STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING _____ B. WING _____	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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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		
F 000	INITIAL COMMENTS Standard Survey: 1/27/23 Census: 66 Sample Size: 18 + 3 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the Minimum Data Set, (an assessment of all residents for Medicare and Medicaid) (MDS) for 2 of 18 residents reviewed for accurate MDS completion, Resident #43 and Resident #21. The MDS is a federally mandated process for the clinical assessment of all residents to facilitate the management of care. This deficient practice was evidenced by the following: 1. On 1/20/23 at 10:56 AM, the surveyor in the	F 641	1. The Minimum Data Set (MDS) of Resident #43 has been corrected to reflect Spanish with an Assessment Reference Date (ARD) 12/08/2022. MDS with ARD 06/14/2022 and 09/14/2022 were reviewed and accurately coded. All Residents have the potential to be affected. Point Click Care (PCC) software will disable the auto pop feature and the Social Service Director was in-serviced by MDS coordinator on reviewing "Section	2/27/23

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

Electronically Signed | 02/17/2023

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F 641	Continued From page 1 presence of the Director of Nursing (DON), observed Resident #43 in their room, awake and alert, seated in their wheelchair. The surveyor introduced self to the resident who responded in Spanish. The DON stated that the resident speaks and understands only Spanish. The surveyor reviewed Resident #43's hybrid medical record: The Admission Record (an admission summary) revealed that Resident #43 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted], Unspecified. It further indicated that the resident's primary language was English. The quarterly MDS (QMDS), with an Assessment Reference Date (ARD) of 12/8/22, reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident had a *Ex Order 26. 4B1* [redacted]. The QMDS assessment further reflected under "Section A1100, Language" did not need or wanted an interpreter to communicate with a doctor or healthcare staff. In fact, it did not indicate the resident's preferred language. A review of Resident #43's Care Plan (CP) revealed the following: "Resident is ESL (English as a Second Language)- Spanish Speaking". "The resident has a communication problem r/t Language barrier-speaks primarily Spanish". On 1/23/23 at 1:35 PM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN	F 641	A1100" before signing off. MDS Coordinator compiled a list of residents who did not need or wanted an interpreter to communicate with a doctor or healthcare staff. MDS Coordinator reviewed the MDS assessment of these identified residents for accuracy. DON/Designee will conduct an audit of all residents who did not need or wanted an interpreter to communicate with a doctor or healthcare staff to ensure accuracy of MDS assessment for compliance 4 times per week for 4 weeks, then two times per week for 4 weeks, then weekly for 4 months as long as compliance is maintained. Any negative findings will be corrected immediately by the MDS Coordinator. Administrator and Director of Nursing will review findings for patterns and trends. Summary of audits will be presented to QAPI committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data. 2.The MDS of Resident #21 was corrected 12/13/22. MDS with ARD 11/07/2022 and 10/22/2022 were also reviewed and were accurately coded. All Residents have the potential to be affected. MDS Coordinator compiled a list of all residents who receive [redacted] medications.	

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F 641	Continued From page 2 stated that Resident #43 spoke and understood Spanish and that "a translator was needed" for the resident 'to address and communicate their needs". 2. On 1/20/23 at 11:04 AM, the surveyor observed Resident #21 in a left side-lying position in bed with their eyes closed in their room. The surveyor reviewed Resident #21's hybrid medical record: The Admission Record revealed that Resident #21 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. The QMDS with an ARD of 11/7/22, reflected that Resident #21's BIMS was not completed due to *Ex Order 26. 4B1*. It further indicated under "Section N," (the section used to indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days) that the resident did not receive any Ex Order 26. 4B1. Review of the November 2022 electronic Medication Administration Record (eMAR) revealed the following medication order, '*Ex Order 26. 4B1* mg Give Ex.Order 26.4(b)(1) [redacted]" with a start date of 10/13/22 and a discontinued date of 12/14/22. The November 2022 eMAR further revealed that the resident received the Ex Order 26. 4B1 on November	F 641	This list was utilized by MDS Coordinator to conduct a review of the MDS assessments of these residents to ensure that section N in MDS assessment was coded accurately. Administrator/DON conducted an in-service on the MDS Coordinator to ensure accuracy of MDS coding. DON/Designee will conduct an audit of MDS assessments on all residents who receive Ex Order 26. 4B1 to ensure that section N is coded accurately. This audit will be conducted 4 times per week for 4 weeks, then two times per week for 4 weeks, then weekly for 4 months as long as compliance is maintained. Any negative findings will be corrected immediately by the MDS Coordinator. Administrator and Director of Nursing will analyze audits for patterns and trends, then summary of audits will be presented to Quality Assurance and Performance Improvement (QAPI) committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	

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F 641	Continued From page 3 1, 2, 3, 4, 5, 6, and 7 for a total of 7 days. On 1/26/22 at 1:50 PM the surveyor interviewed the MDS Coordinator in the presence of 3 surveyors. The MDS Coordinator explained how she completes Section A1100 and Section N in the MDS by stating that Section A1100, "It's auto-populated and it is filled by admissions." She continued to explain that she reviews the residents' eMAR for the 7-day look-back period and records the number of days a resident received medications such as *Ex Order 26. 4B1* , *Ex Order 26. 4B1* , and *Ex Order 26. 4B1* in Section N. She indicated that *Ex Order 26. 4B1* is classified as an *Ex Order 26. 4B1* . The surveyor and the MDS Coordinator reviewed Resident #43's CP and their QMDS with an ARD of 12/8/22. She acknowledged that Section A1100, Language was coded incorrectly. She stated that Resident #43's preferred language was Spanish. The MDS Coordinator established that Resident #43 needed and wanted to communicate with a doctor or health care staff member in Spanish. The surveyor and the MDS Coordinator reviewed Resident #21's November 2022 eMAR and QMDS with an ARD date of 11/7/22. The MDS Coordinator acknowledged that the resident received *Ex Order 26. 4B1* for 7 days and that she did not code the *Ex Order 26. 4B1* as being administered to Resident #43 for the time periods reviewed. The MDS Coordinator acknowledged that it was her responsibility to make sure that all residents' MDSs are completed correctly.	F 641		

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F 641	Continued From page 4 On 1/27/22 at 1:16 PM, the team met with the Licensed Nursing Home Administrator, DON, Regional Board of Director, and Executive Director. The surveyor discussed the above concern. No further information was provided.	F 641		
F 658 SS=D	NJAC 8:39-11.1 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately follow physician's orders (POs), obtain a PO for a Ex.Order 26.4(b)(1) by a resident and obtain Ex.Order 26.4(b)(1) in accordance with the PO. This deficient practice was identified for 2 of 18 residents reviewed for POs, Resident #48 and Resident #8. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching,	F 658	1. Resident's Ex Order 26. 4B1 (Ex.Orde) was immediately taken by the Licensed Practical Nurse (LPN2) and the Ex Order 26. 4 [redacted] medication was administered to Resident #48. On 1/27/23, Director of Nursing (DON)/Designee immediately in-serviced LPN2 on obtaining Ex Order 26. 4B1 (Ex.Orde) and Ex Order 26. 4B1 (Ex.Orde) immediately before providing Ex Order 26. 4B1 medication administration as per instructions on Physician's order (PO). All Residents with Ex Order 26. 4B1 have the potential to be affected. The DON/Designee compiled a list of all residents receiving Ex Order 26. 4B1 with parameters as per PO. This list was utilized by the DON/Designee to conduct	2/27/23

