STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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F 000	INITIAL COMMENTS	F 000		

A Recertification and Complaint Survey was conducted on behalf of the New Jersey Department of Health from 09/25/23 through 09/29/23.

THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT SURVEY.

Complaint #: NJ159120, NJ167234, NJ163179, NJ164052, and NJ166110.

Survey Dates: 09/25/23 through 09/29/23

Survey Census: 145

Sample Size: 41

On 09/27/23 at 5:10 PM, the Administrator was notified of immediate Jeopardy (IJ) in the area: F880- Infection Control. The immediate jeopardy began on 09/27/23 when the survey team identified improper sanitization of a glucometer in between resident use for R61 and R81 increasing the risk of blood borne illness infection.

The facility provided an acceptable removal plan on 09/28/23 at 2:33 PM. The removal plan included nurse removal from the medication cart, education on the facility's protocol for proper cleaning and disinfecting of glucometers intended for reuse, responsible parties including the physician were notified for further monitoring, and facility completion of audits. The survey team

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

Electronically Signed | 10/20/2023

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F 000	Continued From page 1 verified all elements of the facility's IJ Removal Plan and removed the IJ on 09/29/23 at 3:40 PM. Prior to the exit conference, the Administrator was notified the IJ was removed. The deficient practice remained at a scope and severity of an D following the removal of the IJ, with the inclusion of areas identified in the laundry room.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		10/28/23

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F 578	Continued From page 2 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to maintain the proper Advance Directive after one (Resident (R) 112) out of five residents reviewed for advance directives in a total sample of 41 residents. The facility's failure had the potential to prevent the residents from having their wishes granted for advance directives. Findings include: Review of R112's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab, revealed R112 was admitted to the facility on [redacted] with diagnoses that included NJ EX Order. 264b1 [redacted]. Review of R112's "Advance Directive," located in the EMR under the "Miscellaneous" tab, revealed R112 was documented as a NJ EX Order. 264b1 [redacted] Review of R112's "Orders," dated [redacted] and located in the EMR under the "Orders" tab,	F 578	Residents affected by deficient practice: The facility failed to maintain the proper Advance Directive for one (Resident #R112) out of five residents reviewed for advance directives in a total sample of 41 residents. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The resident affected was monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: Resident R#112 Advanced Directive was immediately reviewed and updated. All Resident charts were audited to ensure physician Advanced Directive orders matched each Resident□s POLST. All social work and nursing staff re-educated regarding policy "Advance	

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F 578	Continued From page 3 revealed a [redacted] code status order. Review of R112's "New Jersey Universal Transfer Form," dated [redacted] and located in the EMR under the "Miscellaneous" tab, revealed that R112 returned to the facility from the hospital with a code status of [redacted] Code. During an interview on 09/26/23 at 4:43 PM the Social Services Director (SSD) revealed "R112 was a [redacted] when [redacted] went out to the hospital and upon her return, the discharge summary stated [redacted] code. The SSD stated the nurses receiving the resident back to her room, would have transferred the orders into the EMR. She stated she called R112's [redacted] to confirm the code status and [redacted] stated to keep the original code status of [redacted]. During an interview on 09/26/23 at 4:59 PM the Director of Nursing (DON) revealed "I just changed R112's code status back to [redacted]. When the resident returned to the facility, a hospital summary with all new orders was entered into the EMR by the unit manager. The hospital summary stated [redacted] code and that is what was entered into the system. They did not check to make sure the summary matched the residents original order for [redacted] The unit manager no longer works in this facility." Review of the facility's policy titled "Advance Directives," dated 01/19," documented "Advance directives will be respected in accordance with state law and facility policy ...Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so	F 578	Directives" and that physician orders must match everything indicated on the POLST. Director of Social Services/designee will review annually with each resident his or her advance directives to ensure that such directives are still the wishes of the resident. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Social Services/designee to conduct compliance audits of resident-specific Advanced Directives. The duration of all audits will consist of completion one-time weekly x 4 weeks then three times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion: 10/28/2023	

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F 578	Continued From page 4 ...Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." NJAC 8:39-4.1(a)2 NJAC 8:39-9.6(a) NJAC 8:39-35.2(d)14	F 578		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582		10/28/23

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F 582	Continued From page 5 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a fully completed Form CMS-10055 (Centers for Medicaid and Medicare Services) Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) to include the cost of continued services for three of three residents (Resident (R) 388, R389, and R57) reviewed for liability notices out of a total sample of 41 residents. This failure prevents the resident or responsible party the ability to make an informed decision related to the cost of continued services. Findings include: 1. Review of the beneficiary notice provided by	F 582	Residents affected by deficient practice: The facility failed to provide a fully completed Form CMS-10055 (Centers for Medicaid and Medicare Services) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to include the cost of continued services for three of three residents (Resident R#388, R#389, and R#57) reviewed for liability notices out of a total sample of 41 residents. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice.	

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F 582	Continued From page 6 the facility revealed R389 was admitted to NJ EX Order. 264b1 Services on NJ EX Order. 264b1 The last covered day of NJ EX Order. 264b1 Services was NJ EX Order. 264b1. The SNFABN was issued on NJ EX Order. 264b1 by the Social Services Director (SSD) to the responsible party. In the section labeled " ... F. Estimated Cost ..." the SSD did not put a cost. This failure to include the estimated cost prevented the resident representative from making an informed decision about continuing to receive NJ EX Order. 264b1 and NJ EX Order. 264b1 services. 2. Review of the beneficiary notice provided by the facility revealed R388 was admitted to NJ EX Order. 264b1 Services on NJ EX Order. 264b1. The last covered day of Part A Skilled Services was NJ EX Order. 264b1. The SNFABN was issued on NJ EX Order. 264b1 by the SSD to the responsible party. In the section labeled " ... F. Estimated Cost ..." the SSD did not put a cost. This failure to include the estimated cost prevented the resident representative from making an informed decision about continuing to receive NJ EX Order. 26 therapy. 3. Review of the beneficiary notice provided by the facility revealed R57 was admitted to NJ EX Order. 264b1 Services on NJ EX Order. 264b1 The last covered day of NJ EX Order. 264b1 Services was NJ EX Order. 264b1. The SNFABN was issued on NJ EX Order. 264b1 by the SSD to the responsible party. In the section labeled " ... F. Estimated Cost ..." the SSD did not put a cost. This failure to include the estimated cost prevented the resident representative from making an informed decision about continuing to receive NJ EX Order. 264 and NJ EX Order. 264b1 services. During an interview on 09/27/23 at 2:33 PM the SSD revealed "When I started working at this	F 582	The residents affected were either discharged back to the community or to LTC with no known adverse effects of the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: All affected Residents have all been discharged. The facility provides Residents a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), that has been updated to provide a good faith estimate of projected costs of care in section labeled "F. Estimated Cost", at the time of SNFABN delivery. All social work and business office staff re-educated to ensure a good faith estimate of projected costs of care is included in section labeled "F. Estimated Cost" on each Resident specific Skilled Nursing Facility Advance Beneficiary Notice. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Social Services/designee to conduct compliance audits of resident-specific Skilled Nursing Facility Advance Beneficiary Notices. The duration of all audits will consist of completion one-time weekly x 4 weeks then three times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding	

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F 582	Continued From page 7 facility, the regional director who trained me, told me not to put down the costs because they change daily. I have never put the cost down on the form." During an interview on 09/27/23 at 4:14 PM the Administrator revealed "The costs are covered and reviewed with the resident on the admission paperwork. We do not put the actual cost on the Beneficiary Notices because they are constantly changing." NJAC 8:39-5.1(a)	F 582	the need for continued submission and reporting.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to protect the rights of one (Resident (R) 121) of five residents reviewed for abuse of 41 sample residents to be free from [redacted] abuse by	F 600	Based on record review, staff interviews, and facility policy review, the facility failed to protect the rights of one (Resident (R) 121) of five residents reviewed for abuse of 41 sample residents to be free from	10/28/23

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F 600	Continued From page 8 another resident (R44). This failure had the potential to cause NJ EX Order. 264b1 and/or NJ EX Order. 264b1 harm to R121. Findings include: A. Review of R121's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnoses including NJ EX Order. 264b1 [redacted]. R121 resided on the [redacted] NJ EX Order. 264b1 unit. Review of R121's quarterly "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of [redacted], revealed she was NJ EX Order. 264b1 the "Brief Interview for Mental Status (BIMS)" and was assessed by staff with NJ EX Order. 264b1 and NJ EX Order. 264b1 . R121 was NJ EX Order. 264b1 [redacted] or NJ EX Order. 264b1. She exhibited physical behavioral symptoms directed toward others. R121 required supervision with bed mobility, transfers, and locomotion and ambulated independently. Review of R121's "Care Plan," located under the "Care Plan" tab of the EMR and dated 11/06/22, revealed "The resident has a NJ EX Order. 264b1 r/t [related to] disease process NJ EX Order. 264b1 [redacted] [and] NJ EX Order. 264b1." The interventions included: "Administer medications as ordered. Monitor/document for side effects and effectiveness. . . Anticipate and meet the resident's needs. . . Assist [R121] to develop	F 600	physical abuse by another resident (R44). This failure had the potential to cause NJ EX Order. 264b1 and/or NJ EX Order. 264b1 harm to R121. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #121 and Resident #44 were assessed by RN for signs and symptoms of NJ EX Order. 264b1. No signs of [redacted] were noted on both Residents #121 and #44. Resident #44 was placed on behavior monitoring to ensure that other residents in proximity will not be harmed because of resident□s [redacted]. Resident #121 was monitored for indications of NJ EX Order. 264b1 harm from the incident. None noted II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents in the same unit as Resident #44 are at risk for the same deficient practice. No other residents were affected. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All staff were in-serviced on the regulations governing F-600 and Facility□s Policy regarding Abuse and Neglect - Reporting and Investigating."	

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F 600	Continued From page 9 more appropriate methods of NJ EX Order. 2 and NJ EX Order. 264b1 Encourage the resident to express feelings appropriately. . . [and] Explain all procedures to [R121] before starting and allow the resident to adjust to changes." During an observation in the NJ EX Order. 264b1 unit NJ EX O dining room on 09/25/23 at 12:22 PM, R121 was seated in a reclining wheelchair. NJ EX O did not respond to questioning upon interview and did not make NJ EX Order. 264b1 or any acknowledgement of questioning. Review of R121's "General Note," located under the "Notes" tab of the EMR and dated NJ EX Order. 264b1 revealed "This evening at approximately 6:54 PM, [R121] was observed by the charge nurse ambulating in the hall when another resident [R44] approached NJ EX O and NJ EX Order. 264b1 on the NJ EX O. Staff immediately intervened and separated residents. Head to toe assessment completed with no injuries observed. NJ EX Order. 264b1, or s/s [signs/symptoms] of NJ EX Order at this time. No complaints or s/s of NJ EX Des. MD [physician] and NJ EX Order. 264b1 . .made aware." Review of R121's "Care Plan" under the "Care Plan" tab of the EMR revealed an update on NJ EX Order. 264b1 which documented, "The resident is NJ EX Order. 264b1NJ EX Order. 264b and uses other patient's bathrooms NJ EX Order. 264b1 ." The goal was "The resident's safety will be maintained through the review date." The interventions included: "Distract resident NJ EX Order. 264b1 by offering pleasant diversions, structured activities, food, conversation, television, book. . . Frequent checks to ensure comfort and safety. . . Identify NJ EX Order. 264b1 Is NJ EX Order. 264b1 ? Is resident NJ EX Order. 264b1	F 600	Emphasis was made on close monitoring of residents who exhibit physically aggressive behavior and keeping them away from other residents to prevent them from inflicting potential NJ EX Order. 264b1 abuse or harm on other residents. IV. MONITORING OF CORRECTIVE ACTIONS TO PREVENT REOCCURRENCE: The Unit Manager or Designee will conduct Observation Audits in each unit weekly x 2 weeks and monthly x 3 months to identify any residents who exhibits physically aggressive behaviors. If Unit Manager or designee identifies a resident with NJ EX Order. 264b1 behaviors, Administrator or Designee will be notified immediately. Medical Records will be reviewed for proper documentation, reporting, investigation, and management, as appropriate. Any issues will be addressed immediately by the Administrator/Designee. Results of the audits will be reported to the QAPI Committee monthly. The Administrator or designee will be responsible for ensuring compliance monthly. QAPI Committee will determine the need for further audits and/or action plans.	

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F 600		F 600		

Continued From page 10

NJ EX Order. 264b1? Does it indicate the need for more exercise? Intervene as appropriate. . . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, NJ EX Order. 264b1 [and] NJ EX Order. 264b1 f/u [follow up] . . .Redirect [R121] from NJ EX Order. 264b1 and NJ EX Order. 264b1 . . Scheduled NJ EX Order. 264b1 NJ EX Order. 264b1: Before breakfast, lunch, dinner, HS [hour of sleep] [and] PRN [as needed] . . . [and] SW [Social Worker] to follow up to ensure no lasting effects/offer emotional support from incident on 4/1 [04/01/23]."

B. Review of R44's "Admission Record" under the "Profile" tab of the EMR revealed NJ EX Order. 264b1 was admitted to the facility on NJ EX Order. 264b1 with diagnoses including NJ EX Order. 264b1 NJ EX Order. 264b1 resided in the NJ EX Order. 264b1 NJ EX Order. 264b1 unit.

Review of R44's quarterly "MDS" assessment under the "MDS" tab of the EMR, with an ARD of NJ EX Order. 264b1, revealed NJ EX Order. 264b1 scored NJ EX Order. 264b1 on the "BIMS," indicating NJ EX Order. 264b1 was sometimes able to make NJ EX Order. 264b1 others. She exhibited occasional NJ EX Order. 264b1 of NJ EX Order. 264b1 behaviors directed toward others, and other behaviors not directed toward others. R44 required extensive assistance with transfers and bed mobility and used a wheelchair for locomotion.

Review of R44's "Care Plan" located in the "Care Plan" tab of the EMR, dated NJ EX Order. 264b1, revealed, "[R44] has a NJ EX Order. 264b1 r problem of being NJ EX Order. 264b1 towards others r/t

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COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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NJ EX Order. 264b1." The goal was, "The resident will have fewer episodes of NJ EX Order. 264b1 behaviors by review date." The approaches included: "Administer medications as ordered. Monitor/document for side effects and effectiveness. . . "Anticipate and meet the resident's needs. . . Caregivers provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. . .. Explain all procedures to the resident before starting and allow the resident (X minutes) to adjust to changes. . . Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. . . Minimize potential for the resident's NJ EX Order. 264b1 behaviors (SPECIFY) by offering tasks which divert attention such as (SPECIFY). . . Monitor NJ EX Order. 264b1 episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. . . Praise any indication of the resident's progress/improvement in behavior. . .. Provide a program of activities that is of interest and accommodates residents [sic] status. . . [and] NJ EX Order. 264b1 follow up."

During an observation in the NJ EX Order. 264b1 NJ EX Order. 264b1 unit hallway on 09/25/23 at 3:33 PM, R44 was self-propelling a wheelchair and NJ EX Order. 264b1 a NJ EX Order. 264b1 R44 was talkative, but NJ EX Order. 264b1 and giving NJ EX Order. 264b1. NJ EX Order. 264b1 was NJ EX Order. 264b1 and NJ EX Order. 264b1 sounding.

Review of R44's "General Note," found in the "Notes" tab of the EMR and dated NJ EX Order. 264b1 revealed, "Spoke with . . NJ EX Order. 264b1 to inform her of [R44's] behaviors this shift involving another resident. Residents were separated and are now

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being monitored closely to maintain safety. [R44] was assessed by supervisor head to toe and has positive range of motion with no alterations in skin integrity. [R44] does not show any s/s of [redacted] MD made aware. Resident currently in bed at this time with safety precautions maintained."

Review of R44's "Care Plan" revealed an intervention was added on [redacted] that documented, "Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed."

