STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 000	INITIAL COMMENTS Standard Survey 9/27/19 C# NJ 128464 Census 99 Sample Size 22	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		11/20/19

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

Electronically Signed | 10/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 1	F 623		

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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F 623	Continued From page 2 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify the Office of the Ombudsman when 2 of 2 residents were hospitalized, Residents #31 and #94. This deficient practice was evidenced by the following: 1. The surveyor reviewed the Admission Record Facesheet (one-page summary of important information about a resident) (ARF) for Resident #94. The resident was admitted to the facility on	F 623	1. Ombudsman notified retroactively on [redacted] of transfer for resident #31 and #94. 2. An audit was conducted on all unplanned facility initiated discharges in the past 30 days was completed. Emergency Transfer Policy reviewed and updated. Re-education of all nurses regarding Notification of Transfer/Discharge - Bed Hold Policy form to be completed by the Nurse Educator or Designee. Re-education of Admissions	

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F 623	Continued From page 3 [redacted] with diagnoses that included [redacted] The surveyor reviewed the New Jersey Universal Transfer Form (NJUTF) for Resident #94 which documented that there was a transfer to the hospital on [redacted] due to an [redacted] and a [redacted]. The resident was admitted with a diagnosis of [redacted] and [redacted]. The resident was re-admitted back to the facility on [redacted]. The surveyor reviewed the NJUTF for Resident #94, which documented that there was a transfer to the hospital on [redacted]. The NJUTF section, Reason For Transfer dated [redacted] documented that Resident #94 was transferred because of increased [redacted] and [redacted] levels of [redacted] on [redacted] on [redacted] at [redacted]. The resident complained of [redacted] and a [redacted]. The resident was admitted to the hospital with diagnoses of [redacted]. The resident remained hospitalized until [redacted] On 9/25/19 at 1:15 PM, the surveyor requested documentation from the Director of Nursing (DON) and the Administrator, confirming notification to the Office of the Ombudsman, for the two hospitalizations. As of 9/27/19, the facility was not able to provide the requested documentation. 2. The surveyor reviewed the ARF for Resident #31. The ARF documented that Resident #31 was admitted to the facility on [redacted] with diagnoses that included [redacted].	F 623	staff regarding Notification of Transfer/Discharge □ Bed Hold Policy by Nurse Educator or Designee. 3. Daily check by admissions that all transfers on daily census have received a notice and have been entered into the spreadsheet. An audit of all transfers/discharges for the completion of documentation & notification to the LTC Ombudsman office to be done monthly for compliance by admissions/designee. Copy of the log and fax confirmation will be submitted to the Administrator monthly for review. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

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F 623	Continued From page 4 The surveyor reviewed the NJUTF for Resident #31, which documented that there was a transfer to the hospital on [redacted] The NJUTF section, Reason For Transfer dated [redacted], documented that Resident #31 was transferred to the hospital for evaluation. The resident was re-admitted back to the facility on [redacted]. On 9/27/19 at 11:55 AM, the surveyor requested documentation from the DON and the Administrator, confirming notification to the Office of the Ombudsman, for the one hospitalization. The facility was not able to provide the requested documentation. On 9/27/19 at 12:15 PM, the facility provided an undated copy of their Policy and Procedure for Emergency Transfer Notification. The surveyor reviewed the Policy and Procedure, which includes under #3 that, "CMS requires that copies of the NOTICE for temporary emergency transfer MUST also be sent to the Ombudsman." Under #4 of the Policy and Procedure, the notification can be made when practicable, such as a list of residents on a monthly basis. This list will be sent to the LTCO (Long Term Care Ombudsman) by the Administrator. NJ 8:39-5.3	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		11/20/19

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F 657	Continued From page 5 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to review and revise the care plan (CP) to reflect changes to a resident's plan of care for 1 of 20 residents reviewed, Resident #33. This deficient practice was evidenced by the following: 1. On 9/25/19 at 11:18 AM, the surveyor observed Resident #33 seated in a wheelchair in the resident's room. The resident had difficulty speaking but could make their needs known. The resident stated that they were "tired" and wanted to go to "bed."	F 657	1. Care plan reviewed and updated for resident #33. 2. All Resident care plans were audited and updated as necessary to ensure that the care plan is individualized and reflects the care provided to that resident. Care Planning policy was reviewed and updated. 3. In servicing for all IDT members regarding care plan review & updates for most current & accurate information to be completed by the DON. Care Plans will be updated quarterly as per the MDS schedule and brought to the daily clinical meeting and updated there with any changes in care or treatment.	

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F 657	Continued From page 6 On 9/25/19 at 12:30 PM, the surveyor observed the CNA attempt to feed Resident #33 a [redacted] diet. Resident #33 again stated, "tired" and "bed" and had refused to eat; Resident #33 was transferred from the wheelchair to the bed. Resident #33 was observed lying in bed. The surveyor reviewed the Admission Record Facesheet (one-page summary of important information about a resident) (ARF) for Resident #33. The resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted]. The ARF indicated that Resident #33 was diagnosed with [redacted] in [redacted]) since [redacted]. The surveyor reviewed Resident #33's Physician's Order (PO) dated [redacted], which documented that due to the resident's [redacted] a, the resident has been receiving a [redacted] diet [redacted] that has been [redacted]). The surveyor reviewed Resident #33's current CP dated [redacted] with a Target Date of [redacted]. The CP did not include any documentation indicating that the resident was on a [redacted] diet. The CP included interventions dated [redacted] that documented, "Alternate small bites" and "Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly," The surveyor reviewed Resident #33's 9/2019 PO, which did not indicate that Resident #33 was	F 657	Random samples of (10) care plans will be reviewed monthly by the DON or her Designee to ensure that they reflect the care and treatments provided to that particular resident. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