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F 658	Continued From page 5 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens 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." 1. On 1/27/23 at 9:49 AM, the surveyor observed medication administration (medpass) preparation for Resident #48 by the [redacted] floor Licensed Practical Nurse (LPN2). LPN2 informed the surveyor that she had evaluated Resident #48's [redacted] in the morning at 8:15 AM. LPN2 recorded Resident #48's *Ex Order 26. 4B1* ([redacted]) as [redacted] and *Ex Order 26. 4B1* [redacted]) as [redacted]. LPN2 indicated that Resident #48 had a PO for *Ex Order 26. 4B1* [redacted] 1 tablet two times daily for *Ex Order 26. 4B1* hold for *Ex Order 26. 4B1* [redacted] (Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1). LPN2 verified that since the vitals taken at 8:15 AM were [redacted] and [redacted] that she would administer the *Ex Order 26. 4B1*. On 1/27/23 at 9:57 AM prior to LPN2 administering medication to Resident #48, the surveyor asked if she could recheck the residents	F 658	a medication pass observations on the identified residents to ensure that [redacted] prior to medication administration. The DON/Designee immediately conducted an in-service on all licensed nurses concentrating on the importance of obtaining Ex.Order 26.4(b)(1) [redacted] to medication administration. In-service attendance records are kept for validation. The DON/Designee will conduct an audit of 2 Residents on *Ex Order 26. 4B1* per day to ensure accuracy of instructions and to add additional instructions to [redacted] before medication administration for 4 weeks, then 5 residents weekly for 4 weeks, then 5 residents monthly for 4 months . Director of Nursing will monitor results of these audits on a weekly basis and submit results to the Administrator on a Monthly basis. Administrator and Director of Nursing will analyze audits for patterns and trends, then summary of audits will be presented to the QAPI committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data. 2. The DON/Designee received and entered the Physician Order (PO) and updated Care Plan (CP) on 1/27/23 for *Ex Order 26. 4B1* [redacted] to be placed	

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F 658	Continued From page 6 Ex.Orde and Ex.Orde. LPN2 rechecked Resident #48's Ex.Order 26.4(b)(1) with a new value of Ex.Order 26.4(b)(1). LPN2 proceeded to administer the *Ex Order 26. 4B1* to Resident #48. When the medpass for Resident #48 was completed, the surveyor interviewed LPN2. LPN2 was not aware that when there is a PO that includes a Ex.Order 26.4(b)(1) parameter, it is considered part of the PO. When the *Ex Order 26. 4B1* is associated with a medication that controls Ex.Order 26.4(b)(1) should be taken immediately prior to administering the medication. LPN2 stated, "That makes sense." Review of Resident #48's Facility Information Sheet indicated that they were admitted to the facility on *Ex Order 26. 4B1* with diagnoses included but not limited to *Ex Order 26. 4B1* . A review of Resident #48's Admission Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 11/10/2022, identified that Resident #48 had a Brief Interview for Mental Status (BIMS) of Ex Orde out of 15, indicating that the resident was *Ex Order 26. 4B1* . Review of the January 2023 Electronic Medical Administration Record (eMAR) indicated that *Ex Order 26. 4B1* with directions of 1 tablet two times a day for *Ex Order 26. 4B1* was initially ordered on 11/10/22. The PO included and was documented on the eMAR, Hold for Ex.Order 26 On 1/24/23 at 2:00 PM, the surveyor discussed	F 658	for Ex.Order 26.4(b)(1) for Resident #8. Task was updated for Certified Nurse's Assistant (CNA) to place *Ex Order 26. 4B1* in the Morning and Ex.Order 26.4(b)(1). All Residents receiving Ex.Order 26.4(b)(1) have the potential to be affected. The DON/Designee compiled a list of all residents receiving *Ex Order 26. 4B1* . This list was utilized by the DON/designee to ensure that all POs are obtained, CP in place and CNA Task documents instruction on placement and removal of *Ex Order 26. 4B1* . DON/Designee conducted an in-service to all licensed nurses on the facility policy on *Ex Order 26. 4B1* concentrating on the importance of obtaining POs, following CP and appropriately documenting use of *Ex Order 26. 4B1* as per PO. Copy of in-service attendance records are kept by facility for validation. The DON/Designee will conduct an audit of 2 Residents on *Ex Order 26. 4B1* per day to ensure accuracy of instructions for 4 weeks, then 2 residents weekly for 4 weeks, then 2 residents monthly for 4 months . Director of Nursing will monitor results of these audits on a weekly basis and submit results to the Administrator on a Monthly basis. Administrator and Director of Nursing will	

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F 658	Continued From page 7 the issue regarding parameter monitoring when part of a PO with the Director of Nursing (DON) and the Licensed Nursing Home Administrator. The DON acknowledged that when there is a PO for parameters associated with an *Ex Order 26. 4B1* medication, the Ex.Order 26.4(b)(1) should be taken immediately prior to administration of the medication. The DON could not explain why LPN2 did not do this. No further information was provided. 2. On 1/23/23 at 1:07 PM, Resident #8 was observed seated in a wheelchair. The surveyor interviewed the resident. The surveyor also observed that the resident was wearing a *Ex Order 26. 4B1* to the Ex Order 26. 4B1. The surveyor reviewed Resident #8's electronic medical record (eMR). Resident #8 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included but were not limited to *Ex Order 26. 4B1* . A review of the Quarterly MDS, an assessment tool used to facilitate the management of care, dated 11/10/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex.O out of 15, indicating that the resident had a *Ex Order 26. 4B1* . Further review of the Resident #8's medical records did not include any Care Plan or physician's order (PO) for the *Ex Order 26. 4B1* . On 1/27/23 at 9:27 AM, the surveyor interviewed the Certified Nurse's Assistant (CNA), who cared for Resident #8. The CNA explained that she puts on the *Ex Order 26. 4B1* after rendering	F 658	analyze audits for patterns and trends, then summary of audits will be presented to the QAPI committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data. 3. Resident's #8 Ex.Order 26.4(b)(was immediately obtained and entered into Point Click Care (PCC) on 1/21/23. Resident with subsequent refusals, therefore CP was obtained to reflect *Ex Order 26. 4B1* (Ex.Order) refusals and new interventions. All Residents with current PO for Ex.Order 26. have the potential to be affected. The DON/Designee compiled a list of all residents with POs of Ex.Order 26. This list was utilized by the DON/Designee to ensure that Ex.Order 26.4 are obtained on the identified residents as per PO. The Administrator and DON reviewed the Ex.Order 26.4(b)(s policy and updated the policy to include Ex.Order 26.4(b)(1) for reporting. The DON/Designee conducted an in-service to all Licensed Nurses on the Ex.Order 26.4(b)(1) policy concentrating on importance of obtaining and documentation of Ex.Order 26.4(b) as per PO. Copy of in-service attendance sheets are kept by the facility for validation. The DON/Designee will collect Ex.Order 26.4 from Licensed Nurses before end of shift to ensure compliance and proper documentation.	