C. Review of the facility's "Reportable Event Record/Report," provided on paper and dated [redacted] revealed a resident-to-resident abuse incident was reported at 7:30 PM to the State Survey Agency. The report documented, "On [redacted] on the memory unit around 6:54 PM, [R44] became [redacted] after [R121] used [redacted] r bathroom; [redacted] came into the hallway where agency staff witnessed [redacted] [R121] on the [redacted] Staff then intervened and separated the residents. Both patients are NJ EX Order: 264b1 [redacted] are [redacted], and reside on the [redacted] unit. In an abundance of caution, the [redacted] is being monitored under increased supervision. [The State Survey Agency], MD, [Name] Township Police Department, and responsible parties were notified. Investigation initiated. At this time, head to toe assessments have been completed with no injuries observed . . . No previous history between these two residents. Both residents were immediately separated and assessed with no inuries [sic] observed. Increased supervision initiated for [redacted] "

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F 600	Continued From page 13 Review of the undated "Investigational Summary," provided on paper, revealed "At approximately 6:54 PM on NJ EX Order. 264b1 the Director of Nursing was notified by the on-call manager that [R44] . . . became annoyed after another [R121] . . .used NJ EX Or bathroom. NJ EX Or then came into the hallway where an agency nurse witnessed NJ EX Order. [R121] on the NJMJ EX . . . Action: -Both residents were immediately separated -Both residents were assessed for injury, no injuries found on either resident NJ EX Order were ordered for both residents . . . -SW follow up with both residents noting no lasting negative effect -NJ EX Order. 264b1 re-evaluation ordered for both residents -NJ EX Order. 264b1 evaluation ordered -Statements obtained -Ombudsman office notified -PCPs [primary care providers] notified -Families notified -[State Survey Agency] and [Name] Twp [Township] Police notified . . . Resident's Pertinent Medical Data: [R44] is NJ EX Order. 264b1], "BIMS" NJ E . She is NJ EX Order. 264b1 for bathing and personal hygiene and limited assist for dressing. NJ EX Or has NJ EX Order. 264b1 and she transfers via self at times, and other times requires NJ EX Order. 264b1 is able to NJ EX Order. 264b1 in NJ EX Or w/c [wheelchair]. . . [R121] is NJ EX Order. 26 , "BIMS" NJ EX Order. 264b1 is dependent with bathing, dressing, and personal hygiene. NJ EX Order. 264b1 , is NJ EX Order. 264b1 of NJ EX Order. 264b1 at times however does utilize the toilet. NJ EX Or explores and ambulates ad lib [freely] throughout the unit. . .	F 600		

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F 600	Continued From page 14 Events Preceding Incident: There were no issues between these residents prior to this incident. . . Statement Summary: ". . . Per agency nurse . . . at approximately 6:46 PM, while in [R44's] room attending to [R44], [R121] entered the room and utilized the bathroom. [R44] immediately became [redacted] [sic] and [redacted] to remove [R121] from [redacted] room. Once [R121] was finished using the restroom, [the agency nurse] removed [redacted] from the room. Approximately 8 minutes later, [the agency nurse] observed [R44] self propelling [sic] toward the nurses station where [R121] was standing. [R44] then [redacted] [R121] on the [redacted], stating she was unable to get around the nurses station quick enough. Facility staff immediately intervened and removed [R44] from the area. Both residents were assessed for injury. No other [redacted] was noted for either resident. . .. Follow Up Action: [redacted] results will be reviewed by the MD and make appropriate changes as needed -NJ EX Order. 264b1 will follow up with both residents when they are at the facility -Social services will follow up with both residents and offer emotional support [redacted] evaluation for both residents -Care Plans reviewed for both residents and updated. Conclusions: The IDC [Inter-Disciplinary Care] Team met to discuss and review the incident. After conducting a comprehensive investigation, the facility is not able to validate the allegation of abuse as evidenced by the following facts: both residents have NJ EX Order. 264b1 and based upon re-interview by the DON [Director of	F 600		

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Nursing] on [redacted], neither resident [redacted] the incident. Based on the investigation that included resident and staff interviews, resident record review, the facility has concluded it was an isolated incident between these 2 resident [sic] with no premeditated intent to cause harm. The findings of this investigation have been shared with residents' physicians, who are in agreement with facility findings." This summary was signed by the DON.

Review of a paper "Individual Statement Form," dated [redacted] revealed the agency nurse documented, "This nurse was in [R44's] room . . . at approximately 6:46 PM speaking to [R44] while she was lying in her bed. [R121] walked into the room and walked into the bathroom. [R44] started [redacted] at [R121] to get out of [redacted] bathroom. This nurse walked to the open bathroom door and observed [R121] had [redacted] and was sitting on the [redacted] with toilet paper in [redacted]. This nurse walked back to the still [redacted] [R44]. [R44] [redacted] at this nurse to get [redacted] " out of the bathroom. This nurse explained to [R44] that the patient was utilizing the toilet and that this nurse could not get [redacted] of the [redacted] at this moment or the patient would make a mess on the floor. [R44] kept [redacted] for the other patient to get out of [redacted] bathroom and to NJ EX Order. 264b1 [redacted] [R44] was also [redacted] that [redacted] was going to [redacted] ' and [redacted] This nurse stayed in the bedroom until [R121] left the bathroom and the room. . . At approximately 6:54 PM, this nurse was behind the nurse's station when this nurse observed [R44] in the hallway next to the nurse's station in her wheelchair. [R44] began to [redacted] at [R121] saying, 'you stay out of my room' and 'I'll make sure you do.' [R44] then rolled [redacted] wheelchair towards [R121] who was

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leaning against the nurse's station. While [redacted] [R44] hit [R121] on [R121's] NJ EX Order. 264b1 times. [R121] was attempting to move away from [R44]. Three staff members immediately seperated [sic] [both residents] before this nurse could come from behind the nurse's station. [R44] continued [redacted] for approximately [redacted] at other resident [sic] who walked [redacted]. This nurse obtained vital signs from each resident. This nurse also assessed the skin on each resident. [R121] . . . Skin intact on NJ EX Order. 264b1. No NJ EX Order. 264b1 observed. [R121] stated that [redacted] was not in [redacted] [R44] . . .Skin intact on [redacted] bilateral hands, wrists, and forearms. No skin discolorations observed. [R44] stated that she was not in pain."

On 09/26/23, contact information for the agency nurse was requested from DON, who stated the agency nurse no longer worked in the facility and there was no available information on her. DON did not provide the name of the agency or any additional information prior to survey exit.

During an interview on 09/29/23 at 1:18 PM, the DON stated the incident was isolated with no premediated intent and neither resident remembered the incident a few days later. She stated R44 was witnessed [redacted] R121 on the [redacted] in the hallway after getting [redacted] with R121 for using [redacted] bathroom. The DON stated she did not believe this was a premeditated action, as both residents had [redacted] and [redacted]." The DON stated the IDT Team made the determination that abuse did not occur because the action was not premeditated. The DON stated the incident was reported and investigated, and interventions were developed to prevent recurrence.

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F 600	Continued From page 17 During an interview on 09/29/23 at 2:19 PM the Administrator, who served as the facility's Abuse Coordinator, stated he would follow the facility policy to determine whether abuse occurred, and believed any willful action with an intent to cause harm was considered abuse. The Administrator stated actions such as hitting, kicking, and scratching constituted physical abuse. The Administrator stated he did not believe the incident between R44 and R121 was abuse, as R44 had NJ EX Order. 264b1 and therefore was unable to formulate an intent to harm. Review of the facility's policy titled "Abuse Prevention Program," dated 03/21, revealed, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes . . . verbal, mental, sexual, or physical abuse . . . As part of the resident abuse prevention, the administration will . . . protect our residents from abuse by anyone including . . . other residents . . .[and] identify and assess all possible incidents of abuse." Cross-reference F607: Develop and Implement Abuse Policies and Procedures - The facility's "Abuse Prevention Program" policy did not include a definition of physical abuse or specifically address resident-to-resident altercations.	F 600		
F 607 SS=D	NJAC 8:39-4.1(a)5 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		10/28/23

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F 607	Continued From page 18 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to develop policies and procedures that identified abuse, including NJ EX Order. 264b1 abuse, in order to prohibit and prevent abuse for one (Resident (R) 121 of five residents reviewed for abuse of 41 sample residents. This failure had the potential to cause NJ EX Order. 264b1 injury and/or NJ EX Order. 264b1 harm to R121.	F 607	Based on record review, staff interviews, and facility policy review, the facility failed to develop policies and procedures that identified abuse, including NJ EX Order. 264b1 abuse, in order to prohibit and prevent abuse for one (Resident (R)121 of five residents reviewed for abuse of 41 sample residents. This failure had the potential to cause NJ EX Order. 264b1 injury and/or NJ EX Order. 264b1	

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F 607	Continued From page 19 Findings include: Review of R121's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnoses including [redacted] with NJ EX Order. 264b1 [redacted] unit. Review of R44's "Admission Record" under the "Profile" tab of the EMR revealed she was admitted to the facility on [redacted] with diagnoses including NJ EX Order. 264b1 [redacted] resided in the NJ EX Order. 264b1 [redacted] unit. Review of the facility's "Reportable Event Record/Report," provided on paper and dated [redacted], revealed a resident-to-resident abuse incident was reported at 7:30 PM to the State Survey Agency. The report documented, "On [redacted] on the [redacted] unit around 6:54 PM, [R44] became [redacted] after [R121] used [redacted] bathroom; [redacted] came into the hallway where agency staff witnessed [redacted] [R121] on the [redacted] Review of the undated "Investigational Summary," provided on paper, revealed an agency nurse witnessed R44 get [redacted] when R121 used [redacted] bathroom, and approximately [redacted] later, R44 located R121 in the hallway, yelled things like, "NJ EX Order. 264b1 [redacted]" and proceeded to hit R121 on the arm three times before staff were able to separate the residents. The investigation's conclusion documented, "The IDC [Inter-Disciplinary Care] Team met to discuss and	F 607	harm to R121. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Facility□s "Abuse Prevention Program" policy was revised to include a definition of [redacted] abuse and specifically address NJ EX Order. 264b1 altercations in order to properly identify a situation of potential abuse. Resident #121 and Resident #44 were assessed by RN for signs and symptoms of harm or injury. No signs of physical injury were noted on both Residents #121 and #44. Resident #44 was placed on behavior monitoring to ensure that other residents in proximity will not be harmed because of resident□s behavior. Resident #121 was monitored for indications of [redacted] harm from the incident. None noted. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk for the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All staff were in-serviced on the revised Facility "Abuse Prevention Program" policy. Emphasis was made on the	

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F 607	Continued From page 20 review the incident. After conducting a comprehensive investigation, the facility is not able to validate the allegation of abuse as evidenced by the following facts: both residents have NJ EX Order. 264b1 and based upon re-interview by the DON [Director of Nursing] on NJ EX Order. 264b1, neither resident can recall the incident. Based on the investigation that included resident and staff interviews, resident record review, the facility has concluded it was an isolated incident between these 2 resident [sic] with no premeditated intent to cause harm. The findings of this investigation have been shared with residents' physicians, who are in agreement with facility findings." This summary was signed by the DON. During an interview on 09/29/23 at 1:18 PM, the DON stated the incident was isolated with no premediated intent and neither resident remembered the incident a few days later. She stated R44 was witnessed NJ EX Order. 264b1 R121 on the arm in the hallway after getting NJNJ EX Or with R121 for using NJ EX bathroom. The DON stated she did not believe this was a premeditated action, as both residents had NJ EX Order. 264b1 and NJ Ex Order. 264b1 ." The DON stated the IDC Team made the determination that abuse did not occur because the action was not premeditated. When asked if the IDC Team had discussed whether R44's actions were 'willful,' she stated she based her identification of abuse on a requirement of "premeditation," not "willful action." During an interview on 09/29/23 at 2:19 PM the Administrator, who served as the facility's Abuse Coordinator, stated he would have followed the facility policy to define abuse. The Administrator	F 607	definition of NJ EX Order. 264b1 abuse and how to address NJ EX Order. 264b1 altercations in order to properly identify a situation of potential abuse. IV. MONITORING OF CORRECTIVE ACTIONS TO PREVENT REOCCURRENCE: Administrator or Designee will conduct 5 Staff Interview audits per month x 3 months to determine staff□s knowledge of the revised Facility "Abuse Prevention Program" policy. Questions will be geared towards the definition of physical abuse and how to address resident-to-resident altercations in order to properly identify a situation of potential abuse. Any issues will be addressed immediately by the Administrator/Designee. Results of the audits will be reported to the QAPI Committee monthly.	

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reviewed the facility's "Abuse Prevention Program" policy, and stated the policy did not include a definition of abuse to aid in identification of abuse, especially resident-to-resident abuse.

The Administrator further stated he believed any willful action with an intent to cause harm was considered abuse. The Administrator stated actions such as hitting, kicking, and scratching constituted physical abuse. The Administrator stated he did not believe the incident between R44 and R121 was abuse, as R44 had cognitive impairment and therefore was unable to formulate an intent to harm. The Administrator further explained that "neither [resident] had the NJ EX Order. 264b1 actions and NJ EX Order. 264b1 Because [R44] NJ EX Order. 264b1 doesn't have an NJ EX Order. 264b1 " The Administrator added the investigation showed R44 stated clearly what [redacted] was going to do to R121 as she tracked R121 down in the hallway. The Administrator stated he based his identification of abuse on a definition that included "intent to cause harm," not "willful action."

Review of the facility's policy titled "Abuse Prevention Program," dated 03/21, revealed, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes . . . verbal, mental, sexual, or physical abuse . . . As part of the resident abuse prevention, the administration will . . . protect our residents from abuse by anyone including . . . other residents . . . [and] identify and assess all possible incidents of abuse." The "Abuse Prevention Program" policy did not include a definition of physical abuse or

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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 607	Continued From page 22 specifically address resident-to-resident altercations in order to properly identify a situation of potential abuse. APPENDIX-B IX	F 607		
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 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 record review, staff interview, and	F 657	Residents affected by deficient practice:	10/28/23

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	315219	A. BUILDING _____ B. WING _____	C 09/29/2023

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F 657	Continued From page 23 facility policy review, the facility failed to ensure the comprehensive "Care Plan" was revised to reflect resident-specific information regarding behavioral symptoms and activities of daily living (ADL) assistance for two (Resident (R) 119 and R288) of 41 sample residents. These failures had the potential to lead to unmet behavioral and/or ADL needs for these two residents due to a lack of care-planned interventions. Findings include: 1. Review of R119's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] and re-admitted on [redacted] R119 had diagnoses including [redacted] and [redacted]. Review of R119's quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of [redacted], revealed [redacted] scored [redacted] on the "Brief Interview for Mental Status (BIMS)" indicating [redacted] exhibited [redacted] and no [redacted] symptoms. R119 required extensive assistance by one staff member with bed mobility and transfers. [redacted] received [redacted] medications daily. a. Review of R119's "Orders" tab of the EMR revealed the following active orders: [redacted] medication), [redacted] milligrams (mg) at [redacted], with a start date of [redacted], and	F 657	The facility failed to ensure the comprehensive care plan was revised to reflect resident-specific information regarding behavioral symptoms and activities of daily living assistance for 2 (Resident #R119 and Resident #R288) of 41 sample residents. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The residents affected were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: Resident #R119 and #R288 care plans were immediately reviewed and updated. All residents care plans were reviewed for resident specific ADLs. All residents with behavior care plans were reviewed and updated as appropriate. All nursing staff re-educated on the facility policy for care plans, comprehensive person-centered and the importance of resident-specific care-planning. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing/designee to conduct compliance audits of resident-specific care-planning. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months.	

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F 657	Continued From page 24 NJ EX Order. 264b1 medication), NJ EX mg one time a day for NJ EX Order. 264b1 Review of R119's behavioral problem "Care Plan" found in the "Care Plan" tab of the EMR, dated NJ EX Order. 264b1, revealed it was not completed and did not contain any information specific to the resident. The "Care Plan" documented, "The resident has a NJ EX Order. 264b1 problem, NJ EX Order. 264b1 towards staff, r/t [related to] _____." However, the blank to fill in specific information was not completed. The goal was, "The resident will have fewer episodes of (SPECIFY: behavior) (SPECIFY: daily/weekly) by review date." The areas to specify behaviors and frequency were not specified. The approaches included: "Administer medications as ordered. Monitor/document for side effects and effectiveness; . . .Educate the resident/family/caregivers on successful coping and interaction strategies such as (SPECIFY). The resident needs encouragement and active support by family/caregivers when the resident uses these strategies." The approaches were not specific to R119 and the area to specify intervention strategies was not completed. Review of R119's psychotropic medication use "Care Plan" under the "Care Plan" tab of the EMR, dated NJ EX Order. 264b1 revealed, "[R119] uses NJ EX Order. 264b1 medications to manage target behaviors of _____ r/t NJ EX Order. 264b1." The blank to fill in target behaviors was not completed. The comprehensive "Care Plan" failed to describe R119's behavioral symptoms and appropriate intervention strategies.	F 657	Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 657	Continued From page 25 During an interview on 09/28/23 at 10:42 AM, Registered Nurse Unit Manger (RNUM) 4 stated she was responsible for the input of the specific information into the resident's "Care Plan." She stated she probably had not gotten around to putting in the specific information yet, as she had been busy and the resident's condition had changed at some point. RNUM4 stated the resident-specific information should have been completed upon implementation of the "Care Plan." RNUM4 stated she was not sure whether resident-centered NJ EX Order. 264b1 interventions had been developed for R119. During an interview on 09/29/23 at 9:56 AM, the "MDS" Coordinator (MDSC) stated she developed the "Care Plan" templates upon completion of the "MDS" assessment; however, RNUM4 was responsible for adding the resident-specific information, including medications, target behaviors, and intervention strategies. The MDSC stated the blanks and "SPECIFY" areas should have contained resident-specific information. b. During an observation on 09/25/23 at 2:27 PM in R119's room, his bed was observed with NJ EX Order. 264b1 in the up position. Review of R119's activities of daily living (ADL) "Care Plan" in the "Care Plan" tab of the EMR, dated NJ EX Order. 264b1, revealed it was incomplete and did not contain resident-specific approaches. The "Care Plan" documented, "The resident has an ADL NJ EX Order. 264b1 [disease]." The approaches included: "BATHING/SHOWERING: [R119] requires (SPECIFY what assistance) by (X) staff with (SPECIFY bathing/showering) (SPECIFY FREQ)	F 657		

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and as necessary. . . BED MOBILITY: [R119] requires (SPECIFY what assistance) by (X) staff to turn and reposition in bed (SPECIFY FREQ) and as necessary. . . DRESSING: [R119] requires (SPECIFY what assistance) by (X) staff to dress. . . EATING: [R119] requires (SPECIFY what assistance) by (X) staff to eat. . . PERSONAL HYGIENE/ORAL CARE: [R119] requires (SPECIFY assistive device) to maximize independence. . . TOILET USE: [R119] requires (SPECIFY assistance) by (X) staff for toileting. . . .TRANSFER: [R119] requires (SPECIFY what assistance) by (X) staff to move between surfaces (SPECIFY FREQ) and as necessary." The "Care Plan" did not specify the required resident-specific information, nor did it reflect the resident's use of [redacted]

During an interview on 09/28/23 at 10:40 AM, RNUM4 stated she was responsible for the input of specific information into the resident's "Care Plan." She stated she probably had not gotten around to putting in the specific information yet, as she had been busy, and the resident's condition had changed at some point. RNUM4 stated the resident-specific information should have been completed upon implementation of the "Care Plan." RNUM4 stated R119's use of [redacted] should have been addressed in the "Care Plan."

