's individualized,	F 658	Immediately upon notification, Assistant Director of Nursing (ADON) conducted a Facility wide audit regarding completion of declining of controlled substance form prior to administration, no other residents were affected by the deficient of completion of declining of controlled substance form prior to administration. ADON in-serviced LPN #2 regarding completion of declining of controlled substance form prior to administration. ADON also conducted Nursing wide in-service on completing declining of controlled substance form prior to administration. Director of Nursing (DON)/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure completion of declining of controlled substance form prior to administration. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. 1. Resident #37 was not affected by this deficient practice of Facility failing to clarify physician medication order. 2. All Residents have the potential to be affected by this deficient practice. 3. Immediately upon notification, Unit Manager/Designee conducted a Facility wide audit regarding administration of insulin using the insulin pen, no other residents were affected this deficient practice. ADON conducted an in-service	

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F 658	Continued From page 13 comprehensive care plan reflected that Resident #76 had a EX Order 26 § 4b1 with Interventions that included give EX Order 26 § 4b1 as ordered by doctor. Monitor/document side effects and effectiveness. A review of the electronic Physician Order Summary Report indicated a Physician's order start date of 11/24/21 for Resident #76 to receive EX Order 26 § 4b1 [redacted] A review of the Manufacturer's recommendations for [redacted] reflected that [redacted] should not be crushed. On 2/22/22 at 12:17 PM, Surveyor #2 interviewed the Licensed Practical Nurse (LPN)#2 who regularly administered medications to Resident #76. LPN #2 told the surveyor that she crushed Resident #76's medications including the [redacted] and administered all the medications through the G-tube. The surveyor asked LPN #2 if she was aware that [redacted] should not be crushed. LPN #2 replied, "no I wasn't aware, I will call the doctor now." Review of the Certified Consultant Pharmacist Monthly Progress Notes dated 1/22/22 did not document any recommendations related to the [redacted] tablets being crushed. On 2/22/22/at 3:28 PM, Surveyor #2 conducted a phone interview with Resident #76's Primary Care Physician (PCP) who stated that he was not familiar with the medication [redacted] and wasn't	F 658	with RN #3 regarding administration of insulin using the insulin pen. ADON also conducted Nurse-wide in-service regarding administration of insulin using the insulin pen. 4. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure that insulin pens are used accurately. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. Resident #37 was not affected by this deficient practice of Facility failing to sign for medication that was not administered. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON conducted a Facility wide audit regarding accuracy of medication administration documentation, no other residents were affected this deficient practice. ADON conducted an in-service with RN #3 and LPN #4 regarding accuracy of medication administration documentation. ADON also conducted Nurse-wide in-service regarding medication administration documentation. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure accuracy of medication administration documentation. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. Resident #89, #84, #39, were not affected	

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F 658	Continued From page 14 aware it could not be crushed. He further stated that the pharmacy provider and consultant should have "caught this" and should have "brought it to my attention". He told the surveyor that the hospital physician had originally ordered it and he "just renewed it". The PCP acknowledged that he should have reviewed the medications prior to renewing them. On 2/22/22 at 3:43 PM, Surveyor #2 conducted a phone interview with the Consultant Pharmacist (CP) who stated she was unaware that [redacted] could not be crushed because she used the American Society of Consultant Pharmacy Medications not to be crushed list and [redacted] was not on it. She further stated that the Pharmacy Provider should have identified this and should have notified the facility and the Physician. 2.) On 02/23/22 at 9:02 AM, Surveyor #2 observed the LPN exit Resident #76's room and stated she had just administered the [redacted] to Resident #76. The surveyor observed that the LPN had not signed the Individual Patient Controlled Substance Administration Record (IPCSAR) for the dose the LPN had already administered. The LPN stated, "I Can't sign before I give it". The LPN further stated that it was her routine practice to sign the IPCSAR and Medication Administration Record (MAR) after she administered the medications. On 2/23/22 at 9:07 AM, Surveyor #2 interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she signed the IPCSAR and MAR after the medications were administered. On 2/23/22 at 9:12 AM, the Nursing Supervisor	F 658	by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON conducted a Facility wide audit regarding accuracy of behavior monitoring log documentation, no other residents were affected this deficient practice. Licensed Nursing Home Administrator (LNHA), DON and ADON conducted an in-service with the identified LPN regarding timeliness, completion and accuracy of behavior monitoring log documentation. ADON also conducted Nurse-wide in-service regarding behavior monitoring log documentation. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure accuracy of behavior monitoring log documentation. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. Resident #44, was not affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON conducted a Facility wide audit regarding accuracy of behavior monitoring log documentation, no other residents were affected this deficient practice. Licensed Nursing Home Administrator (LNHA), DON and ADON conducted an in-service	

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F 658	Continued From page 15 stated that the IPCSAR should be signed when the medication is removed from the locked box and that the MAR should be signed after the medication was administered. On 2/23/22 at 9:47 AM, Surveyor #2 discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and the DON who stated that the IPCSAR should definitely be signed when the medication is removed from the locked box and prior to the administration of the medication. The DON stated she would be providing education to the nurses. A review of the Controlled Medication Administration Policy Revised April 2007 indicated: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. No other information was provided by the facility. 3) On 2/14/22 at 9:01 AM, Surveyor #5 observed the Registered Nurse (RN) on the [redacted] floor administering medications to residents including Resident #37. RN #3 opened a box with a pen injector of EX Order 26 § 4b1 [redacted] medication. RN #3 reviewed the order, was unsure of how to use the delivery system pen injector and asked the Unit Manager (UM) for help. RN #3 administered the EX Order 26 § 4b1 The box which contained the medication revealed that the medication was a once weekly dose. Review of the Medication Administration Record (MAR) revealed that the EX Order 26 § 4b1 had been signed off as administered on 2/12/22, 2/13/22, and 2/14/22.	F 658	with the identified LPN regarding timeliness, completion and accuracy of behavior monitoring log documentation. ADON also conducted Nurse-wide in-service regarding behavior monitoring log documentation. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure accuracy of behavior monitoring log documentation. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. Resident #1 was not affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON conducted a Facility wide audit regarding nurse prohibited use of personal equipment/blood pressure cuff. Additionally, ADON conducted in-service with LPN #1 regarding prohibited use of personal equipment/blood pressure cuff. ADON also conducted nurse wide in-service on prohibited use of personal equipment/blood pressure cuff. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure no nurse is using their own personal equipment/blood pressure cuff. All negative findings to be corrected immediately and reported monthly in the	

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F 658	Continued From page 16 A review of Resident #37's Admission Record revealed he/she was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of Resident #37's medical record progress notes revealed a telephone order from a physician to the facility on 2/12/22 for [redacted] one time a day for DM for 1 Week. On 2/14/2022 at 11:49 AM, the Nursing Supervisor (NS) who took the verbal order stated the process was to call the physician, enter the order into the computer and document in the progress note. The NS stated that the pharmacy would obtain the order directly from the electronic medical record where the order was entered. The NS stated that if the order was questionable, the pharmacy would call. She went on to state that the pharmacy did not call regarding the [redacted] was a new medication, she was not familiar with and was not sure if any monitoring needed to be done. She indicated that she plotted the order on the MAR for 7 days. The NS stated that she was not too sure if other nurses were familiar with the [redacted] and that there was a drug book that the nurses can consult for protocol for new medication. During an interview on 2/14/22 at 12:17 PM, the DON stated to two surveyors that the consultant pharmacist sent her a recommendation via email on 2/13/22 regarding the [redacted] being weekly. The DON stated she phoned but was unable to reach the ordering physician on 2/13/22. The	F 658	QA/PI Meeting. Resident #2 was not affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON conducted a Facility wide audit regarding proper disposal of medication. Additionally, ADON conducted in-service with LPN #1 regarding proper disposal of medication. ADON also conducted nurse wide in-service on proper disposal of medication. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure proper disposal of medication. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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DON stated she next called the pharmacy who delivers the medications to the facility this morning 2/14/22. The DON further stated that if a nurse was not familiar with a medication, the expectation would be to "look it up" (the medication) and that the RN supervisor who was unfamiliar with the EX Order 26 § 4b1, should have looked up the EX Order 26 § 4b1. The DON stated that a medication being given for the first time in the facility, should be accompanied by education to the nurses.

During an interview on 2/14/2022 at 1:40 PM, the DON acknowledged that she had not tried to reach the medical director to clarify the order until the following day when the surveyors brought it to her attention.

An interview with RN #1 revealed that she should have prime the pen to ensure that the correct dose was delivered. She further stated that she should have read the instructions inside the box prior to administer the EX Order 26 § 4b1.

Later on during medication reconciliation it was noted that EX Order 26 § 4b1 was ordered and transcribed incorrectly. The pharmacy consultant indicated on the medication review form that EX Order 26 § 4b1 should be administered weekly not daily. The form was faxed to the Director of Nursing on 02/13/2022 for follow up.
Further review of the MAR revealed that nurses signed that EX Order 26 § 4b1 was administered on 02/12 and 02/13/2022.

An interview with the provider pharmacy on 02/16/2022 at 10:28 AM, revealed that one EX Order 26 § 4b1 was delivered at the facility on 02/12/2022. The facility indicated that EX Order 26 § 4b1

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was a new medication and no other resident was ordered EX Order 26 § 4b1 at the facility.

On 02/16/2022 at 12:20 PM an interview with RN #2 who initialed the MAR on 02/12/2022 indicated that she could not remember if the EX Order 26 § 4b1 was available. She stated that she signed the MAR in error. A review of the electronic progress notes failed to indicate that the nurse assessed Resident #37 for first dose response or indicate that the EX Order 26 § 4b1 was not available.

The surveyor reviewed the electronic progress notes from 02/14/2022 to 02/23/2022 and could not find any late entry in the clinical record regarding the EX Order 26 § 4b1 order.

An interview with Registered Nurse #3 on 02/16/2022 at 12:40 PM, who signed the MAR on 02/13/2022, indicated that she did not administer the EX Order 26 § 4b1 although she signed the MAR. Nurse #3 stated that she was aware that the medication was available but failed to administer the EX Order 26 § 4b1 dose because the medication was to be administered weekly.

There was no documented evidence that RN #3 clarified the order with the provider pharmacy or called the physician to clarify the order. She did not discussed the order with the Nursing Supervisor on duty that day nor left a note for the DON to follow up.

On 02/17/2022 at 12:50 PM, the DON was asked to comment on the EX Order 26 § 4b1 order. The DON indicated that she was aware that the EX Order 26 § 4b1 medication had not been administered on 02/12/22 and 02/13/22 as reflected on the MAR. She further stated that the physician was notified,

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the nurses were in-serviced and disciplinary action will follow.

On 02/22/2022 at 10:01 AM, the survey team met with the administrator, the DON, ADON and the Regional Nurse and discussed again the above observations and concerns.

The surveyor requested the facility's policy and procedure for following physician order and for medication administration.

On 02/23/2022 the DON provided a form titled, "Administering Medications" last revised April 2019, which indicated the following:

Policy heading

Medications are administered in a safe and timely manner, and as prescribed.

Policy interpretation and implementation.

Only persons licensed or permitted by this state to prepare, administer and document the administration medications may do so.
The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions.
Medications are administered in accordance with prescriber orders, including any required time frame.
Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes, and or the need for additional staff training.
If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse

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consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician, or the Medical Director to discuss the concerns.
The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

Each nurses' station has a current Physician's Desk Reference (PDR) and/other medication reference, as well as a copy of the surveyor guidance for 755-761 (Pharmacy Services) available. Manufacturer's instructions or user's manuals related to any medication administration devices are kept with the devices or at the nurses' station.

The policy was not being followed. The facility did not contact the Medical Director for guidance until the above concern was brought to the DON's attention on 02/15/2022.

4) On 2/15/22 at 9:44 AM, the DON stated that the Medical Director discontinued the [redacted] ordered blood sugars and monitoring.

On 2/16/22 at 9:29 AM, the ordering physician of the [redacted] for Resident #37 stated the maximum dose of [redacted] would be [redacted] a week and the resident had received three doses of [redacted].

On 2/16/22 at 12:26 PM, Surveyor #5 phoned RN #3 who stated that she signed but did not administer the [redacted]. RN #3 stated that she

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signed in error because she had 30 residents and "just did not document that" she did not administer the EX Order 26 § 4b1

On 2/22/22 at 9:14 AM, the DON stated that she had spoken to RN #3 and LPN #4 about administering the EX Order 26 § 4b1. The DON stated that both nurses informed her they never administered the medication, had signed that they did, and never documented differently.

On 2/16/22 at 12:45 PM, Surveyor #2 reviewed the Behavior Monitoring Form (BMF) for Resident #44 for January 2022 which included the following:
The EX Order 26 § 4b1 for EX Order 26 § 4b1 daily at bedtime had indicated that the behavioral symptoms of EX Order 26 § 4b1 were to have been monitored and documented daily on all three shifts. A review of the BMF reflected that the symptom of [redacted] was only documented for the 7 AM to 3 PM shift and on the 3 PM to 11 PM shift each day for the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January.

On 2/17/22 at 11:09 AM, Surveyor #2 reviewed Resident #44's BMF for January 2022 again and the surveyor observed that additional information had been added to the forms which included the following:

The BMF for Depakote 250 mg had the behavioral symptom of EX Order 26 § 4b1 documented for the 11 PM to 7 AM shift for each day of the month of January.
On 2/17/22 at 11:10 AM, the 4th floor RN/UM stated that the LPN worked last night and that

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"his signature was not there yesterday."

On 2/17/22 at 12:53 PM, the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) met with the survey team. The DON stated that it should not be happening that one staff member signs behavior monitoring every day whether or not they are present on the unit. The DON stated that documentation goes, "forward" and that staff should not go backwards to change documentation logs.

On 2/18/22 at 9:05 AM, the DON presented the survey team a statement from the LPN who changed the BMFs. The statement indicated that the LPN signed and backdated the January 2022 Behavioral Monitoring Sheets and stated that it was an "unwritten common practice to sign the logs for the dates where the nurses cannot [be] reached to sign the log as need demands."

On 2/22/22 at 8:30 AM, the DON presented the survey team a statement from the Registered Nurse Supervisor which indicated that, "Nurses are reminded to complete and initial the behavior monitoring forms every shift during 11-7 shift."

The facility policy, Behavioral Assessment, Intervention and Monitoring, revised March 2019 indicated that staff will evaluate the resident's mood and behavior, will identify, and document the onset, duration, intensity ad frequency of behavioral symptoms, and when medications are prescribed for behavioral symptoms, documentation will include monitoring for efficacy and adverse consequences.
The facility policy, Charting and Documentation, revised July 2017 indicated that documentation in the medical record will be objective, complete,

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and accurate.