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F 658	Continued From page 8 morning care and that the [redacted] is scheduled to be removed before bedtime. The CNA indicated that facility nurses give the instructions for devices used by residents before the start of their shift. The CNA identified that she performs [redacted] checks for all the residents that she cares for in the morning during her shift. The CNA was not able to provide any documented evidence of the resident's [redacted] checks. On 1/27/23 at 10:00 AM, the surveyor interviewed the DON who stated that Resident #8 needed the *Ex Order 26. 4B1* to prevent further *Ex Order 26. 4B1* of the resident's [redacted]. The DON established that for any *Ex Order 26. 4B1*, there must be a PO. The DON verified that there was no PO for Resident #8's *Ex Order 26. 4B1*. The DON could not provide any further information as to why there was no PO, care plan or *Ex Order 26. 4B1* recommendation for Resident #8's *Ex Order 26. 4B1* [redacted]. Further review of Resident #8's eMR revealed an active PO dated 11/18/22 for Ex.Order 26.4(b)(1) [redacted] Daily health monitoring is extremely effective in managing [redacted]. Through daily monitoring of [redacted]s, people can be alerted to Ex.Order 26.4(b)(1) [redacted] when they notice a Ex.Order 26.4(b)(1) of more than Ex.Order 26.4(b)(1) in a 24-hour period. On 1/27/23 at 9:27 AM, the surveyor interviewed the CNA taking care of Resident #8 who stated that the facility staff nurses instruct the CNAs as to which residents needed *Ex Order 26. 4B1* [redacted]).	F 658	The DON/Designee will conduct an audit of 6 Residents on [redacted] per day to ensure accuracy of instructions for 4 weeks, then 4 residents weekly for 4 weeks, then 2 residents monthly for 4 months and refer to the Dietitian any discrepancies or further follow up needed. A CNA will be assigned as the Quality Assurance and Performance Improvement (QAPI) champion to ensure timeliness of obtaining [redacted] A second CNA will be assigned as a co-champion as a backup. Director of Nursing will monitor results of these audits on a weekly basis and submit results to the Administrator on a Monthly basis. Administrator and Director of Nursing will analyze audits for patterns and trends, then summary of audits will be presented to the QAPI committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	

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F 658	Continued From page 9 The CNA further stated that Resident #8 was one of the residents that needed [Ex.Order 26.4] The CNA explained that after [Ex.Order 26.4(b)(1)] the resident, they inform the nurse who then documents in the eMR. On 1/27/23 at 9:30 AM, the surveyor interviewed the LPN assigned to the resident who stated that [Ex.Order 26.] were being documented in the eMR. On 1/27/23 at 9:33 AM, in the presence of the RN Unit Manager, the surveyor reviewed the daily [Ex.Order 26.4(b)(1)] for Resident #8. The surveyor noted that no [Ex.Order 26.4(b)(1)] had been entered daily. The surveyor further observed that the eMAR did not include any documentation for *Ex Order 26. 4B1*. A review of the facility's policy titled, [Ex.Order 26.4(b)(1)] and Measuring the Resident" did not specifically address obtaining *Ex Order 26. 4B1*. On 1/27/23 at 1:30 PM, the surveyor discussed the above concerns with the facility's LNHA and the DON who could not explain why there were no [Ex.Order 26.4(b)(1)] documented for Resident #8. The facility did not provide any further information.	F 658		
F 686 SS=G	NJAC 8:39-11.2 (b); 29.2 (d) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		2/27/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 10 Ex Order 26. 4B1 and does not develop Ex Order 26. 4B1 unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with Ex Order 26. 4B1 receives necessary treatment and services, consistent with professional standards of practice, to Ex.Order 26.4(b)(1) and prevent new Ex Order 26. 4B1 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to a. provide effective Ex.Order 26.4(b)(1) to a known Ex.Order 26.4(b)(1) resident who was admitted to the facility with a Ex Order 26. 4B1 that progressed and developed into an Ex Order 26. 4B1 and, b. accurately monitor and document weekly Ex Order 2 assessments resulting in the development of an Ex Order 26. 4B1 that had a delay in being identified and treated, for a resident who was Ex.Order 26.4(b)(1). This deficient practice resulted in the development, progression delaying the identification and treatment of an Ex Order 26. 4B1. This deficient practice was identified for 1 of 5 resident, Resident #3 reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by the following: On 1/20/23 at 10:25 AM, during the initial tour of the facility, the surveyor observed Resident #3 lying in bed on a regular mattress (Ex.Order 26.4(b)(1)). Resident #3 spoke to the surveyor complaining of Ex.Order 26.4(b)(1) on their Ex Order 26. 4B1 for the past three days. Resident #3 could not articulate their Ex.Order 26.4(b)(1). Resident #3 was able to reveal that the Ex.Order 26. was	F 686	When informed of Resident #3s Ex.Order 26.4(b)(1) on 1/20/23, the Nursing Management team had a Registered Nurse (RN) perform a Ex.Order 26 assessment which resulted in findings of Ex Order 26. 4B1 □. Director Of Nursing (DON) reached out to Physician and Family to discuss interventions and Physician orders (PO) were entered for Ex Order 26. 4B1 to be applied to Ex Order 26. 4B1 covered with Ex Order 26. 4B1 Dressing, Ex.Order 26.4(b)(1) every 2 hours, Ex.Order 26.4(b)(1) and Ex Order 26. 4B1 consult. Ex Order 26. 4B1 as needed order administered with Ex.Order 26.4(b)(1). Care plan and tasks updated accordingly. On 1/23/23 the Nursing management team was informed by Certified Nurse's Aide (CNA) that the resident#3 Ex Order 26. 4B was Ex.Order 26.4(b)(1). The Unit Manager RN assessed area and helped to conduct telehealth visit with Ex Order 26. 4B1 Nurse Practitioner (NP) who confirmed the Resident with Ex Order 26. 4B1 to the Ex Order 26. 4B1 and not a Ex Order 26. 4B1 Recommendations from Ex Order 26. 4B1 NP were discussed with Physician who approved order for Ex Order 2 and Ex Order 26. 4B1 powder to	

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	315416	A. BUILDING _____ B. WING _____	01/27/2023