During an interview on 09/29/23 at 9:56 AM, the MDSC stated she developed the "Care Plan" templates upon completion of the "MDS" assessment; however, RNUM4 was responsible for adding the resident-specific information, including assistance needs and bed rail use. The MDSC stated the blanks and "SPECIFY" areas should have contained resident-specific

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information.

2. Review of R288's "Admission Record," located in the "Profile" tab of the EMR, revealed [redacted] was admitted to the facility on [redacted] with diagnoses including: NJ EX Order. 264b1 [redacted], and [redacted].

Review of R288's significant change "MDS" assessment under the "MDS" tab of the EMR, with an ARD of [redacted] revealed she was unable to complete the "BIMS" and was assessed by staff with NJ EX Order. 264b1 and had NJ EX Order. 264b1 with symptoms of [redacted]. R288 required NJ EX Order. 264b1 [redacted] with bed mobility and NJ EX Order. 264b1 with transfers, toilet use, locomotion, dressing, eating, personal hygiene, and bathing.

Review of R288's ADL "Care Plan" under the "Care Plan" tab of the EMR, dated [redacted] revealed, "[R288] has an ADL [redacted]." The goal was, "[R288] will improve current level of function in (SPECIFY ADLs) through the review date . . . Resident will be able to: (SPECIFY)." The approaches included: "BATHING/SHOWERING: [R288] is totally dependent on (X) staff to provide (SPECIFY bath/shower) (SPECIFY FREQ) and as necessary. . . BED MOBILITY: [R288] requires (SPECIFY what assistance) by (X) staff to turn and reposition in bed (SPECIFY FREQ) and as necessary. . . DRESSING: [R288] requires (SPECIFY what assistance) by (X) staff to dress. . . EATING: [R288] requires (SPECIFY what assistance) by (X) staff to eat. . . PERSONAL HYGIENE: [R288] requires (SPECIFY

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F 657	Continued From page 28 assistance) by (X) staff with personal hygiene and oral care." During an interview on 09/28/23 at 10:40 AM, RNUM4 stated she was responsible for the input of specific information into the resident's "Care Plan." She stated she probably had not had time to input in the specific information yet. RNUM4 stated the resident-specific information should be completed upon implementation of the "Care Plan." During an interview on 09/29/23 at 9:56 AM, the MDSC stated she developed the "Care Plan" templates upon completion of the "MDS" assessment; however, RNUM4 was responsible for adding the resident-specific information. The MDSC stated the blanks and "SPECIFY" areas should have contained resident-specific information. Review of the facility's policy titled "Care Planning," dated 09/13, revealed "Our facility's Care Planning Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident." NJAC 8:39-11.2(h) NJAC 8:39-27.1(b)	F 657		
F 686 SS=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	F 686		10/28/23

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F 686	Continued From page 29 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to ensure a newly identified area of NJ EX Order. 264b1 was assessed and treated in a timely manner for one (Resident (R) 121) of five residents reviewed for NJ EX Order. 264b1 of 41 sample residents. This failure had the potential to cause further NJ EX Order. 264b1 or NJ EX Order. 264b1 of R121's NJ EX Order. 26 Findings include: Review of R121's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on NJ EX Order. 264b1 with diagnoses including NJ EX Order. 264b1 with NJ EX Order. 264b1 Review of R121's quarterly "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of NJ EX Order. 264b1, revealed NJ EX O was unable to complete the "Brief Interview for Mental Status (BIMS)" and was assessed by staff with NJ EX Order. 264b1 R121 was NJ EX Order. 264b1 or NJ EX Order. 264b1 others. She did not exhibit behavioral symptoms. R121 required NJ EX Order. 264b1	F 686	Residents affected by deficient practice: The facility failed to ensure a newly identified area of NJ EX Order. 264b1 was assessed and treated in a timely manner for 1 (Resident #121) of 5 residents reviewed for NJ EX Order. 264b1 of 41 sample residents. Identify those individuals who could be affected by the deficient practice: All residents with NJ EX Order. 264b1 have the potential to be affected by the deficient practice. The affected resident was assessed by NJ EX Order. 26 NP on NJ EX Order. 264b1 3 and found to have the appropriate treatment in place prior to NJ EX Order. 264b1 . What corrective action will be accomplished for those residents affected by the deficient practice: The 6 at risk residents were reviewed for timely assessment and treatment with no concerns noted. All nursing staff re-educated on the policy NJ EX Order. 264b1 . The education of all existing nurse staff is immediate and will be ongoing with all	

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F 686	Continued From page 30 with bed mobility and transfers and was totally dependent with toilet use and personal hygiene. NJ EX Or was at risk for NJ EX Order. 264b1 development but had no current NJ EX Order. 264b1 documented. Review of R121's "Care Plan," located in the "Care Plan" tab of the EMR and dated NJ EX Order. 264b1 revealed "[R121] at risk for NJ EX Order. 264b1 ." The goal was, "The resident will not show signs of NJ EX Order. 264b1 ." The approaches included: providing an NJ EX Order. 264b1 ; using NJ EX Order r cream with each cleansing; observing the skin for signs of breakdown like redness, cracking, and blistering; and reporting observed abnormalities. The "Care Plan" did not address any actual NJ EX Or NJ EX Order. 264b1 Review of R121's "Orders" tab of the EMR revealed an order for NJ EX Order. 264b1 to be applied to the NJ EX Order. 264b1 every shift for ' NJ EX Order. 264b1 which originated on NJ EX Order. 264b1 Review of R121's NJ EX Order. 264b1 , and NJ EX Order. 264b1 "Weekly Skin Reviews," found in the "Assessments" tab of the EMR, revealed NJ EX Order. 264 was intact with no signs of NJ EX Order. 264b1 noted. Review of R121's NJ EX Order. 264 Scale," located in the "Assessments" tab of the EMR and dated NJ EX Order. 264b1 , documented R121 was at risk for development of NJ EX Order. 264b1 Review of R121's NJ EX Order. 264b1 Note" under the "Notes" tab of the EMR, dated NJ EX Order. 264b1 , revealed "Resident has NJ EX Order. 264b1 NJ EX Order. 264b1 . Cleansed with NJ EX Order. 2 , treated, and dressed NJ EX Order. 26 and implemented NJ EX Order. 264b1 The note was written	F 686	new hires. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing/designee to conduct compliance audits of assessment and treatment of NJ EX Order. 264b1 The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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by Licensed Practical Nurse (LPN) 7.

Review of R121's EMR on 09/27/23 revealed there were no treatment orders initiated for treatment of the NJ EX Order. 264b1 identified on NJ EX Order. 264b1. There was no documentation of physician notification of the newly identified NJ EX Order. 26 and no assessment or description of the NJ EX Order. 2 to include NJ EX Order. 264b1, or other descriptors.

During an interview on 09/27/23 at 2:46 PM, LPN3 stated R121 had an NJ EX Order. 264b1, which appeared as NJ EX Order. 264b1, to NJ EX Order. 264b1. She stated the resident recently became sedentary due to a NJ EX Order. 264b1 and this placed NJ EX at risk for NJ EX Ord NJ EJ EX Order. 264b1. She stated R121 had an order for NJ EX Order. 264b1 but did not have a specific treatment order for the NJ EX Order. 2 on NJ EX Order. 264b1. LPN3 stated the NJ EX Order. 264b1 consultant usually did assessments and NJ EX Order. 264b1; however, they did not come this week.

During a telephone interview on 09/28/23 at 9:47 AM LPN7 stated NJ EX Order. 264b1 was the first day she noticed the NJ EX Order. 2 on R121's NJ EX Order. 264 She stated the protocol was to contact the physician and the supervisor to report the newly identified wound; however, it was toward the end of her shift, so she left a message with the physician's answering service and reported to the oncoming nurse for follow-up. LPN7 stated R121 was constantly sitting because of NJ EX Order. 264b1 "so we have to be very careful to prevent NJ EX Or problems."

During an interview on 09/28/23 at 10:43 AM, Registered Nurse Unit Manager (RNUM) 4 stated R121's newly identified NJ EX Orde was reported to

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her on NJ EX Order. 264b1. She stated the physician was notified of the NJ EX Order. 264b1 and the treatment ordered was NJ EX Order. 264b1. RNUM4 stated she did not know if there was an assessment of the [redacted] characteristics or any documentation to describe the [redacted]

During a telephone interview on 09/28/23 at 12:44 PM, R121's physician stated he did not receive a report of newly identified [redacted]; however, the Physician's Assistant (PA) may have received the report. The physician stated he would have expected a [redacted] treatment to be implemented "if it met that level of [redacted]" but had no information about the [redacted].

During a telephone interview on 09/28/23 at 1:38 PM, the PA stated he was notified of R121's new [redacted] on [redacted]. He stated he verbally told the nurse to keep it clean, but did not order any [redacted] treatment, as she was already receiving [redacted] ointment. The PA stated he knew R121 had "NJ EX Order. 264b1" but was not sure of the type of NJ EX Order. 264b1. He stated the [redacted] care consultant would be doing an assessment to formally diagnose and [redacted]

During an observation of R121's [redacted] on 09/28/23 at 2:09 PM, a NJ EX Order. 264b1 was observed covering NJ EX Order. 264b1 on the [redacted] LPN3 removed the [redacted] for observation. A NJ EX Order. 264b1 was observed, approximately NJ EX Order. 264b1 and [redacted].

Review of R121's "Accident/Incident Report," completed by RNUM4, provided on paper, and dated [redacted], documented a NJ EX Order. 264b1 (Cross-reference F842: Medical Records - the

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facility failed to reflect an accurate date the "Accident/Incident Report" was completed.) The "Accident/Incident Report" contained an "Individual Statement Form," dated [redacted], that documented the physician and resident's responsible party were made aware and documented, "Treatment ordered." The report documented, "The nurse was assisting the aid with changing resident when she noticed [redacted] NJ EX Order. 264b1 Resident unable to give description . . . measurements made and MD [physician] and family made aware. Treatment was ordered." The injury type was described as NJ EX Order. 264b1 to the [redacted]. The report also documented, "IDT [Interdisciplinary Team] met to discuss [R121's] NJ EX Order. 264b1 which was noted by nurse while providing [redacted] care. Supervisor made aware and came to assess patient head to toe. No further new alterations [redacted] noted. Resident denied [redacted]. MD was made aware and new treatment orders were obtained and rendered. Intervention: treatment to site as ordered. [redacted] consult. Pt [patient] to be a [redacted] NJ EX Order. 264b1 with [redacted] and [redacted]. Family aware and in agreeance [sic] with plan of care. Care plan updated." The report also included a new [redacted]," dated [redacted] and a new [redacted] Assessment," dated [redacted].

During an interview on 09/28/23 at 2:23 PM RNUM4 stated she initiated the "Accident/Incident Report" on NJ EX Order. 264b1 but dated it [redacted] since that was the day the [redacted] was identified. RNUM stated treatment for the [redacted] was NJ EX Order. 264b1 and there were no orders for [redacted] or other treatments. She stated she documented the NJ EX Order. 264b1 on the "Accident/Incident Report" she opened on

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NJ EX Order. 264b1 but there was no other assessment or description of the NJ EX Order. 26 RNUM4 did not know why R121 had a NJ EX Order. 264b1 on the NJ EX Order. 26 NJ EX Order. 264b1 upon observation, as there was no ordered.

During an interview on 09/29/23 at 1:26 PM, the Director of Nursing (DON) stated the IDT met to discuss the newly identified NJ EX Order. 264b1, NJ EX Order. 264b1. She stated the PA was notified of the NJ EX Order. 2 on NJ EX Order. 264b1 but there were no initial NJ EX Order. 264b1 or assessment on NJ EX Order. 264b1. The DON stated the only description of the NJ EX Order. 2 was documented in the "Accident/Incident Report," not in R121's notes or assessments. The DON stated she expected the nursing staff to assess and document characteristics of a newly identified NJ EX Order. 26

Review of the facility's policy titled "NJ EX Order. 264b1 - Clinical Protocol," dated 10/19, revealed, "Assessment and Recognition: 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing NJ EX Order. 264b1; for example, immobility, recent weight loss, and a history of NJ EX Order. 264b1 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of NJ EX Order. 264b1 including NJ EX Order. 264b1 and NJ EX Order. 2 presence of NJ EX Order. 264b1; b. NJ EX Ord assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. . .4. The physician will assist the staff to identify the type (for example, NJ EX Order. 264b1 r) and characteristics (presence NJ EX Order. 264b1, status of NJ EX Order. 264b1, etc.) of NJ EX Order. 264 NJ EX Order. 2. . .The physician will order pertinent treatments,

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F 686	Continued From page 35 including NJ EX Order. 264b1 surfaces, NJ EX Order. 2 and NJ EX Order. 264b1 t approaches, dressings (NJ EX Order. 264b1, etc.), and application of topical agents." NJAC 8:39-27.1(e)	F 686		
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, record review, and facility policy review, the facility failed to ensure one out of six residents (Resident (R)62) reviewed for NJ EX Ord out of a total sample of 41 residents was adequately supervised resulting in a NJ EX Order. 264b1 while the Certified Nursing Assistant (CNA) went to the bathroom to get supplies. Findings include: Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R62 was admitted to the facility on NJ EX Order. 264b1. R62's diagnoses included NJ EX Order. 264b1 and	F 689	Residents affected by deficient practice: The facility failed to ensure 1 (Resident R#62) out of 6 residents reviewed for NJ EX Ord out of a total sample of 41 sample residents was adequately supervised resulting in a NJ EX Order. 264b1 while the Certified Nursing Assistant went to the bathroom to get supplies. Identify those individuals who could be affected by the deficient practice: All residents who require supervision with care have the potential to be affected. The affected resident was assessed and monitored NJ EX Order. 264b1 for adverse effects with none noted. What corrective action will be accomplished for those residents affected	10/28/23

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F 689	Continued From page 36 NJ EX Order. 264b1 . Review of R62's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R62 was NJ EX Order. 264b1 in NJ EX Order. 264b1 Under activities of daily living (ADLs), R62 was dependent on one person for bed mobility, dressing, toilet use, and personal hygiene. R62 was NJ EX Order. 264b1 and weighed NJ EX Order. 264b1 and received NJ EX Order. 264b1 . R62 was NJ EX Order. 264b1 NJ EX Order. 264b1 on NJ EX Order. 264b1 . R62 had experienced NJ EX Order. 264b1 without injury since the previous MDS assessment. Review of the "Care Plan," dated NJ EX Order. 264b1 , in the EMR under the "Care Plan" tab revealed the focus area of "The resident has an ADL NJ EX Order. 264b1 The goal was, "The resident will maintain current level of function through the review date." Interventions included in pertinent part, 'NJ EX Order. 264b1 : The resident is totally dependent on NJ EX Order. 264b1 and NJ EX Order. 264b1 as necessary ...Personal hygiene/oral care: The resident is totally dependent on NJ EX Order. for NJ EX Order. 264b1 and NJ EX Order. 264b1 ... NJ EX Order. 264b1 : The resident is totally dependent on 1 NJ EX Order. for NJ EX Order. 264b1 Review of the "Accident/Incident Report," dated NJ EX Order. 264b1 and provided by the facility revealed R62 experienced NJ EX Order. l on this date at 8:45 PM. Review of the "Individual Statement Form," dated NJ EX Order. 264b1 by CNA7 (caregiver at the time the incident occurred) and provided by the facility	F 689	by the deficient practice: CNA #7 who was assigned during reviewed fall has been immediately educated at the time of the NJ EX Order. All residents were reviewed for adequate supervision during care, no concerns noted. All facility nursing staff re-educated on the policy "Activities of Daily Living (ADLs), Supporting" and the importance of ensuring all required items for care are present at bedside and residents are left in a safe position if leaving the bedside is necessary. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing/designee to conduct observation compliance audits of preparation and supervision during care. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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revealed CNA7, "I gathered the care materials and left the resident in bed to get a wet towel from the bathroom and on my way back to the resident, NJ EX Order. 264b1 onto the NJ EX Order. 264b1 next to the bed ..."The "Fall" Report, dated NJ EX Order. 264b1, revealed "IDT [interdisciplinary team] met to discuss [R62's] recent NJ EX O with [sic] occurred on NJ EX Order. 264b1 at 2045 (8:45 PM) hrs [hours]. When CNA was given [sic] care to the resident, CNA left unattended for a few seconds to wet a towel in bathroom. CNA found resident lying on the bedside NJ EX Order. 264b1, bed in the lowest position. CNA notified charge nurse who immediately notified RN [Registered Nurse] supervisor. No apparent injury noted, unable to assess NJ EX Order. 264b1] due to resident NJ EX Order. 264b1 were immediately stated [sic] and WNL [within normal limits]. No S&S [signs and symptoms] of injury noted. Resident was assist [sic] back to bed x2 [by two] staff. MD [medical doctor] and family notified. Intervention: Staff education on how not to leave resident unattended while given [sic] care." None of the documentation mentioned whether the NJ EX Order. 264b1 were in the NJ EX Order. 264b1 position or the location or position of R62 on the bed when the CNA left NJ EX O unattended.