5) On 2/16/22 at 10:40 AM, Surveyor #3 reviewed Resident #39's Behavior Monitoring Forms for January 2022 which included the following:
One form for the EX Order 26 § 4b1 had indicated that the behavioral symptoms of and were to have been monitored and documented daily on all three shifts. A review of the form reflected that the symptom of was only documented for the 7 AM to 3 PM shift each day of the month of January. The 3 PM to 11 PM shift and 11 PM to 7 AM shift were blank (not documented) for each day of the month of January. The symptom of pacing was only documented for the 7 AM to 3 PM and 3 PM to 11 PM shift each day of the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January.

One form for the psychoactive medication had indicated that the behavioral symptom of was to have been monitored daily on all three shifts. A review of the form reflected that the symptom of was only documented for the 7 AM to 3 PM shift and 3 PM and 11 PM shift each day of the month of January. 11 PM to 7 AM shift were blank (not documented) for each day of the month of January.

On 2/17/22 at 11:40 AM, Surveyor #3 reviewed Resident #39's Behavior Monitoring Forms for January 2022 again and additional information was added to the forms which included the following:

One form for EX Order 26 § 4b1 had the symptoms of and

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documented for the 11 PM to 7 AM shift for each day of the month of January.

One form for EX Order 26 § 4b1 had the symptom of EX Order 26 § 4b1 documented for the 11 PM to 7 AM shift for each day of the month of January.

At 12:22 PM, Surveyor #3 interviewed the floor Unit Manager (UM). The UM confirmed that the 11 PM to 7 AM shift documentation on both of Resident #39's Behavior Monitoring Forms was not on the forms the day before. She added that a staff member must have signed it during the night. The UM also confirmed that the initial listed each day on the 11 PM to 7 AM shift appeared to be the same initial. She then added that only the staff member that is working on that date should sign the form for that date.

6) On 2/14/22 at 8:27 AM, Surveyor #1 observed LPN #1 during the LPN's medication administration pass. LPN #1 was observed to have used her EX Order 26 § 4b1 with a wrist band, directly on the right wrist of an unsampled resident #1. Surveyor #1 observed that the facility provided portable vitals machine, which included a blood pressure monitor, was in the hall across from LPN #1's medication cart.

7) On 2/14/22 at 8:18 AM, Surveyor #1 was observing LPN #1 during medication administration. LPN #1 had attempted to administer medications to two unsampled residents. The unsampled resident #2 had refused one both medications that were to be administered. LPN #1 returned to the medication

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cart with the refused medications in a paper pill cup and threw them both into the sharp's container located on the side of the medication cart. At 8:39 AM, the unsampled resident #3 had refused one of four medications to be administered. LPN #1 returned to the medication cart with the refused medication in a paper pill cup and threw it into the sharp's container located on the side of the medication cart.

On 2/14/22 at 9:24 AM, LPN #1 stated the facility provided a medication destroyer but it wasn't around so she just threw the refused medications in the sharp's container. LPN #1 stated her personal wrist blood pressure cuff she was using had been approved by the DON for her to use on residents.

On 2/14/22 at 9:43 AM, the DON stated if a resident refused medications, those pills are to be discarded in the drug buster. The DON stated the medications should not be thrown into the sharp's container because the facility would want to be sure nobody can get to them.

On 2/14/22 at 10:10 AM, the DON stated that the staff were not to use their own personal blood pressure cuffs because a wrist blood pressure cuff was different than an arm blood pressure cuff and there would be no way to document the wrist blood pressure. Also, that there was no way to assure the accuracy of the staff's personal equipment.

A review of the facility provided, "Medication Pass Observation", dated 12/1/21 for LPN #1, included but was not limited to PRN, refused and/or partial doses are properly documented and disposed of. The Medication Pass Observation that LPN #1

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had been deemed competent / had passed the medication pass observation competency.

A review of the facility provided Inservice with the topic of Medication Pass, dated 1/14/22, included "if any medication needs to be wasted must use the drug buster", and was signed by LPN #1.

A review of the facility provided, "Blood Pressure, Measuring" policy and procedure, updated 10/19, included but was not limited to a stop in the procedure to wrap the blood pressure cuff evenly around the upper arm, approximately one inch from the elbow.

On 2/16/22 at 10:20 AM, Surveyor #4 reviewed the Behavior Monitoring Forms for Resident #89 for January 2022 which included the following:

The Behavior Monitoring Form for the EX Order 26 § 4b1 medication EX Order 26 § 4b1 had indicated that the behavioral symptoms of delusions were to have been monitored and documented daily on all three shifts. A review of the Behavioral Monitoring Form reflected that the symptom of EX Order 26 § 4b1 was only documented for the 7 AM to 3 PM shift and on the 3 PM to 11 PM shift each day for the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January.

On 2/17/22 at 11:45 AM, Surveyor #4 reviewed Resident #89's Behavior Monitoring Form for January 2022 again and additional information was added to the forms which included the

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following:

The Behavior Monitoring Form for [redacted] had the behavioral symptom of delusions documented for the 11 PM to 7 AM shift for each day of the month of January.

On 2/16/22 at 11:14 AM, Surveyor #4 reviewed Resident #84's Behavior Monitoring Forms for Resident #84 for January 2022 which included the following:

The Behavior Monitoring Form for the [redacted] medication [redacted] had indicated that the behavioral symptoms of [redacted] preoccupied were to have been monitored and documented daily on all three shifts. A review of the Behavioral Monitoring Form reflected that the symptom of [redacted] preoccupied was only documented for the 7 AM to 3 PM shift and on the 3 PM to 11 PM shift each day for the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January.

On 2/17/22 at 11:46 AM, Surveyor #4 reviewed Resident #84's Behavior Monitoring Form for January 2022 again and additional information was added to the forms which included the following:

The Behavior Monitoring Form for [redacted] had the behavioral symptom of [redacted] preoccupied documented for the 11 PM to 7 AM shift for each day of the month of January.

On 2/17/22 at 12:53 PM, the DON and LNHA met with the survey team. The DON stated that it should not be happening that one staff member

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signs behavior monitoring every day whether or not they are present on the unit. The DON stated that documentation goes, "forward" and that staff should not go backwards to change documentation logs.

On 2/18/22 at 9:05 AM, the DON presented the survey team a statement from the LPN who changed the Behavior Monitoring Forms. The statement indicated that the LPN signed and backdated the January 2022 Behavioral Monitoring Sheets and stated that it was an "unwritten common practice to sign the logs for the dates where the nurses can not [be] reached to sign the log as need demands."

On 2/22/22 at 8:30 AM, the DON presented the survey team a statement from the Registered Nurse Supervisor which indicated that, "Nurses are reminded to complete and initial the behavior monitoring forms every shift during 11-7 shift."

The facility policy, Behavioral Assessment, Intervention and Monitoring, revised March 2019 indicated that staff will evaluate the resident's mood and behavior, will identify and document the onset, duration, intensity and frequency of behavioral symptoms, and when medications are prescribed for behavioral symptoms, documentation will include monitoring for efficacy and adverse consequences.

A review of the facility provided, "Charting and Documentation" policy and procedure, revised 7/17, included but was not limited to policy statement: all services provided to the resident, progress toward the care plan goals, or changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in

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F 658	Continued From page 29 the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Interpretation and implementation: 2. the following information is to be documented in the resident medical record: a. objective observations; b. medications administered; c. treatments or services performed; d. changes in the resident's condition; 3. events, incidents or accidents involving the resident; and f. progress toward or changes in the care plan goals and objectives. NJAC 8:39-11.2 (b), 27.1(a)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide personal grooming care to a resident that was dependent on the staff for hygiene for 1 of 23 residents, Resident #63. This deficient practice was evidenced by the following: On 2/17/22 at 10:19 AM, the surveyor observed Resident #63 in the room, awake and was seated on the bed. The resident did not look at the surveyor or speak when spoken to. The resident's fingernails on both hands were long and extended beyond the fingertips. The surveyor also observed Resident #63 with a long, scattered facial hair.	F 677	Resident #63 was not affected negatively by this deficient practice. After encouragement, Resident was agreeable to and had nail care addressed, however resident refused beard to be trimmed. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, Unit Manager/Designee conducted a Facility-wide audit regarding grooming care, no other residents were affected by this deficient practice of grooming care. ADON conducted a Facility wide audit	4/11/22

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F 677	Continued From page 30 The surveyor reviewed the admission record that indicated Resident #63 was admitted to the facility on 5/8/09 with diagnoses that included but not limited to EX Order 26 § 4b1 [redacted] A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate care management dated 11/18/21, indicated a Brief Interview for Mental Status scored at [redacted], which indicated that the resident had EX Order 26 § 4b1 cognition. The surveyor reviewed the interdisciplinary progress notes from November 2021 through February 2022 which reflected that there was no documentation for any refusal of EX Order 26 § 4b1 . On 2/17/22 at 10:21 AM, the surveyor spoke to the Licensed Practical Nurse (LPN) assigned to the resident who stated that Resident #63 was non-compliant with hygienic care. The surveyor interviewed the Certified Nursing Assistant (CNA) who stated that part of her responsibility during the morning rounds, included but was not limited to check resident's facial hair and nails. The LPN and the CNA both agreed that the resident's facial hair and fingernails were long and needed to be shaved and trimmed. A review of the facility's policy titled, "Resident Care" revealed that the purpose of the procedure was to ensure that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. On 2/22/22 at 12:30 PM, the surveyor discussed the above concern to the Administrator, Regional	F 677	regarding grooming care. Additionally, ADON conducted in-service with Certified Nursing Aides (C.N.A.) and Nurses regarding grooming care. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure proper grooming care. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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F 677	Continued From page 31 Nurse and Director of Nursing. The DON also agreed that the facial hair and the fingernails of Resident #63 needed to be trimmed. No further information was provided. NJAC 8:39 - 27.2 (g)	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility staff failed to follow the physician orders for the administration of EX Order 26 § 4b1 [redacted] This deficient practice was identified for Resident #37, one of 23 residents reviewed and was evidenced by the following: Resident #37 was admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted]. The Annual Minimum Data Set (MDS - an	F 684	F684 Resident #37 was not affected negatively by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON conducted Facility wide audit regarding any new medications to the Facility. One other resident was identified, residents physician order form was reviewed, verified for accuracy and was correct. ADON conducted an in-service on researching unfamiliar medication with Nurse who received the initial order. ADON conducted an in-service on	4/11/22

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F 684	Continued From page 32 assessment tool) dated 02/02/22, revealed that Resident #37 had a Brief Interview for Mental Status (BIMS) score of [redacted]/15 which indicated the resident was EX Order 26 § 4b1 [redacted]. During the medication pass observation on 02/14/22 at 9:10 AM, the Registered Nurse (RN) informed the surveyor that she had to administer [redacted] to Resident #37. The RN could not locate the [redacted] pen on the medication cart. The RN went to the medication room, retrieved the [redacted] pen and returned with the sealed box containing the [redacted]. The RN stated that she was not familiar with the medication. The RN enlisted the assistance of the Unit Manager RN, UM/RN and the Consultant Pharmacist (CP), to instruct her how to dial the correct dose on the pen. The RN administered the [redacted] dose as ordered, initialed the Medication Administration Record (MAR), and exited the room. The surveyor asked the RN for Resident #37's blood sugar level, the RN stated that there was no order to monitor Resident #37's blood sugar prior to administering the [redacted] On 02/14/22 at 10:30 AM, the surveyor interviewed the CP regarding his role at the facility and the process for any new medication. The CP indicated that he did not in-service the staff regarding the [redacted]. He went on to state that he reviewed all resident orders monthly and would address any irregularities with the facility. A review of Resident #37's clinical record revealed the following physician order dated 02/11/22: EX Order 26 § 4b1 [redacted]	F 684	researching unfamiliar medication with nursing staff. DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure accuracy of medication orders. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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EX Order 26 § 4b1 [redacted] ."

The EX Order 26 § 4b1 pen was ordered on 02/11/22 and arrived from the pharmacy on 02/12/22. The EX Order 26 § 4b1 was to be administered weekly according to the instructions on the box. The order to administer daily was entered incorrectly into the clinical record. The provider pharmacy did not catch the discrepancy nor alert the Attending Physician.

On 02/13/22, the CP forwarded an e-mail to the Director of Nursing (DON) regarding the discrepancy. The facility failed to act in a timely manner and use all available resources to correct the discrepancy. The Medical Director was not called for guidance when the Attending Physician could not be reached.

On 02/14/22 at 10:49 AM, the RN Nursing Supervisor (RN/NS), who received the telephone order revealed that Resident #37's laboratory results were critical and that she reached out to the physician. The physician next gave her the verbal order for EX Order 26 § 4b1. The RN/NS further stated that she read the order back to the attending physician to verify. She entered the order into the electronic clinical record where the pharmacy provider obtained, reviewed and sent the EX Order 26 § 4b1 to the facility.

A review of the February 2022 MAR revealed that the order was entered to be given daily for 7 days. It was also noted that two nurses signed the MAR indicating that EX Order 26 § 4b1 was administered to Resident #37 on 02/12/22 and

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F 684	Continued From page 34 02/13/22. On 02/16/22 at 11:28 AM, the surveyor called the pharmacist and was informed that the pharmacy technician who took the order was not available. The surveyor spoke with the pharmacist supervisor who stated that the order should be [redacted] once a week. She further stated that the order was checked incorrectly and the pharmacist should have called to clarify the order and notify the facility. Upon further inquiries, she indicated that the order was not double checked. She went on to state that only Intravenous and controlled drugs are double checked. She stated that the resident should be monitored for side effects such as EX Order 26 § 4b1 [redacted] The surveyor further asked the pharmacist how many EX Order 26 § 4b1 pens were delivered. The pharmacist stated only one EX Order 26 § 4b1 pen was sent to the facility on 02/12/22. The surveyor asked if EX Order 26 § 4b1 was ever ordered daily, the pharmacist replied, "No. It is ordered weekly". The pharmacist supervisor indicated that she would investigate further as the pharmacist should have caught the discrepancy and alerted the physician. On 02/16/22 at 12:06 PM, the surveyor interviewed RN #1 who confirmed that one pen was retrieved from the medication room and the box was sealed. RN #1 indicated that once opened, the pen could be stored in the medication cart. RN #1 further stated that she should have read the information on the box as it clearly indicated to administer the EX Order 26 § 4b1 weekly.	F 684		

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A telephone interview was conducted on 02/16/22 at 12:20 PM with RN #2. RN #2 stated she had worked on 02/12/22 and could not remember if the medication was available and that she signed the MAR in error. RN #2 stated she did not remember if she had documented it because she had 30 patients that day. RN #2 did not make any late entry documentations.

A telephone interview was conducted on 02/16/22 at 12:40 PM with RN #3. RN #3 had signed for the EX Order 26 § 4b1 administration on 02/13/22 and stated that she did not administer the medication that day. RN #3 further stated she had signed for the EX Order 26 § 4b1 but did not administer it. She stated the medication was in the refrigerator and was to be given weekly but that she did not clarify the order nor call the doctor because it was a hectic night. RN #3 stated she did not enter a note in the clinical record to indicate that the EX Order 26 § 4b1 medication needed to be clarified, nor did she address the issue with the nursing supervisor on duty or the DON.