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F 657	Continued From page 7 currently treated with any form of an [redacted]; there was no physician order for an [redacted] noted. The resident's current CP, initiated and dated [redacted]4 reflected to, "Administer medication[redacted] as ordered. Monitor for effectiveness and side effects." The surveyor reviewed Resident #33's PO dated [redacted], which reflected a physician's order to "apply [redacted] when in bed." The resident's CP was not updated to reflect this addition to protect the resident's [redacted] while in bed. On [redacted] at 12:30 PM, the surveyor observed the CNA put the [redacted] on Resident #33. On 9/27/19 at 9:13 AM, the DON informed the surveyor that the care plan for Resident #33 was not revised and should have been updated to accurately reflect the resident's plan of care. NJAC 8:39- 11.2 (d)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain professional standards of clinical practice by placing a resident on isolation precautions without clinical evidence or assessment. This deficient practice was observed for 1 of 22 residents reviewed, Resident #296 as	F 658	1. Resident #296 was removed from isolation on [redacted] 2. All Residents on Isolation have been reviewed to ensure that the isolation precautions are correct. 3. Policy entitled Isolation Precautions was reviewed and updated.	11/20/19

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F 658	Continued From page 8 evidenced by the following: On 9/22/19 at 9:30 AM, the surveyor observed Resident #296 seated in a wheelchair in the resident's room and was eating breakfast. The surveyor identified personal protective equipment (PPE), including gloves, gown, and mask in an organizer hanging by the door prior to entering the resident's room. The surveyor donned the PPE and spoke with the resident. Resident #296 informed the surveyor that he/she does not mind spending time in the room, "it's very comfortable." The resident informed the surveyor that they do leave the room for therapy. On 9/23/19 at 10:23 AM, the surveyor reviewed the Admission Record Facesheet (one-page summary of important information about a resident) (ARF) for Resident #296. The resident was admitted to the facility on [redacted] with a diagnosis that included but not limited to [redacted] The surveyor reviewed the Physician's Admission History and Physical dated [redacted] which did not indicate any diagnosis of infection that would require a resident to be on isolation precaution. The surveyor reviewed the New Jersey Universal Transfer Form (NJUTF) dated [redacted] which reflected that the resident was transferred from the hospital to the facility. The NJUTF section 12. Isolation/Precaution identified that Resident #296 was positive for [redacted] or	F 658	The Education nurse re-educated Nurses on the isolation criteria and the Isolation Policy. Education Nurse will audit all residents who are placed on isolation to ensure that the policy has been followed and that the isolation criteria was met. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

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F 658	Continued From page 9 [redacted] .	F 658		

On 9/23/19 at 10:25 AM, the surveyor reviewed the [redacted] Physician's Order sheet (PO). There was no Physician order for [redacted] isolation for Resident #296.

On 9/23/19 at 10:42 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for the resident, who stated that Resident #296 is on contact isolation due to an infection of the [redacted]. The RN stated that Resident #296 has been on isolation since admission.

On 9/25/19 at 1:45 PM, the surveyor discussed Resident #296 and the [redacted] that was only identified on the NJUTF with the Director of Nursing (DON).

On 9/25/19 at 2:00 PM, the surveyor reviewed the [redacted] Policy and Procedure revised on 1/2019. The [redacted] Procedure section 6. indicates "The staff and practioner will evaluate each individual known or suspected to have infection or colonization with a [redacted] for room placement and initiation of [redacted] Precautions on a case-by-case basis."

On 9/27/19 at 9:13 AM, the DON informed the surveyor that the infectious disease doctor confirmed that Resident #296 does not have an active infection at this time and does not require isolation. The DON further stated that she reviewed the hospital records, and other than the NJUTF, there was no evidence that Resident

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F 658	Continued From page 10 #296 had an active infection that required isolation. NJAC 8:39 - 27.1	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to implement interventions that addressed resident [redacted] and ensure that safety devices were operational for use in protecting residents from [redacted]. This deficient practice was identified for 2 of 20 residents reviewed for [redacted] (Resident #23 and #33) and, as evidenced by the following: 1. On 9/22/19 at 9:50 AM, the surveyor observed Resident #23 in bed with the electronic alarm hanging on the top right side of the side rail, unplugged. The resident was lying on top of a [redacted]. On 9/22/15 at 10:50 AM, the surveyor observed the resident ambulate independently to the bathroom; no alarm sound was heard. The surveyor reviewed the Admission Record	F 689	1. Safety and fall risk assessments were completed for Resident # 23 and Resident # 33. Appropriate revisions were made to the care plans to reflect all current safety interventions. The revised assessments and care plans were reviewed with staff involved in the care of each resident. 2. All Residents who have been identified as a potential [redacted] were re-evaluated for safety and fall interventions. Care plans were updated to reflect current interventions and reviewed with staff involved in the care of each resident. The policy for [redacted] Prevention was reviewed and updated. 3. Staff will be re-education on [redacted] Prevention by the Education Nurse/designee. Nursing staff will be responsible to check that safety devices are in place and operational on every shift. Administrator or his designee will	11/20/19

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F 689	Continued From page 11 Facesheet (one-page summary of important information about a resident) (ARF) for Resident #23. The ARF reflected that Resident #23 was admitted on [redacted] from an acute care hospital with the following diagnoses: [redacted]. The surveyor reviewed Resident #23's Minimum Data Set (MDS), a standardized assessment tool that measures health status, dated [redacted]. The MDS reflected that Resident #23 was cognitively [redacted]t, however, required extensive assist of one staff member with Activities of Daily Living (ADL's.) On 9/23/19 on 9:25 AM, the surveyor observed Resident #23 with a bed alarm on the right side of the bed with the wiring detached. On 9/23/19 at 10:10 AM, the surveyor reviewed Resident #23's Care Plan (CP)with an initiated date of 1[redacted] updated on [redacted] and [redacted]. The CP reviewed was titled, "Resident is at risk for [redacted] related to Gait/Balance problems. The CP interventions for this CP are "Ensure that resident is wearing appropriate footwear when mobilizing in wheelchair," dated [redacted], and "Re-educate resident to wear appropriate footwear and to call staff for assistance," dated [redacted]. The surveyor noted that the resident's CP included but was not limited to; an intervention of an electronic bed alarm to ensure the device was in place as needed" and, "Low profile mat to bedside," both initiated on [redacted] The CP interventions for Resident #23 added on [redacted] was, "keep the bed alarm under the bed frame and out of reach of resident."	F 689	conduct random audits 4 times a month to ensure that safety devices are in place and operational. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

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F 689	Continued From page 12	F 689		

On 9/24/19 at 9: 30 AM, the surveyor again observed Resident #23 with a bed alarm on the right side of the bed with the wiring detached.