During observations on 09/25/23 at 11:11 AM and 2:37 PM; on 09/26/23 at 8:45 AM and 4:34 PM; on 09/27/23 at 10:13 AM, 11:01 AM, and 12:46 PM, R62 was lying in bed with NJ EX Order. 264b1 NJ EX Order. 264b1 in the NJ EX Order. 264b1. An NJ EX Order. 264b1 was in use. R62 had NJ EX Order. 264b1 and was NJ EX Order. 264b1. R62 NJ EX Order. 264b1 to NJ EX Order. 264b1

During an interview on 09/26/23 at 4:34 PM, the family member (F)62 stated R62 NJ EX O sometime

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F 689	Continued From page 38	F 689		

between NJ EX Order. 264b1 and NJ EX Order. 264b1. F62 stated the supervisor called her and informed her R62 had fallen out of the bed. F62 stated the CNA left NJ EX on NJ EX Order. 264 in the bed and stepped away to go to the bathroom and R62 NJ EX NJ EX Order. 264b1 F62 stated R62 could not move by NJ EX Order. 264 F62 stated the CNA should not have left R62 on the bed unattended on NJ EX Order. 264b

During an interview on 09/27/23 at 10:37 AM, CNA8 stated R62 was totally dependent on staff for the provision of care.

During an interview on 09/27/23 at 1:21 PM, Licensed Practical Nurse (LPN) Unit Manager (UM)2 stated R62 NJ EX on 05/13/23 after CNA7 was giving care and went to get something in the bathroom. LPNUM2 stated CNA7 should not have left R62 unattended on the bed while going into the bathroom.

During an interview on 09/29/23 at 1:51 PM, the Director of Nursing (DON) stated CNA7 left R62 alone on the bed on NJ EX Order. 264b1 to go into the bathroom. The DON stated she did not remember if the NJ EX Order. 264b were up at the time of the NJ EX or if the resident was on NJ EX Order. 26 or where NJ EX was located on the bed; she stated the NJ EX report should include this information. The DON stated R62 did not have any NJ EX Order. 264b1, but he was on an NJ EX Order. 264b1. The DON stated if R62 was not positioned properly on the NJ EX NJ EX Order. 264b, the NJ EX Order. 264b1 could, NJ EX Order. 26 the resident out of the bed."

During an interview on 09/29/23 at 3:08 PM, CNA7 stated on NJ EX Order. 264b he had gotten his supplies to provide care to R62 who was NJ EX Order. 264b1. CNA7 stated he needed to

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F 689	Continued From page 39 wet a washcloth and left the bed to go into the bathroom. CNA7 stated the [NJ EX Order. 2640] was in the [NJ EX Order. 2640] when he went into the bathroom. CNA7 stated he was only gone a few seconds but when he came back R62 was [NJ EX Order. 2640] on the [NJ EX Order. 2640] to the bed. CNA7 stated when he left R62 to go into the bathroom, R7 was lying on [NJ EX Order. 2640] near the edge of the bed. CNA7 stated he had been educated not to leave a resident in the middle of care following the incident. Review of the facility's policy titled "Accidents and Incidents - Investigating and Reporting," dated 01/23 and provided by the facility, revealed "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator ...The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; ...c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; ...k. Any corrective action taken; ...m. Other pertinent data as necessary or required;..." NJAC 8:39-27.1(a)	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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-	F 693		10/28/23

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F 693	Continued From page 40 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of two residents (Resident (R)62), reviewed for NJ EX Order. 264b1 out of a total sample of 41 residents, had NJ EX Order. 264b1 enough while the NJ EX Order. 264b1 was being administered, which placed the resident at risk for NJ EX Order. 264b1 NJ EX Order. 264b1). Findings include: Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R62 was admitted to the facility on NJ EX Order. 264b1 R62's diagnoses included NJ EX Order. 264b1 Review of R62's quarterly "Minimum Data Set	F 693	Residents affected by deficient practice: The facility failed to ensure 1 (Resident #R62) out of 2 residents reviewed for tube feeding out of a total sample of 41 residents, had NJ EX Order. 264b1 enough while the NJ EX Order. 264b1 was being administered, which placed the resident at NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 . Identify those individuals who could be affected by the deficient practice: All residents who receive NJ EX Order. 264b1 NJ EX residents) have the potential to be affected by the deficient practice. The affected resident was monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice:	

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F 693	Continued From page 41 (MDS)" with an Assessment Reference Date (ARD) of [redacted] in the EMR under the "MDS" tab revealed R62 was [redacted] in [redacted] Under activities of daily living (ADLs), R62 was dependent on one person for [redacted]. R62 was [redacted] and weighed [redacted] and received [redacted] Review of the "Physician's Orders" in the EMR under the "Orders" tab revealed R62 was prescribed [redacted] at [redacted] with administration starting at [redacted] PM until [redacted]. R62 was [redacted]. The resident had an order to receive no [redacted]; received [redacted] the [redacted]. In addition, there was an order to, [redacted] due to [redacted] when [redacted]." Review of the "Care Plan," dated [redacted] in the EMR under the "Care Plan" tab revealed a focus of "[R62] has an [redacted] to meet [redacted] and is currently NPO." The goals included, "[R62] will not develop [redacted] over the next 90 days ... [R62] will display no signs of [redacted] over the next 90 days." Interventions included in pertinent part, "[redacted] during [redacted] ...Monitor for [redacted], [redacted], [redacted], and [redacted] changes and report ..."	F 693	[redacted] residents were observed for proper positioning and signs and [redacted] with no concerns observed. All facility nursing staff re-educated on the facility policy [redacted]-Safety Precautions and on the importance of keeping the [redacted] - [redacted] during [redacted] administration. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing/designee to conduct observation compliance audits of proper positioning for [redacted] in [redacted] residents. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 693	Continued From page 42 Observations on 09/26/23 at 8:45 AM revealed R62 was lying in bed with NJ EX Order. 264b1 being administered with a total NJ EX Order. 264b1 for the NJ EX Order. 264b1. R62's NJ EX Order. 264b1 was minimally NJ EX Order. 264b1 degrees; R62's was making NJ EX Order. 264b1 as NJ EX Order. 264b1. During an observation on 09/26/23 at 4:34 PM, R62's head of the bed continued to be NJ EX Order. 264b1 NJ EX Order. 264b1. R62's family member (F)62 was in the room and was interviewed at this time. F62 stated, "NJ EX Order. 264b1 today on NJ EX Order. 264b1, NJ EX Order. 264b1." 62 stated she notified Licensed Practical Nurse (LPN) Unit Manager (UM)2 of the NJ EX Order. F62 stated the NJ EX Order. 264b1 degrees but it should have been NJ EX Order. 264b1 higher so R62 would have been NJ EX Order. 264b1, closer to NJ EX Order. 264b1. F62 stated R62 was NJ EX Order. 264b1 NJ EX Order. 264b1 in bed or NJ EX Order. 264b1. F62 stated she had tried using the bed control to raise the NJ EX Order. 264b1 higher, but the control was not working properly, and she had been unable to raise it. During an observation on 09/27/23 at 10:13 AM, R62 was lying in bed with the NJ EX Order. 264b1 minimally NJ EX Order. 264b1. NJ EX Order. 264b1 was being administered with NJ EX Order. 264b1 having been administered at this time. R62 made NJ EX Order. 264b1 NJ EX Order. 264b1 while NJ EX Order. 264b1. During an observation on 09/27/23 at 11:01 AM, R62 was lying in bed with the NJ EX Order. 264b1 NJ EX Order. 264b1. Certified Nurse Aide (CNA)8 entered the room with the surveyor and verified the NJ EX Order. 264b1 was not high enough considering R62's NJ EX Order. 264b1 was still being administered. CNA8 took the bed control,	F 693		

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stated it was working, and raised the head of the bed to [redacted].

During an interview on 09/27/23 at 1:21 PM, LPNUM2 stated F62, who was a nurse, informed her about the [redacted] on [redacted] around 3:00-4:00 PM. LPNUM2 stated the Physician was notified by the other nurse on duty (LPN6) and requested [redacted]) and [redacted] ([redacted] lab tests. LPNUM2 stated it was not unusual for R62 to make [redacted]. LPNUM2 stated F62 told her R62 had a [redacted], and the [redacted] may have been due to that. LPNUM2 stated [redacted] could also be a sign of [redacted] LPNUM2 reviewed the EMR and stated there was no documentation of the resident's [redacted] a physical assessment of [redacted] condition, or notification to the Physician in nurses' notes or in an incident report. LPNUM2 stated she would contact the nurse to make a late entry.

During an interview on 09/28/23 at 10:07 AM, Nurse Practitioner (NP)1 stated R62's [redacted] should be elevated to [redacted] for the administration of [redacted]. NP1 stated if the head of the [redacted] than [redacted], R62 could [redacted] and verified R62 had a history of [redacted]. NP1 stated [redacted] was not normal for R62. NP1 stated R62 had many [redacted] and when he was discovered to have [redacted] the nurse should have stopped the [redacted], and contacted the Physician. NP1 stated, had she been notified, she would likely order interventions such as a [redacted] because the resident was [redacted], and nursing staff would have needed to monitor R62's [redacted] A typical course of action might also

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F 693	Continued From page 44	F 693		

include initiation of NJ EX Order. 264b1 and waiting to see how the resident was doing prior to sending NJ EX Or to the hospital immediately.

During an interview on 09/28/23 at 12:43 PM, LPN6 stated he came to work on NJ EX Order. 264b1 around 4:00 PM. LPN6 stated once he arrived, LPNUM2 informed NJ EX Or of the situation with R62 and he and LPNUM2 went to R62's room together. LPNUM2 verified F62 was in the room at that time. LPNUM2 stated he observed NJ EX Order. 264b1 from R62. LPN6 stated he called the Physician group and received a call back and a NJ EX Order. 264b1 NJ EX Order. 264b1 test was ordered for the next morning. LPN6 stated he monitored R62's NJ EX Order. 26 d R62's NJ EX Order. 264b1, and everything was normal. LPN6 verified he did not document anything that occurred until the following day on NJ EX Order. 264b1 after LPNUM2 called him to make a late entry. LPN6 stated when he entered R62's room on NJ EX Order. 26 3, the NJ EX Order. 264b1, and he stated he thought the NJ EX Order. 264b was due to this. LPN6 stated he thought F62 had NJ EX Order. 264 the head of R62's bed. LPN6 stated the NJ EX Order. 264b1 was not being administered when he entered the room on NJ EX Order. 264b1

Review of the facility's policy titled NJ EX Order. 264b1 NJ EX Order. 264b1 policy, dated 01/23 and provided by the facility, revealed "Adequate nutritional support through NJ EX Order. 264b1 will be provided to residents as ordered ...Staff caring for residents with NJ EX Order. 264b1 will be trained on how to recognize and report complications associated with the NJ EX Order. 264b1 and/or use of a NJ EX Order. 264b1 such as: a. NJ EX Order. 264b1 ...Staff caring for residents with NJ EX Order. 264b1 will be trained on how to recognize and report complications related to the

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F 693	Continued From page 45 administration of NJ EX Order. 264b1 products, such as: a. NJ EX Order. 264b1 g ... NJ EX Order. 264b1 may be affected by ...Improper positioning of the resident NJ EX Order. 264b1 ..." NJAC 8:39-27.1(a)	F 693		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and facility policy review the facility failed to ensure appropriate use of NJ EX Order. 264b1 through routine assessments for three (Residents (R) R72, R240, and R288) of 16 residents reviewed	F 700	Residents affected by deficient practice: The facility failed to ensure appropriate use of NJ EX Order. 264b1 through routine assessments for 3 (Resident #R72, #R240, and #R288) out of 16 residents	10/28/23

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F 700	Continued From page 46 for accidents of 41 sample residents. Findings include: 1. R72's "Admission Record," dated 09/29/23 and found in the electronic medical record (EMR) under the "Profile" Tab, revealed the resident was admitted to the facility on [redacted] with diagnoses including [redacted]. R72's admission "Minimum Data Set (MDS)" assessment, dated [redacted] and found in the EMR under the "MDS" Tab, revealed a "Brief Interview for Mental Status (BIMS)" assessment score of [redacted] The assessment indicated the resident required [redacted] from staff to complete all of his activities of daily living (ADLs), including transfers in and out of bed, and indicated [redacted] were not in use for the resident. R72's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" Tab, indicated orders for the resident to [redacted] as needed for [redacted]. Review of R72's "Comprehensive Care Plan," dated [redacted] and found in the EMR under the "Care Plan" Tab, indicated an Activities of Daily Living Care Plan related to the resident's limited [redacted]. Interventions on the care plan included, in pertinent part, '[redacted] as per Dr.'s (doctor's) order for safety during care provision, to assist with [redacted]. Observe for injury or entrapment related to [redacted] use. [redacted] as necessary to avoid injury."	F 700	reviewed for accidents of 41 sample residents. Identify those individuals who could be affected by the deficient practice: All residents who use [redacted] have the potential to be affected by the deficient practice. The affected residents were assessed for adverse effects of [redacted] use, none noted. What corrective action will be accomplished for those residents affected by the deficient practice: All facility nursing staff re-educated on policies "Use of [redacted]ails" and "Bed Safety". Siderail assessments were completed on all residents with [redacted] present on 9/28/2023 with no adverse effects noted. All residents with [redacted] were reassessed for appropriate use and removed as appropriate. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing/designee to conduct observation compliance audits of proper assessment of [redacted]. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and	

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F 700	Continued From page 47 R72's most recent "Nursing Comprehensive Assessment," dated [redacted] and found in the EMR under the "Evaluation" Tab, indicated the resident did not have [redacted] on [redacted] bed because they were "not indicated at this time." Review of R72's comprehensive record revealed nothing to indicate the facility's "[redacted] Assessment" had been completed for the resident since [redacted] admission on [redacted]. R72 was observed in [redacted] room laying in [redacted] bed on 09/28/23 at 2:51 PM and 4:24 PM and again on 09/29/23 at 9:14 AM. The resident's [redacted] were in NJ EX Order. 264b1 during all the observations. 2. R240's "Admission Record," dated [redacted] and found in the EMR under the "Profile" Tab, revealed the resident was admitted to the facility on [redacted] with diagnoses including [redacted] NJ EX Order. 264b1. R240's MDS Assessment was not available due to the resident's recent admission to the facility. R240's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" Tab, indicated orders for the resident to have [redacted] s as needed for mobility. Review of R240's "Comprehensive Care Plan," dated [redacted] and found in the EMR under the "Care Plan" Tab, indicated no care plan related to the resident's use of [redacted] R240's most recent "Nursing Comprehensive Assessment," dated [redacted] and found in the EMR under the "Evaluation" Tab, indicated the	F 700	reporting.	

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resident did not have [redacted] on her bed because they were "not indicated at this time."

Review of R240's comprehensive record revealed nothing to indicate the facility's [redacted] Assessment" had been completed for the resident since [redacted] admission on [redacted].

R240 was observed in her room in [redacted] bed on 09/28/23 at 3:47 PM and 4:27 PM and on 09/29/23 at 9:06 AM. The resident's [redacted] were in the [redacted] during all the observations.

During an interview with the Director of Nursing (DON) on 09/28/23 at 4:45 PM, she confirmed she was not able to find [redacted] assessments for R72 or R240 and indicated her expectation was comprehensive [redacted] assessments should have been completed at admission and at least quarterly for all residents with [redacted] installed on their beds.

3. Review of R288's "Admission Record," located in the "Profile" tab of the EMR, revealed [redacted] was admitted to the facility on [redacted] and readmitted [redacted] with diagnoses including: [redacted] delirium.

Review of R288's significant change "MDS" assessment under the "MDS" tab of the EMR, with an ARD of [redacted] revealed she was unable to complete the "BIMS" and was assessed by staff with [redacted] and had [redacted] with symptoms of [redacted] R288 required [redacted] with [redacted]

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NJ EX Order. 264b1 and NJ EX Order. 264b1. She had a history of NJ EX Or prior to admission and one NJ EX without injury in the facility.