The EX Order 26 § 4b1 medication was ordered to be given on 02/12/22. Although the medication was available, the staff failed to administer the EX Order 26 § 4b1 dose to Resident #37 as ordered by the physician. The facility did not clarify the order with the provider pharmacist. The physician was not made aware that Resident #37 did not receive the EX Order 26 § 4b1 dose as ordered until 02/14/22.

An interview with the Medical Director on 02/16/22 at 10:55 AM, confirmed that the facility did not call to clarify the EX Order 26 § 4b1 until 02/15/22. The DON had received the e-mail on 02/13/22. The DON stated that she could not reach the attending physician. However, the DON

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did not call the Medical Director for guidance. The Medical Director informed the survey team that he was available 24 hours a day, 7 days a week. He further added, "The facility knew how to reach me with any concerns."

On 02/16/22 at 12:17 PM, the DON stated that when she would receive the CP recommendation report, she would review it with the supervisors and call the physician with the recommendations. The DON stated that sometimes the physician would agree and sometimes the physician would not. The DON indicated that she attempted to call the attending physician regarding the [redacted] medication, but the physician could not be reached. The DON acknowledged she did not call the Medical Director for guidance.

On 02/23/22 at 10:30 AM, the DON acknowledged that there was a delay in treatment. The Administrator added that the pharmacist should have picked up the discrepancy and clarified the order with the physician.

Although Resident #37 received the [redacted] first dose on 02/14/22, there was no measures in place to monitor for any responses or side effects associated with the medication. The RN/NS who transcribed the verbal order revealed that the Attending Physician did not inform her of any side effects to monitor for.

According to interviews with the nurses, they were not familiar with the medication, they did not consult the nurse educator nor alert the staff on possible side effects that could be associated with the medication. The facility did not ask the physician about any glucose monitoring.

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F 684	Continued From page 37 NJAC 8:39-27.1(a)	F 684		
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 pertinent documents provided by the facility, it was determined that the facility failed to post cautionary signage to indicate that EX Order 26 § 4b1 was in use and to administer according to the physician's order. This deficient practice was identified for one of two residents reviewed for respiratory care (Resident #24), and was evidenced by the following: Resident #24 was admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted] A review of the most recent Quarterly Minimum Data Set (MDS - an assessment tool) dated 01/08/2022, revealed that Resident #24 was coded as being dependent on staff for some activities of daily living and was coded as having received EX Order 26 § 4b1. Resident #24 was coded a	F 695	F695 Resident #24 was not affected by this deficient practice. O2 signage was immediately posted on the door. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, Unit Manager/Designee conducted a Facility-wide audit regarding accuracy of oxygen (O2) orders and proper O2 signage at the resident room door, and posted O2 signage at door of resident #24. No other resident were affected by this deficient practice of inaccurate O2 order and no signage at the resident room door. ADON/Designee conducted a Facility wide in-service regarding following Doctors oxygen orders and ensuring proper signage outside resident room door.	4/11/22

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F 695	Continued From page 38 EX Or on the Brief Interview for Mental Status which indicated EX Order 26 § 4b1 . During the initial tour on 2/11/2022 at 12:04 PM, the surveyor observed Resident #24 in bed, with EX Order 26 § 4b1 The setting on the concentrator was set to deliver EX Order 26 § 4b1 . The connected EX Order 26 § was not labeled or dated. There was no signage at the entrance door to indicate that EX Order 26 § 4b therapy was in use. On 2/11/2022 at 12:40 PM, during a brief review of Resident #24's clinical record, the surveyor noted that the order was for Resident #24 to receive EX Order 26 § 4b1 . On 2/14/2022 at 8:15 AM, the surveyor observed Resident #24 in bed. The was turned off. The was noted to be directly on the chair not in any protective covering. On 2/15/22 at 10:01 AM, the surveyor observed Resident #24 in bed. The was turned off. The was noted on the chair on top of the resident's clothing and not in any protective covering. On 2/16/2022 at 10:04 AM, the surveyor observed the EX Order 26 § 4b1 lying direct contact with the floor. Resident #24 was not in the room. The EX Order 26 § 4b1 was on and EX Order 26 § 4 at EX Order 26 § 4b1 . The EX Order 26 § was labeled and dated 2/14/2022. There was no bag attached to the EX Order 26 § 4b1 for the	F 695	DON/Designee to conduct weekly audit x4 weeks, x2 months thereafter to ensure accuracy of 02 orders and proper signage at the door. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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F 695	Continued From page 39	F 695		

storage of the EX Order 26 § 4b1 when not in use. There was no signage at the entrance door to indicate that EX Order 26 § 4b1 was in use.

A review of Resident #24's clinical record revealed the following physician orders EX Order 26 § 4b1

A second order indicated the following: " EX Order 26 § 4b ".

A review of Resident #24's comprehensive care plan dated 7/01/2021 revealed the following focus: EX Order 26 § 4b1 " Check EX Order 26 § 4b saturation every shift as ordered. Avoid extreme of hot and cold. Give EX Order 26 § 4b1 as ordered.

On 2/16/2022 at 10:05 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the physician order for the EX Order 26 § 4b. The LPN confirmed that the order was for EX Order 26 § 4b EX Order 26 § 4b to be delivered at EX Order 26 § 4 per minute. The surveyor escorted the LPN to the room where we both observed the EX Order 26 § 4b1 EX Order 26 § 4 at EX Order 26 § 4b1 was noted lying in direct contact with the floor and there was no EX Order 26 § 4b in use signage posted at the entrance door. The LPN told the surveyor that the 11:00 PM-7:00 PM shift was responsible to change the EX Order 26 § 4b and ensure that the EX Order 26 § 4b1 was protected. The LPN exited the room and left the EX Order 26 § 4b1 lying in direct contact with the floor. The LPN did not adjust the EX Order 26 § 4b1 to reflect the physician's order.

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That same day at 10:30 AM, the surveyor escorted the Assistant Director of Nursing (ADON) to Resident #24's room where we both observed the EX Order 26 § 4b1 still lying in direct contact with the floor and no bag attached to the EX Order 26 § 4b1 to protect/store the EX Order 26 § 4b1 when not in use.

The ADON removed the EX Order 26 § 4b1 from the floor, turned off the EX Order 26 § 4b1, exited the room and told the surveyor that she would replace the setting.

On 2/16/2022 at 10:37 AM, the surveyor observed the ADON and the Unit Manager Registered Nurse, (UM/RN) enter Resident #24's room with a new EX Order 26 § 4b1, EX Order 26 § 4b1 and a plastic bag to store the EX Order 26 § 4b1 when not in use.

A review of the Treatment Administration Record (TAR) on 0/21/2022 at 11:20 AM, revealed that the nurses had signed that the EX Order 26 § 4b1 had been delivered at [redacted] even on the days the surveyor observed that the EX Order 26 § 4b1 were at EX Order 26 § 4b1 (2/11/2022) and at EX Order 26 § 4b1 (2/16/2022).

On 2/17/2022 at 8:34 AM, the DON provided a policy titled, EX Order 26 § 4b1 ". The undated facility's policy indicated that EX Order 26 § 4b1 will be administered as per MD [Medical Doctor] order to aid in breathing. Emergency EX Order 26 § 4b1 may be administered by licensed nurse without an MD order. The MD will be consulted as soon as possible and order EX Order 26 § 4b1 if continuation is required. This policy confirmed that it was the procedure of the facility to place a "No Smoking" sign on the resident's door, to check Resident

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F 695	Continued From page 41 every 2 hours and as needed including source and change as necessary. Lastly to date and initial tubing and humidifiers when started each week. Procedure Check MD order Wash hands Assemble Equipment. Attach "No smoking sign" to wall outside the door. Add nasal cannula or mask with tubing to oxygen source. Check for flow and apply to resident. The DON also provided another undated form titled,"EX Order 26 § 4b1 Prevention of infections"which revealed under procedure steps 7 and 8 the following: 7. Change the EX Order 26 § 4b1 every (7) days, or as needed 8. Keep the EX Order 26 § 4b1 used EX Order 2 in a plastic bag when not in use. The procedure was not being followed. On 2/22/2022 at 12:45 PM, the Director of Nursing (DON) and the Licensed Nursing Home Administrator were informed of these concerns and were asked to provide the team with any follow up and policy for EX Order 26 § 4b1 . NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to	F 710		4/11/22

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a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.

§483.30(a) Physician Supervision.
The facility must ensure that-

§483.30(a)(1) The medical care of each resident is supervised by a physician;

§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.
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 seek clarification of a medication order from the Medical Director (MD) when unable to reach a resident's ordering physician. This deficient practice was identified for Resident #37, one of nine residents reviewed during medication administration observation. The deficient practice was evidenced by the following:

On 02/14/22 at 9:01 AM, the surveyor observed the Registered Nurse (RN) on the [redacted] floor, administering medications to residents including Resident #37. The RN opened a box with a pen injector of EX Order 26 § 4b1 [redacted]). The RN reviewed the physician order and was unsure of how to use the delivery system pen injector and asked the Unit Manager for assistance. The RN administered the EX Order 26 § 4b1 [redacted]
The box which contained the medication revealed in large print that the medication was a once

F710

Resident #37 was not affected by this deficient practice.

All Residents have the potential to be affected by this deficient practice.

Immediately upon notification, DON/Designee conducted a Facility-wide audit regarding Nurse ability to contact to contact primary care physician (PCP). No other resident were affected by this deficient practice PCP inaccessibility. ADON/Designee conducted a Facility wide in-service regarding contacting PCP and process in event PCP is unavailable.

DON/Designee to conduct weekly audit once a week for 4 weeks, and once a month for 2 months thereafter to ensure accessibility of PCP, as applicable. Unit

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F 710	Continued From page 43 weekly dose. Review of the February 2022 Medication Administration Record (MAR) revealed that the [EX Order 26 § 4b1] had been signed off as administered on 02/12/22, 02/13/22, and 02/14/22. A review of Resident #37's Admission Record revealed that he/she was admitted to the facility with diagnoses which included but were not limited to [EX Order 26 § 4b1] A review of Resident #37's medical record progress notes revealed a telephone order from a physician to the facility on 02/12/22 for [EX Order 26 § 4b1] On 02/14/22 at 11:49 AM, the Nursing Supervisor (NS) who transcribed the verbal order from the physician, stated the process was to enter the order into the computer and document it in the progress note. The NS stated that if the order was questionable, the pharmacy would call and notify the facility. She went on to state that the pharmacy did not call regarding any discrepancies on the [EX Order 26 § 4b1] and that it was a new medication. The NS stated she was not sure if any monitoring needed to be done. She indicated that she read the order back to the physician for clarification and next plotted the order on the MAR for 7 days. The NS stated that she was not too sure if other nurses were familiar with the medication [EX Order 26 § 4b1] and that there was a drug book that the nurses could consult for protocol regarding new medication.	F 710	Managers/Designee will audit charts on a quarterly basis to ensure residents are being seen by PCP. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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On 02/14/22 at 12:15 PM, two surveyors attempted to phone the ordering physician and a voicemail message indicated that the mailbox was full, so the surveyors were unable to leave a message for the ordering physician. The surveyors attempted to phone the ordering physician's office with no answer.

During an interview on 02/14/22 at 12:17 PM, the Director of Nursing (DON) stated to two surveyors that the Consultant Pharmacist (CP) sent her a recommendation via email on 02/13/22 regarding the EX Order 26 § 4b1 being a weekly dose. The DON stated she phoned but was unable to reach the ordering physician, so she called the pharmacy who delivers the medications to the facility. She stated she called the pharmacy this morning and the pharmacy was 'looking into' why the order was not clarified. The DON further stated that if a nurse was not familiar with a medication, the expectation would be for the nurse to 'look it up' and that the RN supervisor who was unfamiliar with the EX Order 26 § 4b1 should have looked it up. The DON stated that a medication being given for the first time in the facility, should be accompanied by education to the nurses.

A review of the electronic progress note dated 02/14/22 at 12:47 PM, revealed the DON attempted to call the ordering physician again to clarify EX Order 26 § 4b1 order that was given but was unable to get him.

During an interview on 02/14/22 at 1:40 PM, the DON stated that since she was unable to reach the ordering physician, she called the facility Medical Director (MD) and obtained an order to discontinue the EX Order 26 § 4b1 c, do EX Order 26 § 4b1

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F 710	Continued From page 45	F 710		

EX Order 26 § 4b1 before and after meals for 3 weeks and if less than EX Order 26 § 4b1 [redacted], call the MD. The DON stated an incident occurrence report would be completed. The DON acknowledged that she had not tried to reach the MD to clarify the order until the following day when the surveyors brought it to her attention.

During an interview on 02/15/22 at 9:46 AM, the DON stated she had attempted to call the ordering physician again to clarify the EX Order 26 § 4b1 order that was given but was unable to get him. She further stated that any new medication should have some form of monitoring and documentation and if the staff were unable to reach the ordering physician, they should have called the MD.

During an interview on 02/16/22 at 12:17 PM, the DON acknowledged that she called the ordering physician, but could not reach him and stated she had not called the MD for guidance. The DON stated the consequences of a resident receiving too much of the EX Order 26 § 4b1 could lead to a low blood sugar. The DON acknowledged the resident's blood sugars have not been monitored since November 2021.

On 02/16/22 at 10:55 AM, the surveyor interviewed the MD who stated he visited the facility weekly or twice weekly and had an answering service so he was available 24 hours a day, 7 days a week. The MD stated the facility staff were aware that he could be reached at any time.