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F 686	Continued From page 11 at a level to Ex.Order 26.4(b)(1) throughout the night. Resident #3 informed the surveyor that they had informed the nurse staff of the [redacted], but it was not being addressed. The surveyor alerted the Ex Order 26. 4B1 Unit Manager (UM) of the issue. Review of Resident #3's electronic Admission Face Sheet (summary of resident's information) indicated that Resident #3 was admitted to the facility on Ex Order 26. 4B1 with diagnosis that included but were not limited to *Ex Order 26. 4B1* [redacted] The surveyor reviewed the Progress Note (PN) dated 1/20/23 and timed at 12:27 PM, written by RN#1 after she performed a [redacted] assessment on Resident #3. The PN '*Ex Order 26. 4B1* note" established, "Resident Ex.Order 26.4(b)(1) on *Ex Order 26. 4B1*, Ex Order 26. 4B1 given with relief. Ex Order 26. 4B1 noted on Ex Order [redacted] upon assessment, measurement done as follows: *Ex Order 26. 4B1* [redacted], no Ex Order 26. 4B1, one part *Ex Order 26. 4B1* ; other *Ex Order 26. 4B1*. *Ex Order 26. 4B1* Ex.Order 26.4(b)(1) *Ex Order 26. 4B1* [redacted] for protection until Ex.Order 26.4(b)(1) doctor come to assess it. Family member made aware, Ex Order 26. 4B1 consult ordered." Review of PN and Assessments previous to this assessment on 1/20/23 by RN#1 did not provide any proof that an open *Ex Order 26. 4B1* existed with measurements. Review of RN#1 Assessment note dated 1/20/23 and timed at 12:42 PM, titled '[redacted] check-weekly or other" supported with a diagram of the body documenting the affected sights and identified as	F 686	Ex Order 26. 4B1. Additional orders discussed and entered for Ex Order 26. 4B1 Ex.Order 26.4(b)(1) [redacted] to continue. All Residents have the potential to be affected. The Nursing administration team to conduct in-servicing with all Nurses and CNAs in regards to proper documentation and interventions for risk for or actual [redacted] on admission or when identified, CNA reporting of changes in Ex.Order 26.4(b)(1), New Weekly [redacted] assessment schedule and documentation, providing of Ex.Order 26.4(b)(1), family notification of changes and staging of Ex Order 26. 4B1. The Nursing administration team will conduct an audit and will update weekly [redacted] assessment orders to reflect Weekly [redacted] assessment as per [redacted] check schedule. *Ex Order 26. 4B1* assessment will be done for all residents in-house. The Nursing administration team will create a new [redacted] check schedule and tracker. The Nursing management team to follow up daily for 7 days, then Weekly for 7 weeks, then Monthly for 4 months for compliance with weekly [redacted] assessments. Administrator and Director of Nursing will analyze audits for patterns and trends, then summary of audits will be presented	

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F 686	Continued From page 12 "Ex Order 26. 4B1." Further description of the Ex.Order 26.4(b)(included *Ex Order 26. 4B1* Review of the PN documented by RN #2 written on 1/20/23 at 12:54 PM, "Resident verbal Ex.Orde to Ex Order 26. 4B1. Ex Order 26. 4B1 2 tab was given for comfort. Ex Order 26. 4B1 noted on Ex Order 26. 4B1. Measurement taken and was staged as *Ex Order 26. 4B1* no Ex Order 26. 4B1. It was Ex.Order 26.4(b)(1) to it. Nurse supervisor informed." A review of the Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated 12/16/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Ord out of 15, indicating the resident is *Ex Order 26. 4B1* for daily decision making. The surveyor reviewed Section Ex.Order 26.4(b)(1, subsection M0100 of the AMDS, (Determination of *Ex Order 26. 4B1* Risk). The documentation indicated that Resident #3 has "a. Resident has a Ex Order 26. 4B1 or greater *Ex Order 26. 4B1*, a Ex Order 2 over Ex Order 26. , or a non-removable dressing/device." A review of Resident #3's Admission Summary dated 12/11/22 and written by the admission Registered Nurse, indicated "Ex Order 2 intact noted left *Ex Order 26. 4B1*, *Ex Order 26. 4B1*." A review of the resident's electronic Medical Record (eMR) under the assessment section, revealed an assessment titled, "Skilled	F 686	to the Quality Assurance and Performance Improvement (QAPI) committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data	

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Documentation-V2" dated 12/14/22, indicated under Section Ex.Order 26.4(b)(1), that the resident's Ex.Order 26.4(b) for developing Ex Order 26. 4B1 .

Further review of the resident's eMR revealed an assessment titled, Ex.Order 26.4(b)(1) for predicting Ex Order 26. 4B1 " located under the assessment section. Review of the Ex.Order 26.4(b)(1) of developing a Ex Order 26. 4B1 performed during admission on 12/11/22, reflected Ex Ord out of 23, which indicated that Resident #3 was Ex.Order 26.4(b)(1) a Ex Order 26. 4B1 .

Review of Resident #3's December 2022 Electronic Treatment Administration Record (eTAR) revealed a PO started on 12/18/22 for, Ex.Order 26.4(b)(1) ." Review of the December 2022 and January 2023 eTAR indicated that the Ex.Order 26.4(b)(1) was calculated and signed for by the nursing staff on 12/18/22, 12/25/22, 1/1/23, and 1/8/23. Review of the eMR Assessment section presented only one 'Ex.Order 26.4(b)(for Predicting Ex Order 26. 4B1 Risk" calculated on 12/25/22 by a staff RN, with a score of 'Ex Order 26. 4B1 ." No further documentation was initiated or completed for the PO.

A review of Resident #3's Care Plan (CP) with an initiation date of 12/11/22 and target completion date of 12/27/22 did not reveal upon admission or at any time after that a CP was developed that addressed the resident's Ex Order 26. 4B1 , protective and preventative treatments for a Ex Order 26. 4B1 or the need for continued Ex Order 26 assessments.

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F 686	Continued From page 14 A review of the Physician Order (PO) Summary dated 1/24/23, identified an order with an original date of 12/11/22, for "Weekly Ex Order 26 Assessment every Ex.Order 26.4(b)(1) for assessment." Review of the December 2022 eTAR presented the PO that began on 12/18/22 documented as, "Weekly Ex Order 26 Assessment, every Ex.Order 26.4(b)(1) for assessment." Documentation on the December 2022 and January 2023 eTAR recorded that the facility nurses signed performing Ex Order 2 checks on Resident #3 for 12/18/22, 12/25/22, 1/1/23, 1/8/23, 1/15/23 and 1/20/23. Continued review of the two months of documentation in the Assessment and Progress Note (PN) sections of the EMR, revealed that there was no further information related to the facility nursing staff performing Ex Order 2 checks for 12/18/22, 1/1/23, 1/8/23 and 1/15/23. Review of the eMR Assessment section written by a staff RN on 12/25/22 revealed, " Ex Order 26 intact, no pen area noted, *Ex Order 26. 4B1*, Ex.Order 26.4(b)(1) ." No further information or documentation was noted. Review of the December 2022 and January 2023 electronic Medication Administration Record (eMAR) revealed that Ex.Order 26.4(b)(1) for Resident #3 were monitored every 6 hours. Ex.Order 26.4(b)(1) were documented as "0" Ex Order 26. 4B1 on all days for the month of December 2022 and January 2023 except for 4 days with level Ex.Order 26 *Ex Order 26. 4B1* documented in December and 5 days in January 2023. Continued review of the January 2023 eMAR revealed a documented Ex.Order 26.4(b)(1)	F 686		

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Ex Order 26. 4B1 on 1/24/23 at 12:00 PM.

The surveyor reviewed the PO for Ex Order 26. 4B1 (2) tablets every 6 hours as needed for Ex.Order 26.4(b)(1) scale Ex Orde with a start date of 12/11/22, documented on the December 2022 and January 2023 eMAR. Resident #3 was documented as receiving the Ex Order 26. 4B1 (2) tablets on 12/19/22 at 5:46 PM with a Ex.Order Ex Order 26. 4, on 1/18/23 with a Ex.Order 26.4(b)(1) at 6:30 PM, 1/20/23 with a Ex.Order 26.4(b)(1) Ex Order 26. 4B1 at 11:39 AM, and 1/23/23 with a Ex.Orde at 9:07 AM.