During an observation on 09/28/23 at 2:42 PM in R288's room, NJ EX Order. 264b1 were observed on NJ EX Or bed in the NJ EX Order. 264b1.

Review of R288's "Orders" tab of the EMR revealed an order, which originated on NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1.

Review of R288's activities of daily living (ADL) "Care Plan" under the "Care Plan" tab of the EMR, dated NJ EX Order. 264b1, revealed "[R288] has an ADL NJ EX Order. 264b1 r/t [related to] NJ EX Order. 264b1" The approaches included: NJ EX Order. 264b1: NJ EX Order. 264b1 up as per Dr.'s [doctor's] order for safety during care provision, to assist with NJ EX Order. 264b1. Observe for injury or entrapment related to NJ EX Order. 264b1 use. Reposition (FREQ) and as necessary to avoid injury." The "Care Plan" did not indicate a frequency to reposition R288.

Review of the "Assessments" tab of R288's EMR revealed there was no "NJ EX Order. 264b1 Assessment."

A completed "NJ EX Order. 264b1 Assessment" for R288 was requested from the DON, who provided a paper "Nursing Comprehensive Assessment," dated NJ EX Order. 264b1, that documented R288 used NJ EX Order. 264b1 for safety.

During an interview on 09/28/23 at 4:13 PM, the DON stated there was no "NJ EX Order. 264b1 Assessment" completed for R288 to assess NJ EX need for the NJ EX Order. 264b1 with the NJ EX Or, fit of the NJ EX Or on the bed, or risks of using the NJ EX Or

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F 700	Continued From page 50 During an interview on 09/28/23 at 4:46 PM, the DON stated the "[NJ EX Order 2640] Assessment" should have been completed on initiation of the [NJ EX O] and quarterly thereafter. Review of facility's policy titled "Proper Use of [NJ EX Order 2640] Policy;" most recently revised in 05/23, read, in pertinent part "The purpose of these guidelines are to ensure the safe use of [NJ EX Order 2640] as resident mobility aids and to prohibit the use of [NJ EX Order 2640] as [NJ EX Order 2640] unless necessary to treat a resident's medical symptoms;" and "3. An assessment will be made to determine the resident's symptoms, risk of [NJ EX Order 2640] and reason for using [NJ EX Order 2640]. When used for [NJ EX Order 2640] or [NJ EX Order 2640], an assessment will include a review of the resident's a. Bed mobility; Balance; b. Safety; c. Type and Location of [NJ EX Order 2]; d. Risk of [NJ EX Order 2640] from the use of [NJ EX Order 2640]." NJAC 8:39-27.1(a)	F 700		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to	F 804	Residents affected by deficient practice: The facility failed to ensure food was	10/28/23

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F 804	Continued From page 51 ensure food was palatable for nine out of 41 sampled residents (Residents (R)28, R102, R40, R60, R119, R189, R89, R188, R97), for 27 residents residing on the [redacted] unit, and for six residents who attended the resident council interview out of 146 total residents who resided in the facility. Findings include: 1. Interviews with seven residents revealed concerns with food palatability: a. During an interview on 09/26/23 at 11:08 AM, R28 stated she had been served a moldy peanut butter and jelly sandwich. R28 stated the food was not good and the food was cold (when it should be hot). Review of R28's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] in the electronic medical record (EMR) under the "MDS" tab revealed R28 had intact cognition with a Brief Interview for Mental Status Score (BIMS) of [redacted] (score of [redacted] indicates [redacted]). b. During an interview on 09/25/23 at 9:50 AM, R189 stated the food was terrible and the coffee and food was not hot when [redacted] received it. Review of R189's admission "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab revealed R189 had [redacted] with a BIMS of [redacted] c. During an interview on 09/25/23 at 10:25 AM, R119 stated the food was terrible.	F 804	palatable for nine out of 41 sampled residents (Residents R#28, R#102, R#40, R#60, R#119, R#189, #R89, R#188, R#97), for 27 residents residing on the [redacted] unit, and for six residents who attended the resident council interview out of 146 total residents who resided in the facility. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The residents affected were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: Cooks have been educated on flavor and palpability of meals. Cooks, along with Dietary Director and/or their designee, will taste items and follow recipes to ensure good flavor and palatability. All sandwiches are served fresh and those made to be used as in-between meal snacks are properly stored and served prior to the use-by date. Food temperatures will be taken 15 minutes before every service and recorded. Dietary Director to continue monthly Resident Food Committee to determine food is getting better, staying the same or getting worse, and to act upon all reasonable specific suggestions made by the Resident Food Committee with	

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F 804	Continued From page 52 Review of R119's quarterly "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R119 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1 indicates NJ EX Order. 264b1). d. During an interview on 09/25/23 at 11:50 AM, R89 stated the food was rotten. Review of R89's quarterly "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R89 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1 e. During an interview on 09/25/23 at 11:03 AM, R102 stated the food was cold when NJ EX was served and stated it lacked seasoning. Review of R102's admission "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R102 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1. f. During an interview on 09/25/23 at 3:31 PM, R40 stated NJ EX did not like the food and was tired of the same things being served repeatedly. R40 stated the food was not always hot when NJ EX received it. Review of R40's significant change "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R40 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1. g. During an interview on 09/25/23 at 3:36 PM R60 stated NJ EX had only one complaint and it was the food, stating it was not good. Review of R60's significant change "MDS" with	F 804	monthly follow-up at the Resident Council meeting. Measures or systemic changes to ensure that the deficiencies will not recur: Dietary Director/designee to conduct food temperature audits on tray-line and on Units upon delivery. Dietary Director/designee to conduct test Tray audits. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R60 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1

h. During interviews on 09/28/23 at 4:48 PM, R97 and R188 were interviewed together. Both residents stated the food was not good. R188 stated NJ EX did not like how the salads were put together and they did not taste good. Both residents stated the food was not hot. R188 had a grilled cheese sandwich with a slice of tomato and showed the surveyor the sandwich by removing one of the slices of bread. The cheese was not melted; the resident stated it was cold and unappetizing.

Review of R97's quarterly MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R97 had intact cognition with a BIMS of NJ EX Order. 264b1 indicates NJ EX Order. 264b1

Review of R188's quarterly "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed NJ EX Order. 264b1 15 out of 15.

2. During the resident council interview on 09/27/23 at 1:00 PM, six of eight residents attending the meeting stated the food was terrible.

3. During a kitchen observation on 09/27/23 at 3:50 PM, the foods on the tray line for the dinner meal included sliced sausage in tomato-based sauce, egg souffle ("quiche"), pasta, string beans, cooked carrots, and canned fruit. The quiche was the alternative to the sausage entree, and it consisted of baked eggs cut into square pieces

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with a slice of American cheese on top. The Dietary Director (DD) verified the quiche was not actually quiche because it did not have a pie crust. Tray line meal service to residents eating on the first six carts (out of nine total carts) was observed from 4:05 PM - 4:43 PM.

On 09/27/23 at 4:43 PM the cart to the [redacted] unit left the kitchen and was pushed down to the 200 unit. At 5:01 PM, all the residents on the [redacted] unit had received their trays and the test tray of a regular diet consisting of sausage, quiche, green beans, and pasta was evaluated for flavor and temperature. The DD was present and took the temperatures of the foods. The temperatures were as follows: quiche 114 degrees F, green beans 114.7 degrees F, sausage 123 degrees F, and pasta 119 degrees F. All the foods that should have been hot were lukewarm which was verified by the DD. The DD stated his goal was for residents to receive their trays at a minimum temperature of 135 degrees F. The flavor was acceptable; although the quiche was not appetizing in appearance (spongy egg with a slice of American cheese on top, and no pie crust).

4. During an interview on 09/27/23 at 4:44 PM, the DD stated he did not receive many food complaints and residents were complimentary of the food. The DD stated they had a food committee meeting monthly; however, one resident dominated the meeting, and it was difficult for other residents to provide input. The DD stated they did not record how many residents attended the meetings, who attended the meetings, or what individual residents said. The DD stated he was informed of specific preferences during the meeting, and he updated residents' tray cards from the information in the

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F 804	Continued From page 55 meeting. The DD stated the meetings were short and typically lasted less than ten minutes. During an interview on 09/29/23 at 9:18 AM, the Dietary District Manager and the DD stated they would try new approaches to solicit residents' feedback about the food since the residents rarely provided any negative feedback. During an interview on 09/29/23 at 10:00 AM, the Registered Dietitian (RD) stated she had been employed in this capacity for nine months. The RD stated she met with newly admitted residents and obtained their food preferences; she met with residents periodically and as needed after that. The RD stated she received food complaints and passed on specific complaints from residents to the DD so their tray cards could be updated. The RD stated she had given the DD some ideas regarding the food, but there was not much leeway. The RD stated she would like to have input into the menu and tray card system, but she did not have access because she did not work for the same company that the DD worked for (DD and menus were contracted with a specific company). The DD stated the food should be at least 130 degrees F when residents received their meals. Review of the facility's policy titled "Food: Quality and Palatability," dated 09/17 and provided by the facility, revealed "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature ..." NJAC 8:39-17.4(a)2	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime	F 809		10/28/23

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F 809	Continued From page 56 CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure meals were served at regular times comparable to those in the community, failed to ensure there was not more than a 14-hour lapse between dinner and breakfast the next morning, and failed to ensure a substantial evening snack was offered to residents. In addition, the greater than 14-hour timeframe between dinner and breakfast the next day, had not been approved by the resident group. These failures had the potential to affect 142 out of 146 residents (four residents received nutrition via tube feeding.) Findings include:	F 809	Residents affected by deficient practice: The facility failed to ensure meals were served at regular times comparable to those in the community, failed to ensure there was not more than a 14-hour lapse between dinner and breakfast the next morning, and failed to ensure a substantial evening snack was offered to residents. In addition, the greater than 14-hour timeframe between dinner and breakfast the next day, had not been approved by the resident group. These failures had the potential to affect 142 out of 146 residents (four residents received nutrition via tube feeding).	

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F 809	Continued From page 57 1. Review of the undated "Truck Delivery Log" provided by the facility revealed there were nine carts (trucks) that delivered food to residents. The first meal cart was delivered to Unit [redacted] at 7:36 AM, lunch was delivered at 11:36 AM, and dinner was delivered at 4:24 PM. The time span from dinner to breakfast was greater than 15 hours. The last meal cart was delivered to Unit [redacted] dayroom two at 8:24 AM, lunch was delivered at 12:30 PM, and dinner was delivered at 5:18 PM. The time span from dinner to breakfast was greater than 15 hours. The time span for all nine carts from dinner to breakfast the next day was greater than 15 hours. 2. During an interview on 09/25/23 at 10:13 AM, the Dietary Director (DD) stated mealtimes for breakfast, lunch, and dinner were 7:30 AM, 11:30 AM, and 4:15 PM. 3. During an interview on 09/28/23 at 4:48 PM, Resident (R)97 and R188 were interviewed together. R188 stated the dinner meal was served early and she had not eaten dinner this early while in the community. R97 agreed, stating the meal was served early and said, "This is the way it is." Both residents had received their dinner meals and were eating at the time of the interview. R188 stated she was not offered a bedtime snack and R97 stated [redacted] was occasionally, but not routinely, offered a bedtime snack. Review of R97's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] in the electronic medical record (EMR) under the "MDS" tab revealed R97 had [redacted] with a Brief Interview for	F 809	Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The residents affected were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: All dietary staff were re-educated regarding the distribution and maintaining proper par levels of H.S. snacks in the pantries on each Unit. The amount of nutritious and bulk H.S. snacks in the evening were increased to accommodate all the residents. The snacks include the following: a variety of nutritious sandwiches (peanut butter and jelly, meat, and cheese), soft sandwiches for mechanically altered diets, pudding, apple sauce, fruit, crackers, ice cream and cold cereal. The greater than 14-hour timeframe between dinner and breakfast the next day, has been approved by the resident group. Measures or systemic changes to ensure that the deficiencies will not recur: Dietary Director/designee to audit all pantry's snack bins, refrigerators, and freezers for proper par levels and to ensure snacks are being offered to residents at H.S. The duration of all audits will consist of completion three times weekly x 4 weeks	

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F 809	Continued From page 58 Mental Status Score (BIMS) of NJ EX Order. 264b1 (score of NJ EX Order. 4 indicates NJ EX Order. 264b1). Review of R188's quarterly "MDS" with an ARD of 08/28/23 in the EMR under the "MDS" tab revealed R188 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1. During an interview on 09/28/23 at 4:43 PM, R27 was eating NJ EX dinner and stated dinner was served early tonight. R27 stated NJ EX Or usually received dinner around 5:00 PM and breakfast at 8:00 AM, but today dinner came around 4:30 PM. Review of the undated "Truck Delivery Log" provided by the facility revealed the dinner cart should be delivered to R27's unit at 4:54 PM. Review of R27's quarterly "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R27 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1. During an interview on 09/25/23 at 11:03 AM, R102 stated NJ EX only got snacks if NJ EX asked for them and reported NJ EX was served dinner around 4:30 PM and received breakfast at about 8:15 AM. Review of R102's admission "MDS" with an ARD of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R102 had NJ EX Order. 264b1 with a BIMS of NJ EX Order. 264b1. 4. Observations of dinner meal service preparation and service revealed: a. During observations in the kitchen on 09/27/23 from 3:44 PM through 4:43 PM revealed the tray line meal service began at 4:10 PM. By 4:43 PM,	F 809	then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 809	Continued From page 59 six of nine total meal carts had been loaded and taken to the units for delivery. b. During observation on 09/28/23 at 4:35 PM, the [redacted]-unit meal cart (lower numbered rooms) was empty; all meals had been served and residents were eating. During observation on 09/28/23 at 4:36 PM, the [redacted] Unit meal cart (higher numbered rooms) was completely served, and residents were eating in their rooms. During an observation on 09/28/23 at 4:40 PM, the [redacted] Unit meal cart (lower number rooms) was mostly served with residents from [redacted] up through [redacted] eating their meals in their rooms. During an observation on 09/28/23 at 4:45 PM, the remaining trays for the higher number rooms on the [redacted]-Unit were being passed. During an observation in the kitchen on 09/27/23 at 4:22 PM, it was revealed that each cart had a tray with labeled snacks on top of it. The trays had approximately 12 individually labeled snacks for specific residents. Snacks included crackers, sandwiches, yogurt, and pudding cups. No general snacks (without labels with residents' names) were observed. The DD confirmed these were the trays of bedtime snacks for the units. 5. During observations of the pantries on the units with the DD on 09/29/23 from 9:48 AM through 9:58 AM, it was revealed only one of the four pantries had an adequate supply of snacks available. The DD stated the dietary department delivered general snacks (without residents' names and available to all residents) once a	F 809		

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F 809	Continued From page 60 week to the pantries on [redacted] adding, "We could do better with snacks." The DD stated the pantries were not due to be restocked until [redacted] (the day of the observation was [redacted] Observations revealed: a. The pantry across from Unit [redacted] had a few individual sized packages of crackers, approximately five individual sized packages of cheese flavored crackers, and a few packages of individual sized packages of fudge cookies. There was a refrigerator in the pantry; however, there was no food or beverages for residents in the refrigerator. Review of the "Resident List Report" dated [redacted] and provided by the facility revealed there were 57 total residents residing on Unit [redacted] b. Unit [redacted] pantry had a total of two packages of individual sized puddings. There were no additional snacks in the room. There was a refrigerator in the pantry; however, there was no food or beverages for residents in the refrigerator. Review of the "Resident List Report" dated [redacted] and provided by the facility revealed there were 27 total residents residing on Unit [redacted] c. Unit [redacted] pantry had a total of ten packages of individual sized snacks, a combination of chips, cheese flavored crackers, and Cheetos. There was a refrigerator in the pantry; however, there was no food or beverages for residents in the refrigerator. Review of the "Resident List Report" dated [redacted] and provided by the facility revealed	F 809		

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F 809	Continued From page 61 there were 51 total residents residing on Unit [redacted] d. Unit [redacted] pantry was adequately stocked with numerous (more than 50 individual sized packages) chips, pretzels, pudding, and cookies. Review of the "Resident List Report" dated [redacted] and provided by the facility revealed there were 11 total residents residing on Unit [redacted] 6. During an interview on 09/28/23 at 4:59 PM, Licensed Practical Nurse (LPN)5 stated bedtime snacks came to the [redacted]-Unit with the dinner meal cart and they were labeled with specific residents' names. LPN5 stated there were about 10-12 snacks on the cart. During an interview on 09/28/23 at 4:47 PM, LPN Unit Manager (UM)2 stated snacks were delivered to the [redacted] Unit after dinner. LPNUM2 stated dietary sent a tray with snacks with residents' names on them. LPNUM2 stated if other residents wanted snacks, they called the kitchen. During an interview on 09/28/23 at 5:00 PM, Registered Nurse (RN)UM1 stated bedtime snacks came on a tray from the kitchen with residents' names on them and the nursing staff passed them out. RNUM1 stated if someone wanted a snack that did not have a labeled one, nursing staff could call the kitchen. During an interview on 09/29/23 at 9:18 AM the Dietary District Manager and the DD stated labeled bedtime snacks were sent to each unit on a tray daily at 7:00 PM as the last thing dietary	F 809		