A review of the Physician's Progress Note entered by the MD and dated 02/15/22 at 11:27

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F 710	Continued From page 46 AM, included at this point, we will allow permissive EX Order 26 § 4b1 as I (MD) am more concerned about a greater risk of EX Order 26 § 4b1 A review of the facility provided, "Facility Occurrence Report" from the pharmacy, dated 02/14/22, included but was not limited to the error category as incorrect direction and delayed/no clarification. A review of the facility provided, "Attending Physician Qualifications and Conditions", revised 4/13, included but was not limited to Policy Statement: attending physicians having privileges to practice in the facility will meet the minimum qualifications and accept the conditions of practice established in the policy. Interpretation and Implementation: 1.c. designate an alternate physician to care for residents during the primary physician's absence; 5. having practice privileges implies that the physician has agreed in writing to abide by relevant rules and regulations and accepts the Medical Director's authority to oversee physician practice in the facility.	F 710		
F 755 SS=D	NJAC 8:39-23.1(a)(5) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		4/11/22

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F 755	Continued From page 47 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate pharmaceutical services, which included ensuring accurate administering of all drugs, in accordance with professional standards of practice. This deficient practice was identified for 2 of 23 residents reviewed (Resident #76 and #37) and was evidenced by the following: 1.) The surveyor reviewed the medical record for Resident #76. A review of the Face Sheet (an admission summary) reflected that the resident was	F 755	F755 Resident #37 was not affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, DON/Designee conducted a Facility-wide audit regarding accuracy of physician orders. No other resident were affected by this deficient practice of physician orders. ADON/Designee conducted a Nursing wide in-service regarding accuracy of	

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F 755	Continued From page 48 admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/4/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident was EX Order 26 § 4b1 [redacted] A review of the resident's individualized, comprehensive care plan reflected that Resident #76 had a EX Order 26 § 4b1 . Interventions included were to provide EX Order 26 § 4b1 as ordered by the doctor and to monitor/document the side effects and effectiveness. A review of the Physician Order Summary Report for Resident #76, indicated a Physician's order with a start date of 11/24/21. The order revealed for the resident to receive Nothing by mouth due to EX Order 26 § 4b1 , and a Physician's order start date of 11/24/21 for [redacted] A review of the Manufacturer's recommendations for [redacted] reflected that [redacted] should not be crushed. On 2/22/22 at 12:17 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who regularly administered medications to Resident #76. The LPN stated to the surveyor that she crushed Resident #76's medications including the [redacted]	F 755	physician orders. DON/Designee to conduct an audit once a week for 4 weeks, and then once a month for 2 months thereafter to ensure accessibility of PCP, as applicable. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. Resident #76 was not affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, DON/Designee conducted a Facility-wide audit regarding ensuring that non-crushable medication are being not being crushed. No other residents were affected by this deficient practice of not crushing a non-crushable medication. ADON/Designee conducted a Nursing wide in-service regarding reading and following all directions on medication. DON/Designee to conduct an audit once a week for four weeks, and once a month for 2 months thereafter to ensure that medication is being administered as per manufacturer direction. Pharmacy Consultant/Designee will do a monthly medication pass with nurses to ensure compliance. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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and administered all the medications through the EX Order 26 § 4. The surveyor inquired to the LPN if she was aware that EX Order 26 § 4 should not be crushed. The LPN replied, "no I wasn't aware, I will call the doctor now."

A review of the Certified Consultant Pharmacist Monthly Progress Notes dated 1/22/22 did not indicate any recommendations for EX Order 26 § 4 to be changed to a liquid form, or that the EX Order 26 § 4 should not be crushed.

On 2/22/22/at 3:28 PM, the surveyor conducted a phone interview with Resident #76's Primary Care Physician (PCP) who stated that he was not familiar with the medication EX Order 26 § 4 and had not been aware it could not be crushed. He further stated that the pharmacy provider and consultant should have "caught this" and should have "brought it to my attention". He told the surveyor that the hospital physician had originally ordered it and he "just renewed it". The PCP acknowledged that he should have reviewed and become familiar with the medications prior to renewing them.

On 2/22/22 at 3:43 PM, the surveyor conducted a phone interview with the Consultant Pharmacist (CP) who stated she was unaware that EX Order 26 § 4 could not be crushed "until now." She further stated that she used the American Society of Consultant Pharmacy Medications not to be crushed list, and EX Order 26 § 4 was not on the list. She further stated that the Pharmacy Provider should have identified this, and then should have notified the facility and the Physician.

On 2/23/22 at 9:47 AM, the surveyor discussed the above observations and concerns with the

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Licensed Nursing Home Administrator and the DON who stated that the nurses should not be crushing the EX Order 26 § 4b1 and that she would be providing education to the nurses.

2. A review of Resident #37's Admission Summary revealed the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1

The Annual MDS. with an assessment reference date of 2/02/2022. coded Resident #37 as being EX Order 26 § 4b1. Resident #37 scored EX Order 26 § 4b1 out of 15 on the BIMS.

During the medication pass observation on 2/14/2022 at 9:10 AM, the Registered Nurse (RN) informed the surveyor that she had to administer EX Order 26 § 4b1 to Resident #37. The RN could not locate the EX Order 26 § 4b1 on the medication cart. The RN went to the medication room, retrieved the EX Order 26 § 4b1 and returned with a sealed box containing the EX Order 26 § 4b1.

The RN stated that she was not familiar with the medication. The RN enlisted the assistance of the Unit Manager RN, UM/RN, then the Consultant Pharmacist to dial the correct dose on the pen. The RN administered the EX Order 26 § 4b1, initialed the Medication Administration Record and exited the room. The surveyor asked the RN for Resident #37's EX Order 26 § 4b1, the RN indicated that there was no order to monitor Resident #37's EX Order 26 § 4b1 prior to administer the EX Order 26 § 4b1.

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On 2/14/2022 at 10:30 AM, the surveyor interviewed the Consultant Pharmacist regarding his role at the facility and the process for any new medication. The Consultant Pharmacist indicated that he did not in-service the staff regarding the EX Order 26 § 4b1. He went on to state that he reviewed all residents orders monthly and addressed any irregularities with the facility.

A review of Resident #37's clinical record on 2/14/2022, revealed the following order:
"EX Order 26 § 4b1 [redacted] .

The EX Order 26 § 4b1 arrived from the pharmacy on 2/12/2022 and was to be administered daily for one week with a start date of 2/12/2022. The order was entered incorrectly into the clinical record. The provider pharmacy did not catch the discrepancy nor did they alert the Attending Physician of the discrepancy. The Consultant Pharmacist conducted a chart review on 2/12/2022 and sent the discrepancy regarding the EX Order 26 § 4b1 order via email to the Director of Nursing on 2/13/2022.

On 2/15/2022 at 11:00 AM, the DON stated that she reached out to the provider's pharmacy and the provider pharmacy agreed that the discrepancy should have been addressed by the pharmacist who filled the order and the Attending Physician should have been notified.

On 2/15/2022 at 11:40 AM, the DON provided a "Facility Occurrence Report" generated by the provider pharmacy. The following were

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documented:
Summary of Occurrence

The facility entered the directions wrong as daily. No clarification was done by RPH [Registered Pharmacist] to inform the facility to change the order from daily to weekly.
The coder coded the order as once daily weekly without entering the stop date. The days supply was entered wrong. Instead of 7 days supply, the coder enter 28 days supply.
Error Category
Delayed/ No Clarification
Incorrect Directions

Plan of Correction
Upon Investigation, the following actions are being taken to improve organizational performance.

Inservice Education.
Other: After coding the order the data entry technician should utilize the Preview [EX Order 26 § 40] and review what was entered. The sig entered for this order had been entered as Subcutaneous once daily weekly. These directions are incomplete and confusing since they state to give the [EX Order 26 § 40] daily and weekly.

The pharmacist should have caught this error and informed the data entry technician the order was entered incorrectly.. In addition they should have had the order clarified since [EX Order 26 § 40] is a once a week medication, not a daily medication.
Both the coder and the pharmacist to be inserviced regarding this error.

An interview with the provider pharmacy on 2/16/2022 at 11:28 AM, confirmed that the

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Physician order was for EX Order 26 § 4b1 [redacted] to be administered daily for one week. She went on to state, " Absolutely it is overdosed, the order was checked incorrectly". The pharmacist who filled the order should have called the physician and clarified the order.

A review of the facility's provider pharmacy agreement provided by the DON on 2/16/2022 at 9:10 AM, delineated the following responsibilities:

Distribution and related services: For the benefit of residents of the facility, the pharmacy agrees as follows:
Supplies products and services in compliance with all applicable federal, State and local laws, ordinances, rules and regulations (collectively, "Law" or "Laws") for residents at facility;
Render all services in accordance with any Laws, Joint Commission on the Accreditation of Health Care Organizations standards, as required, and the pharmacy's Policies and Procedures Manual, attached hereto and incorporated herein as Exhibit A;

Label all products in accordance with applicable Laws;
Provide Products and Services in a prompt and timely manner, as specified herein; Provide drug information the facility's license professional staff regarding Products ordered for residents by members of the facility's professional staff;
Provide nurse consulting services, in accordance with applicable Laws, set forth in Exhibit B hereto, including, but not limited to, attending monthly Quality Assurance Committee meetings, consulting on medication administration, and issues related to cost containment.

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F 755	Continued From page 54 The provider pharmacy failed to inform the facility of the discrepancy with the EX Order 26 § 4b1 ordered by the physician. During an interview on 2/16/2022 at 11:35 AM, with the physician who ordered the EX Order 26 § 4b1 on 2/11//2022, he stated, "I was surprised that the provider pharmacy filled the order and sent the medication to the facility". He further stated that the provider pharmacy should have caught the discrepancy . A review of the Facility's Policy and Procedure entitled, "Pharmacy Services-Role of the Consultant Pharmacist" indicated: The Consultant Pharmacist shall provide consultation on all aspects of pharmacy services in the facility and collaborate with the facility and medical director to: Develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services, including procedures to support resident quality of life such as safe individualized medication administration programs. NJAC 8:39 - 27.1 (a); 29.3 (a); 29.1 (c);	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		4/11/22

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F 758	Continued From page 55 (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 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 56 Based on observation, interview, and record review, it was determined that the facility failed to consistently and adequately document and monitor specific target behaviors and that Behavior Monitoring Forms (BMF) were completed for EX Order 26 § 4b1 medications after the administration of psychotropic medications. This deficient practice was identified for 9 of 9 residents reviewed for unnecessary medications Resident #23, #44, #39, #363, #63, #55, #79, # 89 and #84 was evidenced by the following: 1. On 2/18/22 at 12:40 PM, surveyor #1 observed Resident #44 ambulating in the dining room. The surveyor attempted to speak to the resident, but the resident did not respond to the surveyor. The Registered Nurse on the 4th floor (RN) stated that Resident #44 was alert, EX Order 26 § 4b1 Surveyor #1 reviewed the medical record for Resident #44. A review of the Admission record reflected that the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1 A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/14/22 reflected that Resident #44 had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated EX Order 26 § 4b1. A further review of the MDS, indicated that the resident exhibited behaviors of EX Order 26 § 4b1 which occurred daily and received EX Order 26 § 4b1 medications on 7 out of the last 7 days during the look back period.	F 758	F758 Residents #23, #44, #39, #363, #63, #55, #79, #89, #84 were not affected negatively by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, DON/Designee conducted a Facility-wide audit regarding use of unnecessary psychotropic medication. No other resident were affected by this deficient practice of use of unnecessary psychotropic medication. ADON/Designee conducted a Nursing wide in-service regarding use of unnecessary psychotropic medication and documentation of behaviors. DON/Designee to conduct weekly audit once a week for four weeks, then once a month for 2 months thereafter to ensure use of psychotropic medication is being monitored for clinical necessity, and related documentation of behaviors, as applicable. DON/Designee will review with psychiatrist gradual dose reduction (GDR) as applicable once a month. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	

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A review of the resident's individualized, comprehensive care plan revised 1/12/22 included a care concern for Resident #44 that had behaviors which included EX Order 26 § 4b1 [redacted] Interventions included to redirect resident; intervene as necessary to protect the rights and safety of other residents; approach in a calm manner; assess personal needs; and to monitor and document behaviors.

A review of the Physician Order Summary (POS) indicated an order dated 2/13/22 for EX Order 26 § 4b1 [redacted]

A further review of the Current POS reflected an order for EX Order 26 § 4b1 [redacted]

On 2/16/22 at 10:30 AM, the surveyor reviewed the BMF(s) for Resident #44. The review indicated that the behavior monitors for the [redacted] were incomplete for November 2021 with behavior monitoring occurring on 3 out of 30 days on the 7 AM- 3 PM shifts 11/1, 11/4, 11/5; 1 out of 30 days (11/1) on the 3 PM- 11 PM shifts and on the 11 PM-7AM shifts monitoring was done from 11/1-11/24 but the remainder of the days and shifts were blank. The review failed to indicate any BMF(s) for December 2021. The review indicated an incomplete BMF(s) for January 2022 with no monitoring occurring on any 11 PM to 7 AM shifts. The review failed to indicate

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any BMF(s) for February 2022.

Further review of the BMF(s) reflected that no monitoring was done for the use of the antidepressant medication.

The BMF(s) for November 2021 listed Resident #44 behavioral symptom as disruptive and pacing. The BMF(s) for January 2022 listed Resident #44's behavioral symptom as disruptive.

The [redacted] Note Monthly effective on 11/22/21 and inclusive of Resident #44's behaviors for the month of November 2021 listed the resident's targeted behaviors as pacing affecting others and EX Order 26 § 4b1 . The EX Order 26 § 4b1 Note Monthly indicated that the resident had 1 episodes of pacing affecting others and 1 episode of "EX Order 26 § 4b1 ". The BMF for November 2021 indicated that Resident #44 was being monitored for disruptive and pacing affecting others and failed to indicate that the resident was being monitored for either EX Order 26 § 4b1 .

The EX Order 26 § 4b1 Note Monthly effective on 1/13/22 and inclusive of Resident #44's behaviors for the month of December 2021 listed the resident's targeted behaviors as pacing affecting others and EX Order 26 § 4b1 . The EX Order 26 § 4b1 Note Monthly indicated that the resident had 30 episodes of pacing affecting others and 30 episodes of EX Order 26 § 4b1 . There was no evidence of a BMF for December 2021.

The EX Order 26 § 4b1 Note Monthly effective on 2/13/22 and inclusive of Resident #44's behaviors for the month of January 2022 listed the

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resident's targeted behaviors as pacing affecting others and EX Order 26 § 4b1 . The EX Order 26 § 4b1 Note Monthly indicated that the resident had 30 episodes of each behavior. The BMF for January 2021 indicated that Resident #44 was being monitored for EX Order 26 § 4b1 and failed to indicate that the resident was being monitored for EX Order 26 § 4b1 .

2. On 2/18/2022 at 12:50 PM, surveyor #1 observed Resident #23 in their room lying in bed. Resident #23 sat up and greeted the surveyor with a smile and EX Order 26 § 4b1 .

The surveyor reviewed the medical record for Resident #23.

A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included EX Order 26 § 4b1

A review of the Annual MDS, dated 12/28/2021 reflected that the resident had a brief interview for mental status (BIMS) score of EX0 out of 15, which indicated EX Order 26 § 4b1 . A further review of the MDS, indicated that the resident exhibited no behavioral symptoms and received EX Order 26 § 4b1 on 7 out of the last 7 days during the look back period.

A review of the resident's individualized, comprehensive care plan dated 12/26/19 included a care concern that the resident had a EX Order 26 § 4b1 related to EX Order 26 § 4b1 and indicated that the resident was taking EX Order 26 § 4b1

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A review of the POS indicated an order dated 4/16/21 for EX Order 26 § 4b1 given once a day which was active and an active order for EX Order 26 § 4b1 at bedtime for EX Order 26 § 4b1.

On 2/18/2022 at 12:55 PM, the surveyor reviewed the BMF for Resident #23's EX Order 26 § 4b1. The review failed to indicate EX Order 26 § 4b1 for November or December 2021 and for February 2022 the monitoring didn't start until the16th. The review indicated incomplete EX Order 26 § 4b1 for November, December 2021 and January, February 2022 with no monitoring for the use of the EX Order 26 § 4b1.

The EX Order 26 § 4b1 Note Monthly effective on 12/8/21 and inclusive of Resident #23's behaviors for the month of November 2021 listed the resident's targeted behaviors as EX Order 26 § 4b1. The EX Order 26 § 4b1 Note Monthly failed to indicate the number of times that the resident exhibited each EX Order 26 § 4b1 There was no evidence of a BMF for November 2021.