On 9/25/19 at 1:25 PM, the surveyor interviewed the Unit Manager (UM) in reference to the use of bed alarms. The surveyor along with the UM entered the resident's room and observed that the fall mat was not in place next to the resident's bed. The bed alarm was then observed with the wiring attached on the right side of the bed. The UM informed the surveyor that Certified Nursing Assistants (CNA) and nurses are responsible for the proper placement of fall mats and checking, monitoring of bed alarms. The surveyor informed the UM that the bed alarm for Resident #23 was witnessed with the wiring detached, and that the fall mat was missing. The UM replied, "I guess, no one checked them."

On 9/25/19 at 1:35 PM, the surveyor interviewed Resident #23's assigned CNA in reference to monitoring the placement and functioning of the fall mat and bed alarm. The CNA informed the surveyor, "No, I have not been checking them."

The surveyor reviewed Resident #23's incident/accidents and noted that the resident had 7 fall incidents since [redacted]. The documented reports were as follows:

a. On [redacted] at 4:15 AM, Resident #23 was found on floor at bedside, agitated, and the [redacted] was found to be [redacted] range), no injury.
The interventions that were documented were: non slip footwear, reinforce call bell for assistance, Nurse Practitioner/Physician to evaluate use of [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 b. On [redacted] at 8:20 PM, Resident #23 was found by a CNA sitting on floor with no injury. The nurse's notes documented that the resident stated that the resident was trying to go to the bathroom. The intervention that was put in place was a soft mat placed on floor at bedside, when the resident was in bed. c. On [redacted] at 5:35 AM, Resident #23 was found on the floormat by a CNA and stated that they were attempting to pick up their glasses that had fallen on the floor, no injury. The interventions documented after this fall were to continue with the previous interventions plus an additional bedside table kept close to bed for easy access to belongings, a [redacted], tab alarm bed was added and a Reacher to aide in item retrieval. d. On [redacted] at 5:00 PM, Resident #23 was found sitting on the floor next to the resident's bed, the alarm was documented as sounding. The resident experienced a [redacted] to the [redacted] The intervention that was added was re-education of the resident about call bell use. The facility also ordered a [redacted] consult to evaluate the resident's [redacted] to evaluate the resident's adjustment to the facility. e. On [redacted] at 5:00 PM, while Resident #23 was standing, the resident lost their balance and lowered themselves to the floor with no injury. The Incident Report stated that the resident was attempting to close the door to the resident's room, the resident's hand slipped off the door knob and balance was lost. The intervention that was added after this fall was appropriate foot wear.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 f. On [redacted] at 6:45 PM, Resident #23 was found sitting between the resident's wheelchair (w/c) and bed, yelling for help. The resident was trying to transfer to their w/c. The resident did not sustain any injuries. The interventions that were added after this fall were, education about w/c locking during transfers, use of call bell and the facility added [redacted] to the resident's w/c. g. On [redacted] at 4:30 AM, Resident #23 was found sitting on the floor next to the w/c calling for help, no injury. The interventions that were added after the fall were a reminder to call for help, use call bell, check placement of alarm on bed and adjust the placement so that the resident can't turn off the alarm. 2. On 9/25/19 at 11:18 AM, the surveyor observed Resident #33 seated in a wheel chair in the resident's room. The resident had difficulty speaking but could make their needs known. The resident stated that they were "tired" and said "bed." The surveyor did not see an alarm on the resident's wheel chair. On 9/25/19 at 12:30 PM, the surveyor observed the CNA attempt to feed Resident #33 a [redacted] diet. Resident #33 again stated, "tired" and "bed" and had refused to eat; Resident #33 was transferred from the wheelchair to the bed. Resident #33 was observed lying in bed without any monitor in place on the resident's bed. On 9/26/19 at 9:30 AM, the surveyor reviewed the ARF for Resident #33. Resident #33 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnosis that included	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 but were not limited to Hypertension, [redacted].	F 689		

On 9/26/19 at 9:45 AM, the surveyor reviewed the [redacted] Annual MDS for Resident #33. The MDS reflected that resident is [redacted], was non ambulating and required "Extensive Assistance" for all activities of daily living.

On 9/26/19 at 10:00 AM, the surveyor reviewed Resident #33's CP. The resident's CP documented, "is a high risk for falls related to unaware of safety needs, poor [redacted], episodes of agitation and anger. The interventions documented on the CP included, "The resident uses sensor alarm to bed, tabs monitor to chair electronic alarms. Ensure the device is in place as needed" initiated on [redacted] and "[redacted]) to top of recliner chair seat" initiated on [redacted]

On 9/26/19 at 1:45 PM, the surveyor accompanied by the Certified Nursing Assistant (CNA) entered Resident #33's room. Resident #33 was seated in a wheelchair (W/C), with the chair alarm in place. The surveyor discussed the Dycem missing from the recliner with the CNA. The CNA located the [redacted] on floor, under the bed, near the fall mat.

The surveyor reviewed prior Incident Reports relating to Resident #33:

a. On [redacted] at 3:45 PM, Resident #33 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

found on the floor near their w/c "Observed by resident roommate" who alerted staff. The resident had no injury and there was no mention of the resident's alarm sounding. The intervention documented was "Encourage out of room for activities as tolerated between 3-4 PM" and "Actions taken to prevent potential for reoccurrence."

b. On [redacted] at 5:50 PM, Resident #33 was in their w/c and fell to the floor reaching for something. Resident #33 was found by their roommate, who called for help. The resident had no injury and there was no mention of the resident's alarm sounding. The interventions documented were "Assist resident to bed after dinner. [redacted] on w/c" and "Actions taken to prevent potential for reoccurrence."

c. On [redacted] at 6:25 PM, Resident #33 was in their w/c, witnessed sliding out. The CNA reported, "I heard Resident #33's roommate yelling for help." The resident had no injury and there was no mention of the resident's alarm sounding. The interventions documented were "Consider [redacted] to w/c and tab alarm" as well as "Actions taken to prevent potential for reoccurrence."

d. On [redacted] at 2:00 AM, Resident #33 was "observed on the floor mat laying on back next to the bed." The resident had no injury and there was no mention of the resident's alarm sounding. The interventions documented were "Recommend [redacted]" and "Actions taken to prevent potential for reoccurrence."

e. On [redacted] at 3:05 PM, Resident #33 "was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

found on the floor in front of w/c, head under w/c." Resident #33 was documented with "found to have some[redacted] to [redacted] A review of the incident report did not find any mention of the resident's alarm sounding. The interventions documented were, "Put resident in recliner chair in room instead of w/c" and "Actions taken to prevent potential for reoccurrence."

f. On [redacted] at 9:45 PM, Resident #33 was "Heard calling, found resident on the floor lying next to bed." The resident had no injury and there was no mention of the resident's alarm sounding. The interventions documented were "Monitor Frequently" and "Actions taken to prevent potential for reoccurrence."

g. On [redacted] at 3:25 PM, Resident #33 was "found on floor in front of recliner in sitting position." The resident had no injury and there was no mention of the resident's alarm sounding. The interventions documented were, "[redacted] to recliner" and "Actions taken to prevent potential for reoccurrence."

On [redacted] at 10:18 AM, the surveyor interviewed Resident #79, the roommate to Resident #33. Resident #79 stated that there were never any alarms sounding "until this week." Resident #79 additionally said, "I was not aware that Resident #33 had any alarms before."

The surveyor reviewed Resident #79's [redacted] MDS Brief Interview for Mental Status (a test used to get how well you are functioning cognitively) with a documented level of [redacted] and [redacted]

On 9/25/19 at 10:40 AM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

the Registered Nurse Unit Manager who stated, "alarm checks are not documented. They are checked by the CNAs when transferring residents."

On 9/25/19 at 11:00 AM, the surveyor interviewed Resident #33's CNA who could not explain how the alarms are checked.

On 9/26/19 at 11:20 AM, the surveyor reviewed the "Fall Prevention Policy," (FPP)revised on 1/19. The FPP explains that, "A fall prevention program will be developed for each resident that will provide the staff with creative functional strategies, while recognizing the resident's rights and their need to maintain their highest practical level of function." The purpose of the FPP explains that, "The fall prevention program is to reduce the number of fall incidents and reduce the risk of injuries from falls." The guidelines section 10. explains that, "The MDS/Carepaln team updates the resident's plan of care including the new intervention."

On 9/26/19 at 11:30 AM, the surveyor reviewed the facility policy for Use of Safety Alarms with a revision date of 1/2019. The surveyor reviewed Procedure #4 which documented, "Nursing staff are also to check the alarms at least once per shift to assure they are applied and functioning."

On 9/26/19 at 2:37 PM, the surveyor discussed the concerns mentioned above for both residents (#23 and #33) regarding the multiple falls and documented interventions with the Director of Nursing (DON) and Administrator (Admin). The surveyor also reviewed the "Unusual Occurrence Incident Reports" and questioned why there was never a mention of any alarms sounding, even

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19 though the alarms were documented as ordered on Resident #33's CP since 7/26/16. The surveyor also discussed the observation of the Dycem on the floor of Resident #33's room. The DON could not provide any additional information to explain why the interventions for either resident were not followed or any proof to show that the alarms are checked and sounding during the documented falls. On 9/27/19 at 12:39 PM, the surveyor discussed the safety of Resident #33 with the resident's Responsible Party. The Responsible Party stated, "They don't always put alarms on the chair and sometimes they don't work. A few weeks ago, when I was visiting, the alarm wasn't functional and was changed. A lot of times alarms are not on areas where [Resident #33] is seated." NJAC 8:39- 27.1 (a)	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		11/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 20 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to accurately monitor, identify and address unplanned weight loss for 2 of 5 residents (Resident #33 and #4) reviewed for nutrition. Resident #33 experienced a [redacted] month significant weight loss of [redacted] lbs), a [redacted]-month total weight loss of [redacted] lbs) and a [redacted]-month total weight loss of [redacted] lbs). Resident #4 experienced a 1-month weight loss of [redacted] lbs) and a [redacted] month weight loss of [redacted] lbs). This deficient practice was evidenced by the following: 1. On 9/25/19 at 11:18 AM, the surveyor observed Resident #33 seated in a wheelchair in the resident's room. The resident had difficulty speaking but could make their needs known. The surveyor asked the resident how they were doing, and the resident responded, "tired" and "bed." The surveyor approached the resident's Certified Nursing Assistant (CNA), who stated that Resident #33 was transferred into bed after lunch. On 9/25/19 at 12:30 PM, the surveyor observed the CNA attempt to feed Resident #33. Resident #33 again stated, "tired" and "bed"	F 692	1. Resident #4 & #33 were reweighed to confirm any significant weight changes and the plans of care were updated according. 2. Audit of all resident weights and meal consumption records to be done by registered Dietitian/designee to identify any significant weight losses/gains and nutritional areas of concern. The policy for obtaining and documenting residents weights has been reviewed and revised. The policy for meal consumption documentation has been reviewed and revised. 3. Re-education of all CNAs regarding complete & accurate documentation as it pertains to meal consumption, PO decline/refusals. Re-education of all nurses regarding identifying and reporting status changes as it relates to weight loss/gain and PO intake. Registered Dietitian to audit all resident weights monthly for any significant changes. Registered Dietitian to meet monthly with IDCP team to review any significant weight changes and to review and update care plans with any changes. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 21	F 692		

and had refused to eat; Resident #33 did not consume any lunch. The CNA informed the surveyor that Resident #33 "ate well for breakfast but was tired and wanted to go to bed."