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F 809	Continued From page 62 staff did before leaving the building. The DD stated the Registered Dietitian (RD) prescribed the snacks for these residents. The DD confirmed the time span between dinner and breakfast the next morning was more than 14 hours and confirmed this had not been reviewed or approved by the resident group. The DD stated he had been employed for [redacted] years and the mealtimes had not changed during this period. During an interview on 09/29/23 at 10:00 AM, the RD stated the normal time for dinner in nursing homes was around 5:00 PM. The RD stated she was not aware the time span between dinner and breakfast the next day exceeded 14 hours. The RD stated she had been employed by the facility for nine months. Review of the facility's policy titled "Frequency of Meals," dated 09/17 and provided by the facility, revealed "At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community. The time between a substantial evening meal and breakfast the following day will not exceed 14 hours, except when a nourishing snack is served at bedtime. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span and a nourishing snack is provided." NJAC 8:39-17.2(f) NJAC 8:39-17.4(b)(d)	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/28/23

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F 812	Continued From page 63 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and facility policy review, the facility failed to ensure the kitchen dish room, floor, countertops, and wall behind the dish machine was maintained in a sanitary condition creating the potential for the spread of foodborne illness for 142 out of 146 residents who resided in the facility NJ EX Order. 264b1). In addition, the facility failed to adhere to proper hand hygiene when serving meals to residents on the secured unit during food delivery to the adjoining dining rooms and the resident's individual rooms. Findings include: 1. During the initial tour of the kitchen with the Dietary Director (DD) on 09/25/23 from 10:14 AM to 10:43 AM, the following concerns were noted: a. The garbage can in the handwashing area had	F 812	Residents affected by deficient practice: The facility failed to ensure the kitchen dish room, floor, countertops, and wall behind the dish machine was maintained in a sanitary condition creating the potential for the spread of foodborne illness for 142 out of 146 residents who resided in the facility (four received nutrition via tube feeding). In addition, the facility failed to adhere to proper hand hygiene when serving meals to residents on the secured unit during food delivery to the adjoining dining rooms and the resident's individual rooms. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The residents affected were monitored for	

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F 812	Continued From page 64 a foot operated pedal which opened the garbage can. After the surveyor washed her hands and operated the foot pedal, the top interior surface of the garbage can lid was observed to be covered (approximately a third of the lid) with a green/black fuzzy substance. This would have been visible every time the garbage can was used. b. The dishwashing room was observed. The floor was concrete with a grey smooth finish. Approximately a quarter of the floor had deteriorated with the finish either partially or completely absent, exposing a rough, jumbled surface of multiple small rocks below. Water was pooled in areas where the concrete had disintegrated. There was black residue streaked down the wall of the dirty side of the dish machine covering an area of approximately two by three feet, above the counter where dirty dishes entered the machine. 2. During a second observation of the kitchen on 09/27/23 from 3:44 PM to 4:33 PM, the following concerns were noted: a. The garbage can in the handwashing area was used by the surveyor at 3:44 PM. After the surveyor washed her hands and operated the foot pedal, the top interior surface of the garbage can lid continued to be covered (approximately a third of the lid) with a green/black fuzzy substance. The DD was asked what was on the top interior surface of the lid and he stated it was dirt. The DD removed the garbage can and cleaned the lid. b. An observation of the dish room was made at 4:33 PM. The floor continued to be in a deteriorated condition, with a lack of finish	F 812	any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: All dietary staff were re-educated regarding all food preparation areas, food service areas, and the dish room area will be maintained in a clean and sanitary condition including floors, walls, ceilings, tables, equipment, and ventilation. The garbage can lid in the handwashing area was immediately cleaned and sanitized. The grey concrete floor in the dish room was repaired to prevent pooling water and protective sealant applied. Black residue streaked down the wall above and below the stainless-steel counter of the dirty side of dish machine was immediately cleaned. Black residue underneath the stainless-steel counter of the dish machine was immediately cleaned. The areas of missing concrete around the floor drain were repaired with the floor to prevent standing water. Area behind the dish machine was re-attached to the wall. Holes in the stainless-steel countertop and along the welded area of the disposal where water was dripping were repaired. All staff that assist residents with meals were educated on the facility policy titled Handwashing/Hand Hygiene which includes use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap (antimicrobial or	

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F 812	Continued From page 65 adhered to the floor. There was pooled water in the areas where the concrete was missing. Underneath the stainless counter of the dish machine where the racks for the dishes were stored, was an area of black slime (residue of approximately ¼ inch in depth) of approximately four feet by one foot in size. The concrete around the floor drain had several areas of a couple inches in depth where the concrete was missing. The areas of missing concrete near the drain were full of brackish water. There were several areas where there was water dripping from the counter onto the floor and onto the area of black slime. The wall behind the dish machine was buckling and coming away from the wall. The area of black residue streaked down the wall of the dirty side of the dish machine covering an area of approximately two by three feet and there was an area with black residue, also approximately two by three feet, on the wall underneath the counter. 3. During an interview on 09/27/23 at 4:44 PM the DD stated the floor in the dish room had been repainted since he had been working at the facility but verified it needed additional repair. The DD stated he had been employed by the facility for about five years. The DD stated he did not know what the black slimy substance was on the floor under the dish machine area, or how long it had been there. However, he stated it needed to be power washed. There were several areas of dripping water onto the floor verified by the DD. The DD stated the dietary staff was responsible for cleaning the floor in the dish room. The DD stated the floor was not a cleanable surface. The DD stated he was not aware of any plans to replace the floor in the dish room. There was black residue on the wall above the dish machine	F 812	non-antimicrobial) and water for the following situations: before and after direct contact with residents, after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, before and after eating or handling food, [and] before and after assisting a resident with meals." Measures or systemic changes to ensure that the deficiencies will not recur: Dietary Director/designee to conduct audits of all food preparation areas, food service areas, and the dish room area to ensure all are maintained in a clean and sanitary condition including floors, walls, ceilings, tables, equipment, and ventilation. Dietary Director/designee to conduct audits of meal serving staff to ensure facility policy regarding Handwashing/Hand Hygiene is being followed during meal service. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 812	Continued From page 66	F 812		

and on the wall under the counter of the dish machine verified by the DD. The DD verified the wall under the dish machine was buckling.

During an interview on 09/28/23 at 9:49 AM, the Maintenance Director and surveyor entered the kitchen and walked into the dish room. The Maintenance Director stated he had no work orders in the electronic maintenance system for the dish room floor. He stated he had been employed for a year and two months. The Maintenance Director stated the floor was not cleanable due to the deteriorated state. He further stated to repair the floor he would close the dish room and he would have to reseal the concrete and then paint the floor, which would take a couple days. The Maintenance Director stated he did not know how long the floor had been in its present condition. The Maintenance Director verified the presence of the black slime on the floor under the counter of the dish machine and stated it would have to be power washed. The Maintenance Director stated he did not know what it (black slime) was. The Maintenance Director stated he did not know if the floor had been power washed on any ongoing basis, adding that maintenance kept the power washer. There were several continuous drips from the counter and the area of the disposal onto the floor and area of black slime. The Maintenance Director showed the surveyor there were holes in the stainless-steel countertop and along the welded area of the disposal and that was where the water was dripping. The Maintenance Director stated a pipe burst the previous winter and that might be the reason the wall was buckling under the dish machine. The Maintenance Director stated there was nothing planned or in place to repair the floor in the dish room.

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	315219	A. BUILDING _____ B. WING _____	C 09/29/2023

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During an interview on 09/29/23 at 10:00 AM the Registered Dietitian (RD) stated she completed monthly sanitation reviews in the kitchen. The RD stated she had identified a sanitation concern with the dish room floor on one of her previous sanitation audits.

Review of the RD's "Kitchen/Sanitation Audit Form" dated 04/28/23 revealed, "Floors need improvement, staff to clean after lunch prep."

Review of the facility's policy titled "Environment," dated 09/17 and provided by the facility, revealed "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition ... The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation."

4. During lunch observation on the [redacted] unit in the left and right dining rooms on 09/25/23 beginning at 12:42 PM, Certified Nurse Aide (CNA)5, CNA3, and Licensed Practical Nurse (LPN)3 were observed serving meal trays to residents in the left and right dining rooms and their own rooms. Neither staff member performed hand hygiene after serving a tray, prior to serving another resident's tray.

-CNA5 served a resident a meal tray, touching the resident, the table, and the resident's wheelchair. She then began to assist the resident to eat without first performing hand hygiene.

-CNA5 was assisting a resident to eat. The CNA touched another resident who was seated on her right side using her right hand. She then began assisting the resident on her left, using her right hand, without performing hand hygiene.

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F 812	Continued From page 68 During lunch observation on the NJ EX Order: 26461 care unit on 09/27/23 beginning at 12:15 PM in the left and right dining rooms, CNA9, CNA2, and LPN3 were observed serving meal trays without performing hand hygiene between residents. -CNA9 served a meal tray to R16 and opened or unwrapped her meal items. She then returned to the meal cart and retrieved another tray without performing hand hygiene. CNA9 then served the tray to R48, set up her meal items, adjusted NJ EX Order: 26461 bedside table, and moved NJ EX Order: 26461, then opened NJ EX Order: 26461 straw completely and placed it in her drink by holding the top. CNA9 then unlocked R288's wheelchair, moved the chair, and locked it again. CNA9 then served another tray from the meal cart to R115 without first sanitizing her hands. CNA9 then returned to the meal cart and retrieved another tray without performing hand hygiene. She served R92 the meal, opened a straw completely and held the top as she placed it in a drink, and picked up the cups holding them at the drinking surface. -CNA2 served R130 of NJ EX Order: 26461 meal and opened or unwrapped her meal items. She then returned to the meal cart and without performing hand hygiene, retrieved another meal tray to serve. -LPN3 unlocked R140's wheelchair and assisted him to reposition in the chair. She locked the brakes and without first performing hand hygiene, retrieved another meal tray from the cart and served R8. LPN3 then began assisting R121 to eat without first performing hand hygiene. In an interview on 09/29/23 at 10:38 AM, the Infection Preventionist (IP) stated she expected staff to sanitize or wash their hands between every tray while serving meals. She stated if a staff member was assisting two residents to eat at the same time, they should have sanitized their	F 812		

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hands between residents. The IP stated staff was taught to leave the paper on top of a straw when opening to avoid touching the drinking surface, and to avoid touching the drinking surface when holding cups. The IP stated she had not done a formal audit of handwashing during meal service, but she would "go around and remind them about hand hygiene." She stated the staff educator had done an audit and provided education on hand hygiene.

Review of a "QA [Quality Assurance] Audit Tool" provided on paper, dated 09/18/23, revealed 30 observations of hand hygiene were completed. The audit did not document the names of staff observed but only their positions (CNA or LPN). The audit tool did not document the location or timing of the observations to determine whether any observations were made during meal service.

In an interview on 09/29/23 at 1:34 PM, the Director of Nursing (DON) stated she expected the staff to sanitize their hands between every resident as they served meals.

Review of the facility's policy titled "Handwashing/Hand Hygiene," dated 01/22, revealed "Use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:. . .before and after direct contact with residents,. . . after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident,. . .before and after eating or handling food,. . .[and] before and after assisting a resident with meals."

NJAC 8:39-17.2(g)
NJAC 8:39-19.7(d)

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		10/28/23

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F 842	Continued From page 71 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure dates of newly identified [redacted] and [redacted] assessments were accurately reflected for two (Resident (R) 121 and R238) of 41 sample residents. This failure had the potential to cause further [redacted] or [redacted] of R121's [redacted] or risk of [redacted] or injury from [redacted] use for R238. Findings include:	F 842	Residents affected by deficient practice: The facility failed to ensure dates of newly identified [redacted] and bed rail assessments were accurately reflected for 2 (Resident #R121 and #R 238) of 41 sample residents. This failure had the potential to cause further [redacted] or [redacted] of #R121's [redacted] or risk of [redacted] or injury from [redacted] use for #R238.	

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F 842	Continued From page 72 1. Review of R121's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnoses including: dementia with [redacted]. Review of R121's quarterly "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of [redacted], revealed she was unable to complete the "Brief Interview for Mental Status (BIMS)" and was assessed by staff with [redacted] and [redacted]. [redacted] was at risk for [redacted] but had no current [redacted]. Review of R121's [redacted] Note" under the "Notes" tab of the EMR, dated [redacted], revealed "Resident has [redacted] on [redacted]. Cleansed with [redacted], treated, and [redacted], and implemented [redacted]" The note was written by Licensed Practical Nurse (LPN) 7. Review of R121's EMR on 09/27/23 revealed there was no documentation of physician notification of the newly identified [redacted] and no assessment or description of the [redacted] to include [redacted], or other descriptors. During a telephone interview on 09/28/23 at 9:47 AM LPN7 stated [redacted] was the first day she noticed the [redacted] on R121's [redacted]. She stated the protocol was to contact the physician and the supervisor to report the newly	F 842	Identify those individuals who could be affected by the deficient practice: All residents who have wounds and all residents who use [redacted] have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: All residents with [redacted] and all residents with [redacted] were reviewed for accurate completion of assessments and updated as necessary. All facility nursing staff re-educated on policies Use of [redacted], [redacted], and Charting and Documentation. Measures or systemic changes to ensure that the deficiencies will not recur: Director of Nursing/designee to conduct observation compliance audits of timely assessment completion. The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 842	Continued From page 73	F 842		

identified [redacted] however, it was toward the end of her shift, so she left a message with the physician's answering service and reported the oncoming nurse for follow-up.

During an interview on 09/28/23 at 10:43 AM, Registered Nurse Unit Manager (RNUM) 4 stated R121's newly identified [redacted] was reported to her on NJ EX Order. 264b1. She stated the physician was notified of the [redacted] on [redacted] and the treatment ordered was [redacted] t. RNUM4 stated she did not know if there was an assessment of the [redacted] characteristics or any documentation to describe the [redacted]

Review of R121's "Accident/Incident Report," completed by RNUM4, provided on paper, and dated [redacted] documented "The nurse was assisting the aid with changing resident when she noticed NJ EX Order. 264b1 [redacted] Resident unable to give description . . . NJ EX Order. 264b1 made and MD [physician] and family made aware. Treatment was ordered." The injury type was described as "NJ EX Order. 264b1" to the [redacted]. The report also documented, "IDT [Interdisciplinary Team] met to discuss [R121's] [redacted] of the [redacted] which was noted by nurse while providing NJ EX Order. 264b1 care. Supervisor made aware and came to assess patient head to toe. No further new alterations in [redacted] noted. Resident denied pain. MD was made aware and new treatment orders were obtained and rendered. Intervention: treatment to site as ordered. [redacted] consult. Pt [patient] to be a NJ EX Order. 264b1 with bed NJ EX Order. 264b1. Family aware and in agreeance [sic] with plan of care. Care plan updated." The report also included a new [redacted]

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F 842	Continued From page 74 NJ EX Order. 26 dated NJ EX Order. 264b1, and a new NJ EX Order. Assessment," dated NJ EX Order. 264b1. The report was signed by RNUM4 and dated NJ EX Order. 264b1 when signed. During an interview on 09/28/23 at 2:23 PM RNUM4 stated she initiated the "Accident/Incident Report" on Monday NJ EX Order. 264b1 but dated it NJ EX Order. 264b1 since that was the day the NJ EX Order. 26 was identified. During an interview on 09/29/23 at 1:26 PM, the Director of Nursing (DON) stated the IDT met to discuss the newly identified NJ EX Order. 26 on NJ EX Order. 264b1 NJU EX Order. 26, even though the "Accident/Incident Report" was dated NJ EX Order. 264b1. She stated the report was dated the day the incident took place; however, the RNUM4 should have used the actual date when signing the report. 2. Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab, revealed R238 was admitted to the facility on NJ EX Order. 264b1. Current diagnoses included NJ EX Order. 264b1 . Review of R238's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ EX Order. 264b1 in the EMR under the "MDS" tab revealed R238 had NJ EX Order. 264b1 NJ EX Order. 264b1 with a Brief Interview for Mental Status (BIMS) score of NJ EX Order. 264b1 (NJ EX Order. 264b1 indicates NJ EX Order. 264b1). R238 required supervision with most activities of daily living (ADLs) and had NJ EX Order. 26 without injury since the prior MDS. R238 was not coded as using bed NJ EX Or as a NJ EX Order. 264b1	F 842		

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F 842	Continued From page 75 During observations on 09/26/23 at 8:47 AM, 09/26/23 at 12:08 PM, 09/26/23 at 04:56 PM, and on 09/28/23 at 8:33 AM, R238 was lying in bed on [redacted] with NJ EX Order. 264b1 in the [redacted] at the NJ EX Order. 264b1. Review of the "Assessment" tab in the EMR on [redacted] revealed that the most recent [redacted] Assessment" had been completed on [redacted]. Review of the "Assessment" tab in the EMR on 09/27/23, showed a [redacted] Assessment" had been completed on [redacted] but the "[redacted] Assessment" was not located in the EMR on [redacted] Additional review of the "[redacted] Assessment" dated [redacted] in the EMR under the "Assessment" tab revealed the effective date of the assessment was [redacted] but the assessment was not signed until [redacted] During an interview on 09/28/23 at 2:35 PM, Licensed Practical Nurse (LPN) Unit Manager (UM)2 stated R238 had been discharged to the hospital and had recently returned to the facility, which prompted completion of a new "[redacted] Assessment." LPNUM2 stated she documented the [redacted] assessment was done on [redacted] because that was the date it was due for completion. LPNUM2 stated, "I completed it today on the 28th." During an interview on 09/29/23 at 3:52 PM, the Director of Nursing (DON) stated entries into the EMR such as the initiation of the [redacted] Assessment" automatically prepopulated with the date and time when the assessment was due and	F 842		