The EX Order 26 § 4b1 Note Monthly effective on 1/10/22 and inclusive of Resident #23's behaviors for the month of December 2021 listed the resident's targeted behaviors as helplessness and loss of interest in activities.

The Psychotropic Note Monthly failed to indicate the number of times that the resident exhibited

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each behavior during the month of December. There was no evidence of a BMF for December 2021.

The [redacted] Note Monthly effective on 2/10/22 and inclusive of Resident #23's behaviors for the month of January 2022 listed the resident's targeted behaviors as pacing affecting others, excessive talking disrupting care and appetite disturbances,. The Psychotropic Note Monthly failed to indicate the number of times that the resident exhibited each behavior. The BMF(s) for January 2022 failed to indicate that the resident was being monitored for either appetite disturbances or helplessness.

5. On 2/17/22 at 10:34 AM, surveyor #3 observed Resident #55 in the unit day area, seated in a [redacted] with eyes closed.

The surveyor reviewed the admission record that indicated Resident #55 was admitted to the facility on [redacted] and was readmitted on [redacted] with diagnoses that included but not limited to [redacted] The surveyor also reviewed the February 2022 electronic POS which reflected an order dated 7/6/21 for [redacted]

A review of the Annual MDS, dated 11/26/21 reflected that the resident had a Brief Interview

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F 758	Continued From page 62 for Mental Status (BIMS) score of [redacted], which indicated that the resident had EX Order 26 § 4b1 [redacted]. Surveyor #3 reviewed the monthly Psychotropic Notes (PN) for the month of January 2022 through February 2022. The resident's target behaviors identified by the facility for monitoring documentation included, [redacted] affecting others, [redacted] affecting others, helplessness, and loss of interest in activities. A review of the BMF for January 2022 revealed that the target behavior monitored was for "difficult to care". Additional review of the February 2022 BMF revealed a target behavior monitored for "pacing". The BMF forms did not match the specific target behaviors being monitored daily for Resident #55. On 2/22/22 at 12:30 PM, the surveyor discussed the above concern to the Administrator, Regional Nurse and Director of Nursing (DON). The DON stated that the target behaviors identified in the PN must match the target behaviors under the BMF form. No further information was provided. 6. On 2/17/22 at 10:19 AM, the surveyor observed Resident #63 in the room, awake and was seated on the bed. The resident did not look at the surveyor or speak when spoken to. The surveyor reviewed the admission record that indicated Resident #63 was admitted to the facility on 5/8/09 with diagnoses that included but not limited to EX Order 26 § 4b1 [redacted] The surveyor also reviewed the February 2022 electronic POS which reflected	F 758		

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F 758	Continued From page 63 an order dated 1/30/21 for EX Order 26 § 4b1 EX Order 26 § 4b1 . A review of the Quarterly MDS, dated 11/18/21, indicated a BIMS score of [redacted], which indicated that the resident had EX Order 26 § 4b1 . Further review of Resident #63's medical records revealed that there was no documentation found on the side effects of the EX Order 26 § 4b1 to the resident being monitored and documented. On 2/22/22 at 12:30 PM, the surveyor discussed the above concern with the Administrator, Regional Nurse and Director of Nursing (DON). No further information was provided. 8. On 2/11/22 at 9:46 AM, Surveyor #2 observed Resident #39 lying in bed with the sheet covering his/her head. Resident #39 then sat up in the bed but did not respond to Surveyor #2. The surveyor reviewed the medical record for Resident #39. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to, EX Order 26 § 4b1 without EX Order 26 § 4b1 [redacted] A review of the quarterly MDS, dated 2/4/22 reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which	F 758		

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F 758	Continued From page 64 indicated EX Order 26 § 4b1 . A further review of the MDS, indicated that the resident had no behaviors and received EX Order 26 § 4b1 , an EX Order 26 § 4b1 medication and an EX Order 26 § 4b1 , on 7 out of the last 7 days during the look back period. A review of the resident's individualized, comprehensive care plan dated included a care concern that the resident used EX Order 26 § 4b1 with diagnosis of EX Order 26 § 4b1 . Interventions included, but were not limited to, EX Order 26 § 4b1 A review of the POS of active orders as of 2/17/22, indicated the following EX Order 26 § 4b1 orders: EX Order 26 § 4b1 A review of Resident #39's November 2021, December 2021, January 2022 and February 2022 electronic Medication Administration Record (eMAR) reflected that the resident received the	F 758		

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F 758	Continued From page 65 three EX Order 26 § 4b1 of EX Order 26 § 4b1, each month. On 2/16/22 at 10:30 AM, in the presence of Surveyor #5, Surveyor #2 asked the Registered Nurse (RN) where the facility documented the behavior monitoring for residents that received EX Order 26 § 4b1. The RN provided Surveyor #2 a black binder labeled Behavior Monitoring which contained BMFs for the residents on the [redacted] floor that received psychotropic medications. Surveyor #2 looked in the binder to obtain Resident #39's February 2022 Behavior Monitoring sheet. There was no BMF(s) for February 2022 for Resident #39. There was 3 BMF(s) for January 2022 for Resident #39. Surveyor #2, in the presence of Surveyor #5, asked the RN what the process was for behavior monitoring for residents on EX Order 26 § 4b1 The RN stated that they use the BMF(s) for any resident on psychotropic medications to monitor target behaviors and for side effects of the medications. She added that the forms for the month were kept in the black binder and that a monthly summary was done in the computer. The RN confirmed that there was not a Behavior Monitoring Form for February 2022 for Resident #39. She added that there should be. Surveyor #2 then reviewed Resident #39's BMF(s) for January 2022 which included the following information: One form for the [redacted] (also known as [redacted]) medication EX Order 26 § 4b1 had indicated that the EX Order 26 § 4b1 [redacted] were to have been monitored and documented daily on all three shifts. A review of	F 758		

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the form reflected that the symptom of [redacted] was only documented for the 7 AM to 3 PM shift each day of the month of January. The 3 PM to 11 PM shift and 11 PM to 7 AM shift were blank (not documented) for each day of the month of January. The symptom of pacing was only documented for the 7 AM to 3 PM and 3 PM to 11 PM shift each day of the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January. The form indicated that Resident #39 did not have any episodes of [redacted] or [redacted] for the month of January 2022.

One form for the EX Order 26 § 4b1 [redacted] had indicated that the behavioral symptom of [redacted] was to have been monitored daily on all three shifts. A review of the form reflected that the symptom of [redacted] was only documented for the 7 AM to 3 PM shift and 3 PM to 11 PM shift each day of the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January. The form indicated that Resident #39 did not have any episodes of [redacted] for the month of January 2022.

One form for the EX Order 26 § 4b1 [redacted] had indicated that the behavioral symptom of [redacted] was to have been monitored daily on all three shifts. A review of the form reflected that the symptom of [redacted] was only documented for the 7 AM to 3 PM shift and 3 PM to 11 PM shift each day of the month of January. The 11 PM to 7 AM shift were blank (not documented) for each day of the month of January. The form indicated that Resident #39 did not have any episodes of [redacted] for the month of January 2022. There was no evidence that the facility documented Resident #39's behavior

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F 758	Continued From page 67 monitoring daily on all three shifts for January 2022. At 10:57 AM, Surveyor #2 reviewed Resident #39's January 2022 Monthly [redacted] Note dated 2/13/22, which included the following: 1st [redacted] Medication EX Order 26 § 4b1 [redacted]; Monthly total-9. 2nd [redacted] Medication- EX Order 26 § 4b1 [redacted] Pacing affecting others; Monthly total-left blank. 3rd [redacted] Medication [redacted] total-9. Resident #39's Monthly [redacted] Note and the Behavior Monitoring Forms for January 2022 did not contain the same information. The target behaviors that were to be monitored for each medication and the total amount of episodes that occurred during the month were different when the facility summarized the daily Behavior Monitoring Forms into the Monthly [redacted] Note. On 2/16/22 at 11:32 AM, in the presence of Surveyor #5, Surveyor #2 interviewed the Assistant Director of Nursing (ADON) regarding the facility process for behavior monitoring for residents on [redacted] medications. The ADON stated that the staff are to document daily on all three shifts on the Behavior Monitoring Form and if they need to describe the behavior additionally, they should write a note in the computer. She then added that the staff would use the daily Behavior Monitoring Forms to document the monthly [redacted] Note Summary. Surveyor #2 then asked the ADON if	F 758		

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the information should be the same on the Behavior Monitoring Form and the monthly [redacted] Note Summary. The ADON stated that the information should be the same.

At 11:35 AM, Surveyor #2 asked the [redacted] floor Unit Manager (UM) for Resident #39's November 2021 and December 2021 Behavior Monitoring Forms.

At 11:38 AM, the UM provided Surveyor #2 an additional black binder which contained previous months of Behavioral Monitoring Forms. The binder contained forms from 2021 for the months of January, February, March, June, July and November. Surveyor #2 then asked the UM for Resident #39's December 2021. The UM stated that she would look in her office for the December 2021 forms.

Surveyor #2 then reviewed Resident #39's Behavior Monitoring Forms for November 2021 which included the following information:

One form for the [redacted] medication [redacted] had indicated that the behavioral symptom of [redacted] and [redacted] was to have been monitored daily on all three shifts. A review of the form reflected that the symptoms of [redacted] and [redacted] was only documented for the 11 PM to 7 AM shift for November 1 through November 23. The remaining 11 PM to 7 AM shifts from November 24 through November 30 were blank (not documented). The 7 AM to 3 PM and 3 PM to 11 PM shift were blank (not documented) for each day of the month of November. The form indicated that Resident #39 did not have any episodes of [redacted] or [redacted] for the November 2021.

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F 758	Continued From page 69 One form for the [redacted] medication [redacted] had indicated that the behavioral symptom of [redacted] and [redacted] was to have been monitored daily on all three shifts. A review of the form reflected that the symptoms of [redacted] was only documented for the 11 PM to 7 AM shift for November 1 through November 28. The remaining 11 PM to 7 AM shifts from November 29 through November 30 were blank (not documented). The symptom of [redacted] was only documented for the 11 PM to 7 AM shift for November 1 through November 23. The remaining 11 PM to 7 AM shifts from November 24 through November 30 were blank (not documented). The 7 AM to 3 PM and 3 PM to 11 PM shift were blank (not documented) for each day of the month of November. The form indicated that Resident #39 did not have any episodes of [redacted] or [redacted] for the November 2021. One form for the [redacted] medication [redacted] had indicated that the behavioral symptom of [redacted] and [redacted] was to have been monitored daily on all three shifts. A review of the form reflected that the symptoms of [redacted] and [redacted] was only documented for the 11 PM to 7 AM shift for November 1 though November 23. The remaining 11 PM to 7 AM shifts from November 24 through November 30 were blank (not documented). The symptom of [redacted] was documented on the 3 PM to 11 PM on November 1. The remaining 3 PM to 11 PM shifts were blank (not documented). The 7 AM to 3 PM shifts were blank (not documented). The form indicated that Resident #39 did not have any episodes of [redacted] or [redacted] the November 2021. There was no evidence that the facility	F 758		

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F 758	Continued From page 70 documented Resident #39's behavior monitoring daily on all three shifts for January 2022. Surveyor #2 then reviewed Resident #39's November 2021 Monthly [redacted] Note dated 12/10/21, which included the following: 1st [redacted] Medication-EX Order 26 § 4b1 [redacted]; Target Behavior- [redacted] affecting others; Monthly total-left blank. 2nd [redacted] Medication- EX Order 26 § 4b1 Target Behavior- [redacted] affecting others; Monthly total-left blank. 3rd [redacted] Medication-EX Order 26 § 4b1 2 mg; Target Behavior- [redacted] affecting others; Monthly total-left blank. The Monthly [redacted] Note and the Behavior Monitoring Forms for November 2021 did not contain the same information. The target behaviors that were to be monitored for each medication were different when the facility summarized the daily Behavior Monitoring Forms into the Monthly [redacted] Note. On 2/17/22 at 12:22 PM, Surveyor #2 interviewed the UM. The UM stated that she did not find Resident #39's December 2021 BMF. Surveyor #2 then reviewed Resident #39's December 2021 Monthly [redacted] Note dated 1/10/22, which included the following: 1st Psychotropic Medication-EX Order 26 § 4b1 [redacted]; Target Behavior- [redacted] affecting others; Monthly total-9. 2nd [redacted] Medication- EX Order 26 § 4b1 [redacted] - [redacted] affecting others; Monthly total-left blank. 3rd [redacted] Medication-EX Order 26 § 4b1 [redacted]; Target Behavior- [redacted] affecting others;	F 758		

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F 758	Continued From page 71 Monthly total-9. 9. On 2/11/22 at 9:41 AM, Surveyor #2 observed Resident #363 lying in bed and was repeating a phrase in [redacted]. Resident #363 did not respond to the surveyor. The surveyor reviewed the medical record for Resident #363. A review of the Admission record reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to, EX Order 26 § 4b1 [redacted] A review of the admission MDS, dated 1/20/22, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated EX Order 26 § 4b1 [redacted]. A further review of the MDS, indicated that the resident had verbal behavioral symptoms directed toward others daily and other behavioral symptoms not directed toward others daily. The MDS also indicated that the resident received psychotropic medication, an EX Order 26 § 4b1, on 7 out of the last 7 days during the look back period. A review of the resident's individualized, comprehensive care plan included a care concern for the resident that had EX Order 26 § 4b1 [redacted] Interventions included but were not limited to; allow resident to vent feelings; if resident exhibits any EX Order 26 § 4b1 [redacted], allow to calm down and then reapproach; medication reductions as needed. A review of the POS of active orders indicated the following [redacted] medication orders:	F 758		

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EX Order 26 § 4b1 [redacted] by mouth one time a day for EX Order 26 § 4b1 [redacted]

A review of Resident #363's January 2022 and February 2022 electronic Medication Administration Record (eMAR) reflected that the resident received the two [redacted] medications of EX Order 26 § 4b1 each month.

On 2/16/22 at 10:30 AM, in the presence of Surveyor #5, Surveyor #2 asked the Registered Nurse (RN) where the facility documented the behavior monitoring for residents that received [redacted] medications. The RN provided Surveyor #2 a black binder labeled Behavior Monitoring which contained BMF(s) for the residents on the [redacted] floor that received [redacted] medications. Surveyor #2 looked in the binder to obtain Resident #363's February 2022 Behavior Monitoring Form. There was no BMF for February 2022 for Resident #363. There was no evidence that the facility documented Resident #363's behavior monitoring daily on all three shifts for February 2022. Surveyor #2 then looked in the binder to obtain Resident #363's January 2022 B. There was no BMF for January 2022 for Resident #363. The RN stated that Resident #363 was originally admitted to the [redacted] floor unit in January and that Resident #363's January 2022 BMF may still be in that unit's binder.