On 1/25/23 at 9:46 AM, another surveyor interviewed RN #2 who stated that she has been working in the facility for a year. The surveyor also interviewed the CNA who stated that she had been working in the facility for 7 months. The surveyor viewed the Ex Order 26. 4B1 with the permission of the Resident, and the aid of RN#2 and the CNA in the privacy of the Resident's room.

The surveyor observed RN #2 Ex.Order 26.4(b)(1) on Resident #3's Ex Order 26. 4B1. The surveyor observed the Ex Order 26. 4B1 having a Ex Order 26. 4B1 and Ex.Order 26.4(b)(1) area.

RN #2 informed the surveyor, "there's Ex.Order 26.4(b)(1) in the Ex Order 26. 4B1. RN #2 explained that RN#1 was the nurse who assessed and staged the Ex Order 26. 4B1. RN #2 acknowledged, "Ex Order 26. 4B1 is when there's an Ex Order 26. 4B1 in the area."

Review of Ex Order 26. 4B1 staging practice defines Ex Order 26. 4B1 as, Ex Order 26. 4B1 skin with Ex.Order 26.4(b)(1) that does Ex.Order 26.4(b)(1) when pressed, Ex Order 26. 4B1 of a localized area,

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F 686	Continued From page 16 usually over a Ex Order 26. 4B1 ." Review of Ex.Order 26.4(b)(1) staging practice defines Ex Order 26. 4B1 as, "the Ex Order 2 breaks open, wears away, or forms an Ex Order 26, which is usually Ex.Order 26.4(b)(1) ." On 1/25/23 at 11:15AM, surveyor interviewed the Certified Nursing Assistant (CNA), who routinely takes care of Resident #3 on the day shift (7:00 AM to 3:00 PM). The CNA stated she has not been assigned to Resident #3, in a few weeks. The CNA informed the surveyor that when assisting residents during changing their clothes, bathing and/or use of the bathroom, she would report any Ex Order 2 conditions found to the resident's nurse and/or the Unit Manager. On 1/25/23 at 11:22 AM, the surveyor interviewed the Ripple 1 Registered Nurse (RN #1). RN #1 stated that she was the nurse that performed the Ex Order 2 assessment for Resident #3 on 1/20/23, when the Ex Order 26. 4B1 was discovered. RN#1 explained that she documents information related to the Ex Order 26. 4B1 in the Assessment and PN section of the EMR. The surveyor discussed the four missing weekly PN and assessments as well as the three missing Ex.Order 26.4(b)(1) with RN#1. RN#1 could not explain why the nurses on duty did not enter information evaluating the residents Ex Order 2 assessment in the eMR as well as calculate the Ex.Order 26.4(b)(1) related to the resident's Ex.Order of developing Ex Order 26. 4B1 . RN#1 stated that if the nursing staff signs the eMAR and eTAR documenting that the task was completed, there should be documented proof of the task.	F 686		

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On 1/25/23 at 11:27 AM, the surveyor interviewed Ex.Order 26.4(b)(1) RN#2, who also assessed Resident #3's *Ex Order 26. 4B1* on 1/20/23. RN#2 informed the surveyor that when performing a Ex.Order 26.4(b)(1) the facility protocol includes: writing the [redacted] note in the eMR PN and Assessment section, documenting the appearance of [redacted], information related to informing the physician, and identifying the physician's recommendations.

The surveyor discussed the four missing weekly PN and assessments as well as the three missing Ex.Order 26.4(b)(1), which should have been documented in the eMR, with RN#2. RN#2 could not explain why the nurses on duty did not enter information evaluating the residents [redacted] in the eMR as well as calculate the Ex.Order 26.4(b)(1) related to the resident's [redacted] developing *Ex Order 26. 4B1*. RN#2 acknowledged that all nursing staff documenting in the eMAR and eTAR that the task was completed, should be documented proof of the task.

On 1/26/23 at 11:18 AM, the surveyor interviewed the Director of Nursing (DON). The DON explained that when a resident is admitted to the facility with *Ex Order 26. 4B1* [redacted], the protocols include: "Alerting the physician, possibly providing Ex.Order 26.4(b)(1) [redacted] are added to the resident's plan of care. We also do [redacted] assessments, which are automatically started for new and re-admitted residents. We may also add a Ex.Order 26.4(b)(1) [redacted] and *Ex Order 26. 4B1* [redacted] if needed."

The DON stated that Resident #3 should have had an *Ex Order 26. 4B1* [redacted] (CP) upon

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F 686	Continued From page 18 admission that addressed the Ex Order 26. 4B1 noted during admission. The CP should have included preventative measures to avoid the development of an Ex Order 26. 4B1 . The DON acknowledged that Resident #3 was admitted with a Ex Order 26. 4B1 that had progressed to a Ex Order 26. 4B1 . The DON verified that after review of RN#1 and RN#2's PN and Assessment Notes, once the Ex Order 26. 4B1 was Ex.Order 26.4 it was staged wrong by RN#1 and was no longer a Ex Order 26. 4B1 but rather a Ex Order 26. 4B1 The DON verified that Resident #3 should have had those protocols in place on admission when the Ex Order 26. 4B1 was discovered. The DON established that the weekly Ex.Order 26 assessments should be completed on the eMR under the Assessment area. The DON could not explain why four weekly Ex.Order 2 PN and assessments as well as the three Ex.Order 26.4(b)(1 for Resident #3 were missing and not performed. On 1/23/23 at 2:40 PM, the DON provided the surveyor with a facility policy titled, Ex.Order 26.4(b)(1) Assessment," last reviewed on 11/11/2022. Under the "Purpose" section of the policy it states, "The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents Ex.Order 26.4(b) of developing new Ex.Order 26.4(b)(1) of existing Ex Order 26. 4B1 (Ex.Order)." Continued review of the policy under "General Guidelines" identifies; "1. The purpose of a Ex Order 26. 4B1 injury risk	F 686		

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assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take rime to modify.
3. The risk assessment should be completed as soon as possible after admission, but no later than eight hours after the admission.
4. Use only a facility-approved risk assessment tool to obtain risk assessment data.
5. Supplement the risk assessment tool with assessment of additional risk factors.
6. Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for Ex Order 26. 4B1 .
7. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition."

Documented under "Steps in the Procedure," it explains;
"1. Gather assessment tools and documentation and conduct the assessment in the manner most appropriate to the resident's condition and willingness to participate.
4. Conduct a comprehensive Ex.Order 26 assessment with every risk assessment.
a. When conducting a Ex.Order 26 assessment, provide for the resident's privacy.
b. Once inspection of the Ex.Order 2 is completed document the findings on a facility-approved skin assessment tool.
c. If a new Ex.Order 2 alteration is noted, initiate a Ex Order 26. 4B1 form related to the type of alteration in Ex.Order 26
5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the Ex Order 2, the