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F 842	Continued From page 76 not with the actual date and time when it was completed. The DON stated the date could be changed to the actual date and time when the assessment was completed (instead of when it was due) when the document was created. The DON verified the date should be accurate with the actual date and time the document was filled out. Review of the facility's policy titled "Charting Errors and/or Omissions," dated 10/19, revealed "Late entries in the medical record shall be dated at the time of entry and noted as a 'late entry'." NJAC 8:39-35.2(g)	F 842		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		10/28/23

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F 880	Continued From page 77 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 78 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure the proper sanitization of a NJ EX Order. 264b1 used to obtain NJ EX Order. 264b1 results for two (Residents (R) R61 and R81) of seven residents reviewed during medication administration observations. This failure had the potential to lead to serious illness and death for R61 and R81 related to the transmission of NJ EX Order. 264b1 NJ EX Order. 264b1 from resident to resident via the un-sanitized NJ EX Order. 264b1 In addition, the facility failed to ensure all areas in the laundry room were cleaned. The facility's Administrator was informed on 09/27/23 at 5:10 PM, that Immediate Jeopardy existed related to the failure to ensure that two of seven residents identified as receiving NJ EX Order. NJ EX Order. 264b1 checks received g NJ EX Order. 264b1 properly sanitized in between resident use. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 09/28/23 at 2:33 PM. The survey team validated the implementation of the removal plan through interviews, and record review. Immediate Jeopardy was removed on 09/29/23 at 3:40 PM. After removal of the Immediate Jeopardy, the deficiency remained at a "D" scope and severity for an isolated potential for more than minimal harm and in addition to the findings in the laundry room. Findings include:	F 880	Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure the proper sanitation of a NJ EX Order. 264b1 used to obtain NJ EX Order. 264b1 results for two (Residents (R) R61 and R81) of seven residents reviewed during medication administration observations. This failure had the potential to lead to serious illness and death for R61 and R81 related to the transmission of NJ EX Order. 264b1 from resident to resident via the un-sanitized NJ EX Order. 264b1 In addition, the facility failed to ensure all areas in the laundry room were cleaned. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Upon notification of the deficient practice, Involved LPN was stopped from doing Med Pass. LPN educated and trained on facility□s Infection Control and Prevention policies and procedures related to Medical Device Safety. Focus was made on the significance and importance of properly cleaning and sanitizing NJ EX Order. 264b1 (utilizing the proper disinfectant and complying with the manufacturer prescribed wet time) to prevent transmission of NJ EX Order. 264b1 from resident to resident via the	

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F 880	Continued From page 79 1. During an observation on 09/27/23 at 11:19 AM Licensed Practical Nurse (LPN1) was observed obtaining a NJ EX Order. 264b1 check for Resident (R81). LPN1 obtained a NJ EX Order. 264b1 (one of two stored in her medication cart) and then obtained an NJ EX Order. 264b1 which she used to wipe the NJ EX Order. 264b1 result display window for approximately one to two seconds. LPN1 was then observed taking the NJ EX Order. 264b1 and other supplies to R81's room, where she obtained the resident's NJ EX Order. 264b1 from one of the resident's NJ EX Order. 264b1. After obtaining the result of R81's NJ EX Order. 264b1 check, LPN1 placed the NJ EX Order. 264b1 monitor just used to obtain R81's NJ EX Order. 264b1 back on the top of the medication cart. LPN1 was not observed to clean the NJ EX Order. 264b1 machine with a facility approved cleaning agent/sanitizer. On 09/27/23 at 11:41 AM, immediately after obtaining R81's NJ EX Order. 264b1 and administering NJ EX Order. 264b1 LPN1 was observed obtaining a NJ EX Order. 264b1 check for R61 with the same NJ EX Order. 264b1 r. The glucometer's result display window was, again, observed to be wiped with an NJ EX Order. 264b1 for approximately one to two seconds and then LPN1 went to R61's room and obtained NJ EX Order. 264b1 with the monitor. After obtaining R61's NJ EX Order. 264b1, LPN replaced the monitor back into the medication cart without cleaning it. a. R61's "Admission Record" dated 09/29/23 and found in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on NJ EX Order. 264b1 with diagnoses including NJ EX Order. 264b1. R61's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ EX Order. 264b1 indicated a Brief Interview for Mental	F 880	un-sanitized NJ EX Order. 264b1. Director of Nursing conducted a Demonstration of the Procedure: Proper Cleaning and Sanitizing of a NJ EX Order. 264b1 To ensure competency, LPN performed a Return Demonstration of properly Cleaning and Sanitizing of a NJ EX Order. 264b1. Responsible Parties and Physicians for Residents affected (R61 and R81) were notified. Both residents were not adversely harmed by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents who have orders for NJ EX Order. NJ EX Order. 264b Monitoring have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All Nurses were in-serviced on facility□s Infection Control and Prevention policies and procedures related to Medical Device Safety. Focus was made on the significance and importance of properly cleaning and sanitizing glucometer (utilizing the proper disinfectant and following manufacturer prescribed wet time) to prevent transmission of NJ EX Order. from resident to resident via the un-sanitized NJ EX Order. 264b1. Facility implemented the Directed Plan of Correction as directed by the NJ-DOH: Facility engaged the services of a	

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F 880	Continued From page 80 Status (BIMS) score of NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1). R61's physician's orders located in the EMR under the "Orders" tab included an order for NJ EX Order. 264b1 checks to be obtained NJ EX Order. 264b1 daily NJ EX Order. 264b1 and at NJ EX Order. 264b1. Review of R61's "Medication Administration Record (MAR)" located in the EMR under the "Orders" tab confirmed the resident was receiving her NJ EX Order. 264b1 checks routinely as ordered. b. R81's "Admission Record" dated NJ EX Order. 264b1 and found in the EMR under the "Profile" tab revealed the resident was admitted to the facility on NJ EX Order. 264b1 with NJ EX Order. 264b1 NJ EX Order. 264b1 R81's quarterly MDS with an ARD of NJ EX Order. 264b1 indicated a BIMS that could not be done due to the resident's NJ EX Order. 264b1. The assessment indicated R81 had NJ EX Order. 264b1 NJ EX Order. 264b1. R81's physician's orders located in the EMR under the "Orders" tab included an order for NJ EX Order. 264b1 checks to be obtained NJ EX Order. 264b1 times daily NJ EX Order. 264b1 NJ EX Order. 264b1. Review of R81's MAR located in the EMR under the "Orders" tab confirmed the resident was receiving NJ EX Order. 264b1 checks routinely as ordered. During an interview on 09/27/23 at 11:56 AM, LPN1 stated the facility process for cleaning NJ EX Order. 264b1 monitors was that the night shift normally cleaned the monitors at night. She	F 880	qualified consultant to provide consultation & oversight for infection prevention and control within the facility. On 10/13/2023, the QAA Committee convened to conduct Root-Cause Analysis to determine why the deficient practices under F880 occurred. RCA was completed with assistance from the Infection Preventionist, Director of Nursing, QAPI) committee, Governing Body and qualified consultant. Issue identified were incorporated in the facility□s QAPI Program. On 10/18/2023, a Follow Up QAPI Meeting was held to discuss implementation status of the Directed POC/POC and to ensure that systems for on-going monitoring of corrective actions are in place. IV. MONITORING OF CORRECTIVE ACTIONS: The Infection Preventionist or Designee will conduct Med Pass Observation Audits of 2 nurses per week x 4 weeks, then 2 nurses per month x 3 months to ensure that nurses are properly cleaning and sanitizing NJ EX Order. 264b1 (utilizing the proper disinfectant and complying with the manufacturer prescribed wet time) - to prevent transmission of blood borne pathogens from resident to resident via an un-sanitized NJ EX Order. 264b1 Infection Preventionist or Designee will report to the QAPI Committee on a monthly basis. The QAPI Committee will review the audit results and determine the need for further audits and/or action.	

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F 880	Continued From page 81 stated, "I clean (the NJ EX Order: 264b1) with an NJ EX Order: 2 I NJ EX Ord before and after I use it because I have been a nurse for 30 years and that is just what I have always done, but generally it (cleaning and sanitizing the NJ EX Order: 264b1) is done at night." LPN1 stated it was facility procedure for the glucometers to be cleaned each night with an NJ EX Order: 264b1 LPN1 stated she was not familiar with the concept of "kill" or "wet" time, but stated she let the alcohol dry before using the glucometer to obtain NJ EX Order: 264b1 . LPN1 stated she thought someone from the pharmacy had been in the facility to watch her do medication administration, but she was not sure if she had been taught about obtaining NJ EX Order: 264b1 checks at any time by the facility. During an interview on 09/27/23 at 12:16 PM, the Director of Nursing (DON) stated the facility process and her expectation related to the cleaning of NJ EX Order: 264b1 s was NJ EX Order: 264b1 NJ EX Order: available in all nursing cart in the bottom drawer, were to be used to clean NJNJ EX Order: 264b1 s before and after each use and indicated wet/kill time instructions were to be followed based on manufacturer's directions on the container of NJ EX Order: 264b1 used. During a follow-up interview with the DON on 09/27/23 at 12:49 PM, she confirmed the only two residents receiving NJ EX Order: 264b1 checks on that medication cart were R81 and R61 and confirmed LPN1 worked only on the unit and medication cart observed by the surveyor. She stated, "[LPN1] only works on that cart. That is her cart". The DON confirmed that although R81's NJ EX Order NJ EX Order: 264 had been obtained prior to R61's NJ EX Order NJ EX Order: 264b at the time of the surveyor's observation of LPN1 administering NJ EX Order: 264b1 checks to	F 880		

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F 880	Continued From page 82	F 880		

both residents; there was no way to predict which order the two residents would have their [redacted] monitored, placing R81 at risk for exposure to the [redacted] when [redacted] were not appropriately sanitized between resident use. The DON confirmed LPN1 had received previous training.

The facility's policy titled [redacted] Sampling-[redacted]) Policy," dated 03/23 was reviewed and indicated, "The purpose of this procedure is to guide safe handling of the [redacted] sampling devices to prevent transmission of b[redacted]s to residents and employees;' and "General Guidelines: 1. Always ensure that [redacted] intended for reuse are leaned and disinfected between resident uses;" and "Steps in the Procedure: 8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devises after each use."

The '[redacted] Monitoring User Instruction Manual" (the manufacturer's instructions for use of the [redacted] monitor used by the facility) indicated, "Page 47 Maintenance: Cleaning and Disinfecting Guidelines: ...Contact with [redacted] presents a [redacted] We suggest cleaning and disinfecting [redacted] between patient use. Option 1: Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or [redacted]; ...Option 2: To disinfect the meter, dilute [redacted]). The solution can then be used to dampen a paper

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F 880	Continued From page 83 towel (do not saturate the towel). The use the damped paper towel to thoroughly wipe down the [redacted] and "With all the recommended meter cleaning and disinfecting methods, it is critical that the meter be completely dry before testing a resident's [redacted] level. Please follow the disinfectant product label instructions to ensure proper drying time." Review of the product label instructions for [redacted] Healthcare NJ EX Order. 264b1 (the facility's indicated [redacted] disinfecting product) revealed the wet/dry time to be used for the product to ensure all potential pathogens were eliminated from the surface of the [redacted] machines/other facility equipment was three minutes (this indicated the cleaned/disinfected surface was to remain wet for at least three minutes to ensure disinfection of the surface). 2. Observations on 09/28/23 from 11:00 AM through 11:30 AM of the facility laundry room revealed the door was open and remained open throughout the entire observation. There were plastic strips hung up on each side of the washer room and the folding room. Those strips remained hanging beside the doorway throughout the observation. They had scattered water-like stains on them and served as a barrier between the washers and clean folding area when they were down and in their place. An unpainted, cracked and broken wooden palette with torn and worn cardboard on top of it sat between two washing machines. On the floor there were many rust-like and white flake particles around the bottom and edges of the palette. Continued observations revealed Housekeeper	F 880		

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F 880	Continued From page 84	F 880		

(HK)1 loaded soiled laundry into a washing machine without protection covering her uniform then went directly to fold clean laundry. She did not complete hand hygiene or spray and clean the gray dirty laundry tub. Four gray dirty empty laundry tubs sat in the sorting area and had unknown debris in them. One of the tubs had a brown sticky substance that was four centimeters (cm) long and two cm wide on the longest side of the tub. None of them had been lined. The washing machines all had multiple rust like and white flakes around the entire bottoms and sides. There was water on the floor around the machines in front of the window. The wrap on the elbow joint area of two pipes, hanging from the ceiling, was frayed, and hanging down. There was debris of an unknown substance on the windowsill, and a spider web in the corner. The backsplash area, faucets, bases, soap holder and paper towel dispenser of both sinks were dirty. The laundry room floor had scattered loose debris on it.

During an interview on 09/28/23 from 11:00 AM through 11:45 AM, the Housekeeping Supervisor (HKS) and the Housekeeping District Manager (HDM) revealed they agreed with all the above. The HDM stated he was surprised by the findings. The HKS remarked she intended to get the staff cleaning the laundry room immediately and denied having any documentation or cleaning schedules in place.

Review of the facility's policy titled "Laundry Room Cleaning and Upkeep," dated 01/10/10, revealed the washers, dryers, bins, sinks fans, tables, floors, walls, pipes, and windowsills were to have been cleaned daily. When soiled linen was sorted; eye protection, gowns, and gloves

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F 880	Continued From page 85 were to be worn. All bins and washers should have been sanitized between sorting each wash load and at the end of each day using approved disinfectant. All washers should have been dusted and cleaned: top, sides, and front at the end of each shift. Floors, walls, sinks, pipes, windowsills should have been dusted/cleaned at the end of each shift and as needed if visually soiled. The laundry room should have been scheduled monthly for deep cleaning to include machines, scrubbing of floor, corners/edges behind and around bins, chemical buffets, chemical dispensers, and dusting behind dryers, and racks. Laundry employees cleaned, dusted, and disinfected daily. NJAC 8:39-19.4(a) NJAC 8:39-19.4(n) NJAC 8:39-21.1(d)(e)(g)	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the antibiotic screening documentation was completed for the use of [redacted] including identifying trends and implementing protocols to	F 881	Based on interview, record review, and facility policy review, the facility failed to ensure the [redacted] screening documentation was completed for the use of antibiotics including identifying trends	10/28/23

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F 881	Continued From page 86 monitor the antibiotic use, measure the effectiveness of the NJ EX Order. 264b1, and create an action plan to lower the use of NJ EX Order. 264b1 that did not meet the screening criteria for R91 and all residents receiving NJ EX Order. 264b1 with the potential to affect any residents who have taken NJ EX Order. 264b1 Findings include: 1. Review of NJ EX Order. 264b1 Infection Log revealed there were NJ EX Or residents who received NJ EX Order. 264b1 for NJ EX Order. 264b1. All NJ EX residents received a complete course of NJ EX Order. 264b1 as ordered. All NJ EX of them did not meet the NJ EX Order. 264b1 criteria. Review of the "Order Listing Report," provided on paper and dated NJ EXEX Order. 26, revealed 17 residents had antibiotics in the month of September. There was no documentation in the electronic medical record (EMR) or in the Infection Preventionist's (IP) paper documents for any of the NJ EX residents who received NJ EX Order. 264b1. During an interview on 09/29/23 at 10:45 AM the IP revealed she was responsible for the Antibiotic Stewardship program. She confirmed she had not completed screening tools for the NJ EX residents who had an infection in NJ EX Order. 264b1. She stated sometimes the screening was not completed until after the course of NJ EX Order. 264b1 had already been completed because she did not always have time to do it immediately upon initiation of an NJ EX Order. 264b1. She confirmed sometimes those residents had NJ EX Order. 264b1 treatment when it had not been indicated by the screening tool. The IP stated she had not completed any reviews of facility NJ EX Order. 264b1 use and the effectiveness or lack of, for the NJ EX Order. 264b1	F 881	and implementing protocols to monitor the NJ EX Order. 264b1 use, measure the effectiveness of the NJ EX Order. 264b1 and create an action plan to lower the use of antibiotics that did not meet the screening criteria for R91 and all residents receiving NJ EX Order. 264b1 with the potential to affect any residents who have taken NJ EX Order. 264b1. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Infection Preventionist was counseled and in-serviced by the Regional Registered Nurse re: the regulations and facility□s policies and procedures related to the NJ EX Order. 264b1 stewardship program. This includes antibiotic use protocols and a system to monitor NJ EX Order. 264b1 use, measure the effectiveness of the antibiotics, and create an action plan to lower the use of NJ EX Order. 264b1 that did not meet the screening criteria. The Infection Preventionist was instructed to communicate to the Director of Nursing if he/she is unable to complete the screening tools so assistance in complying them will be provided. Resident #91 was evaluated by Nurse Practitioner and referred to the Medical Director for further management. Resident #91 was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	