The surveyor reviewed the Admission Record Facesheet (one-page summary of important information about a resident) (ARF) for Resident #33. Resident #33 was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted]

The resident's most recent, Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that the Brief Interview for Mental Status (BIMS) was marked "resident is [redacted] understood" and identified the resident's cognition as [redacted] impaired. The [redacted] MDS showed that the resident had no weight loss, with a documented weight of [redacted] lbs), when the resident had lost [redacted]. from [redacted] lbs.), a [redacted] weight loss, found documented on the Monthly Weight and Vital Signs Record (MWVR). There was no significant Change MDS created at any time after Resident #33's annual MDS on [redacted], to identify the significant weight loss documented on the MWVR, with the resident's weight loss of [redacted]. from [redacted] lbs.) to [redacted] lbs.), a [redacted] weight loss. In addition, the [redacted] MDS indicated that the resident required extensive assistance and one-person physical assistance for eating.

A review of the resident's care plan (CP) initiated on [redacted], revealed an intervention for [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 22	F 692		

[redacted] for dinner, and an additional lunch [redacted] initiated on [redacted] by the Registered Dietician (RD). The [redacted] was not documented as consumed on the [redacted] Medication Administration Record (MAR), or the [redacted] Meal Consumption Sheet (MCS).

The [redacted] Physician Order Sheet (POS) specified that Resident #33 received a [redacted] liquids diet. The POS also documented that Resident #33 was ordered [redacted] (a medication used to trea[redacted] and [redacted]) [redacted] ml ([redacted] mg) twice daily as of [redacted]. The resident's CP also included [redacted] soup twice daily since [redacted] (which was requested by the resident's responsible party).

A review of the [redacted] MCS (a tool used to by the facility to monitor a resident's food intake) did not have any entries (blank) for the entire month, except [redacted] for dinner), [redacted]% for breakfast and lunch), [redacted]% for breakfast and lunch), and [redacted] for breakfast and lunch). There was no further documentation noted on the [redacted] MCS, and no monitoring of the specific amount of consumed [redacted] for lunch and dinner for [redacted].

The surveyor reviewed [redacted] 2019 MCS. The [redacted] 2019 MSC documented [redacted] and [redacted] daily for breakfast and lunch in the same handwriting and only had 1 entry on [redacted] for dinner of [redacted], all other dinner entries were left blank for the month. There was no documentation noted for [redacted] referring to the amount of consumed [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 23	F 692		

supplementation.

The surveyor reviewed [redacted] 2019 MCS. The [redacted] 2019 MSC had entries that documented [redacted] consumed for [redacted] breakfast in the same handwriting. There were no further entries monitoring food intake for the rest of the month of [redacted]. There was no documentation noted for [redacted] 2019 referring to the amount of consumed [redacted].

The surveyor reviewed the 2019 Monthly Weight and Vital Signs Record which documented the following:

-Review of the overall weight loss from [redacted]. to [redacted]. on [redacted] presented a [redacted] significant weight loss of [redacted] in [redacted] months.

-Review of the overall weight loss from [redacted] lbs. to [redacted] lbs., presented a [redacted] significant weight loss of [redacted] lbs. in [redacted] months.

-Review of the overall weight loss from [redacted] lbs. to [redacted] lbs. presented a [redacted] significant weight loss of [redacted] lbs. in [redacted] month.

On 9/26/19 at 11:50 AM, the surveyor interviewed the Registered Dietician (RD) who stated that she is a consultant to the facility, and visits the facility three times weekly. The RD stated that she was aware of the inaccuracies of the MCS and had made the facility aware. The RD also informed the surveyor that the facility residents are evaluated quarterly unless there is concern. The RD is alerted via a Dietary Alert Sheet (DAS). The RD added, that the facility procedure is that nursing staff fills out a DAS informing the RD of any nutrition issues that need to be addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 24	F 692		

The RD further stated, that she reviews all MCS sheets quarterly and when a DAS is sent to her, she is alerted that there is a problem with Nutrition. The RD also stated that she informed the facility that the MCSs were not being filled out accurately but could not recall the exact date. The RD stated that she informed the facility, "sometime last month."

On 9/26/19 at 12:00 PM, the RD informed the surveyor that a DAS sheet was filled out on [redacted] recommending that staff feed the resident. There was another DAS on [redacted], for a 3-day [redacted] count. The RD reviewed the 3-day calorie count that was ordered on [redacted], monitoring the complete food calorie intake for Resident #33 on [redacted] and [redacted] The RD informed the surveyor of the outcomes of the Calorie Count Sheet included monitoring the intake of the [redacted] for lunch (L) and dinner (D), [redacted] L and [redacted] D, [redacted] L and D, [redacted] L and 75% D. There was no further DAS's alerting the RD of any further weight loss for Resident #33 after [redacted]

On 9/26/19 at 12:15 PM, the RD informed the surveyor that there was a problem previously with the facility scale.

On 9/26/19 at 12:30 PM, the surveyor interviewed the Maintenance Director, who stated that the was some inaccurate weights with the facility scale previously, on [redacted]. The Maintenance Director proceeded to reveal a receipt, dated [redacted], documenting a weight discrepancy that was found and corrected on [redacted]. The receipt documented that the scale was immediately repaired and was now functioning properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 25	F 692		

The surveyor reviewed the Monthly Weight and Vital Signs Record (W/VR) that revealed monthly weights from [redacted] to [redacted]. The W/VR documented the monthly weight for Resident #33 of [redacted] lbs. on [redacted] and [redacted] lbs. on [redacted] This demonstrated that weights for Resident #33 were accurate during the scale discrepancy period.

The surveyor further reviewed the W/VR for Resident #33 which revealed a documented weight of [redacted] lbs. on [redacted] and a re-weigh (no date documented) of [redacted] lbs., documenting a [redacted] lb. weight loss for [redacted] month, an [redacted] lb. weight loss for [redacted] months and a [redacted] lb. weight loss for 6 months. The W/VR also documented a [redacted] lb. weight on [redacted] which was documented with a re-weigh (no date documented) of [redacted] lbs., documenting a 1 lb. weight gain for 1 month, a 17 lb. weight loss for 3 months and a 20 lb. weight loss for 6 months.

A Review of the Nutritional Progress Notes (NPN), dated [redacted] revealed that after the [redacted] day calorie count, the RD documented "Calorie count completed confirms a varied intake with an overall decline. Nursing, Responsible Party aware. Resident continues to be fed, redirected, preferences updated. Resident eats well for a meal then skips or good for a day then skips. Decline acknowledged."

Another note from the RD in the NPN dated [redacted] states, "Preferences updated. [redacted] twice daily." On 8/9/19 the RD charted "Weight (wt.) 118 lbs. suggests a significant decline. Review requested. Continue to provide items in addition to meals. Assisted by staff, continues to communicate to staff when resident is done with meals." The NPN dated [redacted], and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

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FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 692	Continued From page 26	F 692		

documented by the RD identified, "wt. [redacted]. confirm decline in spite of staffs efforts to provide and encourage, resident's responsible party aware."

A review of the Physician Progress Notes (PPN) from [redacted] did not identify any nutritional issues. The PPN dated [redacted] documented, "no new reported problem," [redacted] 9 document revealed, "no change clinically," [redacted] recorded, "no new problem reported," and the PPN dated [redacted] documented, "no reported problem."

On 9/26/19, the surveyor reviewed Resident #33's laboratory report dated [redacted] and stamped "Faxed." The [redacted] was noted with a red highlighting tab alerting the physician to review and sign, which had not been done at the time of the surveyor's review. The surveyor identified that the resident's [redacted] in [redacted] on the [redacted] work up was found to be [redacted] (may be [redacted] with a normal range of [redacted] as well as the low documented [redacted] with a normal range of [redacted].

There was no further evidence or documentation to demonstrate new interventions put in place or, alerts, RD or Physician follow-up identifying and addressing the resident's continuous weight loss.

On 9/26/19 at 11:00 AM, the surveyor interviewed Resident #33's CNA. The resident's primary CNA stated that she was familiar with Resident #33, and has had no issues feeding the resident. The CNA also informed the surveyor that Resident #33 has an order for [redacted] for lunch. The CNA stated that Resident #33 doesn't like the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 692	Continued From page 27	F 692		

[redacted] and has refused to eat it at lunch when she attempts to feed the resident. The CNA stated that she never informed anyone about the resident's refusal of the [redacted].

On 9/26/19 at 11:15 AM, the surveyor interviewed the RD who stated that she was not aware of the resident's dislike of [redacted]. The RD stated, "this is the first time I'm hearing about this matter." The RD could not provide documentation to show how much or if, Resident #33 was consuming the [redacted].

On 9/27/19 at 12:39 PM, the surveyor called the Residents Responsible Party (RRP), via telephone. The RRP informed the surveyor that he/she attends every care conference and that the resident has been at the facility for [redacted]. The RRP informed the surveyor that Resident #33 likes and enjoys the soup when offered.

On 9/27/19 at 9:40 AM, the Director of Nursing could not explain why there was no immediate review or follow-up regarding Resident #33's significant weight loss.

2. On 9/22/19 at 9:40 AM, the surveyor observed Resident #4 in bed, sleeping. The resident's breakfast appeared untouched and was set up on an overbed table on the right side of the resident's bed. The surveyor observed the resident's CNA remove the tray from the resident's room. The CNA stated, "The resident feeds self-didn't like breakfast."

On 9/23/19 at 10:05 AM, the surveyor observed Resident #4 seated in a wheel chair. The surveyor approached the resident for an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 28	F 692		

interview, but the resident was not alert or oriented.

On 9/23/19 at 10:30 AM, the surveyor reviewed the Resident #4's ARF. The resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted].

Resident #4's MDS dated [redacted] indicated that the BIMS was [redacted] which identified the resident's cognition as [redacted] impaired. The [redacted] MDS was created prior to any documented weight loss and no other MDS's were created. The [redacted] MDS showed that the resident had no weight loss, with a documented weight of [redacted] lbs. In addition, the [redacted] MDS indicated that the resident was "independent-no help or staff oversight at any time" and required only "Setup help only" for eating.

The surveyor reviewed Resident #4's [redacted] 2019 MCS, which had an entry of 100% for breakfast consumed on [redacted]. A review of the entire month of [redacted] 2019 revealed [redacted] and [redacted] entered daily for lunch and dinner, except for 9/5, 9/9, 9/14, 9/15. The surveyor identified that 21 of 30 days in the month dinner entries were found blank. The September 2019 MCS entries were all found to be documented in the same handwriting.

The surveyor reviewed July and August 2019 MCS which were documented in the same handwriting as the September 2019 MCS. The July and August 2019 MCS documented [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 692	Continued From page 29	F 692		

for breakfast and lunch daily except for [redacted]. The surveyor also identified that 22 of 31 dinner entries for July and 23 of 31 dinner entries for August were found blank.

The surveyor reviewed the Nurse's Notes dated [redacted] and [redacted] that documented "Resident refused to eat lunch." Resident #4 had no orders for and was not receiving any food supplements.

The surveyor reviewed the annual [redacted] Monthly Weight Record, which documented a [redacted] lb. Weight loss on from [redacted] to [redacted] ([redacted] lbs. on [redacted] to [redacted] lbs. on [redacted]), a [redacted] weight loss and a [redacted] lb. Weight loss on from [redacted] to [redacted] ([redacted] lbs. on [redacted] to [redacted] lbs. on [redacted]), a [redacted] weight loss. The surveyor reviewed the overall weight loss from [redacted] lbs.) to [redacted] lbs.), which presented a [redacted] lbs.) weight loss. No documentation was found by the surveyor or presented by the facility to warrant that there were any alerts or interventions put in place identifying or treating weight loss.

On 9/26/19 at 10:00 AM, the surveyor interviewed the RD who stated that there was no alert, DAS documented for Resident #4. The RD stated that she was unaware of any weight loss for Resident #4 or any desired weight loss.

On 9/26/19 at 10:50 AM, the surveyor interviewed Resident #4's CNA who stated that the resident is very concerned about weight gain. The CNA stated that Resident #4 skips lunch regularly, refusing to eat. The surveyor asked the CNA if she documents Resident #4's meal consumption daily on the MCS. The CNA responded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 692	Continued From page 30	F 692		

"sometimes."

On 9/26/19 at 11:00 AM, the surveyor reviewed Resident #4's Careplan (CP) which did not include a nutrition area. There was no documentation of Resident #4 in the CP that highlighted the resident with desired weight loss.

The surveyor reviewed the Meal Monitoring Policy and Procedure revised on 1/19, which documented:

1. The CNA assigned to each resident will document all food and fluid intake on that shift using the worksheet titled "Meal Consumption Sheet." This documentation is to include all meals and snacks.

5. The Licensed Nurse will document poor intake in the progress notes. Three or more episodes of poor meal intake in a two-day period will be reported to the Dietician via the Dietary Alert form.

On 9/27/19 at 12:40 PM, the surveyor discussed concerns with with the Director of Nursing (DON) and Administrator with respect to staff communication, DAS between nursing and the RD along with the documentation discrepancies found with monitoring resident's nutrition intake. Also the concern regarding the MCS resulting in no follow up for residents that continue to lose weight. The DON could not provide any further information to explain why the MCS (a facility tool) was inaccurate or lacked documentation for both Resident #33 and Resident #4. The DON could not explain why there were no DAS's generated when there was significant and/or, non-significant weight loss. The DON could not explain why the residents weight losses were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 692	Continued From page 31 addressed or why there was no documented follow- up by staff. There was no facility policy for nutrition or specific to weight loss and/or, significant weight loss other than the Meal Monitoring Policy & Protocol as mentioned above. NJAC:8:39-11.2(e)	F 692		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: C# NJ128464 Based on observation, interview, and record review, it was determined that the facility failed to assure that the physician responsible for supervising the care of residents signed and dated monthly physician's orders. This deficient practice continued over numerous months for 7 of	F 711	1. Physician Orders were reviewed and signed for Residents #4, #14, #33, #40, #63, #79 and #80. 2. An audit of the all resident charts was completed by the Medical Records Coordinator and any deficient charts were flagged and signed by the Attending physician. The facility policy and	11/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 711	Continued From page 32 20 residents reviewed, Resident #4, #14, #33, #40, #63, #79 and #80 residing on all the three facility units. The deficient practice was evidenced by the following: 1. On 9/22/19 at 9:40 AM, the surveyor observed Resident #4 in bed asleep. On 9/23/19 at 10:05 AM, the surveyor observed Resident #4 seated in a wheelchair. The surveyor approached the resident for an interview, but the resident was not alert or oriented. The surveyor was unable to interview Resident #4. The surveyor reviewed the Admission Record Facesheet (one-page summary of important information about a resident) (ARF) for Resident # 4. The resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted]. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) of [redacted] indicating that the resident was [redacted] cognitively impaired. A review of Resident #4's Physician's Order Sheets (POS), from January 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders.	F 711	procedure to assure timely physician visits has been reviewed and updated according. 3. All physicians on the facility□s staff have been reminded of the facility policy and procedure on physician visits and the requirement of those visits. Monthly audits will be conducted of the physician orders by the Medical Records Coordinator and reviewed by the DON and Administrator. Follow up to the physicians will initiated by Medical Records Coordinator with subsequent contact by the DON, Medical Director or Administrator as needed. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 711	Continued From page 33 2. On 9/23/19 at 10:51 AM, the surveyor observed Resident #14 seated in a wheelchair. The resident was alert and oriented and was observed in the dining room attending an activity. The surveyor reviewed the ARF for Resident #14. The resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted]. A review of Resident #14's POS, from January 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders. 3. On 9/25/19 at 11:18 AM, the surveyor observed Resident #33 seated in a wheelchair in the resident's room. The resident had difficulty speaking but could make their needs known. The resident stated that they were "tired" and said, "bed." The surveyor reviewed the ARF for Resident #33. The resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted]. A review of Resident #33's POS, from March 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders.	F 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

(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 711	Continued From page 34 4. On 9/23/19 at 10:25 AM, the surveyor observed Resident #40 seated in a wheelchair. The resident was alert and was observed in the dining room attending an activity. The surveyor reviewed the ARF for Resident #40. The resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted] A review of Resident #40's POS, from January 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders. 5. On 9/22/19 at 9:15 AM, during the initial tour, the surveyor observed Resident #63 wearing [redacted] while lying in bed. The surveyor noted that the bed had a low [redacted] The surveyor reviewed the ARF for Resident #63. The resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted] A review of Resident #63's POS, from January 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders. 6. On 9/23/19 at 11:12 AM, the surveyor observed Resident #79 in their room, awake, sitting upright in bed, watching television. The resident had a [redacted] hanging on the side of the bed covered by a [redacted] The surveyor	F 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 711	Continued From page 35 noted a [redacted] of the [redacted] The surveyor reviewed the ARF for Resident #79. The resident was admitted to the facility on [redacted] with diagnoses that included [redacted]. A review of Resident #63's POS, from January 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders. 7. On 9/22/19 at 9:40 AM, the surveyor observed Resident #80 out of bed. Resident #80 informed the surveyor that they are independent with self-care. The surveyor reviewed the ARF for Resident #80. The resident was admitted on [redacted] with diagnoses that included but were not limited to [redacted]. A review of Resident #80's POS, from January 2019 through September 2019, revealed that the resident's physician did not sign and date the monthly Physician's Orders. On 9/26/19 at 10:55 AM, the surveyor reviewed the Physician Visits to Residents Policy and Procedure, revised 1/2019. The Procedure section 3. documents, "The physician must also sign and date all orders at each visit."	F 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 711	Continued From page 36 On 9/26/19 at 2:45 PM, the surveyors met with the Director of Nursing and the Administrator who could not provide any further information to explain why the physician's did not sign or date the facility resident's POS. NJAC 8:39-27.1	F 711		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		11/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FOREST MANOR HCC	145 STATE PARK ROAD HOPE, NJ 07844

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F 756	Continued From page 37 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the Consultant Pharmacist (CP) failed to clarify and identify the duration of treatment for a medication ordered for 1 of 20 residents, reviewed Resident #33. The deficient practice was evidenced by the following: On 9/25/19 at 11:18 AM, the surveyor observed Resident #33 seated in a wheelchair in the resident's room. The resident had difficulty speaking but could make their needs known. The resident stated that they were "tired" and stated that they would like to go to "bed." The surveyor reviewed the Admission Record Facesheet (one-page summary of important information about a resident) (ARF) for Resident #33. Resident #33 was admitted to the facility on [redacted] diagnosis that included but were not limited to [redacted] A review of the September 2019 Physician's	F 756	1. Resident #33 [redacted] order was reviewed and addressed by the physician. 2. A Pharmacy review was completed by the DON/ Pharmacy Consultant? to ensure that there was no other residents prescribed [redacted] for more than the recommended time period. 3. A Meeting was held with the Pharmacy Consultant Supervisor on 10/19/19 to discuss survey findings as it related to pharmacy consultant services and the issues identified during DOH survey. Pharmacy Consultant will be re-educated chart reviews in the elderly by her supervisor. DON/ designee will review all residents on [redacted] monthly to assure duration of treatment is appropriate. 4. The results of these audits and the pharmacy consultant reports will be review quarterly at the Quality Assurance Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

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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 756	Continued From page 38	F 756		

Order sheets revealed that Resident #33 was treated with [redacted] mg) twice daily for [redacted] since [redacted]. [redacted] is a [redacted] similar to the [redacted]. [redacted] e is used to treat [redacted] in people. The recommended duration of therapy is approximately [redacted] weeks as per the Federal Drug Administration and the manufacturer.

A review of the resident's Monthly Weight and Vital Signs Record reveals weight loss in January 2019 of [redacted] (lbs.) (weight [redacted] lbs.) to August 2019 loss of 19 lbs. (weight [redacted] lbs.). Despite the use of [redacted] for [redacted], the resident had a 1[redacted] weight loss in [redacted] months, from [redacted] to [redacted] 2019.

A review of the Consultant Pharmacist Evaluation sheet dated [redacted] to [redacted], revealed no recommendation entries to evaluate the duration of therapy or continued need of therapy with [redacted]

The surveyor requested any CP written recommendations for Resident #33, evaluating for continued treatment of [redacted] therapy from the Director of Nursing (DON).

On 9/26/19 at 3:00 PM, the surveyor met with the DON, Administrator and Regional Nurse. The Regional Nurse informed the surveyor that there were no written recommendations to evaluate the continued need for [redacted] from the CP. The DON stated that she reached out to the Consultant Pharmacist who could not provide any further information as to why an evaluation of need or the duration of therapy with [redacted] was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315224	A. BUILDING _____ B. WING _____	C 09/27/2019

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F 756	Continued From page 39 not recommended.	F 756		
F 761 SS=D	NJAC 8:39 - 29.3 (a 1, 6) 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 maintain proper refrigerator temperatures for storing medication. This deficient practice was	F 761	1. The Refrigerator was defrosted on 9/27/19 and is maintaining temperature within the acceptable range. Log on the refrigerator indicating the appropriate	11/20/19

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F 761	Continued From page 40 observed for 1 of 2 facility medication refrigerators inspected. The deficient practice was evidenced by the following: On 9/22/19 at 12:25 PM, the surveyor inspected in the presence of the unit Registered Nurse # 1 (RN 1), the refrigerator located in the medication storage room of the [redacted] Unit. RN 1 confirmed that the temperature displayed on the thermometer read 32 degrees Fahrenheit (F). The surveyor interviewed RN 1 who stated that the refrigerator was routinely inspected, and temperatures are documented on the 11-7 facility nursing shift. The surveyor reviewed the September 2019 "Medication Refrigerator Audit" sheet (MRA) located in a plastic sleeve attached to the refrigerator. The MRA section titled "Temperature (34-46 degrees F) had numerous entries at or below the temperature limits. The MRA showed documentation of temperatures on 9/3/19 of 32 F, 9/7/19 34 F, 9/11/19 30 F, 9/13/19 34 F, 9/14/19 32 F, 9/15/19 32 F, 9/16/19 30 F, 9/17/19 30 F, 9/19/19 34 F, 9/20/19 30 F and 9/21/19 32 F. The MRA section titled, "Action Taken" had daily entries of "maintenance notified" from 9/1/19 to 9/21/19. The surveyor informed the facility that the refrigerator temperature when inspected on 9/22/19, was below the required storage temperature. The Regional Nurse informed the surveyor that the temperatures documented on the MRA section "Temperature" were not correct and should have been "36-46 F" for storing	F 761	temperature range was updated and replaced. 2. All Unit Refrigerators were audited by the Maintenance Director to ensure that the temperatures were with the appropriate range. The logs on the unit refrigerators were audited to ensure that the appropriate temperature range present on the signs. The policy for medication storage was reviewed and revised. 3. Re-education of nurses regarding the use of the temperature log on the unit refrigerators and the notification of maintenance of any abnormalities. Licensed nurses will continue to audit the medication refrigerators daily. The results of these audits will be review by the Nurse Manager weekly and the DON monthly to maintain compliance. 4. Audits results will be submitted to the Quality Assurance Performance Improvement Committee quarterly.	

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F 761	Continued From page 41 medications. The Director of Nursing and Administrator could not provider any further information as to the outcomes of "maintenance notified" documented on the MRA or why the low temperature of the medication storage refrigerator on the Long-Term Care Unit continued to be documented with no follow up or adjustments. NJAC 8:39- 29.4(b)2	F 761		