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F 686	Continued From page 20 resident's overall clinical condition, and the resident's stated wishes and goals. a. The interventions must be based on current, recognized standards of care." b. The effects of the interventions must be evaluated. c. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Explained under the "Documentation" it states, "The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment(s) conducted. 2. The date and time and type of Ex.Order 26.4(b)(1) provided, if appropriate. 5. The condition of the resident's Ex.Order 26.4(b)(1) [redacted]), if identified. 11. Initiation of a (Ex.Order 26.4(b)(1)) form related to the type of alteration in Ex.Order 26 if Ex.Order 26.4(b)(1) alteration noted." On 1/26/23 at 1:37 PM, the DON provided an additional facility policy titled, Ex.Order 26.4(b)(1) [redacted]-Clinical Protocol," which was last updated on 11/11/22. Under the "Assessment and Recognition" section, it states, "1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing *Ex Order 26. 4B1*; for example, immobility, recent weight loss, and a history of *Ex Order 26. 4B1* 2. In addition, the nurse shall assess and reassess, describe and document/report on PCC (computer program used by the facility) / Paper and upload weekly assessments"	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 On 1/26/23 at 1:35 PM, the surveyor met with the DON to further discuss the issue. No further information was provided.	F 686		
F 761 SS=D	NJAC 8:39-27.1 (a) 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 expired, unidentified bottle and	F 761	On 1/19/23 all carts were immediately checked and no additional expired medications/discontinued [redacted]	2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING _____ B. WING _____	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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F 761	Continued From page 22 discontinued medications were removed from the medication cart in a timely manner. This deficient practice was identified in 2 of 4 medication carts inspected. The deficient practice was evidenced by the following: 1. On 1/18/23 at 1:12 PM, the surveyor inspected Ex.Order 26.4(b)(1) floor unit medication cart 1 in the presence of the Licensed Practical Nurse (LPN). The inspection of Ex Order 26. 4B1 floor unit medication cart 1, presented an unopened bottle of Ex Order 26. 4B1 [redacted] 100 tablets which expired 12/2022 and an unlabeled bottle of liquid that was found on the top drawer. The LPN could not identify the liquid found in the bottle and could not explain why the bottle was there without a label. On 1/18/23 at 2:00 PM, the surveyor discussed the above observations with the Director of Nursing (DON) who stated that the unidentified bottle was the solution used for Ex Order 26. 4B1 testing. The DON could not explain why the liquid was unlabeled and stored in the medication cart. There was no further information provided for any of the other items found in the Ex Order 26. 4B1 floor medication cart. 2. On the same day at 1:39 PM, the surveyor inspected Ex Order 26. 4B1 floor medication cart 1 in the presence of LPN 2. The surveyor found a Ex Order 26. 4B1 mg tablet for Resident #14 locked inside a Ex Order 26. 4B1 box inside the medication cart. The documented delivery from the Provider Pharmacy date was 8/12/22.	F 761	medications were found. LPN and LPN 2 on duty were re-in serviced by DON regarding returning expired or discontinued Ex Order 26. 4B1 packs/ medications to DON/Designee. 1. Unopened bottle of Ex Order 26. 4B1 and unlabeled bottle of liquid was removed from the medication cart immediately. 2. Ex Order 26. 4B1 tablet for Resident #14 was removed from the Ex.Order 26.4(b)(1) inside the medication cart immediately. Resident#14 was referred to MD for medication reconciliation, with no changes necessary. All Residents have the potential to be affected. All Nurses were in- serviced on inspecting their carts at the beginning of their shift and ensuring there are no expired medications, as well as returning Ex.Order 26.4(b)(1) [redacted] to DON/Designee upon discontinuation of order. The DON/designee will audit all 4 Ex Order 26. 4B1 boxes inside the 4 medication carts daily for 7 days, then all 4 Ex Order 26. 4B1 boxes inside the 4 medication carts Weekly for 7 weeks, then all 4 Ex Order 26. 4B1 boxes inside the 4 medication carts Monthly for 4 months for compliance with storage of drugs and Ex Order 26. 4B1 until a 100% threshold is met.	

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F 761	Continued From page 23 A review of Resident #14's active January 2023 Physician's orders (PO) did not include a current PO for Ex Order 26. 4B1 tablet. A review of the PO history revealed that the order for Ex Order 26. 4B1 tablet was discontinued as per the physician on 12/30/22. A review of the facility's policy titled; Ex.Order 26.4(b)(1) " indicated under "#5. Should a Ex.Order 26.4(b)(1) order be discontinued the Nurse must return the medication to the Director of Nursing and/or designee. a. Director of Nursing and/or designee will conduct at least bi-weekly rounds for discontinued medications." On 1/20/23 at 10:30 AM, the Director of Nursing (DON) stated that she has not been able to perform her rounds recently. The DON explained the facility policy indicated that bi-weekly rounds should be established to make sure that the discontinued Ex Order 26. 4B1 are removed from the medication cart Ex Order 26. 4B1 box. On 1/27/23 at 1:30 PM, the surveyor discussed the above observations with the facility's Licensed Nursing Home Administrator and DON who did not provide any further information.	F 761	Administrator and Director of Nursing will analyze audits for patterns and trends, then summary of audits will be presented to the Quality Assurance and Performance Improvement (QAPI) committee Quarterly for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	
F 812 SS=D	NJAC 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		2/27/23

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F 812	Continued From page 24 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined that the facility failed to maintain proper kitchen sanitation practices by not disinfecting a food thermometer prior to taking food temperatures during the lunch service. This deficient practice was evidenced by the following: On 1/23/23 at 11:35 AM, while in the presence of the Food Service Director (FSD), the surveyor observed the chef test the temperature of the roasted potatoes on the steam table without disinfecting the food thermometer prior to use. Upon interview with the chef and FSD, the chef stated that he disinfected the food thermometer two hours ago. When asked how long prior to testing any food items should a food thermometer be disinfected, the chef was unable to answer. The FSD stated that the food thermometer needs to be disinfected just prior to testing any food	F 812	The roasted potatoes were immediately discarded and the thermometer was washed, rinsed, sanitized before and after use. All dietary staff were re-educated on foodborne Illness and Food Handling. All Residents have the potential to be affected. Food Service Director (FSD) to audit Food Handling for 5 days in one week, then 2 days for 4 weeks, then once a week for 4 months. FSD will monitor results of these audits on a weekly basis and submit results to the Administrator on a Monthly basis. Administrator will analyze audits for patterns and trends, then summary of audits will be presented to the Quality Assurance and Performance Improvement (QAPI) committee Quarterly	

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F 812	Continued From page 25 temperatures. On 1/24/23 at 11:00 AM, the FSD provided the surveyor with a policy titled, Preventing Foodborne Illness - Food Handling which was last reviewed on 11/11/22. Under the Policy Interpretation and Implementation, it states: "1. This facility recognizes that the critical factors implicated in foodborne illness are: a. poor personal hygiene of food service employees; b. inadequate cooking and improper holding temperatures; c. contaminated equipment; and d. unsafe food sources 3. All employees who handle, prepare or serve food will be trained in practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practice prior to working with food or serving food to residents. 9. All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations." On 1/25/23 at 10:30 AM, the FSD provided the surveyor with the food thermometer Manufacturer's guidelines for sanitizing, which explained, "Always wash, rinse and sanitize products thoroughly before and after each use." On 1/26/23 at 11:18 AM, the surveyor met with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) to discuss the concerns found during the kitchen inspection. Both the LNHA and DON stated that the chef should have disinfected the thermometer just before checking the temperature of the food. Neither could explain why the chef did not follow	F 812	for two quarters for review and any further recommendations, then quarterly plan will be adjusted based on data.	