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F 881	Continued From page 87 used by the [redacted] residents. During an interview on 09/29/23 at 1:35 PM the Director of Nursing (DON) revealed she had been aware the IP had completed some [redacted] screening tools and thought those tools should have been completed in the mornings by the IP. She also stated it had been discussed at their morning meetings. She agreed that the lack of screening with not utilizing the correct documents until several days after [redacted] had been started was not correct use of their screening tools. 2. Review of R91's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of [redacted] with medical diagnoses that included NJ EX Order. 264b1 Review of R91's "[redacted] Note" located in the EMR under the "Progress Notes" tab, dated [redacted] revealed a [redacted] assessment on R91 following [redacted] report of [redacted] in the [redacted] area. Reopening of previous NJ EX Order. 264b1 noted measuring NJ EX Order. 264b1) with red [redacted]. [redacted] g and [redacted] le NJ EX Order. 264b1 Review of R91's "Health Status Note" located in the EMR under the "Progress Notes" tab, dated [redacted], revealed that the case was reviewed with the collaborating physician. Discussed plan of care for NJ EX Order. 264b1 that was now a [redacted] to the [redacted] and [redacted]. No need for [redacted]. [redacted] was likely to delay treatment, NJ EX Order. 264b1 and offer no	F 881	All residents who have orders for [redacted] have the potential to be affected by the same deficient practice. Residents who are currently on [redacted] will be reviewed by the Infection Preventionist and Director of Nursing to ensure that the [redacted] screening documentation was completed for the use of [redacted] III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: To enhance compliance with the Antibiotic Stewardship Program, the Infection Preventionist will submit a weekly report to the Director of Nursing regarding the status of completing the [redacted] screening tools for appropriate residents. This will allow the Director of Nursing to make arrangements in providing assistance to the Infection Preventionist in completing the screening tools. All Nurses were in-serviced on the facility□s policies related to Antibiotic Stewardship with focus on completing the [redacted] screening tools for residents on [redacted]. IV. MONITORING OF CORRECTIVE ACTIONS: The Director of Nursing or Designee will conduct medical record audits of 5 residents who have orders for [redacted] on a monthly basis x 3 months. Audit will focus on ensuring that the [redacted] screening tools for residents on [redacted] were completed promptly to enhance	

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F 881	Continued From page 88 additional information toward treatment plan. Would continue with [NJ EX Order. 264b1] treatment of [NJ EX Order. 264b1]) via a [NJ EX Order. 264b1] with a stop order of [NJ EX Order. 264b1] During an interview on 09/27/23 at 4:10 PM the Infection Preventionist (IP) revealed "I knew [R91] had a [NJ EX Order. 264b1] and was on an [NJ EX Order. 264b1], but I did not have time to look into it. I do not know if the [NJ EX Order. 264b1] was [NJ EX Order. 264b1] or what type of [NJ EX Order. 264b1] the resident had." When asked how the nursing staff would know what type of precautions to use, she stated "That is a good question." During an interview on 09/28/23 at 9:50 AM the Nurse Practitioner (NP)1 revealed "I discussed [R91] with the Medical Director, and he felt the resident needed to start on the [NJ EX Order. 264b1] immediately. The [NJ EX Order. 2] was [NJ EX Order. 264b1] and [NJ EX Order. 264b1]. I ordered the [NJ EX Order. 264b1] and [NJ EX Order. 264b1] line. R91's pain has improved, and the [NJ EX Order. 264b1] no [NJ EX Order. 264b1]. The IP never came to me for not obtaining a [NJ EX Order. 264b1] During an interview on 09/29/23 at 1:35 PM the Director of Nursing (DON) revealed "I do not know why the IP missed this [NJ EX Order. 264b1]. At morning meetings, all antibiotics are discussed. If the [NJ EX Order. 264b1] does not meet the McGreers Criteria, then the doctor is called for their rationale." NJAC 8:39-19.1(a) NJAC 8:39-19.4(d)	F 881	antibiotic stewardship. Results of audits will be reported in the quarterly QA Meeting. The QAPI Committee will review the need for further action as needed.	
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3)	F 909		10/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315219	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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F 909	Continued From page 89 §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and facility policy review, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible [redacted] for four (Resident (R) 288, R41, R72, and R240) of seven residents reviewed for bed rail use of 41 sample residents. These failures had the potential to cause risk of [redacted] or injury due to use of [redacted] for these four residents. Findings include: 1. Review of R288's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed [redacted] was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses including: [redacted]. Review of R288's significant change "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of [redacted] revealed she was unable to complete the "Brief Interview for Mental Status (BIMS)" and was assessed by staff with [redacted] and had [redacted]	F 909	Residents affected by deficient practice: The facility failed to conduct regular inspection of all bedframes, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible [redacted] for four (Resident R#288, R#41, R#72, and R#240) of seven residents reviewed for [redacted] use of 41 sample residents. Identify those individuals who could be affected by the deficient practice: All residents with [redacted] have the potential to be affected by the deficient practice. The residents affected were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: The Maintenance Director and maintenance staff were educated on the facility [redacted] policies entitled "Bed Safety" and "Proper Use of [redacted], the FDA's Seven Zones of Entrapment, and when to perform an [redacted] assessment which includes all new	

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F 909	Continued From page 90 with NJ EX Order. 264b1 was NJ EX Order. 264b1 R288 required NJ EX Order. 264b1 with bed mobility and total assistance with transfers. She had a history of NJ EX Order. prior to admission and NJ EX Order. 264 without injury in the facility. During an observation on 09/28/23 at 2:42 PM in R288's room, NJ EX Order. 264b1 were observed on NJ EX Order. bed in the up position. Review of R288's "Orders" tab of the EMR revealed an order, which originated on NJ EX Order. 264b1, for NJ EX Order. 264b1 for NJ EX Order. 264b1. Review of R288's activities of daily living (ADL) "Care Plan" under the "Care Plan" tab of the EMR, dated NJ EX Order. 264b1 revealed, "[R288] has an ADL NJ EX Order. 264b1 " The approaches included: NJ EX Order. 264b1: NJ EX Order. 264b up as per Dr.'s [doctor's] order for safety during care provision, to assist with NJ EX Order. 264b1. Observe for injury or NJ EX Order. 264b1 t related to NJ EX Order. 264 use. Reposition (FREQ) and as necessary to avoid injury." Review of the "Assessments" tab of R288's EMR revealed there was no "NJ EX Order. 264b1 Assessment." Cross-reference F700: NJ EX Order. 264b1 - the facility failed to assess R288's need for the NJ EX Order., safety with the NJ EX Or, fit of the NJ EX Or on the bed, or risks of using the NJ EX Order. During an interview on 09/29/23 11:36 AM, the Maintenance Director (MD) stated he had assessed all the beds with NJ EX Order. 264b1 on NJ EX Order. 264b1 however, he had not done any assessments of	F 909	admissions assessed for NJ EX Order. 264 usage, anytime a resident gets new bed with siderails, annually and as needed. R#288's bed and NJ EX Order. 264b1 were assessed for proper fit and NJ EX Order. 264b1 using an FDA approved assessment tool. R#41's bed and NJ EX Order. 264b were assessed for proper fit and NJ EX Order. 264b1 using an FDA approved assessment tool. R#72's bed and NJ EX Order. 264b were assessed for proper fit and NJ EX Order. 264b1 t using an FDA approved assessment tool. R#240's bed and NJ NJ EX Order s were assessed for proper fit and entrapment using an FDA approved assessment tool. Measures or systemic changes to ensure that the deficiencies will not recur: Maintenance Director/designee to conduct whole house bed/siderail entrapment audit and then one bed per Unit 3x a week x4 weeks and 1x per week per month x2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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F 909	Continued From page 91 newly installed NJ EX ORD EX Ord after NJ EX Order. 264b1, so R288's bed had not been assessed for proper fit and NJ EX Order. 264b1 risk. During an interview on 09/28/23 at 4:46 PM, the Director of Nursing (DON) stated the maintenance bed assessment should have been completed on initiation of the NJ EX Ord and quarterly thereafter. 2. Review of R41's "Admission Record" revealed she was admitted to the facility on NJ EX Order. 264b1 with diagnoses including: NJ EX Order. 264b1, NJ EX Order. 264b1 Review of R41's admission "MDS" assessment, with an ARD of NJ EX Order. 264b1, revealed she scored NJ EX Order. 264b1 on the "BIMS" indicating NJ EX Order. 264b1 required NJ EX Order. 264b1 with NJ EX Order. 264b1 and transfers. R41 had a history NJ EX Order. 2 prior to admission. During an observation and interview with R41 in NJ EX room on 09/28/23 at 4:10 PM, NJ EX Order. 264b1 were observed at the NJ EX Order. 264b1 of R41's bed. The resident stated she used them to assist with getting into bed. Review of R41's "Orders" tab revealed an order for NJ EX Order. 264b1 NJ EX Order. 264b1, dated NJ EX Order. 264b1. Review of R41's ADL "Care Plan," dated NJ EX Order. 264b1, revealed, NJ EX Order. 264b1: NJ EX Order. 264b up as per Dr.'s order for safety during care provision, to assist with NJ EX Order. 264b1 Observe for injury or entrapment related to NJ EX Order. 264 use. Reposition	F 909		

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F 909	Continued From page 92 (FREQ) and as necessary to avoid injury. Review of R41's "[redacted] Assessment," dated [redacted] revealed, "Based upon above assessment findings, the [redacted]) is not a [redacted] and will be utilized to enable resident to attain or maintain his/her highest practicable level. Type: NJ EX Order. 264b1 In an interview on 09/29/23 11:36 AM, the MD stated he had assessed all the beds with [redacted] on [redacted]; however, he had not done any assessments of newly NJ EX Order. 264b1 after [redacted] so R288's bed had not been assessed for proper fit and NJ EX Order. 264b1 In an interview on 09/28/23 at 4:46 PM, the DON stated the maintenance bed assessment should have been completed on initiation of the [redacted] and quarterly thereafter. 3. R72's "Admission Record," dated [redacted] and found in the EMR under the "Profile" Tab, revealed the resident was admitted to the facility on [redacted] with diagnoses including [redacted] R72's admission "Minimum Data Set" assessment, dated [redacted] and found in the EMR under the "MDS" Tab, revealed a BIMS assessment score NJ EX Order. 264b1 [redacted] y NJ EX Order. 264b1 The assessment indicated the resident required NJ EX Order. 264b1 from staff to complete all his activities of daily living (ADLs), including NJ EX Order. 264b1 d, and indicated [redacted] were not in use for the resident. R72's "Order Summary Report," dated [redacted]	F 909		

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F 909	Continued From page 93 and found in the EMR under the "Orders" Tab, indicated orders for the resident to have [redacted] and [redacted] as needed for mobility. Review of R72's "Comprehensive Care Plan," dated [redacted] and found in the EMR under the "Care Plan" tab indicated an Activities of Daily Living Care Plan related to the resident's [redacted]. Interventions on the care plan included, in pertinent part, '[redacted]: half [redacted] as per Dr.'s (doctor's) order for safety during care provision, to assist with [redacted] Observe for injury or [redacted] related to [redacted] use. Reposition as necessary to avoid injury." Nothing could be found in facility or resident records to indicate a bed check had been done by maintenance or any other department to ensure the physical safety of R72's [redacted] R72 was observed in [redacted] room laying in [redacted] bed on 09/28/23 at 2:51 PM and 4:24 PM and again on 09/29/23 at 9:14 AM. The resident's [redacted] were in the [redacted] during all the observations. 4. R240's "Admission Record," dated [redacted] and found in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [redacted] with diagnoses including [redacted] R240's MDS assessment was not available due to the resident's recent admission to the facility. R240's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" Tab, indicated orders for the resident to have [redacted] as needed for [redacted]	F 909		

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F 909	Continued From page 94 Review of R240's "Comprehensive Care Plan," dated 09/10/23 and found in the EMR under the "Care Plan" tab, indicated no care plan related to the resident's use of [redacted] R240's most recent "Nursing Comprehensive Assessment," dated [redacted] and found in the EMR under the "Evaluation" Tab, indicated the resident did not have [redacted] on [redacted] bed because they were "not indicated at this time." Nothing could be found in facility or resident records to indicate a bed check had been done by maintenance or any other department to ensure the physical safety of R72's [redacted]. During an interview on 09/29/23 at 11:36 AM, the MD indicated he had completed physical bed checks on the beds of residents who had [redacted] most recently on [redacted]. He stated the facility process was the physical therapy department would send him a request to check a bed for side rail safety through the facility's TELS system and then he would check the bed, however he had not done any additional physical bed checks since [redacted] when he did his annual bed safety checks. The MD confirmed he was unable to locate physical bed safety checks for either R72 or R240. During an interview on 09/29/23 at 1:46 PM, the DON indicated her expectation was a physical bed/rail safety check was to be done for every resident with [redacted] on their bed when [redacted] were initiated and then at least annually after that. Review of facility's policy titled "Proper Use of	F 909		

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F 909	Continued From page 95 [redacted] Policy;" most recently revised in 05/23, read, in pertinent part "The purpose of these guidelines are to ensure the safe use of [redacted] as resident mobility aids and to prohibit the use of [redacted] as [redacted] unless necessary to treat a resident's medical symptoms;" and "10. Inspection by maintenance department annually for bed safety and [redacted] risk." NJAC 8:39-27.5(b) NJAC 8:39-31.2(d)(e)	F 909		

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	060414	A. BUILDING: _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S 560	Residents affected by deficient practice: The facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The resident affected was monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice:	10/28/23

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

Electronically Signed | 10/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -09/10/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/11/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/12/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -09/13/23 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -09/17/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -09/18/23 had 13 CNAs for 143 residents on the day shift, required at least 18 CNAs. -09/20/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -09/21/23 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. -09/22/23 had 15 CNAs for 146 residents on the day shift, required at least 18 CNAs. -09/23/23 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs.	S 560	The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. The facility will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff. Measures or systemic changes to ensure that the deficiencies will not recur: Administrator/designee to audit the effectiveness of hiring strategies to include open CNA and Licensed Nurse positions vs. new hires, reporting on successful strategies-to-hire based on percentages, and turnover rates. The duration of all audits will consist of completion one-time weekly x 4 weeks then three times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and	

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S 560	Continued From page 2	S 560	reporting.	

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
315219 Y1	A. Building B. Wing Y2	11/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0578	Correction	ID Prefix	F0582	Correction	ID Prefix	F0600	Correction
Reg. #	483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. #	483.10(g)(17)(18)(i)-(v)	Completed	Reg. #	483.12(a)(1)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0607	Correction	ID Prefix	F0657	Correction	ID Prefix	F0686	Correction
Reg. #	483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. #	483.21(b)(2)(i)-(iii)	Completed	Reg. #	483.25(b)(1)(i)(ii)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0689	Correction	ID Prefix	F0693	Correction	ID Prefix	F0700	Correction
Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.25(g)(4)(5)	Completed	Reg. #	483.25(n)(1)-(4)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0804	Correction	ID Prefix	F0809	Correction	ID Prefix	F0812	Correction
Reg. #	483.60(d)(1)(2)	Completed	Reg. #	483.60(f)(1)-(3)	Completed	Reg. #	483.60(i)(1)(2)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0842	Correction	ID Prefix	F0881	Correction	ID Prefix	F0909	Correction
Reg. #	483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	483.80(a)(3)	Completed	Reg. #	483.90(d)(3)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/29/2023	☐ YES ☐ NO

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
315219 Y1	A. Building B. Wing Y2	11/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0578	Correction	ID Prefix	F0582	Correction	ID Prefix	F0600	Correction
Reg. #	483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. #	483.10(g)(17)(18)(i)-(v)	Completed	Reg. #	483.12(a)(1)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0607	Correction	ID Prefix	F0657	Correction	ID Prefix	F0686	Correction
Reg. #	483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. #	483.21(b)(2)(i)-(iii)	Completed	Reg. #	483.25(b)(1)(i)(ii)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0689	Correction	ID Prefix	F0693	Correction	ID Prefix	F0700	Correction
Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.25(g)(4)(5)	Completed	Reg. #	483.25(n)(1)-(4)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0804	Correction	ID Prefix	F0809	Correction	ID Prefix	F0812	Correction
Reg. #	483.60(d)(1)(2)	Completed	Reg. #	483.60(f)(1)-(3)	Completed	Reg. #	483.60(i)(1)(2)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023
ID Prefix	F0842	Correction	ID Prefix	F0881	Correction	ID Prefix	F0909	Correction
Reg. #	483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	483.80(a)(3)	Completed	Reg. #	483.90(d)(3)	Completed
LSC		10/28/2023	LSC		10/28/2023	LSC		10/28/2023

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/29/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315219	A. Building B. Wing	11/9/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT VOORHEES, LLC	3001 EVESHAM ROAD VOORHEES, NJ 08043

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 10/28/2023	ID Prefix F0607 Reg. # 483.12(b)(1)-(5)(ii)(iii) LSC	Correction Completed 10/28/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			