At 12:23 PM, the [redacted] floor Unit Manager provided Surveyor #2 Resident #363's January

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F 758	Continued From page 73 2022 Behavior Monitoring Form. Surveyor #2 then reviewed Resident #363's BMF for January 2022 which included the following information: One form with no medication listed under [redacted]e Medication had indicated that the behavioral symptoms of [redacted] and [redacted] was to have been monitored daily on all three shifts starting 1/14/22 (day after admission). A review of the form reflected that the symptoms of yelling and screaming was only documented for the 7 AM to 3 PM shift on 1/15/22. The remaining 7 AM to 3 PM shifts from January 16 through January 31 were blank (not documented). The 3 PM to 11 PM and 11 PM to 7 AM shift were blank (not documented) for each day of the month of January. There was no evidence that the facility documented Resident #363's behavior monitoring daily on all three shifts for the days the resident resided at the facility during January 2022. Surveyor #2 then reviewed Resident #363's electronic health record (EHR) for the January 2022 Monthly [redacted] Note. There was no January 2022 Monthly [redacted] Note in the EHR. On 2/17/22 at 12:59 PM, during surveyor interview, the Director of Nursing stated that Resident #363 should have had a Monthly Psychotropic Note done for January 2022. She added that the Monthly [redacted] Note should be done by the fifteenth of the month. A review of the facility policy titled, "Behavioral Assessment, Intervention and Monitoring" with a revised date of March 2019 included the	F 758		

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following:
Policy Statement
1. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.
2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment ....
6. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes.
Policy Interpretation and Implementation
Management
10. When medications are prescribed for behavioral symptoms, documentation will include: ...
e. Specific target behaviors and expected outcomes; ...
h. Monitoring for efficacy and adverse consequences ...
Monitoring
1. If the resident is being treated for altered behavior or mood, the IDT (interdisciplinary team) will seek and document any improvements or worsening in the individual's behavior, mood and function.
2. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported.

A review of the facility provided, "Charting and Documentation" policy and procedure, revised 7/17, included but was not limited to policy statement: all services provided to the resident, progress toward the care plan goals, or changes

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F 758	Continued From page 75 in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Interpretation and implementation: 2. the following information is to be documented in the resident medical record: a. objective observations; b. medications administered; c. treatments or services performed; d. changes in the resident's condition; 3. events, incidents or accidents involving the resident; and f. progress toward or changes in the care plan goals and objectives. A review of the facility policy titled, "Tapering Medications and Gradual Drug Dose Reduction" with a revised date of April 2007, included the following: The Attending Physician and staff will identify target symptoms for which a resident is receiving various medications. The staff will monitor for improvement in those target symptoms, and provide the Physician with that information ... The staff and practitioner will monitor side effects closely for antidepressant. When a medication is tapered or stopped, the staff will closely monitor the resident and will inform the Physician if there is a return or worsening of symptoms. The facility did not provide the surveyors a policy regarding the Behavioral Monitoring Forms or the Monthly [redacted] Note. NJAC 8:39 27.1 (a), 29.3(a)	F 758		

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3. On 2/16/2022 at 9:46 AM, surveyor #5 observed Resident #89 in bed in their room.

The surveyor reviewed the medical record for Resident #89.

A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]

A review of the quarterly Minimum Data Set (MDS), dated 1/12/2022 reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated EX Order 26 § 4b1 [redacted]. A further review of the MDS, indicated that the resident exhibited no behavioral symptoms and received EX Order 26 § 4b1 [redacted] on 7 out of the last 7 days during the look back period.

A review of the resident's individualized, comprehensive care plan dated 12/24/2020 included a care concern that the resident received antipsychotic medication related to EX Order 26 § 4b1 [redacted] Interventions included to monitor for the effectiveness of the medication and to monitor for signs and symptoms of adverse reactions to the medication every shift.

A review of the POS indicated an order dated 6/8/2021 for EX Order 26 § 4b1 [redacted] by mouth two times a day. The Order Summary Report

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F 758	Continued From page 77 indicated that [redacted] was an active order, and that Resident #89 was still ordered to receive the medication. On 2/16/2022 at 10:20 AM, the surveyor reviewed the BMF(s) for Resident #89. The review indicated incomplete behavior monitoring in November 2021 with no monitoring occurring on any 7 AM- 3 PM shifts or on any 3 PM- 11 PM shifts. The review failed to indicate any BMF for December 2021. The review indicated an incomplete BMF for January 2022 with no monitoring occurring on any 11 PM to 7 AM shifts. The review failed to indicate any BMF for February 2022. The BMF for November 2021 listed Resident #89's behavioral symptom as yelling. The BMF for January 2022 listed Resident #89's behavioral symptom as delusions. The [redacted] Note Monthly effective on 12/10/21 and inclusive of Resident #89's behaviors for the month of November 2021 listed the resident's targeted behaviors as [redacted] affecting others and hallucinations. The [redacted] Note Monthly indicated that the resident had 6 episodes of [redacted] affecting other and 4 episodes of [redacted] EX Order 26 § 4b1 . The BMF for November 2021 indicated that Resident #89 was being monitored for [redacted] and failed to indicate that the resident was being monitored for either [redacted] affecting others or [redacted] The [redacted] Note Monthly effective on 1/10/22 and inclusive of Resident #89's behaviors for the month of December 2021 listed the resident's targeted behaviors at [redacted] affecting others and [redacted] s. The [redacted] Note	F 758		

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Monthly indicated that the resident had 6 episodes of [redacted] and 5 episodes of [redacted]. There was no evidence of a Behavior Monitoring Form for December 2021.

The [redacted] Note Monthly effective on 2/14/22 and inclusive of Resident #89's behaviors for the month of January 2022 listed the resident's targeted behaviors as [redacted] affecting others and [redacted] The Psychotropic Note Monthly indicated that the resident had 0 episodes of either behavior. The Behavior Monitoring Form for January 2021 indicated that Resident #89 was being monitored for delusions and failed to indicate that the resident was being monitored for [redacted] affecting others or [redacted].

On 2/16/2022 at 10:35 AM, the surveyor interviewed the RN regarding the February BMF, the RN stated, "I don't see any right now" and went on to state that there should be a February BMF.

On 2/16/2022 at 11:09 AM, the 4th floor RNUM provided two surveyors with BMF(s) for the past year. A review of these forms failed to indicate BMF(s) for December 2021 or February 2022 on Resident #89 or #84 or on any other resident.

On 2/16/2022 at 11:32 AM, two surveyors interviewed the Assistant Director of Nursing (ADON). The ADON stated that she would expect to see daily monitoring over all three shifts. The ADON further stated that she would expect for the Behavior Monitoring Sheets to lend themselves to the monthly summaries and that the monitored behavioral symptoms would be the

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F 758	Continued From page 79 same for both. On 2/17/2022 at 10:39 AM, two surveyors requested all of the past Behavior Monitoring Forms from the RNUM. The RNUM provided the surveyors the monitoring forms. The surveyors asked if this was all of the monitoring that existed for the unit. The RNUM stated, yes. A review of these BMF revealed a February 2022 BMF for Resident #89 that began on 2/16/2022. The review failed to reveal a BMF for December 2021. On 2/17/2022 at 12:53 PM, the survey team interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON stated that the behaviors monitored on the BMF should match the [redacted] Note Monthly. The DON stated that it is the responsibility of the night shift nursing supervisor to make sure that the BMF(s) are created monthly. On 2/18/2022 at 9:35 AM, the survey team again interviewed the DON and LNHA. The DON stated that the behaviors being monitored need to be accurate and that the behaviors logs need to be updated to make sure that each behavior is logged and accounted for. The DON also stated that each shift is responsible to complete the Behavior Monitoring Forms daily. 4. On 2/16/2022 at 10:34 AM, the surveyor observed Resident #84 in a [redacted] in their room. The surveyor reviewed the medical record for	F 758		

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F 758	Continued From page 80 Resident #84. A review of the Admission Record reflected that the reflected that the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/3/2021 reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated EX Order 26 § 4b1 [redacted]. A further review of the MDS, indicated that the resident exhibited no behavioral symptoms and received EX Order 26 § 4b1 [redacted] medications on 7 out of the last 7 days during the look back period. A review of the resident's individualized, comprehensive care plan dated 10/9/2020 included a care concern that the resident had a EX Order 26 § 4b1 [redacted] related to EX Order 26 § 4b1 [redacted] and indicated that the resident was taking antidepressant and EX Order 26 § 4b1 [redacted]. Another care concern was included indicated that the resident had a problem related to EX Order 26 § 4b1 [redacted]. Interventions included to monitor and document Resident #84's behaviors. A review of the Order Summary Report indicated an order dated 7/18/2021 for a EX Order 26 § 4b1 [redacted] given at bedtime every Monday, Wednesday, and Friday which was discontinued on 1/19/2021.	F 758		

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F 758	Continued From page 81 On 2/16/2022 at 11:14 AM, the surveyor reviewed the Behavior Monitoring Forms for Resident #84. The review failed to indicate behavior monitoring for November or December 2021 or for February 2022. The review indicated incomplete behavior monitoring for January 2022 with no monitoring completed on the 11 PM- 7AM shift for the month of January. The Behavior Monitoring Form for January 2022 listed the targeted behavioral symptom as [redacted] preoccupied. The [redacted] Note Monthly effective on 12/13/21 and inclusive of Resident #84's behaviors for the month of November 2021 listed the resident's targeted behaviors as appetite disturbances and delusions disrupting care. The [redacted] Note Monthly failed to indicate the number of times that the resident exhibited each behavior. There was no evidence of a Behavior Monitoring Form for November 2021. The [redacted] Note Monthly effective on 1/13/22 and inclusive of Resident #84's behaviors for the month of December 2021 listed the resident's targeted behaviors as [redacted] and as [redacted] care. The [redacted] Note Monthly indicated that each of these behaviors were not exhibited during the month of December. There was no evidence of a Behavior Monitoring Form for December 2021. The [redacted] Note Monthly effective on 2/12/22 and inclusive of Resident #84's behaviors for the month of January 2022 listed the resident's targeted behaviors as appetite	F 758		

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disturbances and as helplessness. The [redacted] Note Monthly failed to indicate the number of times that the resident exhibited each behavior. The Behavior Monitoring Form for January 2022 failed to indicate that the resident was being monitored for either appetite disturbances or helplessness.

7. On 2/16/22 at 10:13 AM, surveyor #4 observed Resident#79 lying in bed, awake and alert, calm and soft spoken but with clear speech and was able to answer questions appropriately.

A review of the Admission Record reflected that the resident was admitted on [redacted] and was readmitted to the facility from the hospital on [redacted]

A review of the 1/6/22, Admission MDS indicated a BIMS score of [redacted], which reflected that the resident's cognition was EX Order 26 § 4b1.

A review of the POS reflected physician orders for EX Order 26 § 4b1 [redacted].

On 2/17/22 at 12:22 PM, the surveyors observed a black binder titled "3RD FLOOR-HIGH SIDE" with "Behavior Monitoring Form"(s) in the binder and Resident #79's form could not be located in the binder. Registered Nurse/Supervisor (RN/S) informed the surveyors that residents' BMF should be in the [redacted] floor low side binder. While the RN/S was looking for the binder, she stated "we started filling them out last night." RN/S stated that when a resident was on EX Order 26 § 4b1

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EX Order 26 § 4b1, the nurses should complete the BMF(s) daily on every shift.

On the same date at 12:28 PM, 3rd floor Licensed Practical Nurse #1 (LPN#1) provided BMF(s) to surveyor #4. The surveyor and LPN#1 could not find BMF for Resident #79. LPN#1 stated that the resident was receiving [redacted] medications and there were supposed to be completed BMFs for the resident. LPN#1 stated, "I'm looking for it."

At 1:09 PM, on the same day, the surveyor met again with RN/S and LPN#1 and they both stated that the nurses should complete BMF(s) for the residents who were on [redacted] and [redacted] medications. RN/S and LPN#1 also stated that they did not complete BMF(s) for residents who were on antidepressant medications but monitored for side effects by completing "Suspected Side Effect Codes" forms.

LPN#1 stated the suspected side effects form for Resident#79 was not completed and stated, "it was not addressed."

The RN/S informed the surveyor that there were no "Suspected Side Effect Codes" forms completed for the resident and stated, "You won't be able to find one." The RN/S showed an undated BMF for Resident #79 and stated, "it's not dated." The form reflected a written "Monitor S/E" (side effects) and a line across the form. The opposite side of the form titled "Suspected Side Effect Codes" was blank and not filled out. The RN/S could not provide further information.

LPN#2 informed the surveyor that monthly psych

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notes for residents on psych medications were generated programmatically, which alerted the nurses to complete [redacted] notes that were due for the residents and stated, "computer is programmed, and it will pop in the computer to alert us that it is due for monthly [redacted] notes for the resident."

The 3rd floor RN/UM informed the surveyor that the nurses should document initial [redacted] notes electronically, a month after the resident was admitted to the facility for newly or readmitted residents. She stated, "the nurse was supposed to keep tab when the patient came with [redacted] meds and know when to do the initial [redacted] notes." RN/UM also stated that when the initial psych notes was initiated and completed electronically, the computer will automatically alert the nurses for due monthly [redacted] notes documentation thereafter.

The 3rd floor RN/UM stated that the resident was readmitted to the facility on 12/30/21 with [redacted] medications and "the nurses should've been done initial [redacted] notes on 1/30." The [redacted] floor RN/UM informed the surveyor that the initial monthly [redacted] notes was missed and there were no initial [redacted] notes completed for Resident #79 after his/her readmission on 12/30/21. She also stated that she will remind the nurse to complete monthly [redacted] notes for the resident "so it will start rolling." The RN/UM was unable to provide further information.

Surveyor #4 reviewed resident's hybrid medical records reflected there were no monthly behavioral notes for December 2021 and January 2022.

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F 761	Continued From page 85	F 761		
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 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 record review, it was determined that the facility failed to ensure that biological drugs and supplies were removed from the crash cart when expired. This deficient practice was identified on one of two units and was evidenced by the following: On 02/14/2022 at 10:30 a.m., the surveyor inspected the 400's Unit crash cart with the Unit	F 761	F761 No residents were affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, Unit	4/11/22

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F 761	Continued From page 86 Manager Registered Nnurse (UM/RN) and noted 3 bottles of normal saline solution with an expiration date of 03/2021. The Ambu bag (a self inflating, hand held device commonly used to provide ventilations to patients who are not breathing) with a used by date of 04/2021. An interview with the nurse on 2/14/2021 at 11:30 a.m., revealed that the night supervisor was responsible to check the crash cart. The nurse could not provide any rationale regarding the expired saline solution bottles and the Ambu bag still on the crash cart for use in an emergency. The facility was made aware of the above issue on 2/21/2022 at 1:15 p.m. On 2/23/2022 at 10:15 a.m.; the Director of Nursing (DON) stated that the expired saline and the Ambu bag were removed from the crash cart. The DON further stated that the 11:00 PM- 07:00 AM supervisor was in- serviced on removing expired drugs and supplies from the crash cart. No policy was provided. NJAC 8:39-29.4 (g)	F 761	Manager/Designee immediately removed three (3) bottles of normal saline solution and an ambu bag. Unit Manager/Designee conducted a Facility-wide audit to ensure that there are no other expired biological drugs an d supplies stored in the crash cart. No other crash carts were affected by this deficient practice of having expired biological drugs and supplies in the crash cart. ADON in serviced Nursing Night Supervisor regarding checking the crash cart nightly to ensure all biological drugs and supplies in the crash cart are not expired. DON/Designee to conduct weekly audit once a week for four 4 weeks, then once a month for 2 months thereafter to ensure biological drugs and supplies in the crash cart are not expired. Infection Preventionist/Designee will audit all crash carts once a week to ensure compliance. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.	
F 880 SS=D	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. §483.80(a) Infection prevention and control program.	F 880		6/3/22

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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 contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 88 (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, record review, and review of pertinent facility documentation, it was determined that the facility failed to 1) store respiratory care equipments in a manner to prevent infections, 2) adhere to infections control practices for hand hygiene according to CDC (Center for Disease Control) and the facility policy, and 3) failed to properly wear an N95 fitted respiratory mask. This deficient practice was identified for three staff members on two units. The deficient practice was evidenced by the following: 1) On 2/11/2022 at 12:04 PM, the surveyor toured the 400's Unit and observed Resident # 24 in bed. The EX Order 26 § 4b1 [redacted] The EX Order 26 § 4b1 and the EX Order 26 [redacted] were not labeled or dated and were observed on top of the concentrator not in any	F 880	F880 Resident #24 was not negatively affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, ADON immediately removed the oxygen tubing that was observed on floor, and replaced with a newly labeled and dating oxygen tubing. Unit Manager/Designee conducted a Facility-wide audit to ensure that any resident with oxygen orders had oxygen tubing were labeled, dated and bagged when not in use. No other residents were affected by this deficient of having oxygen tubing on the floor. ADON conducted nursing wide in-service on proper oxygen tubing storage.	

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F 880	Continued From page 89 protective covering. On 2/14/2022 at 8:15 AM, the surveyor observed Resident #24 in bed, the EX Order 26 § 4b1 was turned off. The EX Order 26 § 4b1 was on the chair next to the bed and not in any protective covering. On 2/15/22 at 10:01 AM, the survery observed that the EX Order 26 § 4b1 was turned off. The EX Order 26 § 4b1 was noted on top of the resident's clothing on the chair next to the bed and not in any protective covering. On 02/16/22 at 10:04 AM, the surveyor went to the room and observed the EX Order 26 § 4b1 and the EX Order 26 § 4b1 in direct contact with the floor. The EX Order 26 § 4b1 was running and the EX Order 26 § 4b1 was set to deliver EX Order 26 § 4b1. There was no EX Order attached to the EX Order 26 § 4b1 to store the EX Order 26 § 4b1 when not in use. On 02/16/22 at 10:05 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who administered medications that day. The LPN confirmed that Resident #24 had an physician's order for EX Order 26 § 4b to be delivered at EX Order 26 §. The surveyor escorted the LPN to the room where we both observed the EX Order 26 § 4b1 and the EX Order 26 § 4b1 and EX Order 26 § 4b1 in direct contact with the floor. Upon further inquiry, the LPN stated that that the night shift was responsible to change the EX Order 26 § and ensure that the EX Order 26 § 4b1 was stored in a plastic bag when not in use. The LPN exited the room and left the EX Order 26 § 4b1 and the EX Order 26 lying in direct contact with the floor. That same day at 10:30 AM the surveyor	F 880	DON/Designee to conduct weekly audit once a week for four weeks, then once a month for 2 months thereafter to ensure all resident with oxygen order have proper storage for oxygen tubing when not in use and that all oxygen tubing are labeled and dated appropriately. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. F880 Cont□ No residents were affected by this deficient practice. All Residents have the potential to be affected by this deficient practice. Immediately upon notification, Infection Preventionist/Designee conducted a facility wide audit on hand hygiene competency. No other staff were identified with the deficient practice of improper hand hygiene. ADON conducted an in-service with the identified RN regarding proper hand hygiene. ADON/Designee conducted a facility wide in-service on proper hand hygiene. DON/Designee to conduct weekly competency audit x4 weeks, once a month for 2 months thereafter to proper hand hygiene practice is being followed. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting. No residents were affected by this deficient practice.	

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F 880	Continued From page 90 escorted the Assistant Director of Nursing (ADON) to Resident #24's room where we both observed the EX Order 26 § 4b1 still lying in direct contact with the floor. There was no bag attached to the EX Order 26 § 4b1 to protect/store the EX Order 26 § 4b1 when not in use. The ADON removed the EX Order 26 § 4b1 from the floor, turned off the concentrator, exited the room and told the surveyor that she would replace the setting. On 2/16/2022 at 10:37 AM, the surveyor observed the ADON and the Unit Manager Registered Nurse (UM/RN) entered Resident #24's room with a new concentrator, new tubing and a plastic bag to store the tubing when not in use. On 2/17/2022 at 10:30 AM, the ADON provided an in-serviced education folder which addressed care of the EX Order 26 § 4b1. The following were noted: The tubing must be dated and changed weekly on Sunday with the date. When not in use the EX Order 2 must be stored in a plastic bag. If the nurse observed the EX Order 26 on the floor, the EX Order 26 must be thrown away and replaced with a new one. 2. On 02/14/20222 at 08:25 AM, the surveyor informed the Registered Nurse (RN) that she would be observed for medication pass administration. Prior to the start of the medication pass, the RN entered the room, identified and informed the resident of the procedure. The RN proceeded to	F 880	1. No residents were affected by this deficient practice. The identified CNA immediately removed the cloth mask. The identified RN was in-serviced about donning gloves prior to administering injection. 2.All Residents have the potential to be affected by this deficient practice. 3. Immediately upon notification, Infection Preventionist/Designee conducted a facility wide audit on proper donning of doffing personal protective equipment (PPE), including properly fitted N95 mask and appropriately donning and doffing gloves when administering injections. No other staff were identified with the deficient practice of improper donning of PPE, N95 fitted mask. ADON conducted an in-service with the identified C.N.A. regarding proper donning and doffing of fitted N95 mask. ADON conducted an in-service with the identified RN regarding proper donning and doffing of gloves when administering injection. ADON conducted facility wide in-service on proper donning of fitted N95 mask. 4.DON/Designee to conduct weekly competency audit once a week for four weeks, then once a month for 2 months thereafter for proper fitting of N95 mask and donning and doffing gloves. Infection Preventionist/Designee will conduct and in-service two times a month for two months on proper usage of PPE. Audits will be reviewed on a monthly basis at our	

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F 880	Continued From page 91	F 880		

the sink and performed hand hygiene. The RN lathered her hands for 07:09 seconds and completed the hand hygiene under running water.

On 2/14/2022 at 9:01 AM, the surveyor observed the RN administer the following medications to Resident # 30 an unsampled resident:

EX Order 26 § 4b1 [redacted]

The RN stated that the medications had to be given with apple sauce. The RN placed the tablets in the medication cup and added the apple sauce.

During the procedure, the RN dropped one of the medications on the medication cart. The RN picked the tablet up with her bare hand and added it to the other medications that were already in the cup. The RN locked the medication cart and proceeded to enter Resident #30's room to administer the medications. The surveyor stopped the procedure and informed the RN that she could not proceed with the medication administration. The RN told the surveyor "I should have discarded the tablet and poured another one". The RN went to the medication room, got the drug buster and destroy the above medications.

After the medication pass, the RN again washed her hands for 12.04 seconds.
The surveyor showed the RN the timing on the phone. The RN stated: "I singed Happy Birthady

monthly QA/PI meeting. All negative findings to be corrected immediately and reported monthly in the QA/PI Meeting.
No residents were affected by this deficient practice. Please see details of the Directed Plan of Correction(DPOC):
The facility shall provide in-service training to appropriate staff ,
with staff competency validated by the Director of Nursing, Medical
Director or Infection Preventionist, as follows ,
Nursing Home Infection Preventionist Training Course
Module 1 - Infection Prevention & Control Program
https : //www . train . org/main/course/ 1081350 /
Provide the training to : Topline staff and infection preventionist
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff :
Keep COVID-19 Out
https : //youtu . be/7srwrF9MGdw
Provide the training to : Frontline staff
CDC C:OVID-19 Prevention Messages for Front Line Long-Term Care Staff :
Sparkling Surfaces
https , //youtu . be /t 70H80Rr5 lg
Provide the training to : Frontline staff
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff :
Clean Hands
https : //youtu . be/xmYMUly7qIE
Provide the training to : Frontline staff
CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff :
Use PPE Correctly for COVID-19
https : //youtu . be/YYTATw9yav4

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F 880	Continued From page 92 too fast". On 2/14/2022 at 9:10 AM, the surveyor observed the RN preparing EX Order 26 § 4b1 for Resident #37. The RN entered the room, informed Resident #37 of the procedure and washed her hands. The RN returned to the medication cart, prepared the EX Order 26 § 4b1 aided by the Consultant Pharmacist, then returned to the bedside to administer the medication. The RN used an alcohol swab to disinfect the site, then proceed to administer the EX Order 26 § 4b1 without donning (putting on) gloves. The surveyor observed that some of the medication was dripping from the site, the RN wiped the site, disposed of the used alcohol pad in the receptacle bin at the bedside and washed her hands for 12.31 seconds. An interview with the RN regarding the observed practice stated that she should have donned gloves prior to administer the EX Order 26 § 4b1 for infection control practices. She went on to state that she had received in-services and education on infection control. A review of the RN's file confirmed receipt of in-services and education on Insulin administration. The facility was made aware of the observed practices on 2/15/2022. On 2/16/2022 at 9:41 AM, the Director of Nursing (DON) provided a policy titled, " Handwashing/ Hand Hygiene, dated 01/05/2021. The following were noted: Policy Statement The facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and implementation	F 880	Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https : //www . train . org/cdctrain/course/1081803 / Provide the training to : ToE>line staff and infection preventionist Nursing Home Infection Preventionist Training Course Module IIB - Environmental Cleaning and Disinfection https : //www . train . org/main/course/1081815/ Provide the training to : All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https : //www . train . org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Tralning Course Module 6A - Principles of Standard Precautions https , //www . train . org/main/course/1081804 / Provide the training to : All staff includIng topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https : //www . train . org/main/course/1081805/	

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F 880	Continued From page 93 All personnel should be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Including in the policy was for staff to " Rub hands together using full friction for twenty seconds (20 sec) (Not under running water) singing happy birthday. A review of the RN's files confirmed that she received in- services education on infections control. On 2/14/22 at 8:58 AM, the surveyor observed a staff member walking down a resident hall and back again past the surveyor. The surveyor observed the staff member was wearing a black cloth mask under an N95 fitted mask. During an interview at that time, the staff member was identified as a CNA. The CNA stated she had worked at the facility for 3 years, had been educated on PPE, and had been fit tested for the N95 mask. Donning (applying) and doffing (removing) personal protective equipment (PPE) and washing hands. The CNA further stated she wore the cloth mask under the N95 mask because it was easier to breath that way. The CNA stated she knew she should not have worn	F 880	Provide the traIning to: All staff includIng topllne staff and infection preventionist Nursing Home Infection Preventionist TraIning Course Module IIA - Reprocessing Reusable Resident Care EquIpment https : //www . train . org/main/course/1081814 / Provide the training to: Topllne staff and infectIon preventionist only Further optional training is available in the Nursing Home Infection Preventionist Training Course located at https : //www . train . org/cdctrain/trainingJ>lan/ 3814 Root cause analysis completed. WHY The Director of Nursing interviewed the License Practical Nurse (LPN) cited in the deficient practice. The License Practical Nurse explained that, she informed the surveyor that the resident is alert and oriented and that the resident takes the oxygen on and off, when the LPN went in the room to administered the resident□s medications the resident had the oxygen on. The LPN did not check the date on the oxygen tubing since its change and dated by the 11-7 shift on Sunday night, and is aware that if the oxygen tubing need changing she can change it, and knows that she must date the oxygen tubing. The LPN went to get a new set of Oxygen tubing	

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F 880	Continued From page 94 the masks like that but was not sure why. On 2/14/22 at 9:44 AM, the DON stated if a staff member wore two masks, there should not be any mask under a fitted N95 because that would cause the N95 to not be properly fitted at that point. A review of the facility provided in-service topic Mask N-95 to be worn at all times, staff must properly wear N-95, dated 1/18/22, revealed that the CNA had attended the educational in-service. A review of the facility provided in-service topic to wear PPE put on and take off, dated 2/1/22, revealed that the CNA had attended the educational in-service. A review of the CDC N95 PPE, Respirators (https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html) included the following: A respirator is a personal protective device that is worn on the face or head and covers at least the nose and mouth. A respirator is used to reduce the wearer ' s risk of inhaling hazardous airborne particles (including infectious agents), gases or vapors. Respirators, including those intended for use in healthcare settings, are certified by the CDC/NIOSH. N95 respirators reduce the wearer ' s exposure to airborne particles, from small particle aerosols to large droplets. N95 respirators are tight-fitting respirators that filter out at least 95% of particles in the air, including large and small particles. Not everyone is able to wear a respirator due to medical conditions that may be made worse	F 880	and the bag in which the tubing is placed when not in use, by the time the LPN got back the surveyor was talking to the Assistant Director of Nursing (ADON). The Director of Nursing interviewed the Registered Nurse (RN) cited in the deficient practice. The RN informed the Director of Nursing that according to her timing, (which was her singing the happy birthday song) she thought she was in compliance. She knows that she is supposed to have actual friction for 20 seconds. She informed the surveyor that she has been in-serviced on infection control practices; including proper hand washing, and donning or gloved prior to administering injection. The RN said she got nervous by the surveyor. The Director of Nursing (DON) interviewed the Certified Nursing Assistant (CNA) cited in the deficient practice. The CNA told the DON that she knows that she is not allowed to wear the cloth mask, or put the N95 respirator over the cloth mask. According to the CNA involved, she was walking off the unit to go on her break, so she removed the N95 respirator and put on her cloth mask, when she saw the surveyor she quickly put her N95 mask over the cloth mask. She acknowledged that she was wrong for putting the N95 respirator over the cloth mask, she said she did so not to get in trouble.	

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when breathing through a respirator. Before using a respirator or getting fit-tested, workers must have a medical evaluation to make sure that they are able to wear a respirator safely.

Achieving an adequate seal to the face is essential. United States regulations require that workers undergo an annual fit test and conduct a user seal check each time the respirator is used. Workers must pass a fit test to confirm a proper seal before using a respirator in the workplace.

When properly fitted and worn, minimal leakage occurs around edges of the respirator when the user inhales. This means almost all of the air is directed through the filter media.

Unlike NIOSH-approved N95s, facemasks are loose-fitting and provide only barrier protection against droplets, including large respiratory particles. No fit testing or seal check is necessary with facemasks. Most facemasks do not effectively filter small particles from the air and do not prevent leakage around the edge of the mask when the user inhales.

The role of facemasks is for patient source control, to prevent contamination of the surrounding area when a person coughs or sneezes. Patients with confirmed or suspected COVID-19 should wear a facemask until they are isolated in a hospital or at home. The patient does not need to wear a facemask while isolated.

NJAC 8:39-19.4(a)(1-2), (b), (k), (n)

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to 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 for 13 of 14 day shifts, 2 of 14 evening shifts, and 4 of 14 overnight shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 No Residents were affected by this deficient practice All Residents have the potential to be affected by this deficient practice DON/Designee to in-service Staffing Coordinator on appropriate staffing levels. DON/Designee to conduct a weekly audit once a week for four weeks, and then	4/11/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/16/22

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/23/22 and 1/30/22, the staffing to resident ratios that did not meet the minimum requirements as documented below: - 01/23/22 had 10 CNAs for 112 residents on the day shift, required 14 CNAs. - 01/23/22 had 7 total staff for 112 residents on the overnight shift, required 8 total staff. - 01/24/22 had 11 CNAs for 112 residents on the day shift, required 14 CNAs. - 01/25/22 had 11 CNAs for 112 residents on the day shift, required 14 CNAs. - 01/26/22 had 11 CNAs for 111 residents on the day shift, required 14 CNAs. - 01/27/22 had 13 CNAs for 019 residents on	S 560	once a month for two months thereafter to determine effectiveness of staffing levels. Facility has an active contract with a recruiter and staffing agencies to recruit staff. Facility is conducting a Certified Nursing Assistant program. All findings will be reported in the QA/PI meeting monthly.	

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S 560	Continued From page 2	S 560		

the day shift, required 14 CNAs.
- 01/29/22 had 9 CNAs for 108 residents on the day shift, required 14 CNAs.
- 01/29/22 had 10 total staff for 108 residents on the evening shift, required 11 total staff.
- 01/30/22 had 9 CNAs for 108 residents on the day shift, required 14 CNAs.
- 01/30/22 had 10 total staff for 108 residents on the evening shift, required 11 total staff.
- 01/30/22 had 7 total staff for 108 residents on the overnight shift, required 8 total staff.
- 01/31/22 had 9 CNAs for 108 residents on the day shift, required 14 CNAs.
- 01/31/22 had 7 total staff for 108 residents on the overnight shift, required 8 total staff.
- 02/01/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs.
- 02/01/22 had 7 total staff for 110 residents on the overnight shift, required 8 total staff.
- 02/02/22 had 13 CNAs for 109 residents on the day shift, required 14 CNAs.
- 02/03/22 had 11 CNAs for 109 residents on the day shift, required 14 CNAs.
- 02/04/22 had 11 CNAs for 109 residents on the day shift, required 14 CNAs.
- 02/05/22 had 11 CNAs for 109 residents on the day shift, required 14 CNAs

On 2/16/22 at 12:26 PM, The Licensed Practical Nurse (LPN) stated she did not give a medication to a resident but signed that she did. The LPN stated that she did not have time to call the doctor and that she had 30 residents so she just did not have time to document.

NJAC 8:39-5.1(a)

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
315331 Y1	A. Building B. Wing Y2	6/9/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	77 EAST 43RD STREET PATERSON, NJ 07514

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0636	Correction	ID Prefix F0638	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(c)	Completed
LSC	04/11/2022	LSC	04/11/2022	LSC	04/11/2022
ID Prefix F0658	Correction	ID Prefix F0677	Correction	ID Prefix F0684	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25	Completed
LSC	04/11/2022	LSC	04/11/2022	LSC	04/11/2022
ID Prefix F0695	Correction	ID Prefix F0710	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.30(a)(1)(2)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	04/11/2022	LSC	04/11/2022	LSC	04/11/2022
ID Prefix F0758	Correction	ID Prefix F0761	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/11/2022	LSC	04/11/2022	LSC	06/03/2022
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	
2/23/2022	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
706000		6/9/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	77 EAST 43RD STREET PATERSON, NJ 07514

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 04/11/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/23/2022	☐ 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
	315331	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	**77 EAST 43RD STREET** **PATERSON, NJ 07514**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 02/24/22 and 02/25/22 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This facility is a 4-story building that was built in 90's, It is composed of Type I Fire Resistant construction. The facility is divided into 11- smoke zones. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 180 certified beds. At the time of the survey the census was 106.	K 000		

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

Electronically Signed | 03/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	**77 EAST 43RD STREET** **PATERSON, NJ 07514**

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K 000	Continued From page 1 * Currently the facility does not have a Maintenance Director and the Documents and Life Safety Code building tour was conducted by the Regional Plant Operations Director.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/25/22, it was determined that the facility failed to provide an operational battery backup emergency light above the emergency generator's transfer switches, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 1 of 1 transfer switches and was evidenced by the following: At 10:04 AM, the surveyor and Regional Plant Operations Director, observed in the floor 1 generator transfer switch room, that no emergency lighting was provided. This finding was verified by the Regional Plant Operations Director, at the time of the observation's. The Administrator was notified of the above findings at the Life Safety Code exit conference	K 291	K291 All residents have the potential to be affected by this deficient practice No Residents were affected by this deficient practice Immediately upon notification, Regional Director of Maintenance/Designee conducted facility-wide regarding ensuring that the facility has an operational backup battery emergency light above the emergency generator transfer switches. Vendor installed an operational backup battery emergency light above the emergency generator transfer switches. Regional Director of Maintenance/Designee will conduct an audit once a week for four weeks, then once a month thereafter to test and ensure that the operational backup	4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	**77 EAST 43RD STREET** **PATERSON, NJ 07514**

(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 291	Continued From page 2 on 02/25/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	battery emergency light above the emergency generator transfer switches is working properly. Negative finding will be corrected immediately and reported at the monthly QA/PI meeting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on surveyor's observation and interview on 02/25/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents and was evidenced by the findings noted below: At approximately 12:00 PM, the surveyor observed along with the Regional Plant Operations Director, that the fire alarm annunciator panel indicated "trouble in system". The amber trouble light was activated in 3 of 3 panels observed. The annunciator panel identified as MS-5012 Fire Control/Communicator indicated A-2. The remote annunciator panel indicated at 22:58:02 MW127	K 345	K345 All residents have the potential to be affected by this deficient practice No Residents were affected by this deficient practice Immediately upon notification, Regional Director of Maintenance/Designee made surveyor aware that the Facility was in contact with a third party vendor to address fire alarm system. Facility has signed a contract with third party vendor to replace fire alarm system. Anticipated completion date for repairs is June 27, 2022. Regional Director of Maintenance/Designee conducted facility-wide education regarding ensuring	5/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 3 Superv. open 0309, 3rd floor smoke sensor-elevator lobby. An interview was conducted with the Plant Operations Director where he stated and confirmed that the fire alarm panel was in trouble mode on both 02/24/22 and 02/25/22 during the Life Safety Code building tour. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70,National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. The Regional Plant Operations Director stated that the facility fire alarm vendor was scheduled to respond ASAP. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 02/25/22. NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345	that the facility has an operational fire alarm system. Regional Director of Maintenance/Designee will conduct an audit once a week for four weeks, and monitoring within state regulation thereafter to ensure that annunciator panel is showing a normal fire alarm system. Negative findings will be corrected immediately and reported at the monthly QA/PI meeting.	
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	K 353		4/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 4 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 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain the sprinkler system to ensure that provided documentation, that the fire pump was run under emergency power on an annual basis in accordance with NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12 and 9.7.5 and NFPA 25, 2011 Edition, Section 5.1, 5.2.1.1, NFPA 25, 2011 Edition, Section 8.3, 8.3.1, 8.3.1.1, 8.3.1.2, 8.3.2.1, 8.3.2.3, 8.3.2.8, 8.3.3 and 8.3.3.4. This deficient practice was evidenced by the following. Based on interview and record review on 02/25/22, at approximately 2:15 PM the facility failed to provide any documentation that the electric fire pump, had been run under emergency power or testing of the automatic transfer switch. The findings were verified by the Regional Plant Operations Director at the time of the observation. The Administrator was informed of the findings at the Life Safety Code Exit conference on	K 353	All residents have the potential to be affected by this deficient practice No Residents were affected by this deficient practice Immediately upon notification, Regional Director of Maintenance/Designee contracted with third party vendor who conducted a test standpipe system. Regional Director of Maintenance/Designee conducted facility wide in-servicing regarding ensuring annual testing of the standpipe system. Regional Director of Maintenance/Designee will conduct monthly audit to ensure that the inspection tag dates reflect compliance with annual test expectation . Negative findings will be corrected immediately and reported at the monthly QA/PI meeting. All residents have the potential to be affected by this deficient practice	

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K 353	Continued From page 5 02/25/22. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	No Residents were affected by this deficient practice Immediately upon notification, Regional Director of Maintenance/Designee contacted a third party vendor who conducted a test to the electric fire pump to been run under emergency power and testing of the automatic transfer switch. Regional Director of Maintenance/Designee conducted facility wide in-servicing regarding testing and documentation of the electric fire pump to been run under emergency power and testing of the automatic transfer switch Regional Director of Maintenance/Designee will conduct a weekly audit once per week for four weeks, monitor per state regulation thereafter to ensure that the fire pump is in working order in conjunction with the emergency generator. Negative findings will be corrected immediately and reported at the monthly QA/PI meeting.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		4/11/22

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 521	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 02/25/22, in the presence of the Regional Plant Operations Director, it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. This deficient practice was identified for 9 of 9 PTAC units observed and was evidenced by the following: While touring the facility on 02/25/22 from approximately 09:00 AM, to 01:30 PM, the surveyor observed dirty PTAC units 3 on each floor with clogged and dirty filters (including missing filter's) in the corridors identified as South, North and East wings, of floors #4, #3 and #2. When interviewed at the time of the observations, the Plant Operations Director agreed that 9 of 9 PTAC unit's had clogged and dirty filters (including missing filters) in the above areas of the facility. No policy and procedure on the maintenance of PTAC units were provided. A PTAC filter cleaning log was provided by the Housekeeping Director and it indicated that the Air Conditioner filters were cleaned monthly: dated: 02/02/22 and 01/03/22, but did not indicate that PTAC units were cleaned on the current log. The Administrator was notified of the deficiency at the Life Safety Code exit conference on	K 521	1. All residents have the potential to be affected by this deficient practice 2. No Residents were affected by this deficient practice 3. Immediately upon notification, Regional Director of Maintenance/Designee conducted a facility-wide audit to remove any clogged and dirty filters from the PTAC Units and replaced all PTAC Unit systems with new filters. Regional Director of Maintenance/Designee conducted facility wide education regarding ensuring that the facility is equipped with clean filters for all PTAC Units. 4. Regional Director of Maintenance/Designee will conduct a weekly audit once a week for four weeks,to ensure that all PTAC Units are equipped with clean filters. Regional Director of Maintenance/ Designee will check once per month, on a monthly basis, moving forward. Negative finding will be corrected immediately and reported at the monthly QA/PI 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 521	Continued From page 7 02/25/22. N.J.A.C. 8:39 - 31.2(e) 19.5.2.1 Heating, Ventilating, and Air-Conditioning.	K 521		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on interview on 02/25/22, the facility failed to ensure that elevators were inspected and tested monthly in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3, 9.4.6, 9.4.6.2 and ASME A17-1 Safety Code for Elevators and Escalators 2004 Edition Section 8.11.1.3 and Table N.	K 531	K531 All residents have the potential to be affected by this deficient practice No Residents were affected by this deficient practice Immediately upon notification, Regional	4/11/22

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 531	Continued From page 8 This deficient practice was identified for 2 of 2 elevators and evidenced by the following: At 11:18 AM, the surveyor interviewed the Plant Operations Director Director, at the start of the building tour who stated, he currently did not have a record that Firefighter's Monthly Service test was performed and documented for 12 of 12 tests. An interview was conducted with the Plant Operations Director Director, during the record review where he stated that the facility did not perform a Fighterfighter Monthly Service test. The Administrator was informed of this finding at the Life Safety Code exit conference on 02/25/22. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	Director of Maintenance/Designee conducted a monthly Phase 1 key recall and smoke detector automatic recall and Phase 2 firefighters service emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors. Regional Director of Maintenance/Designee conducted facility wide in-servicing regarding Phase 1 and Phase 2 testing and documentation of the elevator recall system. Regional Director is trained to completed phase 1 and phase 2 recall Regional Director of Maintenance/Designee will conduct an audit once a week for four weeks, audit Phase 1 and Phase 2 testing thereafter. Negative findings will be corrected immediately and reviewed monthly in Facility QA/PI meeting.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		4/11/22

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COMPLETE CARE AT FAIR LAWN EDGE	**77 EAST 43RD STREET** **PATERSON, NJ 07514**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 9 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 interview and review of facility documents on 02/25/22, in the presence of the Regional Plant Operations Director, it was determined that A.The facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. B. The facility did not ensure a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. A. This deficient practice was evidenced for 1 of 1 generator logs provided by the Regional Plant Operations Director by the following:	K 918	All residents have the potential to be affected by this deficient practice No Residents were affected by this deficient practice Immediately upon notification, Regional Director of Maintenance/Designee conducted facility-wide regarding ensuring that the facility has an operational backup battery emergency light above the emergency generator transfer switches. Vendor installed an operational backup battery emergency light above the emergency generator transfer switches.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. BUILDING **01** B. WING _____	**02/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	**77 EAST 43RD STREET** **PATERSON, NJ 07514**

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K 918	Continued From page 10 A review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds, when the load test was conducted on the following dates: 01/28/22, 12/29/21, 11/26/21, 10/26/21, 10/15/21, 09/18/21, 08/20/21, 07/16/21, 06/18/21, 05/21/21, 04/16/21 and 02/19/21. An interview was conducted with the Regional Plant Operations Director at the time of the record review, who confirmed there was no transfer time data on 12 of 12 monthly load tests documented on the facilities report's. B. On 02/17/22, the Surveyor and Maintenance Director observed that the facility generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the Regional Plant Operations Director, where he stated that he was unsure if the exterior encased generator had a remote manual stop station. The area was observed not to have a remote manual stop station. The Administrator was informed of the finding's at the Life Safety Code exit conference on 02/25/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918	Regional Director of Maintenance/Designee will conduct an audit once a week for four weeks, then once a month thereafter to test and ensure that the operational backup battery emergency light above the emergency generator transfer switches is working properly. Negative finding will be corrected immediately and reported at the monthly QA/PI meeting.	

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
315331 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/18/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT FAIR LAWN EDGE	77 EAST 43RD STREET PATERSON, NJ 07514

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	04/12/2022	LSC K0345	05/17/2022	LSC K0353	04/11/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	04/11/2022	LSC K0531	04/11/2022	LSC K0918	04/11/2022
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?
2/23/2022	☐ YES ☐ NO