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F 812	Continued From page 26 the correct procedure. No other information was provided. NJAC 8:39-17.2(g)	F 812		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315416 Y1	A. Building B. Wing Y2	3/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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 F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	02/27/2023	LSC	02/27/2023	LSC	02/27/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	02/27/2023	LSC	02/27/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
1/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a three- story building Type II (000) construction and is fully sprinklered. The main facility consists of 3 buildings with residents: CPCH, AL, and SNF. 1. Barker 3-story W/full basement 2. Rippel Pavillion 2-story W/partial basement 3. Moorings 2-story W/partial basement There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The 250 KW generator outside the facility (Diesel), is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The generator does approximately 40 % of the main building. 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 77 certified beds. At the time of the survey the census was 66. The requirement at 42 CFR Subpart 483.90(a) is	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2023

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K 000	Continued From page 1 NOT MET as evidenced by:	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the	K 161		3/22/23

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K 161	Continued From page 2 construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 01/24/23, in the presence of the facility's Maintenance Director, and corporate staff, it was determined that the facility failed to provide an acceptable construction type and fire resistance rating of a building's structural elements in accordance with the requirements of NFPA 101, 2012 Edition, Section Table 19.1.6.1, 19.1.6.2 through 19.1.6.7. The deficient practice could affect all residents. At 10:22 AM, the surveyor, Maintenance Director and Corporate staff member, observed in the Barker building that was an exit/egress for the SNF and LTC residents and indicated so on the provided evacuation floor plan as 1 of 2 designated exit's through that section of the building.The Barker building entrance by the receptionist desk was observed to have an open stairway from the entrance up to the 3rd floor. The surveyor had the Maintenance Director remove 3-areas of 2'x'2' drop ceiling tiles in the LTC exit/egress area outside 2-sets of smoke doors, for verification of protection and both observations determined that a large girder was unprotected and not enclosed in fire rated material, to the concrete decking above. The basement area was observed to have a combination of timber joist, steel and concrete. The closet in the conference room in the basement was observed to have a partial concrete enclosed steel beam that was missing	K 161	The facility concurs through Brommer and Associates Architectural firm, that the Barker Building entry/exit into the Skilled Nursing Facility (SNF) of the compound is non-conforming to NFPA 101 2012 standards for Skilled Nursing Home building construction type. The Barker building is licenses and registered as Residential Health Care facility and was constructed as a type (2) (000). The facility is aware that this standard does not meet the NFPA standards for Skilled Nursing Facility. The facility maintains that the SNF facility is fully separated from the Barker Building by the required 2-hour separation on all levels. The Skilled Nursing Facility is a Type 2(222) construction type without breaches or concerns to the buildings structural integrity. The facility Ownership has decided that the entry/exit to the Skilled Nursing Facility will be closed off from the Residential Health Facility and relocated to the East side of the [redacted] building by the solarium (see attached architectural plans with the solarium highlighted). The solariums entry into the skilled nursing side of the building was previously used as an entry/exit and would be made equipped with the necessary equipment to	

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K 161	Continued From page 3 approximately a 6' section of concrete protection. The Maintenance Director removed the ceiling tiles to observe and confirm the construction type and protection. GIRDER: a large iron or steel beam or compound structure used for building framework of large buildings. A girder is a support beam used in construction. The findings were verified by the Maintenance Director and Corporate staff member during the observations. Plans identifying the UL assembly and fire resistance rating for the steel beams were requested but were not provided. It was determined that the construction type indicated Type II (000) Noncombustible with sections of unprotected steel. The Administrator and Corporate staff were informed of the findings at the Life Safety Code exit conference on 01/24/23. No other plans were provided indicating building construction type. NJAC 8:39-31.2(e) NFPA 220, standard on types of construction.	K 161	facilitate all required services to the nursing home. An entire facility audit was conducted by the architect on 2/17/2023 to inspect for similar concerns. There were no other areas of concern noted. When compliance is achieved the facility will perform quarterly inspections to ensure the facility is kept in compliance. All inspection records would be maintained on site. All residents residing in the facility are potentially affected. Quarterly inspections will be conducted by the Maintenance Team/Designee to ensure compliance and provide copy of the audit to the administrator. Results of these audits will be reviewed at the Quality Assurance and Performance Improvement (QAPI) committee for the next 2 quarters.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6	K 311		3/22/23

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K 311	Continued From page 4 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, it was determined that facility failed to protect vertical openings between floors with a one-hour fire rated enclosure. This deficient practice was evidenced for 1 of 1 open stairways by the following: At 10:22 AM, the surveyor, Maintenance Director and Corporate staff member observed that the Barker building TYPE II (000) construction was observed to have an open stairway at the entrance by the receptionist desk. The open stairway went from the [redacted] floor to the [redacted] floor. The open stairway corridor was designated as an exit/egress for the SNF and LTC residents on the evacuation floor plan.The [redacted] floor was observed to have LTC residents on floor #1, that would use the Ex Order 26. 4B1 room and in the event of an evacuation would have to use 1 of 2 exit/egress route's from the Ex Order 26. 4B1 building through the [redacted] building as designated on the emergency evacuation floor plan provided. It was determined that the open stairway between floors was not enclosed with construction having a fire resistance rating of at least 1 hour. In an interview, at the time, the Maintenance Director and Corporate staff confirmed that the [redacted] main entrance exit/egress corridor passed through the open unprotected stairway to the main exit to the public way.	K 311	The facility has procured the services of an architect to ensure that relocating the entry/exit for the Skilled Nursing Facility from the non-conforming building ([redacted] Building) to the Ex Order 26. 4B1 building will be feasible and conforming to the requirements of NFPA 101 2012 Ed. Entry/Exit for the SNF will be rededicated to the previous Ex Order 26. 4B1 Solarium. The open stairway between floors of the 3 story [redacted] Building will no longer be a part of the evacuation route for the SNF. All entry/exits within the SNF will be conformed to NFPA 101 egress pathway requirements. An entire facility audit was done by the architect to ensure that there were no similar concerns, none were noted. The maintenance team was in-serviced by the Administrator to ensure that there is a clear understanding of what appropriates an exit, all exits and exit discharges will be inspected daily. Daily inspections will be conducted by the Maintenance Team/Designee to ensure exit are maintained in full compliance. Results of these audits will be reviewed at the Quality Assurance and Performance	

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K 311	Continued From page 5 The Administrator and Corporate staff were informed of the observation's at the Life Safety Code exit conference on 01/24/23. NJAC 8:39-31.2(e) NFPA 101, Life Safety Code 2012 Edition: 19.3.1 Protection of Vertical Openings. Any vertical opening shall be enclosed or protected in accordance with Section 8.6, unless otherwise modified by 19.3.1.1 through 19.3.1.8. 19.3.1.1 Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. 19.3.1.2 Unprotected vertical openings in accordance with 8.6.9.1 shall be permitted. 8.6.9 Convenience Openings. 8.6.9.1 Where permitted by Chapters 11 through 43, unenclosed vertical openings not concealed within the building construction shall be permitted as follows: (1) Such openings shall connect not more than two adjacent stories (one floor pierced only). (2) Such openings shall be separated from unprotected vertical openings serving other floors by a barrier complying with 8.6.5. (3) Such openings shall be separated from corridors. (6)*Such openings shall not serve as a required means of egress.	K 311	Improvement (QAPI) committee for the next 2 quarters.	
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	K 345		3/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING **01** B. WING _____	**01/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	**103 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 07052**

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K 345	Continued From page 6 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 interview, and document review on 01/19/23, in the presence of the Maintenance Director (MD), the facility failed to ensure A) smoke detection sensitivity testing report was fully operational of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2., B), that their building's fire alarm system was maintained in optimal condition and in accordance with the requirements of NFPA 70 and 72. The deficient practice was identified for 1 of 1, System Description: Sensitivity Testing of the Fire Smokes, and was evidenced by the following: A). On 01/19/23 at 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD, from the fire alarm vendor to see the results of the fire smoke detector sensitivity test. Documentation review revealed " Sensitivity Testing of the Fire Smokes" dated 12/13/2021 that itemized inspection and testing did not include all of the required information including the device type, make/model, method of testing. The report indicated Deficiencies: "There are several smoke detectors that failed Sensitivity test and need to be replaced". The report indicates the system was left: "Partially	K 345	A). 10 smoke detector devices are scheduled to be replaced and tested by vendor. B). Vendor replaced water motor gong with weatherproof outdoor horn. Removed and replaced water flow switch. Please see report # 1 attached. All residents can be affected. Quarterly Inspection by vendor. Director of Maintenance will complete QAPI on Sprinklers to check for compliance for the next 2 quarters. Results of these inspections will be reviewed at the QAPI committee for the next 2 quarters.	

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	315416	A. BUILDING **01** B. WING _____	**01/27/2023**

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K 345	Continued From page 7 Operational". Documentation of deficiency repairs were not provided and the following smoke detectors failed the sensitivity test: Device # 12 [redacted] floor by 3013 fail Device # 15 [redacted] floor elevator lobby 5 fail Device # 115 [redacted] floor Salon Hall by 1071 fail Device # 117 [redacted] floor Corner store hallway fail Device # 124 [redacted] floor Main dining room fail Device # 125 [redacted] floor Main Dining room fail Device # 126 [redacted] floor Main Dining room fail Device # 127 [redacted] floor Main Dining room fail Device # 128 [redacted] floor Main lobby by lounge fail Device # 176 Basement by FACP fail An interview was conducted with the MD during document review. He stated he was not sure if the sensitivity test report deficiencies were repaired and currently could not provide any further documentation indicating so. B). The Maintenance Director provided a document dated: 01/06/2023 from there fire alarm vendor: Quote # 149153 indicating: "technicians were on site removing a fire water gong and found there were other pipe leaking from another device. Customer requested remove both water motor gongs and installing one new waterflow switch in the [redacted] building basement". The same report dated 01/06/2023 indicated under notes: "The alarm panels on-site are older and one Harrington panel has been discontinued". The Maintenance Director signed off for quote #149153 on 01/13/23. No further repair document's were provided.	K 345		

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	315416	A. BUILDING **01** B. WING _____	**01/27/2023**

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K 345	Continued From page 8 The Administrator and Corporate team was informed of the findings at the Life Safety Code Exit conference on 01/24/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review on 01/23/23, in the presence of the Maintenance Director (MD) and corporate staff (CS), it was determined that the facility failed to maintain the fire sprinkler system in accordance with NFPA 13 and 72, by failing to ensure that the water supply valves were provided with tamper alarms. This deficient practice was identified for 1 of 1 post indicator valve's and was evidenced by the following: At 12:30 PM, the surveyor observed on the outside of the facility that the red wall mounted	K 352	Vendor assessed the sprinkler valve and will place a tamper valve switch on the fire alarm system. All residents can be affected. Maintenance/Designee will inspect the tamper switch weekly and provide copy of the monthly log to the administrator. Quarterly inspection will be conducted by vendor and Director of Maintenance will keep a monthly audit to ensure compliance and provide copy of the audit to the administrator.	3/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315416	A. BUILDING **01** B. WING _____	**01/27/2023**

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K 352	Continued From page 9 unlocked post indicator valve was not monitored. The red wall mounted post indicator valve window that indicates open or closed was not obvious, as the clarity of window was dirty inside. The MD indicated he was not sure if the post indicator valve was monitored. The red exterior valve was observed to have no monitor wires indicating the control valve was electronically supervised by a device connected to the fire alarm system. The Administrator and corporate staff were notified of the finding at the Life Safety Code exit conference on 01/24/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25, 72 NFPA 101 2012 edition Life Safety Code 9.7.2.1* (Supervisory Signals)	K 352	Results of these audits will be reviewed at the QAPI committee for the next 2 quarter.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 10 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 conducted on 01/19/23 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure A). that their automatic sprinkler system was inspected/tested at the required 5-year interval in accordance with the National Fire Protection Association (NFPA) 25. B). that the fire sprinkler system was in optimal condition.This deficient practice was identified for 1 of 1 complete fire sprinkler system's and was evidenced by the following: A). At 10:05 AM, the surveyor reviewed the facility's automatic sprinkler system inspection reports. The most recent documentation by the facility's vender indicated that on 12/21/22 that the 5-year internal obstruction investigation of the pipe was marked N/A (not applicable). It was also unknown when the inspection of the system was last conducted. The fire sprinkler report reflected under deficiencies: There are (3) sprinkler guages that are out of date or not operating correctly located in rear stairwell mainfolds. At 11:30 AM, the surveyor interviewed the Maintenance Director who acknowledged that he was not sure when the 5-year internal obstruction investigation of the fire sprinkler pipe was last conducted including the system guages. NFPA 25 requires an internal inspection of the fire sprinkler system piping every five years; this needs to be conducted to inspect for the presence of foreign organic material that can	K 353	A). 5-year Internal pipe and valve inspection completed by vendor on 1/27/2023. Please see report#2 attached. B). 1). System ID# 10 wet Sprinkler system was repaired and inspected by vendor. Status: Operational. Please see report #1 attached. 2). System ID# 23 Wet Sprinkler System was repaired and inspected by vendor. Status: Operational. Please see report #1 attached. All residents can be affected. Quarterly and Annually Inspections will be conducted by vendor and Director of Maintenance will complete a monthly audit to ensure compliance and provide copy of the audit to the Administrator. Results of these audits will be reviewed at the QAPI committee for the next 2 quarters.	

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K 353	Continued From page 11 cause obstructions to pipe and sprinklers. B). The MD provided a document from there fire sprinkler vendor dated: 01/18/2023 indicating "Inspections of Fire Protection Equipment (Certificate #116043) that: 1). System ID #10 Wet Sprinkler System location: Ex Order 26. 4B1 Hall Status: Partially Operational 2). System ID # 23 Wet Sprinkler System location: Ex Order 26. 4B1 Residence NCU-Boiler room Status: Partially Operational An interview was conducted with the MD during document review, he stated he was not sure why the document indicated the 2 areas above were under Status as: "Partially Operational". On 01/24/23 the Administrator and Corporate staff were informed of the findings at the Life Safety Code exit conference. NJAC 8:39-31.1(c); 31.2(e) NFPA 25	K 353		

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
315416 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILL	103 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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 K0161	03/22/2023	LSC K0311	03/22/2023	LSC K0345	03/14/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0352	03/14/2023	LSC K0353	02/27/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
1/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO