STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 000	INITIAL COMMENTS Survey Date: 02/23/2022 Census: 105 Sample: 23 + 3 Closed A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		3/10/22

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

Electronically Signed | 03/14/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain resident dignity by not providing a privacy cover for 1 of 1 resident (Resident [redacted] reviewed for urinary catheter. This deficient practice was evidenced by: On 02/11/2022 at 11:51 AM, the surveyor observed Resident [redacted] lying in bed. The resident had a [redacted] bag secured to the bed frame without a privacy cover. There was [redacted] visible inside the [redacted] bag and could be seen from the hallway due to the resident's door being open. On 02/14/2022 at 1:49 PM, the surveyor observed Resident [redacted] lying in bed. The resident had a [redacted] bag secured to the bed frame without a privacy cover. There	F 550	1. [redacted] bag was immediately provided to cover the [redacted] bag for Resident [redacted] 2. All residents have the potential to be affected by the deficient practice of failing to maintain resident dignity by not providing a privacy cover. 3. An audit was conducted of all residents with [redacted] bags to ensure the presence of a [redacted] bag. The Director of Nursing in-services all nursing staff regarding the purpose of [redacted] bags and the frequency of changing the [redacted] bag. 4. The Assistant Director of Nursing or designee will monitor for the presence of [redacted] bags of all residents with [redacted] bags weekly for one month. All findings will be reported at the quarterly quality assurance (QAPI) meeting.	

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F 550	Continued From page 2	F 550		

was [redacted] visible inside the [redacted] bag.

According to the Admission Record, Resident [redacted] was admitted with a diagnosis of [redacted].

Review of Resident [redacted] Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status score of [redacted] indicating the resident's cognition was [redacted].

Review of Resident [redacted] Care Plan, dated [redacted], included the resident's [redacted] and an in intervention to "[redacted] bag."

During an interview with the surveyor on 02/22/2022 at 12:05 PM, the Certified Nursing Assistant (CNA) stated that if a resident has a [redacted] bag, they are provided with a privacy cover. The CNA further stated that if the resident did not have a privacy cover, she would notify the nurse and obtain one from the storage closet.

During an interview with the surveyor on 02/22/2022 at 1:43 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated residents with a [redacted] should have privacy covers for the [redacted] bag. The LPN/UM further stated that privacy covers should be used when the resident is in his/her room or in his/her wheelchair. The LPN/UM added that if the resident's [redacted] bag does not have a privacy cover, one could be obtained from the supply room.

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F 550	Continued From page 3 During an interview with the surveyor on 02/22/2022 at 2:16 PM, the Assistant Director of Nursing/LPN (ADON/LPN) stated that all residents with a [redacted] should have privacy covers on his/her [redacted] bag. The ADON/LPN further stated the importance of privacy covers was for the resident's dignity. During an interview with the surveyor, in the presence of the survey team, on 02/23/2022 at 9:50 AM, the Regional LPN acknowledged that Resident [redacted] should have had a privacy cover on his/her [redacted] bag. Review of the facility's [redacted] Care policy, undated, failed to address privacy covers for [redacted] bags. Review of the facility's Comprehensive Resident Centered Care Plan policy, dated [redacted] included, "the comprehensive, person-centered care plan will: ... describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."	F 550		
F 578 SS=E	NJAC 8:39-4.1 (a)(12) 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	F 578		3/11/22

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F 578	Continued From page 4 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 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 observation, interview, and record review, the facility failed to ensure the resident's wishes were followed in the advance directives with each readmission to the facility for 1 of 3 residents reviewed for advance directives	F 578	1. Resident [redacted] original Advanced Directive and Physician Orders for Life Sustaining Treatment (POLST) form was received and a physician order was written to indicate the initial Advance	

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F 578	Continued From page 5 (Resident [redacted]). This deficient practice was evidenced by the following: According to the Medical Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to: [redacted] On 02/11/22 at 10:05 AM, during the initial tour, the surveyor observed Resident [redacted] in bed covered in a blanket with the call bell next to the resident. On 02/14/22 at 1:41 PM , the surveyor observed that Resident [redacted] was not in his/her room. On 02/15/22 at 9:30 AM, the surveyor observed that Resident [redacted] was not in his/her room. At that time, the surveyor interviewed the Assistant Director of Nursing/Licensed Practical Nurse(ADON/LPN) who stated that the Resident #60 was transferred to the hospital on 02/14/22 for an evaluation. Review of the Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed Resident [redacted] had [redacted], was dependent for ambulation and activities of daily living and was receiving [redacted] A review of the MDS and medical records revealed the following for Resident [redacted]: -Discharged to the hospital on [redacted] and readmitted to the facility on [redacted] -Discharged to the hospital on [redacted] and readmitted to the facility on [redacted] -Discharged to the hospital on [redacted] and readmitted to the facility on [redacted]	F 578	Directive [redacted] and POLST form was created [redacted] indicating Cardiopulmonary Resuscitation (CPR) and Full Code status. the DNR/DNI status form was removed from Resident [redacted] chart as well as the red adhesive strip reflecting [redacted] status. The comprehensive care plan of Resident [redacted] was updated to reflect CPR and Full Code status. 2. All residents have the potential to be affected by this deficient practice of failing to ensure a resident's healthcare wishes are followed. 3. All resident charts were reviewed to ensure that healthcare wishes initiated were completed at a time when the resident was competent to make healthcare decisions. The Director of Nursing in-serviced all nurses and facility social worker on the purpose of Advanced Directives and POLST forms, the frequency of reviewing resident healthcare orders, and ensuring that all necessary adhesive strips and forms correlate with the healthcare wish is present in the resident's chart. 4. The Director of Nursing or designee will review five resident charts weekly for one month to ensure that all residents who have formulated an Advance Directive and POLST form are documented as a physician order in the resident's chart and all accessory components are present in the chart. All findings will be reported are the quarterly quality assurance meeting.	

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F 578	Continued From page 6	F 578		

-Discharged to the hospital on [redacted] and readmitted to the facility on [redacted]
-Discharged to the hospital on [redacted] and readmitted to the facility on [redacted]

Review of the Physicians Orders Sheets (POS) for Resident [redacted] revealed the following:
-The [redacted] readmission POS revealed a Physician Order (PO) for advance directives as [redacted].
-The September [redacted], October [redacted], and November [redacted] POS, for the readmission date of 09/29/21, revealed a PO for advance directives as [redacted]
-The facility did not provide the [redacted] readmission POS.
-The [redacted] readmission POS revealed a PO for [redacted].
-The January [redacted] POS, for the readmission date of [redacted] revealed a PO for [redacted].
-The [redacted] readmission POS did not reveal a code status.
-The February [redacted] POS, for the readmission date of [redacted], did not reveal a code status.

Review of Resident [redacted] hard chart record revealed a "red-colored" page that had [redacted] and [redacted] checked. The chart also had a red sticker inside the hard chart that reflected [redacted].

Review of the baseline care plan, dated [redacted] reflected [redacted] was written in red ink on the front page of the care plan.

Review of the Advance Directives Declaration (AD) for Resident [redacted], dated [redacted], and signed by Resident [redacted], revealed the resident wanted [redacted] -if the person's heart

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F 578	Continued From page 7	F 578		

stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive).

Review of the Physician Orders for Life Sustaining Treatment (POLST), dated [redacted], and signed by the physician, revealed the resident had the capacity to make [redacted] own decisions and wanted [redacted] and [redacted] treatment.

Review of the Annual MDS, dated [redacted] revealed Resident [redacted] was [redacted] at the time when the POLST and Advance Directives were initiated.

Review of the most recent MDS, dated [redacted], revealed Resident [redacted] had [redacted]

Review of the Interdisciplinary Care Conference Summary dated [redacted] and [redacted] revealed the code status for Resident [redacted] was [redacted]

Review of the Physician/Nurse Practitioners notes dated [redacted] reflected no documentation of a code status.

Review of the transfer records from the acute hospital, dated [redacted] did not reveal the code status for Resident [redacted]

During an interview with the surveyor on 02/18/22 at 10:19 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the doctor would write the code status when a resident was admitted or readmitted to the facility. If the resident was a [redacted], then the resident's

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F 578	Continued From page 8	F 578		

chart would have a "red-colored" sticker on the hard chart that indicated the resident was a [redacted] If a resident was unable to make his or her own decisions, then the facility would reach out to the next of Kin or Power of Attorney (POA). If the facility was unable to reach the next of Kin or the POA, then the facility would follow the AD or the POLST.

During an interview with the surveyor on 02/22/22 at 9:33 AM, the Social Worker (SW) stated that the facility would follow the resident's AD if the resident was unable to make their own decisions.

During an interview with the survey team on 02/22/22 at 4:15 PM, the Regional LPN stated that if the resident was unable to make his own decisions and readmitted to the facility, then the facility would maintain the code status they were before admitted.

During an interview with the survey team on 02/23/22 at 10:17 AM, the Regional LPN stated that the facility was unable to find a recent AD or POLST and had been unable to contact the family member that was listed on the face sheet. The Regional LPN stated an Advance Directive would be made when a resident was awake and oriented and able to make healthcare decisions for the future. The Regional LPN confirmed that the resident's healthcare wishes should have been followed when he/she returned from the hospital since the resident was unable to make his/her own decisions.

Review of the facility's policy undated "Advance Directive Policy and Procedure" revealed that the plan of care for each resident will be consistent with his or her documented treatment

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F 578	Continued From page 9 preferences and/or advance directives. The policy defined an Advance Directive as a written instruction relating to the provisions of health care when the individual is incapacitated. The policy further revealed that the Director of Nursing or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident medical record and plan of care. Review of the facility's policy "Resident Code Status," dated 03/2019, revealed a DNR/DNI may be completed if the resident meets the following requirements: is alert/oriented and able to make decisions, had an advance directive or the resident has a legal guardian who may speak on behalf of the resident. NJAC 8:39-19.6	F 578		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		4/15/22

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F 623	Continued From page 10 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 11	F 623		

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

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F 623	Continued From page 12 Based on interview and record review, it was determined that the facility failed to notify, in writing, the representative of the Office of the State of Long-Term Care Ombudsman about a resident's transfer to the hospital for 2 of 2 residents (Resident [redacted] and [redacted]) reviewed for hospitalization. This deficient practice was evidenced by: 1.) According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to, [redacted] Review of Resident's [redacted] Nurse's Note, dated [redacted], included that the resident was sent to the hospital related to symptoms of a [redacted]. Review of Resident [redacted]'s Nurse's Note, dated [redacted], included that the resident was sent to the hospital related to [redacted]. Review of Resident [redacted]'s Nurse's Note, dated [redacted], included that the resident was sent to the hospital related to a [redacted] sustained from a [redacted] 2.) According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to, [redacted]. Review of Resident's [redacted] Nurse's Note, dated [redacted], indicated that the resident was sent to the hospital due to a [redacted] and admitted with a [redacted].	F 623	1. Resident [redacted] was provided a copy of the Notice of Emergency Transfer form for emergency transfer date [redacted] and [redacted]. Resident [redacted] family representative was provided a copy of the Notice of Emergency Transfer for emergency transfer date [redacted]. The Ombudsman Office was notified. 2. All residents have the potential to be affected by this deficient practice of failing to provide written notification to a resident's family representative upon an emergency facility initiated transfer to the hospital. 3. Director of Nursing will in-service all nurses and social worker regarding the appropriate procedure for emergency transferring and/or discharges of a resident with emphasis of written documentation to the family representative, contents contained within the notification prior to discharge, and adequate time frame of notice. Education provided on Ombudsman notification also. 4. The Director of Nursing or designee will monitor daily for one month completed documentation of family representative notification of all facility initiated emergency transfers. Monthly transfer logs will be submitted to the Long Term Care Ombudsman office via fax by the Social Worker or other facility designee. All findings will be reported to the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 623	Continued From page 13	F 623		

During an interview with the surveyor on 02/16/2022 at 12:33 PM, after the surveyor requested the notifications made to the Office of the State of Long-Term Care Ombudsman related to hospitalizations since July 2021, the Regional Licensed Practical Nurse (Regional LPN) stated that she was unable to locate the notifications due to a change in the administration. The Regional LPN further stated that it was the responsibility of the Social Worker (SW) to notify the Ombudsman of residents transferred to the hospital.

During an interview with the surveyor on 02/16/2022 at 12:43 PM, the SW stated that she was not aware of the process of notifying the Ombudsman of residents who were transferred to the hospital.

During an interview with the surveyor on 02/22/20222 at 2:16 PM, the Assistant Director of Nursing/LPN stated that when a resident is transferred to the hospital, the Office of the State of Long-Term Care Ombudsman should be notified via fax within 24 hours.

Review of the facility's Notification to the Ombudsman policy, dated 02/2022, included, "Sending a copy of the notice to a representative of the Ombudsman ensures the Ombudsman is aware of facility practices and activities related to transfers and discharges, providing added protection to residents," and, "The Admissions Director or designee will obtain on a daily basis names of residents who have been transferred to another facility or hospital and complete the Notice of Emergency Transfer Form. A copy of this form will be provided to the following: The resident or family representative; and The Office

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F 623	Continued From page 14 of the Ombudsman. A copy of this form must be placed in the resident's chart along with the fax confirmation sheet." NJAC 8:39-4.1(a)(32)	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		3/8/22

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F 655	Continued From page 15 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a person-centered baseline care plan for a resident within 48 hours of admission. This deficient practice was identified for 1 of 23 residents reviewed for person-centered baseline care plans (Resident [redacted] and was evidenced by the following: According to the Admission Record, Resident [redacted] 5 was admitted to the facility with diagnoses which included, but not limited to, [redacted]) and [redacted] in [redacted]. A review of the Baseline Care Plan revealed that the Baseline Care Plan was initiated on [redacted] including the resident's name, attending physician and room number. The Baseline Care Plan reflected that the following areas were not	F 655	1. Resident [redacted] Baseline Care Plan was completed and reviewed with the resident and signed by the Interdisciplinary Team (IDT) 2. All residents have the potential to be affected by the deficient practice of failing to develop a person-centered Baseline Care Plan within 48 hours of admission. 3. an audit was completed for all newly admitted residents to confirm that a Baseline Care Plan was initiated at the time of admission. The Director of Nursing in-serviced all nurses regarding the purpose, components, and time frame of completing a resident Baseline Care Plan. 4. The Assistant Director of Nursing or designee will monitor five resident charts weekly for one month to ensure that newly admitted residents Baseline Care Plan has been initiated and completed. Findings will be reported at the quarterly quality assurance (QAPI) meeting .	

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F 655	Continued From page 16 completed: -Time of Admission -Baseline Care Plan Implementation Date -Code Status -Admitted from -Allergies -Preferred Name -Resident Representative -Phone Number -Hospice/End-of-Life -Resident Discharge Goals -Resident's Daily Routine/Preferences -Resident's Ethnic/Cultural Preferences -Resident's Goals on Admission -Cognitive Status -Safety -Dietary Orders -Therapy(ies) Ordered -Therapy/Functional Goals -Meal Location Preferences, -Denture/Teeth -Activities of Daily Living -Equipment -Bowel/Bladder Needs -Skin Care Needs -Communication/Vision/Hearing -Behavior Concerns -Social Service Needs -Special Treatments/Procedures -Restraints/Alarms/Side Rails -Pain -Medication/Treatment Orders -Additional Comments/Changes for Baseline Care Plan and -Signatures of IDT [interdisciplinary team] Members involved in Developing Baseline Care Plan.	F 655		

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F 655	Continued From page 17 During an interview with the surveyor on 02/14/22 at 2:35 PM, the Licensed Practical Nurse #2 (LPN) stated that the admitting nurse was responsible to complete the Baseline Care Plan within 48 hours of admission. LPN #2 further stated that if the admitting nurse did not complete it, the next shift would complete the Baseline Care Plan. During an interview with the surveyor on 02/14/22 at 3:29 PM, the Director of Nursing #1 (DON) stated that the baseline care plan was completed by the admission nurse and should be completed within 48 hours of admission. Review of the facility's Baseline Care Plan Policy and Procedure, dated 12/2018, reflected "To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission." NJAC 8:39 - 27.1(a)	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) document the administration of [redacted] (administration into the [redacted] s, in accordance with a physician's	F 658	1. Resident [redacted] site was assessed with no adverse findings. Resident [redacted] MAR was reviewed and the nurses assigned to care for the resident on the following days signed	4/22/22

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F 658	Continued From page 18 order for 1 of 1 resident (Resident [redacted]) reviewed for a [redacted] line, b.) ensure a physician's order was obtained prior to a resident's transfer to the hospital for 2 of 2 residents (Resident [redacted] and [redacted] reviewed for hospitalization, c.) properly measure a dietary supplement for a resident, consistent with professional standards during the medication pass, d.) properly dispose of a medication tablet, in accordance with professional standards during the medication pass for 1 of 2 nurses, on 1 of 2 nursing units observed during completion of the Medication Administration task, and e.) clarify and accurately transcribe an admission medication order in accordance with the facility policy for 1 of 26 residents (Resident [redacted]) reviewed for medications. This deficient practice was evidenced by: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	confirmed that the [redacted] was [redacted] as ordered and signed by the Medication Administration Record (MAR)for the following dates and shifts: 2/2/200 11-7, 2/5/2022 11-7, 2/6/2022 11-7, 2/7/2022 11-7, 2/8/2022 11-7, 2/9/2022 11-7, 2/10/2022 11-7, 2/11/2022 11-7, 2/12/2022 11-7, 2/13/2022 7-3, 2/13/2022 11-7. an order was written in Resident [redacted] Medical record for transfer to the hospital on [redacted]. An order was written on Resident [redacted] medical record for transfer to the hospital on [redacted] and [redacted]. LPN #1 was immediately in-serviced regarding pouring liquid medication at eye level and measuring on a flat surface, proper disposal of medications; a medication drug disposal solution bottle was immediately placed in LPN #1 medication cart. A physician order was written to clarify Resident [redacted] order for a total of [redacted] mg to be administered. 2. All residents have the potential to be affected by the deficient practice of failing to document the administration of [redacted] in accordance with physician order, failing to ensure a physician order is obtained prior to a resident transfer to the hospital, failing to properly measure a dietary supplement for a resident, consistent with professional standards during medication pass, failing to properly dispose of a medication tablet in accordance with professional standards during medication pass, failing to clarify and accurately transcribe an admission medication order in accordance with facility policy.	

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F 658	Continued From page 19 responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 02/11/2022 at 11:13 AM, the surveyor observed Resident [redacted] sitting up in bed. The resident showed the surveyor his/her [redacted] on his/her [redacted] and stated that the staff do not consistently [redacted] (administer [redacted] his/her [redacted]. Review of Resident [redacted] Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status score of [redacted], indicating the resident's [redacted]. Review of Resident [redacted]'s February 2022 Physician's Order Form included an order for [redacted] per protocol every shift for patency," dated [redacted]. Review of Resident's [redacted] February 2022 Medication Administration Record (MAR) included the aforementioned order was not signed as administered on the following dates: 02/02/2022 11-7 Shift 02/05/2022 11-7 Shift 02/06/2022 11-7 Shift 02/07/2022 11-7 Shift 02/08/2022 11-7 Shift 02/09/2022 11-7 Shift	F 658	3. The Director of Nursing (DON) in-services all nursing staff regarding facility [redacted] protocol. Nursing staff were also in-serviced regarding documentation required during hospital transfer process. All nursing staff were in-serviced to ensure that the medication cart is appropriately supplied prior to starting medication administration pass. An audit completed on all medication carts for the presence of drug disposal bottles. All nursing staff were in-services regarding ensuring that medication orders are accurately transcribed to the resident's medication record. 4. The Assistant Director of Nursing ADON or designee will monitor 5 residents weekly for one month to ensure that nurses sign the resident MAR after flushing the resident's [redacted]. ADON or designee will monitor five resident charts weekly for one month to ensure that residents transferred to the hospital also have a physician order indicating transfer. The ADON or designee will review all medication cards daily got one month assuring that medication drug disposal bottles are in the cart. The ADON or designee will monitor five resident physician orders weekly for one month to ensure that orders are correctly transcribed to the MAR. All findings will be reported a the quarterly quality assurance meeting.	

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F 658	Continued From page 20 02/10/2022 11-7 Shift 02/11/2022 11-7 Shift 02/12/2022 11-7 Shift 02/13/2022 7-3 Shift 02/13/2022 11-7 Shift During an interview with the surveyor on 02/22/2022 at 1:43 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that nurses should sign off on the MAR after administering medications. The LPN/UM further stated that if the MAR is not signed, "you don't really know if it was given or not." During an interview with the surveyor on 02/22/2022 at 2:16 PM, the Assistant Director of Nursing/LPN (ADON/LPN) stated that nurses sign off on the MAR after the resident receives the medication. The ADON/LPN further stated that if the MAR is not signed, it means "the medication was not administered." During an interview with the survey team on 02/23/2022 at 9:50 AM, the Regional LPN stated that if the MAR is not signed, "you cannot assume that it was given," and that the MAR should have been signed. Review of the facility's Administering Medications policy, dated 06/2018, included, "the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication." 2a. According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to: [redacted].	F 658		

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F 658	Continued From page 21 Review of Resident [redacted] Nurse's Note, dated [redacted], included that the resident was sent to the hospital related to a [redacted] sustained from a [redacted] Review of Resident [redacted] s [redacted] Physician's Orders (PO) revealed there was no PO to send Resident [redacted] to the hospital on [redacted] 2b. According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to: [redacted] . Review of Resident [redacted] s Nurse's Note, dated [redacted], included that the resident was sent to the hospital related to [redacted]. Review of Resident [redacted] 's [redacted] PO revealed there was no PO to send Resident [redacted] to the hospital on [redacted] Review of Resident [redacted] 's Incident Report, dated [redacted] included that the resident was sent to the hospital related to a [redacted] Review of Resident [redacted] 's [redacted] PO revealed there was no PO to send Resident #[redacted] to the hospital on [redacted] During an interview with the surveyor on 02/22/2022 at 1:43 PM, the LPN/UM stated that if a resident had to be sent to the hospital, the nurse would notify the physician and obtain a PO to send the resident to the hospital. During an interview with the surveyor on	F 658		

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F 658	Continued From page 22 02/22/2022 at 2:16 PM, the ADON/LPN stated that if a resident had to be sent to the hospital, the nurse would notify the physician and obtain a PO to send the resident to the hospital. During an interview with the survey team on 02/23/2022 at 9:50 AM, the Regional LPN stated that there should have been a PO to send Resident [redacted] to the hospital on [redacted]. The Regional LPN further stated that there should have been a PO to send Resident [redacted] to the hospital on [redacted] and [redacted] Review of the facility's Resident Emergency Transfer/Discharge policy, dated 09/2018, included, "Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: Notify the resident's Attending Physician; ... Others as appropriate or as necessary." The policy did not include the procedure for obtaining a PO prior to sending residents to the hospital. 3. On 2/14/22 at 9:38 AM, the surveyor, in the presence of another surveyor, observed the Licensed Practical Nurse (LPN #1) prepare a medication for administration to Resident [redacted]. At this time, LPN #1 poured [redacted] (a liquid protein supplement) into a metered dose cup she held in her hand, which was suspended in air. LPN #1 did not level the metered dose cup on a flat surface or pour the dose at eye-level. On the same date at 9:40 AM, during an interview with the surveyors, LPN #1 revealed she pours above the graduated marking to compensate for the viscosity (thickness) of the liquid. LPN #1	F 658		

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F 658	Continued From page 23	F 658		

further revealed the liquid poured in the metered dose cup measured [redacted] milliliters (ml).

On the same date at 10:08 AM, during an interview with the surveyors, Licensed Practical Nurse Unit Manager (LPN/UM) and the Director of Nursing (DON), both confirmed that liquids to be administered must be placed on a flat surface, poured, and measured at eye level.

A review of Resident [redacted] medical record revealed a PO dated [redacted], for [redacted] mL to be given orally twice daily.

DON #2 acknowledged liquid medications must be measured on a flat surface, poured, and measured at eye level.

A review of the facility policy titled, "Administering Medications Policy and Procedure" with an effective date of 6/2018 and under section 'Policy Interpretation and Implementation" number 3 revealed, "Medications must be administered in accordance with orders, including any required time frame" and number 7 reflected, "The individual administering medications must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.". The policy did not address the preparation and administration of dietary supplements.

A review of the undated facility documentation titled, "Administering Oral Medications Protocol", under section "Steps in the Procedure" number 9, subsection (a) indicated, "For liquid medications. Remove the cap from the bottle and place cap upside down on the work surface. Hold the

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F 658	Continued From page 24	F 658		

medication cup at eye level and use your thumb to mark the desired level on the cup. Fill to the bottom of the meniscus at the desired level. Place cup on a level surface and read the poured amount at eye level to check accuracy." The referenced document did not address preparation and administration of dietary supplements.

4. On the same date at 9:56 AM, the surveyor, in the presence of another surveyor, observed LPN #1 dispose of a medication tablet by placing it into the red needle container attached to the medication cart. At this time, LPN #1 revealed she did not have a drug disposal solution (bottle of solution used to disintegrate pills and tablets) in the medication cart. LPN #1 confirmed medications should not be disposed of in the Sharps container (red needle container).

On 2/14/22 at 10:08 AM, during an interview with the surveyor, the LPN/UM confirmed medications are to be disposed using drug disposal solution. In addition, she confirmed drug disposal solution should be in the medication carts. Finally, she confirmed medications should not be disposed of in the trash, sink, or in a red needle container.

A review of the facility policy titled, "Discarding and Destroying Medications" with an effective date of 3/2018, under section "Policy Interpretation and Implementation" number 2, revealed " Non- controlled and Schedule V (non hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications". Number 6, subsection (b) revealed "Mix medications, either liquid or solid, with an undesirable substance. Undesirable substances include sand, coffee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

(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 658	Continued From page 25	F 658		

grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage (c) Dispose with the solid waste (i.e., regular trash) in the presence of two witnesses .... Staff shall contact the provider pharmacy if they are unsure of proper disposal methods for a medication."

5. According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted], acute [redacted] and [redacted].

Review of Resident [redacted]'s "After Visit Summary" report (hospital discharge instructions) reflected under the "Medication List" section, a PO for [redacted] milligrams/milliliters (mg/mL) (a medication used for the treatment [redacted]). The PO instructed to administer [redacted] mL [for a total of [redacted] mg] by mouth daily.

Review of Resident [redacted]'s 02/08/22 admission physician orders sheet (POS) revealed PO for [redacted] mg/mL and to administer [redacted] mg/mL [for a total of [redacted] mg] by mouth daily. The PO did not indicate to administer '[redacted] mL [for a total of [redacted] mg] by mouth daily per the hospital discharge instructions.

Review of Resident [redacted]'s "Chain of Custody/Off-site Dosing form (declining sheet) indicated that [redacted] mg was signed out on the following days: 02/16/22, 02/17/22, 02/18/22, 02/19/22, 02/20/22, and 02/21/22.

The facility was unable to provide Resident [redacted]s declining sheet for the 02/10/22, 02/11/22, 02/12/22, 02/13/22, 02/14/22, and 02/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 658	Continued From page 26 [redacted] doses. Review of Resident [redacted]'s MAR revealed the aforementioned PO for [redacted] mg/mL and to administer [redacted] mg by mouth daily. The MAR further revealed that [redacted] mg was signed as administered on the following days: 02/10/22, 02/11/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/18/22, 02/19/22, 02/20/22, and 02/21/22. During an interview with the surveyor on 02/23/22 at 9:52 AM, the Regional LPN stated the admitting nurse did not transcribe the admission physician orders properly. The Regional LPN further stated the nurses should follow the five rights when administering medications. The Regional LPN added that the five rights included: right resident, right route, right time, right dose, right frequency. Review of the facility's "Reconciliation of Medications on Admission," dated 1/2018, indicated that if there was a discrepancy or conflict in medications, dose, route or frequency, staff were to determine the most appropriate action to resolve the discrepancy. The policy included but was not limited to: contacting the nurse or physician from the referring facility and contacting the admitting and/or attending physician.	F 658		
F 677 SS=D	NJAC 8:39- 11.2(b), 27.1(a), 29.2(d), 29.7(g) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 677	Continued From page 27 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain proper grooming for a resident who was unable to independently carry out activities of daily living. This deficient practice was identified in 1 of 26 residents (Resident [redacted]) reviewed for activities of daily living and was evidenced by the following: On 02/11/22 at 11:30 AM, two surveyors observed Resident #33 lying in bed. The resident's [redacted] were [redacted], meaning that his/her [redacted] were turned inward towards his/her [redacted]. The surveyors noted that the [redacted] on both [redacted] were long and there was a brown-colored substance in the [redacted] of the [redacted]. During an interview with the surveyor on 02/11/22 at 2:03 PM, Resident [redacted] stated that he/she usually receives assistance with cutting his/her [redacted], feels that his/her [redacted] needed cutting, and agrees to have them cut when staff assists him/her. In addition, the resident confirmed that he/she was not in pain due to his/her [redacted]. On 02/11/22 at 2:10 PM, two additional surveyors observed Resident [redacted] lying in bed, with a brown-colored substance in the [redacted] of his/her unopened [redacted]. During an interview with the surveyor on 02/11/22 at 2:31 PM, the Certified Nursing Assistant (CNA #3) stated that Resident [redacted] was assisted with getting out of bed and changing his/her clothes.	F 677	Resident [redacted] fingernails were cleaned and trimmed. CNA #3 was immediately in-serviced regarding her scope of practice and duties related to resident care. 2. All residents have the potential to be affected by this deficient practice of failing to maintain proper grooming for a resident who is unable to independently carry out activities of daily living. 3. An audit of resident [redacted] condition was completed by CNA QA of all resident [redacted]. The DON in-serviced all nursing staff regarding grooming, hygiene, and nail care during their shift; emphasis on residents with [redacted] was included during the education process. 4. The ADON or designee will monitor five residents daily for one month to ensure that appropriate grooming is performed daily. All findings will be reported at the quarterly quality assurance meeting.	

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 677	Continued From page 28	F 677		

CNA #3 stated that Resident [redacted] sometimes screamed and yelled at others but is usually pretty good about accepting care from staff. CNA #3 further stated that the resident had [redacted] of both [redacted]. When asked about who is responsible for cutting the resident's [redacted], CNA #3 stated that she does not assist the resident with this task. She stated that she thinks the activities staff helped Resident [redacted] cut his/her [redacted], but she does not help [redacted] because there were no [redacted] available to her for that purpose. CNA #3 added that, if necessary, staff members that needed new [redacted] obtained them from the Staffing Coordinator, but she had not made such a request for [redacted], since she was an agency staff member. CNA #3 further stated that she did not know when the resident's [redacted] were last cut.

On 02/15/22 at 9:53 AM, the surveyor observed the resident lying in bed with both [redacted], with a brown-colored substance in the [redacted] of the [redacted], and long [redacted] on both [redacted].

On 02/15/22 at 12:49 PM, the surveyor observed the resident in bed, eating lunch. His/her [redacted] were long, and he/she stated that he/she was okay.

On 02/16/22 12:22 PM, the surveyor observed the resident sitting in his/her wheelchair, in the room. Both [redacted] were contracted, and the [redacted] of both [redacted] were long.

On 02/17/22 at 10:30 AM, the surveyor observed the resident lying in bed, with [redacted] and [redacted], with a brown-colored substance present on both [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 677	Continued From page 29 On 02/22/22 at 9:28 AM, the surveyor observed Resident [redacted] lying in bed. The resident's [redacted] were long. Review of the Admission Record and Physician's Orders for Resident [redacted] revealed diagnoses, that included but were not limited to, [redacted] Review of the resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], meaning the resident had a [redacted] (thought). In addition, the MDS further reflected there were no behaviors related to the rejection of care, the resident could understand staff and be understood by staff, and that the resident required extensive assistance with personal hygiene including care of the hands. A review of the resident's current care plan included monitoring for evidence of skin breakdown every shift. During an interview with the surveyor on 02/22/22 at 12:06 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that Resident [redacted] required assistance with grooming and hygiene, indicating that it was primarily the responsibility of the CNA to cut the resident's [redacted], although anyone could assist with this task. The LPN/UM further stated that [redacted] cutting for residents should occur approximately once per week but that when	F 677		

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 677	Continued From page 30	F 677		

done, it is not documented anywhere for reference. In addition, the LPN/UM stated that it is important for routine [redacted] cutting to occur, particularly for Resident [redacted], since he/she has [redacted], because [redacted] could result in injury to the resident or the staff providing care to him/her.

On 02/22/22 at 12:15 PM, the surveyor and LPN/UM observed Resident [redacted] together with the use of overhead bed lighting. The resident's [redacted] were both [redacted], and the LPN/UM acknowledged that the resident's [redacted] were long and needed to be cut at this time. The LPN/UM stated that it is sometimes difficult to reach the resident's [redacted] on the [redacted] but reaffirmed that his/her [redacted] needed to be cut and that this was important due to the presence of [redacted] and the need to protect the skin on his/her [redacted], as well as staff providing care to the resident. When asked for possible reasons why the resident's [redacted] were not cut, the LPN/UM stated that the resident's CNA was a member of the agency staff and that some staff members are better than others; however, this was not an excuse and the resident's [redacted] should have been cut accordingly.

During an interview with the surveyor and team on 02/22/22 at 3:24 PM, the Regional Licensed Practical Nurse (Regional LPN) stated that a resident's assigned CNA would be responsible in assisting him/her with grooming and hygiene tasks. If the resident's [redacted] appeared to be long or jagged, they should be cut, as long [redacted] was a reason for concern, especially for residents having [redacted] The reason was because long [redacted] could become embedded into the [redacted]

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 677	Continued From page 31 Review of the facility's "Sterling Manor Nursing Center Activities of Daily Living Policy and Procedure," dated 02/2020, revealed that residents who are unable to carry out activities of daily living independently would receive the services necessary to maintain good grooming. NJAC 8:39-4.1(a)22	F 677		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain current equipment for the purposes of immediate response to potential life-threatening, cardiac emergencies. This deficient practice was identified in 1 of 1 Automated External Defibrillator (AED) kits reviewed during the medication labeling and storage task and was evidenced by the following: On 02/16/22 at 12:55 PM, the surveyor observed an AED emergency response kit, mounted on the wall of the main dining room, in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM). The surveyor, with the assistance of the LPN/UM, removed the AED kit from the wall mounting, opened it, and observed the	F 678	1. the expired Automatic External Defibrillator (AED) pad was immediately discarded and replaced. The emergency crash cart list was updated to include the functioning of the AED machine and expiration status of the AED pads. 2. All residents have the potential to be affected by this deficient practice of failing to maintain current equipment for the purposes of immediate response to potential life-threatening, cardiac emergencies. 3. The DON in-serviced all nursing staff regarding the frequency of monitoring the AED machine and defibrillator pad. Additional education included the location of extra defibrillator pads as well as the updated emergency crash cart list. 4. The ADON or designee will monito all	3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 678	Continued From page 32 defibrillator pads within the kit, with an expiration date of January 2021. At that time, the expiration date was acknowledged by the LPN/UM. During an interview with the surveyor and team on 02/16/22 at 1:05 PM, the Director of Nursing (DON #2) acknowledged the expiration date of January 2021 on the AED pads. She stated that the Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN) checked the AED device daily, but she could not provide detail regarding what exactly was checked each day. DON #2 further stated that staff should be checking to see if the AED pads are currently in date; and if expired, this should be reported to the DON. DON #2 confirmed that the AED pads should not be expired, because there will be no conductivity in the pads, and they cannot work properly. The surveyor asked DON #2 to send the ADON/LPN to the conference room, to speak to the team at this time, indicating the importance of doing so. During a subsequent interview at 1:22 PM, DON #2 stated that the pads have not been checked since a former staff member left their position but could not provide further details. DON #2 did confirm that there was only one AED device in the building. When the surveyor asked to speak to the ADON/LPN again, DON #2 stated that the ADON/LPN was in the building but reviewing facility documentation. On 02/16/22 at 1:29 PM, the surveyor interviewed the Consulting Administrator (CA) and the Administrator. The CA stated that the AED pads were probably checked for their presence within the emergency kit, but the dates on them were probably not checked. The Administrator stated	F 678	AED pads within the facility daily to ensure that the dates of expiration noted on the exterior package are not expired. Findings will be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 678	Continued From page 33	F 678		

that she expected the AED pads to be checked and acknowledged that the expired pads found by the surveyor should not have been present within the kit.

During an interview with the surveyor on 02/16/22 at 2:10 PM, the ADON/LPN confirmed that there was only one AED device present in the building and that she heard that expired pads were discovered by the surveyors. The ADON/LPN stated that she routinely checked for the presence of the AED device, and this was documented on a form related to the emergency carts. She clarified that she checked for the presence of the pads but did not know they expired.

During an interview with the surveyor on 02/16/22 at 3:15 PM, DON #2 was able to access a set of AED device pads with an expiration date of April 2022. According to DON #2, these pads were in the nursing office.

Review of the "Emergency Cart Check List," provided by the facility, reflected that the AED was reviewed daily from January 1, 2021 through February 16, 2022.

A review of the facility's "Sterling Manor Use and Care of Automatic External Defibrillator" policy, dated 04/2018, revealed that the policy addressed the maintenance of the AED device, explicitly stating to keep a spare battery and adhesive pads in the case and to record the expiration date of the battery and pads accordingly.

NJAC 8:39-23.3(b)1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 686	Continued From page 34	F 686		
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 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 observation, interview, and record review, it was determined that the facility failed to follow an active physician's order to elevate [redacted] while in bed. This deficient practice was identified 1 of 2 residents (Resident [redacted]) reviewed for positioning and mobility and was evidenced by the following: On 02/11/21 at 12:13 AM, the surveyor observed Resident [redacted] resting in bed with the head of bed slightly elevated. The surveyor observed that the resident's [redacted] were not offloaded and were positioned directly on the bed. The surveyor made the same observation on 02/14/22 at 10:08 AM, 02/15/22 at 10:06 AM, 02/16/22 at 11:29 AM, 02/17/22 at 11:13 AM, 02/18/22 at 10:49 AM, and 02/22/22 at 1:46 PM. According to the Admission Record, Resident [redacted] had diagnoses that included, but were not limited	F 686	1. Resident [redacted] s were immediately assessed, offloaded, and positioned on the bed. 2. All residents have the potential to be affected by this deficient practice of failing to follow an active physician's order to elevate [redacted] while in bed. 3. An audit was completed on all resident's charts related to orders of impaired skin and residents with such orders were physically reviewed to ensure that the active order was followed. The DON in-serviced all nursing staff regarding the structure of the skin, problem related to the [redacted] skin, preventing [redacted], and reporting changes in skin condition. 4. The Assistant Director of Nurses (ADON) or designee will monitor five residents daily for one month to ensure	4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 35 to: [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status of [redacted], which indicated that the resident was [redacted]. Further review of the MDS revealed the resident had impairment on both sides of the body, required extensive assistance of one staff for bed mobility, and was at risk for [redacted]. Review of the [redacted] Braden Scale, an assessment tool used to predict the risk for [redacted], revealed that the facility identified Resident [redacted] as being [redacted] risk for [redacted] Review of the [redacted] Physician's Order Form included a physician order (order) to "Elevate heels off the bed every shift while in bed," with a start date of [redacted]. Review of the Interdisciplinary Care Plan (CP) revealed a problem that, "[Resident [redacted]] was at risk for [redacted]. The CP further revealed an intervention to "elevate [redacted] with pillow to offload." During an interview with the surveyor on 12/03/2021 at 9:20 AM, the Certified Nursing Assistant (CNA #4) stated Resident [redacted] was [redacted], and required total assist with care. CNA #4 further stated the resident was compliant with care, was able to move lower extremities, but didn't like to move them much.	F 686	that physician instructions related to risk for or present skin impairment are followed as ordered. All findings will be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 36 During an interview with the surveyor on 02/22/22 at 1:49 PM, the Licensed Practical Nurse (LPN #3) stated Resident [redacted] was pleasant with no behaviors, had a history of [redacted], and required total assist with care. At that time, LPN #3 accompanied the surveyor to the resident's room and confirmed the resident's [redacted] were not offloaded and were positioned directly on the bed. During a follow up interview with the surveyor on 02/22/22 at 1:58 PM, LPN #3 stated Resident [redacted] had [redacted] prevention orders and that the resident's [redacted] should be offloaded when in bed. During an interview with the Regional Licensed Practical Nurse (Regional LPN) on 02/23/22 at 9:58 AM, the Regional LPN stated the resident's [redacted] should have been offloaded while in bed. Review of the facility's "Prevention of [redacted] /Injuries Policy and Procedure" reflected to reposition the resident as indicated on the care plan.	F 686		
F 689 SS=D	NJAC 8:39-27.1(a) 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	F 689		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 689	Continued From page 37 accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to complete incident reports in their entirety for 1 of 6 residents (Resident [redacted]) reviewed for accidents. This deficient practice was evidenced by: According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to: [redacted]. Review of Resident [redacted]s Nurse's Note, dated [redacted], included that the resident [redacted] trying to transfer into a wheelchair. Review of Resident [redacted]'s Nurse's Note, dated [redacted], included that the resident was sent to the hospital related to a [redacted] sustained from a [redacted] Review of Resident [redacted]'s Incident Report, dated [redacted], included a form titled, "[redacted] Investigation" and had directions for licensed staff to complete the form following each resident [redacted]. The front page was completed and at the bottom of the front page there were instructions to "please complete the back of this page." The back of the form was not completed and included sections for the following: resident interview, a checklist of the resident's condition, environment, history and last observations, witness statements, additional comments, and signature lines for the nurse completing the investigation and the Unit Manager (UM).	F 689	1. The fall investigation form was completed for the incident pertaining to resident [redacted]'s incident on [redacted]. 2. All residents have the potential to be affected by this deficient practice of failing to complete incident reports in their entirety. 3. The DON in-serviced all nursing staff regarding the facility's policy and procedure related to resident incident and accidents, with emphasis of completing all assessment forms which is critical to ensuring that the incident has been fully investigated. 4. The ADON or designee will review five resident incident reports weekly for one month to ensure that all components of the resident incident report has been completed. All findings will be reported at the quarterly quality assurance meeting.	

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F 689	Continued From page 38 Review of Resident [redacted]'s Incident Report, dated [redacted], did not include the [redacted] Investigation form. During an interview with the surveyor on 02/22/2022 at 1:43 PM, the Licensed Practical Nurse (LPN)/UM stated that when a resident [redacted], an Incident Report is completed in addition to a separate [redacted] Investigation. The LPN/UM further stated that the purpose of the [redacted] Investigation is to try to determine why the resident [redacted] and that it should be completed in its entirety. During an interview with the surveyor on 02/22/2022 at 2:16 PM, the Assistant Director of Nursing/LPN (ADON/LPN) stated that when a resident [redacted], an Incident Report and a [redacted] Investigation is completed. When shown the Incident Reports for Resident [redacted]'s [redacted], the ADON/LPN stated the [redacted] Investigation for the [redacted] should have been completed in its entirety and there should have been a [redacted] Investigation completed for the [redacted] as well. During an interview with the survey team on 02/23/2022 at 9:50 AM, the Regional LPN acknowledged that the [redacted] Investigations for Resident [redacted] should have been completed in their entirety. Review of the facility's Resident Incident policy, dated 02/2018, included, "Incident reports must be completed in its entirety in order to confirm that incident was fully investigated." The policy also included, "The following information will be included with the [redacted] Incident Report pertaining: ... [redacted] Investigation Questionnaire."	F 689		

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F 689	Continued From page 39 NJAC 8:39-27.1 (a)	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to (a) consistently complete ongoing records of communication between the facility and the [redacted] center and (b) ensure a physician's order was obtained for [redacted] for 1 of 2 residents reviewed for [redacted] (Resident [redacted]). This deficient practice was evidenced by the following: 1.According to the Medical Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to: [redacted] On 02/11/22 at 10:05AM, during the initial tour, the surveyor observed Resident [redacted] in bed, covered in a blanket and the call bell was next to the resident. On 02/14/22 at 1:41 PM , the surveyor observed that Resident [redacted] was not in his/her room. On 02/15/22 at 9:30 AM, the surveyor observed	F 698	1. Resident [redacted] medical record was updated to include a physician order for dialysis treatment. All communication forms from the dialysis treatment center that Resident [redacted] attends were obtained and reviewed. The [redacted] communication form was updated to include additional pertinent information related to comprehensive written exchange. 2. All residents have the potential to be affected by this deficient practice of failing to consistently complete ongoing records of communication between the facility and the [redacted] center and ensure a physicians order was obtained for [redacted] treatment. 3. An audit was completed on all resident charts receiving [redacted] treatment to ensure that a physician order was present. The DON in-serviced all nurses regarding the components of a [redacted] order, the updated dialysis communication form, and [redacted] Communication Policy and Procedure.	3/9/22

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F 698	Continued From page 40 that Resident [redacted] was not in his/her room. At that time, the surveyor interviewed the Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN) who stated that the Resident [redacted] was transferred to the hospital on [redacted] for an evaluation. Review of the Significant Change Minimum Data Set (MDS), an assessment tool used to manage care dated [redacted], revealed Resident [redacted] had [redacted], was dependent for ambulation and activities of daily living and was receiving [redacted] Review of Resident [redacted]'s Facesheet, with a readmission date of [redacted], revealed that the resident was scheduled for [redacted] on [redacted], and [redacted] at 2:00 PM. Review of [redacted] Physician Orders Sheet (POS) for the Readmission date of [redacted] revealed there was no Physician Order(PO) for [redacted] for Resident [redacted] During an interview with the surveyor on 02/15/22 at 12:35 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the process for communication with [redacted]s was that the nurses would fill out a [redacted] communication form which would be kept in the [redacted] communication book. The nurses would fill out the paperwork which included the [redacted], [redacted] and [redacted]. The book would then go with the resident to [redacted] and the [redacted] center would fill out any information from [redacted] and send the book back with the resident after [redacted] If the book did not return with the resident or the paperwork was not completed, then the nurse would call the [redacted] center and have them fax	F 698	4. ADON or designee will monitor all [redacted] residents monthly physician orders for complete [redacted] orders for three months. The ADON or designee will monitor all [redacted] residents communication forms weekly for one month to completion. All findings will be reported at the quarterly quality assurance meeting.	

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F 698	Continued From page 41	F 698		

the paperwork to the facility or find out how the resident did during [redacted] and then document their findings in the nurse's notes.

During an interview with the surveyor on 02/15/22 at 12:45 PM, the ADON/LPN stated that she tried to get a communication form from the [redacted] center to use but was unable to attain a copy so she made up a communication form for the facility to use. The ADON/LPN further stated that the new communication form was implemented probably around [redacted]. The ADON/LPN provided the surveyor a copy of the [redacted] communication forms for Resident [redacted].

Review of the nurse's notes dated [redacted] until [redacted] revealed one note dated [redacted] at 4:30 AM that the [redacted] book was left at dialysis and that nurse called the [redacted] center to make them aware to return the book with the resident. No other notes revealed any communication with the [redacted] center regarding the book or missing documentation.

Review of the forms titled "Sterling Manor Communication form for [redacted]" revealed the form included the residents' name, date, vital signs, medication changes, new orders, labs and a contact name and number. The forms did not reflect who was to complete the forms and did not have a space for the [redacted] center to complete or document any changes or recommendations from the [redacted] center.

Further review of the communications forms provided by the ADON/UM included the following: [redacted] - vital signs, weight, medication changes-0, new orders-0, labs-0 ,contact name: [redacted] nurse

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F 698	Continued From page 42 01/6/22- vital signs, weight, medication changes-0, new orders-0, labs-0 ,contact name: blank 01/8/22- vital signs, weight, medication changes-blank new orders-blank, labs-blank, contact name: blank 01/11/22- vital signs, weight, medication changes-N/A, new orders-N/A, labs-N/A, contact name: [redacted] nurse 01/13/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank ,contact name: [redacted] nurse 01/15/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 01/18/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 01/20/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 02/1/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 02/3/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 02/5/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: blank 02/5/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 02/8/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse 02/10/22- vital signs, weight, medication changes-no changes, new orders-0, labs-blank, contact name: [redacted] nurse	F 698		

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F 698	Continued From page 43 02/12/22- vital signs, weight, medication changes-blank, new orders-blank, labs-blank, contact name: [redacted] nurse During a follow up interview with the surveyor on 02/18/22 at 10:19 AM, the LPN/UM stated that Resident [redacted] was scheduled for [redacted] on [redacted] and [redacted] and left the facility around 4:00 AM and returned to the facility around 12 noon. During an interview with the surveyor on 02/22/22 at 9:46 AM, then Infection Preventionist LPN (IP/LPN) stated that she has been Resident [redacted]s nurse for many years and Resident [redacted] had been on [redacted] for more than [redacted] years. During an interview with the survey team on 02/22/22 at 3:23 PM, the ADON/LPN stated that the nurses would complete the [redacted] communication form and attach any medication changes or lab work to the form and send with the resident to [redacted]. The ADON/LPN confirmed that the communication form given to the surveyor was the form the facility was currently using. The Regional LPN stated that the communication form should be filled out by the staff before they leave for [redacted] and should be signed by a licensed nurse. The Regional LPN confirmed the [redacted] communication form was not a complete [redacted] communication form. During an interview with the survey team on 01/23/22 at 10:17 AM, the ADON/LPN again stated, "I had contacted the [redacted] center to obtain a communication form but was not supplied one so that is why I made up this form." The ADON/LPN stated that Resident [redacted] had been on [redacted] for several years but was unable	F 698		

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F 698	Continued From page 44 to provide any additional [redacted] communication records. A review of the facility's policy titled "[redacted] Policy", dated 8/2017, revealed that the communication with the [redacted] center will be maintained through the use of communication book. The book is located at the nurse's station and is clearly labeled with the resident's name. The communication book is sent with the resident each time they are transported to [redacted] The nursing staff and the [redacted] center will communicate any pertinent resident information through the communication book. Any need for clarification of information will require verbal communication with the [redacted] center. The communication book will be reviewed by the licensed nurse upon return from [redacted]. 2. A review of admission and readmission physician orders sheets (POS) dated [redacted] and [redacted]'s revealed there was no Physician Order (PO) for [redacted] for Resident [redacted]. During an interview with the surveyor on 02/18/22 at 10:19 AM , the LPN/UM stated that the resident should have a [redacted] order which should include the days and times attended [redacted] and that Resident [redacted] was scheduled for [redacted] on [redacted] and [redacted] and left the facility around 4:00 AM and returned to the facility around 12 noon. During an interview with the surveyor on 02/22/22 at 9:46 AM, the IP/LPN stated the resident should have an order for [redacted] depending on when it was initiated and further stated that Resident [redacted]	F 698		

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F 698	Continued From page 45 had been on [redacted] for more than [redacted] years. During an interview with the surveyor team on 02/22/22 at 3:23 PM, the Regional LPN stated that when the resident was admitted and readmitted to the facility, a PO is needed which would include the chair time, dates, and days the resident would attend [redacted] Review of the facility's policy titled '[redacted] Policy", dated 8/2017, revealed that the recommended Physician order for [redacted] may include, but is not limited to, [redacted] frequency and days.	F 698		
F 755 SS=E	NJAC 8:39 - 27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		3/10/22

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F 755	Continued From page 46 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to a.) properly administer medications to a resident and remove the dispensing agent from the resident's room (Resident [redacted], identified for 1 of 3 nurses reviewed for medication dispensing, b.) ensure the accurate completion of a Drug Enforcement Agency (DEA) Form-222 (a federal narcotic requisition form), to enable accurate reconciliation of controlled-dangerous substances (medications, that due to their high potential for abuse, are tracked with detail), which was identified in 1 of 1 form reviewed, c.) consistently document the administration of an as-needed (PRN) narcotic medication in the Medication Administration Record (MAR) and d.) maintain accurate accountability and reconciliation for a controlled drug, [redacted]) (a medication used to treat [redacted]) in accordance with the facility policy for (Resident [redacted]), 1 of 3 residents reviewed for [redacted] management, e.) administer medication in accordance with professional standards of practice and according to the physician's order for 1 of 2 nurses observed on 1 of 2 nursing units	F 755	1. The white souffle cup and empty [redacted] bottle was removed from Resident [redacted] bedside table. LPN #2 was immediately in-services regarding ensuring that medication administered to residents are completely consumed and promptly removing all dispensing devices used to administer resident medication. The facility pharmacy provided a delivery invoice form related to the DEA Form-222 that was submitted verifying the date the medications were delivered "received" to the nursing facility and number of packages delivered. The Controlled Substances, Ordering, and Reconciling Policy and Procedure was updated to include the completion of the DEA Form-222, all nurses were immediately in-serviced regarding the updated policy and procedure. A DEA Form-222 was completed in its entirety and submitted to the pharmacy for a request of delivery of [redacted] mg. LPN #1 was immediately in-serviced regarding the proper administration of [redacted] medication.	

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F 755	Continued From page 47 during the Medication Administration task. These deficient practices were evidenced by the following: 1). On 02/11/22 during tour at 12:05 PM, the surveyor observed a white empty soufflé cup (used to administer medications) and an empty [redacted] bottle ([redacted] on the resident's bedside table. At that time, the surveyor interviewed Resident [redacted] who stated, "Sometimes the nurse will leave my medications to take when I want, and sometimes the nurse will observe me when I take my medications." At that time, the surveyor was unable to locate the nurse assigned to Resident [redacted]. At 12:11 PM, the surveyor returned to the resident's room and observed that the empty souffle cup and [redacted] bottle were removed from the bedside table. According to the resident's Admission Record and [redacted] Physician's Order Form (POF), the resident was admitted to the facility with diagnoses which included, but not limited to, urinary retention, hypertension, generalized [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted] reflected that the resident was [redacted]. Review of the [redacted] POF revealed an order dated [redacted] for [redacted] mg/mL to	F 755	2. All residents have the potential to be affected by the deficient practice of failing to properly administer medications to a resident and remove the dispensing agent from the resident's room, failing to ensure the accurate completion of a Drug Enforcement Agency (DEA) form-222 to enable accurate reconciliation of controlled-dangerous substances, failing to consistently document the administration of an as-needed narcotic medication in the MAR, and failing to maintain accurate accountability and reconciliation for a controlled drug, and administer medication in accordance with professional standards of practice according to the physician order during medication administration task. 3. The DON in-services all nurses regarding the facility's Medication Administration Policy and Procedure with emphasis of ensuring that the resident consumes the medication at the time of administration and immediately removes container utilized to dispense the medication. Additional in-servicing consisted of directions/proper use related to [redacted]. Regional Nurse in-serviced the DON regarding the updated Controlled Substances, Ordering, Reconciling Policy and Procedure as well as DEA Form-222 components with emphasis of completing the form in its entirety. All nursing staff were in-serviced regarding communication required for replenishing back-up facility narcotics. A complete audit was completed of the narcotic back-up box. 4. The ADON or designee will complete a	

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

(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 755	Continued From page 48 administer [redacted] mL ([redacted] mg) daily for the diagnosis of [redacted]. Review of the [redacted] Medication Administration Record (MAR) reflected the order dated [redacted] for [redacted] mg/mL to administer [redacted] mL [redacted] mg) daily for the diagnosis of [redacted] On 02/14/22 at 10:30 AM the surveyor observed an empty bottle of [redacted] located on the overbed table dated [redacted] and an empty bottle of [redacted] located on the resident's nightstand dated [redacted]. At that time, the surveyor interviewed Resident [redacted]. The resident stated, "This morning, the nurse left the [redacted] for me to drink at my convenience." Resident [redacted] reiterated that sometimes the nurse will watch him/her take the [redacted] and sometimes not. During an interview with the surveyor on 02/14/22 at 10:35 PM, the Licensed Practical Nurse #2 (LPN) stated that she watched Resident [redacted] take the [redacted] this morning and today the roommate distracted her and she forgot to remove the bottle after Resident [redacted] took the medication. LPN #2 stated that normally she would either open the bottle or the resident would open the bottle, she would watch the resident drink the medication, collect the bottle from the resident, and throw it in the trash. During an interview with the surveyor on 02/14/22 at 10:44 AM, the Director of Nursing #1 (DON) stated that full and empty bottles of [redacted] should not be left in the resident's room. During an interview with the surveyor on 02/23/22 at 10:12 AM, the Regional Licensed Practical	F 755	medication pass on two nurses weekly for one month to ensure that the protocol related to resident medication administration pass is properly completed. The DON will monitor the narcotic back-up box for necessary replenishing of narcotic medications for one quarter. The Regional Nurse will monitor the completion of DEA form-222 components prior to submission to the pharmacy for one quarter. 5. All findings will be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 755	Continued From page 49	F 755		

Nurse (Regional LPN) stated that the nurse must observe the resident take the [redacted] and then remove the container from the room after the medication was taken.

Review of the facility's Medication Administration Policy and Procedure, dated 02/2022, revealed that "The nurse administering medications must ensure that all medication dispensing agents are removed from the resident's bedside after administration."

2. On 02/22/22 at 2:18 PM a review of the facility's DEA Form-222 revealed the facility did not complete "last line completed" in Part 1 or the "number of packages received" and the "date the medication was received" in Part 5, as instructed on the face of DEA Form-222, within each section. The inaccuracies were as follows:

Order Form Number: 211510998 did not include the last line completed (bottom, left corner) or indicate the number received or the date received for Items 1, 2, 3, 4, or 5.

During an interview with the surveyor and team on 02/22/22 at 3:35 PM, the Regional Licensed Practical Nurse (Regional LPN) and Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN) acknowledged that the provided DEA Form-222 was incomplete, specifically as related to the last line completed (corresponding to the number of items ordered), the number of items subsequently received upon delivery, and the date on which the referenced items were received.

Review of instructions titled, "DEA 222 Form Instructions for Schedule I & II Substances"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 755	Continued From page 50	F 755		

provided by facility staff, revealed that the last line completed must be filled in before submission of the form and the number of items received and date received must be completed once the order is received.

Review of the facility's "Sterling Manor Nursing Center Controlled Substances Ordering, Receiving, Reconciling Policy and Procedure," dated 08/2019, indicated that it was necessary to maintain all controlled substances dispensed by the pharmacy in accordance with state, federal, and facility policies and procedures. It did not address the need for accurate completion of DEA Form-222, for obtaining narcotics.

3. According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted] of [redacted], [redacted], and [redacted].

Review of the [redacted] Admission Orders revealed a physician order (order) for [redacted] mg [milligram] tablet. Take 2 tablets by mouth every 6 hr [hours] as needed for seven days, then 1 tab [tablet] every 6 hours as needed for up to 7 days."

Review of Resident [redacted]'s MAR reflected an undated order for [redacted] mg. Take two tablets by mouth every six hours as needed. The MAR further revealed that two tablets of [redacted] mg was administered on the follow date and times:

02/08/22 at 10:00 PM, 02/09/22 at 5:00 AM, 02/09/22 at 5:30 PM, 02/10/22 at 12:45 AM, 02/10/22 at 6:00 AM, 02/10/22 at 6:00 AM, 02/11/22 at 12:30 AM, 02/11/22 at 12:30 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 755	Continued From page 51	F 755		

02/11/22 at 6:30 PM 02/12/22 at 1:00 PM, 02/13/22 at 10:00 AM, 02/13/22 at 4:00 PM, 02/13/22 at 10:00 PM, 02/14/22 at 6:00 AM, 02/14/22 at 1:30 PM, 02/15/22 at 6:00 AM, 02/16/22 at 4:00 AM, 02/16/22 at 2:00 PM, 02/16/22 at 9:00 PM, 02/17/22 at 5:00 AM, and 02/17/22 at 12:00 PM

Review of Resident [redacted] "Individual Patient's Controlled Drug Record" (declining sheet) revealed [redacted] were signed out on the declining sheet but not signed out as administered on the MAR on the following date and times:

02/10/22 at 5:00 PM, 02/12/22 at 6:30 AM and 8:00 PM, 02/13/22 at 1:00 AM, 02/14/22 at 2:00 AM and 8:30 PM, 02/15/22 at 12:30 PM and 8:00 PM, 02/17/22 at 6:00 PM, 02/18/22 at 3:00 AM, 1:00 PM and 7:00 PM, 02/19/22 at 1:00 AM, 6:00 AM, 1:00 PM, and 7:00 PM, 02/20/22 at 1:00 AM, 7:00 AM, 2:00 PM and 9:00 PM, and 02/21/22 at 6:00 AM.

During an interview with the surveyor on 02/23/22 at 9:52 AM, the Regional Licensed Practical Nurse (Regional LPN) stated the nurse should sign for any medication administered on the MAR. The Regional LPN stated the nurse should have rewritten the [redacted] order on a new MAR and signed the MAR after administering the medication. The Regional LPN further stated it was important sign the MAR when administering a medication because it was a form of communication and it ensured medications were administered per the physician's order.

4. Review of Resident [redacted] declining sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 755	Continued From page 52	F 755		

revealed one tablet of [redacted] was signed out on 02/22/22 at 1:15 AM and 6:00 AM. The declining sheet further revealed that the nurse documented "[redacted] next to the signature.

Review of Resident [redacted]'s MAR revealed that two tablets of [redacted] mg were administered on 02/22/22 at 1:45 PM. The MAR did not reveal any documentation that Resident [redacted] received the 1:15 AM and 6:00 AM doses of [redacted] mg.

According to the Admission Record, Resident [redacted], who resided in Room [redacted], was admitted to the facility with diagnosis that included [redacted].

Review of Resident [redacted]'s physician's order form revealed a [redacted] order for [redacted] mg every four hours as needed for [redacted].

Review of the [redacted] MAR revealed the corresponding physician's order for [redacted] mg every four hours as needed for severe pain. The MAR further revealed that Resident [redacted] was administered [redacted] mg on 02/22/22 at 1:15 AM and 6:00 AM.

Review of Resident [redacted]s declining sheet revealed no documentation that [redacted] mg was removed for administration on 02/22/22 at 1:15 AM and 6:00 AM.

Review of Resident [redacted] Nurse's Notes revealed on 02/22/22 at 3:00AM, nurses noted that the resident received a dose of [redacted] mg at 1:15 AM. The Nurses notes revealed no documentation that Resident [redacted] received a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 755	Continued From page 53	F 755		

dose of [redacted] mg on 02/22/22 at 6:00 AM.

During an interview with the surveyor on 02/22/22 at 1:54 PM, the Licensed Practical Nurse (LPN #2) stated that there was not supposed to be borrowing of medications between residents. LPN #2 further stated that if medication was unavailable on the medication cart; she would go check the medication back-up box located in the nursing office for that medication.

During an interview with the surveyor on 02/22/22 at 2:30 PM, the Assistant Director of Nursing/LPN (ADON/LPN) stated that nurses were not supposed to borrow medications between residents. The ADON/LPN further stated that medications could be removed from the medication back-up box located in the nursing office.

During an interview with the surveyor on 02/23/22 at 9:52 AM, the Regional LPN was unable to provide an answer for the two tablets that were signed out on Resident [redacted]s declining sheet on 02/22/22 at 1:15 AM and 6:00 AM. The Regional LPN further stated that she would have to get back to the surveyor.

On 02/23/22 at 12:36 PM, the surveyor, accompanied by the ADON/LPN and Regional LPN, inspected the medication back-up box located in the nursing office and confirmed that the were no [redacted] tablets in the back-up box.

A review of the facility's "House Stock-Control Countdown Sheet" for [redacted] mg revealed the last dose had been administered on 12/16/21.

During a follow-up interview with the surveyor on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 755	Continued From page 54	F 755		

02/23/22 at 1:03 PM, the ADON/LPN stated she tried to get a hold of the medicating nurse but had been unsuccessful. When asked about the investigation into the 02/22/22 at 1:15 AM and 6:00 AM doses documented on Resident [redacted] declining sheet, the ADON/LPN stated she did not do any additional investigation besides trying to call the medicating nurse. The ADON/LPN further state the nurse should have called the physician to obtain a new order, call the pharmacy and find out when the resident's medications would be available. The ADON/LPN further stated that nurses were not allowed to borrow medications between residents because of resident's rights. In addition, it was important to have accurately documentation of the administration of controlled substances in order to accurately account for them.

A review of the facility's "Medication Administration Policy and Procedure," dated 2/2022, indicated that the "individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones." The policy further indicated that medications ordered for a particular resident may not be administered to another resident, unless permitted by State law, facility policy, and approved by the Director of Nursing Services."

Review of the facility's "Controlled Substances Ordering, Receiving, Reconciling Policy and Procedure," dated 8/2019, indicated it was the policy of the facility to maintain all controlled substances dispensed by the pharmacy according to state, federal, and facility policies and procedures. The policy reflected the purpose was "to monitor controlled substance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 55	F 755		

administration, assure accountability of controlled substance administration, and storage and prevention of drug diversion.

5). On 02/14/22 at 9:28 AM during medication administration, the surveyor, in the presence of a second surveyor, observed the Licensed Practical Nurse (LPN #1) administer [redacted] to Resident [redacted] LPN #1 administered one spray to each of Resident [redacted]. After administration of the [redacted] and when questioned by the surveyor, LPN #1 stated that she should have administered two [redacted] into each [redacted] and instructed the resident to blow his/her [redacted] before the [redacted] was administered.

Review of Resident [redacted] POF and MAR revealed an order dated [redacted] for [redacted] micrograms, two [redacted] to each [redacted] daily for [redacted].

During an interview with the surveyor on 02/14/22 at 10:09 AM, in the presence of the survey team, Licensed Practical Nurse Unit Manager (LPN/UM) confirmed the resident should have been instructed to blow their [redacted] prior to administration. The LPN/UM further confirmed the [redacted] should have been administered by the specific number of [redacted] prescribed in the physician's orders.

During an interview with the surveyor on 2/22/22 at 3:23 PM, in the presence of the survey team, Regional LPN confirmed that medications being administered must follow the instructions as written on the MAR. The Regional LPN further stated that a resident should be instructed to blow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 56 their [redacted] prior to the administration of a [redacted] Review of the facility's "Administering Medications Policy and Procedure" dated 06/2018, under section "Policy Interpretation and Implementation" number "3" revealed, "Medications must be administered in accordance with the orders, including any required time frame" and number "7" reflected, "The individual administering medications must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." A review of the manufacturer specifications for [redacted]) under "Instructions for use" revealed, to prime the [redacted] prior to use (for the first time or if it has not been used for a week or more), shake the bottle gently ...blow the [redacted] to clear the [redacted] NJAC 8:39-11.2(b); 29.2(a)(b)(d); 29.4(a)(b); 29.7	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 756	Continued From page 57 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure recommendations made by the Consultant Pharmacist was acted upon in a timely manner and documented for 1 of 5 residents (Resident [redacted]) reviewed for unnecessary medications. This deficient practice was evidenced by:	F 756	1.The pharmacy recommendation for Resident [redacted] was reviewed and the order related to [redacted] mg orally daily before a meal and [redacted] one teaspoon with eight ounces of water orally daily remain in place without a new order due to resident preference. Resident [redacted] was educated regarding the recommendation of the consulting	

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 756	Continued From page 58 According to the Admission Record, Resident [redacted] was admitted with diagnoses that included, but were not limited to, [redacted] Review of Resident [redacted] Physician Order Form included an order for [redacted] milligrams (mg) orally daily before a meal for [redacted] dated [redacted], and Metamucil one teaspoonful with eight ounces of water orally daily for [redacted] dated [redacted]. Review of [redacted], [redacted], [redacted] and [redacted] Medication Administration Records revealed [redacted] and [redacted] were scheduled to be given at 9:00 AM daily each month. Review of the facility's document titled "Meal Times" included that the first breakfast meal truck was at 7:30 AM and the last breakfast meal truck was at 7:57 AM. The document further included, "Please allow +/- 10 minutes for meal truck delivery." Review of the Consultant Pharmacist's Summary Report from [redacted] through [redacted] included a recommendation that, '[redacted] should be administered on an empty stomach at least 1 hour before meals. Please review time(s) plotted," and, "Separate [redacted] from other medication by at least two hours before or two hours after. Please review time(s) plotted," dated [redacted] Further review of the report revealed the same recommendations were made on [redacted]. The report included a section under each recommendation for "Response recorded by Nursing" which was blank for the aforementioned recommendations on [redacted] and [redacted]	F 756	pharmacist. The assigned physician was called and requested to provide documentation related to denial of recommendation. A nurses note was written indicating the denial of the pharmacy consultant's recommendation, the resident's preference to maintain the scheduled medications, this was also included on the pharmacy consultant's recommendation form. 2. All residents have the potential to be affected by the deficient practice of failing to ensure recommendations made by the consultant pharmacist is acted upon in a timely manner. 3. The DON in-serviced all nurses regarding the facility's Consultant Pharmacy Recommendation Policy and Procedure with emphasis of documenting physician approval of recommendations on the consultation form and in the nurses notes. 4. The ADON or designee will monitor monthly for three months all responses to pharmacy consultant recommendations and documentation from the physician. Findings will be reported a the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 756	Continued From page 59	F 756		

Review of the physician's and Advanced Practice Nurse's (APN) progress notes, dated [redacted] through [redacted] did not include a physician's or APN's response to the Consultant Pharmacist's recommendations.

Review of the Nurse's Notes, dated [redacted] through [redacted], did not include a nurse's note related to the Consultant Pharmacist's recommendations.

During an interview with the surveyor on 02/22/2022 at 11:22 AM, the Regional Licensed Practical Nurse (Regional LPN) stated that, "if it is not noted on the Consultant Pharmacist's recommendations, it probably was not noted."

During an interview with the surveyor on 02/22/2022 at 2:16 PM, the Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN) stated that the Consultant Pharmacist comes to the facility once a month and will email any recommendations within five days of the visit. The ADON/LPN further stated that the Director of Nursing (DON) will then give the report to the Unit Manager (UM) to follow-up in the following five to six days. The ADON/LPN added that after the recommendations had been addressed, there should be a new physician's order if the physician agreed with the recommendation, or there should be a nurse's note or documentation on the Consultant Pharmacist's report if the physician disagreed.

During a follow-up interview with the surveyor, in the presence of the survey team, on 02/23/2022 at 9:50 AM, the ADON/LPN stated that the physician did not want to change the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 756	Continued From page 60 orders due to the resident's preference. The ADON/LPN further stated that the physician should have documented the response to the Consultant Pharmacist's recommendations. Upon request, on 02/23/2022 at 11:11 AM, the ADON/LPN stated that she was unable to provide documentation of the physician's response to the Consultant Pharmacist's recommendations. Review of the facility's Consultant Recommendation policy, dated 05/2018, included, "the nurse must document the acceptance or denial of the recommendations provided by the consultant," and "consultant recommendations not approved by the attending MD [physician] will be documented by nurse in the nurses notes."	F 756		
F 757 SS=E	NJAC 8:39-29.3 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		3/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 61 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record, and other facility documentation, it was determined that the facility failed to accurately transcribe an admission medication order which resulted in a resident receiving a [redacted] medication in excess of the physician prescribed dose and duration. This deficient practice was identified for Resident [redacted] 1 of 3 residents reviewed for [redacted] management and was evidenced by the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included, but were not limited to, [redacted] and [redacted]. A review of Resident [redacted]s "After Visit Summary" report (hospital discharge instructions) reflected under the "Medication List" section, a physician order (PO) for [redacted] (a narcotic used to treat [redacted] milligrams (mg) tablet, with a start date of [redacted]. The PO instructed to administer two tablets [for a total of [redacted] mg] every six hours as needed for seven days, then one tablet [for a total of [redacted] mg] every six hours as needed for up to 7 days. A review of Resident [redacted]'s hospital discharge	F 757	1. The physician was notified of the continuation of [redacted] mg tablets despite the inital order as indicated on the admission physician order for Resident [redacted]; the order was discontinued. As assessment was completed on resident [redacted] which concluded no adverse effects. 2. All residents have the potential to be affected by the deficient practice of failing to accurately transcribing an admission medication order. 3. The DON in-serviced all nurses regarding the process of verifying and transcribing medication orders upon admission and reviewing all resident orders written within a 24 hour period with the purpose of ensuring accurate orders are followed. 4. The ADON or designee will review five admission physician orders with coinciding MARS weekly for one month. All findings will be reported at a quarterly quality assurance meeting.	

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 757	Continued From page 62	F 757		

medication prescription (prescription) revealed the corresponding [redacted] physician's order for [redacted] mg tablet. The prescription instructed to administer two tablets every six hours as needed for seven days, then one tablet every six hours as needed for up to 7 days.

A review of Resident [redacted] admission physician orders sheet (POS) revealed the corresponding [redacted] physician's order for [redacted] mg tablet. The PO instructed to administer two tablets every six hours as needed for seven days, then one tablet every six hours as needed for up to 7 days.

A review of Resident [redacted] "Nurse's Notes" indicated the resident's medications were reviewed and faxed to the pharmacy.

A review of Resident [redacted] "Medication Administration Record" (MAR) revealed an undated PO for [redacted] mg tablet and to administer two tablets every six hours as needed. The undated PO did not indicate to administer two tablets every six hours as needed for seven days, then one tablet every six hours as needed for up to 7 days per the physician orders. The MAR further revealed that Resident [redacted] received the first dose on [redacted] at 10:00 PM.

A review of Resident [redacted] POS did not reveal any new physician orders for [redacted].

A review of Resident [redacted]s "Individual Patient's Controlled Drug Record" (declining sheet) for [redacted] mg revealed the facility administered the wrong dose on the following days:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 757	Continued From page 63	F 757		

02/16/22 at 4:30 AM, 2:00 PM, and 9:30 PM
02/17/22 at 5:00 AM, 12:00 PM, and 6:00 PM
02/18/22 at 3:00 AM, 1:00 PM, and 7:00 PM
02/19/22 at 1:00 AM, 6:00 AM, 1:00 PM, and 7:00 PM
02/20/22 at 1:00 AM, 7:00 AM, and 9:00 PM

During an interview with the surveyor on 02/22/22 at 1:54 PM, the Licensed Practical Nurse (LPN #2) stated the hospital sends a medication list with the resident when admitted to the facility. LPN #2 stated the nurse receiving the resident would review the medication list with the physician and obtain any new orders. The nurse would then complete an admission PO form, document all the approved medications, and then transcribe the orders on to the resident's MARs and Treatment Administration Records (TARs). LPN #2 further stated any change in medication would require the nurse to write a new PO on a POS.

During an interview with the surveyor on 2/22/22 at 2:30 PM, the Assistant Director of Nursing/LPN (ADON/LPN) stated that she expected the admitting nurse to review the medication list with the physician for approval. The nurse would then complete an admission PO form and transcribe the orders on to the resident's MARs and TARs. The ADON/LPN stated that any change in medications wound be written on the POS. The ADON/LPN further stated the Unit Managers and herself reviewed the newly/readmitted residents' charts to make sure the medications were transcribed correctly and that nothing was missed.

During an interview with the surveyor, in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 64 presence of the survey team, on 02/23/22 at 9:52 AM, the Regional LPN confirmed the surveyor's findings and stated the admitting nurse did not transcribe the admission physician order onto the MAR properly. A review of the facility's "Reconciliation of Medications on Admission' policy, dated TT 1/2018, revealed the purpose was to ensure medication safety by accurately accounting for the resident's medication, routes, and dosages upon admission or readmission to the facility. The policy revealed that medication reconciliation reduced medication errors and enhanced resident safety by ensuring that the medications were administered in correct dosages. A review of the facility's "24 Hour Chart Check Procedure policy, dated TT 6/2019, revealed the objective was to ensure that orders were recognized and transcribed appropriately and that the necessary actions had been initiated for all physician orders. The policy indicated, under the "Procedure" section, to ensure all new orders were carried out completely and correctly on the MAR, TAR, POS and telephone order form.	F 757		
F 758 SS=D	NJAC 8:39-27.1(a) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		3/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 758	Continued From page 65 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 66 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to order "as needed" (PRN) [redacted] medications in accordance with appropriate durations and facility-designated discontinuation dates for 3 of 26 residents reviewed (Resident [redacted], #[redacted] and [redacted]) for medications. This deficient practice was evidenced by the following: 1. On 02/11/22 during tour at 12:05 PM, the surveyor observed Resident [redacted] seated on his/her bed. According to the resident's Admission Record, the resident was admitted to the facility with diagnoses, which included but not limited to, [redacted] Review of the [redacted] Physician's Orders (PO) revealed a diagnosis of anxiety for Resident [redacted] The [redacted] PO admission orders further reflected an order for [redacted]) (a medication that helps to [redacted] with the instructions to administer [redacted] milligrams (mg) daily PRN for the diagnosis of [redacted]. Further review of the record revealed the order did not contain a [redacted]-day duration. Review of the [redacted] Medication Administration Record (MAR) reflected the order	F 758	1. Resident [redacted] mg PRN order was discontinued,, with a follow up [redacted] consult. Resident [redacted] mg PRN was discontinued and changed to a standing order with a follow up [redacted] consult. Resident [redacted] mg PRN order was renewed for an additional [redacted] days with a designated stop date and a [redacted] consult was scheduled. 2. All residents have the potential to be affected by the deficient practice of failing to order as needed (PRN) [redacted] medications in accordance with appropriate duration. 3. An audit was completed for all residents receiving PRN [redacted] medications; [redacted] consultations were scheduled. The DON in-serviced all nursing staff regarding including stop dates for PRN [redacted] medications orders and scheduling [redacted] consults for all residents ordered PRN [redacted] medications. 4. The Assistant Director of Nurses (ADON) or designee will monitor five residents prescribed PRN [redacted] medications weekly for one month to ensure that residents prescribed PRN [redacted] medications have not surpassed the [redacted] day reevaluation time frame. 5. All findings will be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 67 for [redacted] mg daily PRN for the diagnosis of [redacted]xiety. Review of the [redacted] Physician's Order Form (POF) reflected an order dated [redacted] for [redacted] mg daily PRN for diagnosis [redacted]. Further review of the order revealed the order did not contain a [redacted] day duration. Review of the [redacted] MAR reflected the order for [redacted] mg daily PRN for diagnosis [redacted]. The medication was administered on [redacted]. During an interview with the surveyor on 02/14/22 at 2:35 PM, Licensed Practical Nurse #2 (LPN) stated that when a resident has an order for [redacted], a [redacted] consult would be scheduled and the [redacted] will evaluate the resident. Review of the [redacted] Evaluation dated [redacted] reflected that the "Plan" for Resident [redacted] was to "DC [discontinue] [redacted] - not needed." During an interview with the surveyor on 02/14/22 at 3:29 PM, the Director of Nursing #1 (DON) stated that PRN [redacted] should be written for [redacted] days and then the physician has to reevaluate the medication. The DON further stated that if the [redacted] recommended to discontinue the order, the physician would be notified. If the physician agrees, the medication would be discontinued and the resident would be monitored each shift for 7 days. During an interview with the surveyor on 02/17/22 at 10:40 AM, the LPN #3 stated that when a	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 758	Continued From page 68 [redacted] makes a recommendation, the physician should be notified to determine if the physician agrees or disagrees with the recommendation and the nurse would document the discussion with the physician in the progress notes. Review of the [redacted] PO did not reflect an order to discontinue the medication. Review of the Nurse's Notes did not reflect that the physician was notified. 2). According to the Admission Record, Resident [redacted] was admitted with the diagnoses, which included but not limited to, [redacted] Review of Resident [redacted] s Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted] included the resident received an [redacted] medication. Review of Resident [redacted] POF included an order for [redacted] mg 1 tablet orally every eight hours "as needed" for [redacted] dated [redacted] Further review of the order revealed the order did not contain a [redacted] day duration. Review of [redacted] Medication Administration Record (MAR) included that the [redacted] order dated [redacted] was signed as administered six times after [redacted]. Review of Resident [redacted] MAR included that the [redacted] order dated	F 758		

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 758	Continued From page 69 [redacted] was signed as administered 12 times. Review of the physician's and Advanced Practice Nurse's Progress Notes dated [redacted] through [redacted] did not include a rationale for continuing the "as needed" [redacted] for longer than [redacted] days. During an interview with the surveyor on 02/22/2022 at 1:43 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that she was unsure of the specific duration for the "as needed" [redacted] medications ([redacted] medications are a type of [redacted] medication). During an interview with the surveyor on 02/22/2022 at 2:16 PM, the Assistant Director of Nursing/LPN (ADON/LPN) stated "as needed" [redacted] medications are ordered with a [redacted]-day duration and should not be given past the duration ordered. During an interview with the survey team on 02/23/2022 at 9:50 AM, the Regional LPN stated that Resident [redacted] "as needed" [redacted] medication order should have included a [redacted]-day duration. Review of the facility's [redacted] Medication Use policy, dated 12/2018, included, "the need to continue PRN [as needed] orders for [redacted] medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order." 3). Review of Resident [redacted] Admission Record	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 758	Continued From page 70	F 758		

reflected the resident was admitted to the facility with diagnoses, including but not limited to, [redacted]

Review of the [redacted] PO for Resident [redacted] revealed an order dated [redacted] for [redacted] (a p[redacted] medication used [redacted]) [redacted] mg 1 tablet by mouth every 6 hours "as needed" for 7 days for [redacted]

Review of the [redacted] MARs revealed the [redacted] mg tablet was administered to Resident #[redacted] on 02/11/22 at 5 PM (five days after the stop date ordered by the prescriber).

During an interview with the surveyor on 02/22/22 at 1:44 PM, in the presence of the survey team, the LPN/UM confirmed the signatures on the MAR reflected the medication was administered. The LPN/UM further stated that the PRN order would include the original date of the order, directions, and the duration of the medication administration.

During an interview with the surveyor on 02/22/22 at 2:21 PM, in the presence of the survey team, the ADON/LPN confirmed the MAR was signed after the administration of a medication. She further stated that PRN medications should not be given beyond the prescribed duration because this would be considered a medication error.

Review of the facility's [redacted] Medication Use Policy, dated 08/2018, reflected that "PRN orders for [redacted] medications will not be renewed beyond [redacted] days unless the healthcare practitioner has evaluated the resident for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 758	Continued From page 71 appropriateness of that medication." Review of the facility's "Medication Treatment Orders Policy and Procedure," dated 04/2019, under section "Proceudre [Procedure]" reflected "Orders for medications must include" in subsection "b" the "Number of doses, start and stop date and/or specific duration of therapy... ." Review of the facility's "Administering Medications Policy and Procedure," dated 06/2018, under section "Policy Interpretation and Implementation" number 3 reflected "Medications must be administered in accordance with the orders, including any required time frame." The policy further reflected under number 7 "The individual administering medications must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."	F 758		
F 761 SS=E	NJAC 8:39 - 27.1(a), 29.3(a)(4) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		3/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 72 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) properly store medication within an acceptable environment and with appropriate security measures and b.) store medications within acceptable temperature ranges, in accordance with manufacturer guidelines. This deficient practice was identified for 2 of 3 medication storage areas ([redacted] nursing unit and the Nursing Office) reviewed as part of the medication storage and labeling task and was evidenced by the following: 1). On 02/11/22 at 10:15 AM, the surveyors observed that the [redacted] nursing unit medication room door was ajar. On 02/16/22 at 11:03 AM, the surveyor observed that the [redacted] nursing unit medication room door was ajar. In addition, the surveyor observed that there was no lock on the refrigerator door, within the medication room, at this time.	F 761	1. The [redacted] medication door was repaired with a device that allows automatic closure and locking within the door frame. A new lock was applied to the clasp of the refrigerator door in the medication room. The refrigerator was replaced with a new refrigerator in the west wing medication room. The three bottles of [redacted] vaccine, one bottle of [redacted] vaccine, and two bottles of [redacted] test solutions were discarded. The maintenance director repaired the refrigerator in the nursing office and sent the temperature at the appropriate temperature ranges 2. All residents have the potential to be affected by the deficient practice of failing to properly store medications within an acceptable environment and the appropriate security measures and failing to store medications within acceptable temperature ranges in accordance with manufacturer guidelines. 3. The DON in-services all nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 761	Continued From page 73 On 02/16/22 at 12:31 PM, the surveyor conducted the medication storage room inspections with the Licensed Practical Nurse/Unit Manager (LPN/UM) and observed a worker repairing the medication storage room door. During an interview with the surveyor at that time, the worker identified himself as a Maintenance Staff Employee (MSE) and confirmed that he was repairing a device located at the top of the door, to ensure that there would be proper closure because there were times when the door failed to completely close. He assured the surveyor the repair would be finished soon. The surveyor entered the medication storage room with the LPN/UM after speaking to the MSE. The surveyor, in the the presence of the LPN/UM, noticed that there was a latch on the upper, left side of the refrigerator door, but no accompanying lock affixed and locked on it. The LPN/UM acknowledged the absence of a lock on the refrigerator and could not provide further explanation. The surveyor opened the refrigerator door and observed a small puddle of water on the top shelf of the refrigerator and on the floor, in front of the refrigerator. The LPN/UM acknowledged the presence of water on the top shelf of the refrigerator and floor and could not provide any further explanation regarding its origin or reason for its presence. On 02/16/22 at 12:40 PM, the surveyor observed the presence of the following items, in the refrigerator, all of which were contained within plastic bags: [redacted] milligrams (mg)/milliliter (ml) x1 vial (a medication used to [redacted]	F 761	regarding the safekeeping of medications that are stored for future usage, the necessity of ensuring that medication refrigerators remain within the appropriate temperature range and communication required when a malfunction occurs with a medication refrigerator. The DON in-serviced nurses regarding reviewing manufacturer guidelines of medications requiring refrigeration 4. The ADON or designee will monitor will monitor all medication room doors each shift for one month to ensure that the medication refrigerator room doors remains closed and locked. The ADON or designee will monitor for the presence of a lock on all medication refrigerator doors daily for one month. The ADON or designee will monitor the temperature with the medication refrigerators daily for one month to ensure that the temperature remains within appropriate range. All findings will be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 761	Continued From page 74 in individuals with [redacted]), [redacted] mg/[redacted] x1 unit (a medication used to treat various [redacted]), [redacted] mg/ml [redacted] (medication to treat [redacted]), [redacted] units/ml x[redacted] unit (a medication used to treat [redacted] [redacted] x[redacted] units (a medication used to prevent or [redacted], [redacted]-units/ml x1 vial (a medication used to treat [redacted] [redacted] units/ml x1 vial (a medication used to treat [redacted]), [redacted]-units/ml x3 vials (a medication used to treat [redacted] [redacted]-units/ml x1 vial (a medication used to treat [redacted]), and [redacted] x 1 bottle (a medication used to treat [redacted]. During an interview with the surveyor on 02/16/22 at 1:57 PM, the LPN/UM confirmed that none of the stored items were controlled-dangerous substances, items which must be tracked and counted due to their potential for abuse. The LPN/UM acknowledged there was no lock on the refrigerator door and there should have been one in place. The LPN/UM further acknowledged the presence of water on the top refrigerator shelf	F 761		

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 761	Continued From page 75	F 761		

and stated it should not have been there. She could not provide a reason for either of the observations.

On 02/17/22 at 11:00 AM, the surveyor observed the [redacted] nursing unit medication room. There was no lock on the upper, left side of the refrigerator door and there was a puddle of water on the top shelf, within the refrigerator.

During an interview with the surveyor on 02/17/22 at 11:08 AM, the same LPN/UM acknowledged the absence of the refrigerator lock and presence of water within the top shelf of the refrigerator but could not provide further explanation for these observations.

During an interview with the survey team on 02/17/22 at 1:42 PM, the Regional Licensed Practical Nurse (Regional LPN) stated that medications should be stored according to manufacturer guidelines, including acceptable temperature range, and retained in accordance with expiration dates. The Regional LPN further acknowledged that the presence of water in or near the refrigerator would be problematic, especially if it caused the label of the medication to be illegible. The Regional LPN also clarified that there should have been two functional locking systems present regarding the storage of medication, indicating proper closure of the door to lock the medication room and the presence of one lock on the refrigerator door. An absence of locks would be problem because it would decrease security to the rooms and possibly allow resident access.

The Regional LPN further stated that nursing staff is responsible for checking medication rooms and

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 761	Continued From page 76	F 761		

refrigerators daily. If the presence of water in and near the refrigerator and a lack of a lock on the refrigerator door were present and brought to the attention of staff yesterday, they should not have been observed on a second occasion.

2). On 02/17/22 at 1:17 PM, the surveyors observed the presence of a refrigerator located within the nursing office. There was a temperature log on the door of the refrigerator, with a recorded temperature of 38-degrees Fahrenheit (F) for 02/17/22.

During an interview with the surveyor on this date and time, the Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN) stated that the refrigerator temperature is checked by nursing staff daily, usually during the 7:00 AM to 3:00 PM shift, but possibly later in the day.

The ADON/LPN opened the refrigerator door at the request of the surveyors during the referenced interview, which revealed a temperature reading of 14 F (a temperature at or below 32 F is considered freezing). The temperature was acknowledged by the ADON/LPN, who further stated that maybe she made it too cool in the morning and adjusted the setting. The items in the refrigerator included three bottles of [redacted] vaccine, one bottle of [redacted] vaccine, and two bottles of [redacted] solution within one box, all of which contained a date of "01/25" ([redacted], which is often diagnosed by using a testing solution to determine its presence or absence in the human body).

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 761	Continued From page 77 On 02/18/22 at 11:42 AM, the surveyors observed the refrigerator located in the nursing office. There was a temperature log on the door of the refrigerator, with a recorded temperature of 38 F on 02/17/22. Upon opening the refrigerator door, the surveyors observed a temperature reading of 22 F and one vial of [redacted] solution contained within a box, dated "01/25". In addition, the box of the referenced solution contained a label indicating, "Refrigerate/Do Not Freeze" on it. During an interview with the surveyors on 02/18/22 at 11:45 AM, the ADON/LPN stated she tried to change the temperature of the refrigerator yesterday, to attain a temperature within an acceptable range. The ADON/LPN confirmed a reading of 27 F at this time and acknowledged the presence of the T[redacted] solution bottle, within its box. When asked by the surveyors, she stated she did not know for how long the refrigerator's temperature remained out of an acceptable range but acknowledged that there were two observed temperature readings below freezing, in the presence of surveyors, within the last 24 hours. In addition, she acknowledged that the remaining box, containing the bottle of [redacted] solution had a label on it which indicated "Refrigerate/Do Not Freeze". The ADON/LPN acknowledged that it is necessary for such a solution to be stored at an acceptable temperature per the manufacturer, for it to function properly in the body. She further stated that it could have been discarded, should have been discarded, and would be discarded as a result. Review of the facility's policy, "Sterling Manor Nursing Center Medication Storage Policy and Procedure," dated 04/2018, revealed that the	F 761		

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 761	Continued From page 78 facility shall store all drugs and biologicals in a safe, secure, and orderly manner. This includes compartments, such as rooms and refrigerators which contain drugs and biologicals, being locked when not in use. In addition, medications requiring refrigeration must be stored in a refrigerator. Further review of the policy revealed it did not address acceptable temperature ranges for refrigeration. NJAC 8:39-29.4(h)	F 761		
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 - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous	F 812	All residents have the potential to be affected by the deficient practice of failing to handle food items appropriately;	3/11/22

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 812	Continued From page 79 foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by: On 02/11/2022 at 10:45 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the kitchen tour: 1. A stack of opened and undated tea bags exposed in a box on a multi-tiered cart. 2. A stack of opened and exposed coffee filters stored directly on the bottom of the multi-tiered cart. When interviewed, the FSD stated the stack of coffee filters and opened tea bags should be stored in plastic packaging, dated, labeled and not directly on the multi-tiered cart. 3. In the walk-in refrigerator, a clear plastic container on a multi-tiered cart contained 17 ham and cheese sandwiches with one of 17 sandwiches dated 02/09/2022 and 16 out of 17 sandwiches were wrapped and undated. 4. In the walk-in refrigerator, a flat surface pan containing a box of turkey breast thawing on the bottom shelf of a multi-tiered cart had no pull date. When interviewed, the FSD stated all food items should be dated, and pulled items for thawing should have a pulled date. The FSD further stated all sandwiches are good for only 48 hours. 5. In Freezer #4 the surveyor observed five bags of sliced carrots and one bag of whole carrots unopened and undated. When interviewed, the FSD stated all food items once out of the original	F 812	however, no residents were adversely affected. 1. The following items were discarded with regards to survey observations these include: stack of opened and undated tea bags, stack of opened and exposed coffee filters, 17 ham and cheese sandwiches, box of turkey breast thawing, five bags of sliced carrots and one bag of whole carrots, opened and undated 14 oz box of corn starch, package of cream of rice, plastic bag of styrofoam plates and lids, 14oz dented can of tomato juice, six pound 8 ounce dented can of beets, 2 six pound bag of eight ounce dented of unsweetened applesauce, two six and a half pound of solid packed sliced apples, five yellow lemons, two stalks celery, two heads of cabbage, six green bell peppers, 52 four ounce styrofoam cups with lids containing cranberry sauce, 16 ounce personal bottle of sports drink, one package of corn on the cob undated, one 10 lb package of frozen chicken thighs, three six pound dented cans of crushed pineapple. The can opener and blade holder were immediately cleaned and sanitized. Food Service Worker (FSW) directly covered entire hair with hair net, all FSW (3) with beards immediately provided beard covers. 1.Tea bags are held in a in a zip lock bag, labeled and dated when not in use or on the coffee cart. 2. Coffee filters are stored in a plastic bag,	

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F 812	Continued From page 80 box, should be dated. 6. In the dry storage room, an opened and undated 14 oz box of corn starch with contents exposed on a multi-tiered cart. 7. In the dry storage room, a package of cream of rice opened and undated on a multi-tiered cart. 8. In the dry storage room, an undated and unopened plastic bag of sugar free Jello directly on the multi-tier cart. 9. In the dry storage room, a plastic bag containing styrofoam plates stored on the top of a multi-tiered cart, with contents opened and exposed. 10. In the dry storage room, a plastic bag containing styrofoam lids stored on the top of a multi-tiered cart, with contents opened and exposed. When interviewed, the FSD stated the plastic packaging should have been closed. The FSD also stated all food items should be wrapped and dated. 11. The can opener and blade holder were both soiled with a brown and dark sticky unknown substances on the blade and holder. When interviewed, the FSD stated the blade and holder should be washed and cleaned daily after each use. 12. In the dry storage room, one 14 oz dented can of 100% Tomato juice on the multi-tiered shelf alongside undented cans. 13. In the dry storage room, one six-pound eight-ounce dented can of diced beets on the	F 812	dated and labeled in the box in which they were delivered 3. Sandwiches are no longer made in advance, rather they are prepared the same day as needed for service - each shall be wrapped and dated accordingly - left overs will be discarded within 48 hours. 4. Frozen meat that is thawing will be labeled with the pull and discard date in a shallow mental container at the bottom lower rack of the walk-in refrigerator 5, 21, 22. All single bags of unopened frozen vegetables and meats will remain in the original box or will be individually dated 6, 7, 8. All opened items mentioned in dry storage #6, #7, and #8 IE. corn starch, cream of rice package, sugar free jello will be stored in a sealed dated, container 9, 10. All styrofoam plates and lids will be stored in a sealed bag or container at all times 11. The can opener and blade will be washed, sanitized, and air dried after each use 12, 13, 14, 15, 23. All dented cans will be stored in an area by itself with a label identifying it as "dented cans" separate from undented cans which will be processed for return to the original vendor. 16. All Dietary staff was in-serviced on the importance of wearing a hair not to cover their entire head. 17. All male employees were immediately in-serviced on wearing a beard cover when working in the kitchen 18. All employees were in-serviced on the	

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 812	Continued From page 81 multi-tiered shelf alongside undented cans 14. In the dry storage room, two six-pound eight-ounce dented cans of unsweetened applesauce on the multi-tiered shelf alongside undented cans 15. In the dry storage room, two six and a half pound of solid pack sliced apples on the multi-tiered shelf alongside undented cans. When interviewed, the FSD stated all dented cans should be placed on a separate multi-tiered shelf designated for dented cans only and send back to vendors. 16. The surveyor observed a Food Service Worker (FSW) prepping tomatoes in the prep area. The FSW was wearing a hairnet that didn't properly cover his entire hair. When interviewed, the FSD stated all staff are to have their hairnet fully covering their hair. On 02/23/2022 at 11:23 AM, the surveyor in the presence of the Food Service Director (FSD), observe the following during a follow-up kitchen tour. 17. The surveyor observed three male staff in the kitchen area with no beard cover with their N95 mask. When interviewed the FSD, he stated "I thought it was ok because we all have on N95 mask". 18. In the walk-in refrigerator, one gray plastic container on a multi-tiered cart containing the following contents: one clear plastic bag containing five yellow lemons exposed and undated, one clear plastic bag containing two stalks of celery exposed and undated, one clear	F 812	storage of raw vegetables in he walk-in refrigerator - lemons, celery, cabbage, and green bell peppers - emphasizing the importance of covering and dating all items. 19. All dietary staff were in-serviced on the proper storage and dating of all items while in the walk-in refrigerator 20. All dietary staff were immediately in-serviced on our policy for the storing of personal items in the for service area (kitchen) - no personal items of any kind are to be stored anywhere in the kitchen Regarding the deficient practices listed about all dietary Staff was in-services on: dry food storage, receiving food and storage, proper dating of frozen items, undated canned goods, infection control policy regarding hair and facial hair, proper cleaning procedures All deficient practice will be monitored and checked daily by the Food Service Director using a check list to be initialed and dated for one month. The findings will be reported at the quarterly quality assurance meeting.	

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 812	Continued From page 82	F 812		

plastic with two heads of cabbage exposed and undated, one clear plastic bag with six green bell peppers exposed and undated.

19. In the walk-in refrigerator, on the multi-tiered shelf a large tray containing 52 four-ounce styrofoam cups with lids containing cranberry sauce were undated. When interviewed, the FSD stated all food items should be properly wrapped, labeled, and dated.

20. In freezer #3, an unopened 16 oz personal bottle of water along with a 32 oz unopened personal bottle of sports drink on a multi-tiered shelf. When interviewed, the FSD stated that staff personal items should not be stored in the freezer.

21. In freezer #4, one package of corn on the cob undated. When interviewed, the FSD stated that all packages should be dated once out of the original packaging box.

22. In freezer #5, one 10 lb package of frozen chicken thighs undated. When interviewed, the FSD stated all food items should be dated once out of the original packaging box.

23. In the dry storage room, three six pound dented cans of crushed pineapple was stored alongside undented cans. When interviewed, the FSD stated he thought that the cans were ok since the dent was only on the top of the cans.

Review of the facility's undated " Dry Food Storage" policy indicated that dry food items when opened will be dated and stored tightly wrapped or in a sealed container.

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 812	Continued From page 83 Review of the facility's undated "Food Receiving and Storage" policy indicated that dry foods that are stored in bins will be removed from original packaging, labeled, and dated ("used by" date). All food stored in the walk-in refrigerator or freezer will be wrapped, labeled, and dated ("use by "date). The policy also revealed raw meat will be labeled with the date that item is pulled to defrost and the date that it will be used by. Review of the facility's undated "Frozen Food Items" revealed all frozen products will be left in the original box that indicates the date of the delivery. If products need to be stored outside of the original box, product must be securely sealed and labeled with the date open, or date taken out of the original box. Review of the facility's undated "Canned Goods" policy indicated that all canned items will be inspected for dents and if found will be put in the dented canned section of the stock room that is labeled "dented cans". Review of the facility's undated "Infection Control" policy indicates all food service personnel will be required to have hair off shoulder, confined in a hair net. The policy did not address beards. Review of the facility's undated "Proper Cleaning Procedures" policy indicated the can opener is cleaned after every use, by running the opener through the dish machine. The table-mounted section is washed and sanitized as well. NJAC 8:39-17.2(g)	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		3/11/22

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 814	Continued From page 84 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public. The facility failed to have a cover over the opening for 2 of 3 garbage dumpsters on several observations. This deficient practice was evidenced by the following: On 02/14/2022 at 08:35 AM, the surveyor observed the middle dumpster that was uncovered and exposed to the elements. The middle dumpster had a closed lid on the right-side but the left-side was uncovered exposing multiple trash bags inside. On 02/16/2022 at 08:40 AM, the surveyor observed the middle dumpster that was uncovered and exposed to the elements. The middle dumpster had a closed lid on the right-side but the left-side was uncovered exposing multiple trash bags inside. On 02/17/2022 at 08:30 AM, the surveyor observed the middle dumpster uncovered and exposed to elements. The left-side of the dumpster had a closed lid, but the right-side lid was opened exposing multiple trash bags inside. Multiple pests were observed in and out of the opened right-side of the dumpster. On 02/17/2022 at 2:44 PM, the surveyor observed the first dumpster from the left-side uncovered and exposed. The left-side of the	F 814	1. On multiple dates during the survey the first and middle dumpsters were found with the lid up leaving the trash uncovered exposing bags of trash inside of the dumpster. 2. Squirrels were observed jumping in and out of the dumpster. 3. All residents have the potential to be adversely affected by the lid to the dumpster not being closed, however, no residents were adversely affected. 4. Upon detection of the exposed trash in the dumpsters the lids were immediately closed. An in-service was provided to the Dietary staff as they are responsible for condition of the dumpster at all times 5. The dumpster will be inspected multiple times throughout the day by the food service director especially after meal service and clean up when the trash is deposited into the dumpster. The condition of the dumpster will be noted on a checklist. 6. The results for the findings will be reported to the Administrator daily for 2 weeks then monthly for the next month. The results will also be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 814	Continued From page 85 dumpster had a closed lid, but the right-side was opened exposing multiple cardboard boxes. 02/18/2022 at 08:36 AM, the surveyor observed the middle dumpster uncovered and exposed. The right-side of the dumpster had a closed lid, but the left-side lid was opened with multiple trash bags inside. Multiple pests were noted on the opened and exposed left-side of the middle dumpster. The facility failed to provide a policy for the dumpster.	F 814		
F 880 SS=D	NJAC 8:39-19.7 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	F 880		6/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 86	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 880	Continued From page 87 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) proper hand washing was performed, and b.) eye protection was worn according to the New Jersey Department of Health (NJ DOH) and Centers for Disease Control and Prevention (CDC) guidelines for 1 of 2 nurses observed during medication pass. This deficient practice was evidenced by: 1. On 02/14/22 at 9:19 AM, the surveyor approached Licensed Practical Nurse (LPN) #1 at the [redacted] medication cart to observe medication pass. At that time, the surveyor observed LPN #1 complete medication administration to an unsampled resident. The surveyor observed LPN #1 did not use alcohol-based hand rub or wash her hands prior to beginning the medication preparation for the next resident (Resident [redacted]). After preparing the medications, the surveyor observed LPN #1 did not perform hand hygiene prior to applying gloves to both hands to administer the prescribed nasal spray to the Resident [redacted]. During an interview with the surveyor on 02/14/22 at 12:56 PM, LPN #1 stated that prior to medication preparation, hand hygiene should be performed, and hand hygiene should be	F 880	1. LPN #1 was immediately in-serviced regarding her frequency of proper hand washing and wearing eye protection. A handwashing competency was immediately completed with LPN #1. LPN #1 immediately applied eye protection. 2. All residents have the potential to be affected by the deficient practice of failing to perform proper hand washing and donning appropriate eye protection. 3. The Infection Preventionist (IP) in-serviced all staff regarding proper hand washing and wearing of eye protection. As RCA was completed with all top-line and front-line staff as a means of determine the cause of these deficient practices. It was determined that staff required additional education related to the mandatory Personal Protective Equipment required when the facility is in an outbreak and the frequency of utilizing hand hygiene while interacting with residents. All Staff will reviewed the following CDC COVID-19 Prevention videos: Keep COVID-19 out!, Clean Hands, and Use of PPE Correctly for COVID-19. Top line staff completed the following Nursing Home Infection Preventionist & Control Program modules: Module 1 - Infection Prevention & Control Program, Module 5 -	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 88 performed before every resident. LPN#1 further stated that handwashing or hand gel should be performed before and after applying gloves. During an interview with the surveyor on 02/22/22 at 3:39 PM, the Regional LPN stated that hand hygiene should be performed prior to preparing medications and after physical contact with a resident. Review of the facility's policy " Hand Washing/Hand Hygiene Policy and Procedure," dated 7/2020, revealed to use alcohol-based hand rub or alternatively, soap and water before and after direct contact with residents, before preparing or handling medications, and before applying non-sterile gloves. 2. During entrance conference with the team coordinator on 02/11/22 at 9:31 AM, the Director of Nursing (DON#1) stated the facility was in a COVID outbreak and the required Personal Protection Equipment (PPE) throughout the facility was a N-95 mask, goggles or a faceshield On 02/14/22 from 9:19 AM until 9:56 AM, the surveyor observed LPN #1 wearing a N-95 mask but no eye protection while administering medications to 2 residents (Resident [redacted] and Resident [redacted]) on the [redacted]. During an interview with the surveyor on 02/14/22 at 11:08 AM, the LPN/Unit Manager stated the required PPE on the [redacted] was a N-95 mask, goggles or faceshield in the hallway and in patient rooms. During an Interview with the surveyor on 02/14/22	F 880	Outbreaks, Module - 7 Hand Hygiene, Module 6A - Principles of Standard Precautions, and Module 6B- Principles of Transmission Based Precautions. IP and staff watched the required modules. All front line staff completed the required modules. 4. The IP will complete employee hand washing competencies on five staff members weekly for one month and ensure all staff are wearing appropriate eye protection daily for one month during facility outbreak and as needed based on the county's substantial or high transmission COVID rate. 5. All findings will be reported at the quarterly quality assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 880	Continued From page 89 at 12:45 PM, in the presence of the Director of Nursing (DON#1), DON#2 and the Infection Preventionist/LPN (IP/LPN), the IP/LPN stated the required PPE on the all units was a N-95 mask and goggles or faceshield. The IP/LPN further stated that the COVID community transmission rate was monitored weekly. The facility provided a copy of CDC's county transmission positivity rate, dated 2/11/22, which revealed a "High" community Covid transmission rate. During an interview with the surveyor on 02/22/22 at 4:30 PM, the Regional LPN stated that the required PPE for all staff in the facility was a N-95 mask and eye protection. Review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidelines, revised 02/02/22, revealed the "Implement Universal Use of Personal Protective Equipment" section was last updated on 02/10/21 and included, "If SARS-coV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP [healthcare professionals] working in facilities located in counties with substantial or high transmission should also use PPE as described below: ... Eye protection (i.e. goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters." NJAC 8:39-19.4(a)1	F 880		
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 888	Continued From page 90 §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.	F 888		

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	315149	A. BUILDING _____ B. WING _____	02/23/2022

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STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 888	Continued From page 91 §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 888	Continued From page 92	F 888		

documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 888	Continued From page 93 the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) accurately track the vaccination status of facility staff, b.) consistently input the facility staff vaccination data, on a weekly basis, into the Centers for Disease Control's National Healthcare Safety Network tracking system (NHSN) (a data tracking system which provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections) and c.) develop and implement a comprehensive policy and procedure to track the facility staff vaccination status and input the facility staff vaccination data into NHSN. This deficient practice was identified for facility staff, including any individual who provides care, treatment, or other services for the facility and/or its residents. Review of the NHSN tracking system revealed that 89.7% of the facility staff were fully vaccinated for the week ending 01/30/22, as per the data entered by facility administration. Review of the COVID-19 Staff Vaccination Matrix (Matrix), provided by the facility, revealed that 75% of the staff were completely vaccinated. The surveyor noted that the NHSN percentage of staff vaccinated (89.7%) and the percentage of staff	F 888	1. 2/22/2022 NHSN was updated to reflect the correct vaccination status of all staff and the COVID-19 Staff Vaccination Matrix for providers twice weekly. Current Administration was unable to document and substantiate and verify which staff were included in the tracking specimen to equal an 89.7% staff vaccination percentage at the time of the survey 2. Due to the nature of this deficiency all staff and residents could have potentially been affected by the deficient practice of failing to track and document the status of all employees previously reported. However, no adverse affect on residents and staff. 3. The Administrator sought assistance from CDC Youtube videos outlining how the reporting tool works and the collection of data. One such video "Updates to the NHSN COVID-19 Point of Care Reporting Tool" was instrumental in assisting with current staff vaccination numbers. 4. NHSN was updated to reflect the correct information supported by collection of COVID-19 vaccination cards from Staff paid by the facility, Medical Practitioners, and Agency staff currently working at the center. 5. COVID-19 Vaccination Matrix for Providers was initiated education the Administrator received from videos was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

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F 888	Continued From page 94 vaccinated according to the Matrix (75%) were not reasonably consistent, with a difference greater than 10% (14.7% difference). During an interview with the surveyor on 02/18/22 at 10:30 AM, the Administrator could not explain why the NHSN data was not reasonably consistent with the Matrix and requested an opportunity to review the Matrix. Review of the revised Matrix, provided by the facility on 02/22/22, revealed that 76.08% of the staff were completely vaccinated. The surveyor noted that the NHSN percentage of staff vaccinated (89.7%) and the percentage of staff vaccinated according to the Matrix (76.08%) were not reasonably consistent with a difference greater than 10% (13.62% difference). During an interview with the surveyor on 02/22/28 at 8:18 AM, the Administrator stated that she was employed by the facility on 01/03/22 and was assigned the task of NHSN data entry. The Administrator stated that she had not been trained on the NHSN data entry process and indicated that the Consultant Administrator (CA) had been doing the task prior to it being assigned to her. She acknowledged that she did not have a login to NHSN and the CA logged her into the system. She indicated that the CA told her that the program was self-explanatory. The Administrator indicated that she attempted to input data into NHSN and was unable to post the data, as "Sections 2 and 3 did not match." The Administrator acknowledged that she completed the first Matrix as of 02/11/22, based on the total number of staff members referencing her notebook of facility staff vaccination cards. The Administrator further demonstrated a	F 888	provided to DON, ADON, and IP and was completed on 3/11/2022. 6. The Administrator, DON, ADON, and IP are awaiting NHSN and SAMS (Secure Access Management Services) access. 7. All staff, providers and agency staff will be tracked according to NHSN guidelines 8. The DON, ADON, and IP moving forward will complete the NHSN survey reporting twice weekly and track the employees and residents 9. Any problems will be tracked weekly and reported to the administrator. Outlier results/difficulties will be reported in the quality assurance meetings monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

(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 888	Continued From page 95	F 888		

computerized spreadsheet which she maintained to track the vaccination status of facility staff and residents. The surveyor noted that the spreadsheet reflected columns indicating that the first, second and booster vaccination dosages for facility staff were administered but did not reflect a date of administration. The surveyor inquired, how do you know when a staff member is due for the second dose of the vaccine or a booster shot. The Administrator stated that the Infection Preventionist (who started a couple of days ago) or the Assistant Director of Nursing (ADON) tracks the dates of an employee's vaccination status (the first, second and booster doses). The Administrator could not produce any reports from NHSN.

During an interview with the surveyor on 02/22/22 at 10:43 AM, the CA stated that he was only in the facility for the survey and acknowledged that he did input data into NHSN "a couple of times." He further stated that a former ADON and Director of Nursing (DON) also had the responsibility to input data into NHSN and it is currently the responsibility of the Administrator. He indicated that he gave the Administrator a brief training of the system "last week." The CA stated that he does not know about the current NHSN Sections 2 and 3 and acknowledged that if these sections are not done perfectly, the data cannot be submitted. The CA further stated that the data had been inconsistently documented into NHSN for the "past couple of months." The CA stated that he was unfamiliar with the nursing staff vaccination status and is unsure who is responsible for staff vaccination tracking.

During an interview with the surveyor on 02/22/22 at 2:31 PM, the Assistant Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	02/23/2022

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F 888	Continued From page 96	F 888		

Nursing/Licensed Practical Nurse (ADON/LPN) stated that when the former ADON left, she was assigned the task of keeping track of the facility staff vaccines and she has been doing the task for approximately three weeks. The ADON/LPN stated that she intended to take all of the employee vaccination cards and prepare a spreadsheet indicating the dates of the first, second and booster vaccine doses. The ADON/LPN indicated that she believed the second dose of the vaccine series is completed six months after the first dose, and indicated, "I would have to check; I am not sure." The ADON/LPN could not produce a detailed tracking of the dates the facility staff received their first, second and booster vaccines.

Review of the facility's COVID-19 Vaccine Policy and Procedure, dated 01/04/22, reflected under "Record keeping" that "Staff will be requested to provide the IP [Infection Preventionist] with a copy of their immunization card." The policy did not reflect the process to track facility staff vaccinations and/or the process to input facility staff data into NHSN.

NJAC 8:39-5.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060312	A. BUILDING: _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

(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) COMPLETE DATE
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 interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident for 7 of 14 day shifts reviewed and was evidenced by the following: Findings include: 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	S 560	1. The facility recognized that staffing requirements were not maintained on 01/23/22, 01/26/22, 01/28/22, 01/29/22, 01/30/22, 02/01/22, 02/05/22. 2. All residents have the potential to be affected by the deficient practice of failing to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. 3. The Director of Nursing completed an audit of the Certified Nursing Assistant staffing schedule for the previous 30 days and rendered education to the Staffing Coordinator regarding the daily staffing requirements as indicated by the State of New Jersey. 4. The Administrator or designee will	3/4/22

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

Electronically Signed | 03/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 01/23/22-01/29/22 and 01/30/22-02/05/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: - 01/23/22 had 10 CNAs for 100 residents on the day shift, required 13 CNAs. - 01/26/22 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. - 01/28/22 had 10 CNAs for 95 residents on the day shift, required 12 CNAs. - 01/29/22 had 10 CNAs for 95 residents on the day shift, required 12 CNAs. - 01/30/22 had 11 CNAs for 97 residents on the day shift, required 13 CNAs. - 02/01/22 had 11 CNAs for 96 residents on the day shift, required 12 CNAs. - 02/05/22 had 11 CNAs for 98 residents on the day shift, required 13 CNAs.	S 560	continue hiring and recruitment efforts which include online job listings, job fairs, open houses, and referral bonuses to ensure that the facility is being competitive in the marketplace and positively attracting staff. The Administrator or designee will conduct a wage analysis of all Certified Nursing Assistants. The facility will continue to utilize agency contracts and solicit additional nursing agencies. The DON or designee will review staffing schedules daily to ensure adequate staffing on all shifts. Open shifts will be posted in advance to alert all staff of the facilities staffing needs with a sign-up sheet attached for those who might want to work. 5. All findings will be reported at the Quarterly Quality Assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 During an interview with the surveyor on 02/22/22 at 12:31 PM, the Staffing Coordinator (SC) stated that the day shift staffing should be comprised of 1 CNA to 8 residents. The SC was not certain of the staffing ratio for direct care (CNA) to resident ratios for the evening and night shifts. She further stated that she formed a schedule based on how many staff members are available, indicating that she has 12 CNAs for day shift, for evening shift she can use up to 9 CNAs, and for the overnight shift she can use up to 6 CNAs. Finally, the CNA addressed the potential issues related to staff shortages, indicating that she does scheduling a few weeks in advance and pursues the use of agency staff if there will be a chance of a staffing shortage. During an interview with the surveyor on 02/23/22 at 1:21 PM, the Administrator stated that facility staff members call several agencies to obtain additional CNA coverage, but agency workers do not always show up as planned, and this is especially apparent on the late shift. In addition, the Administrator stated that that facility administrative staff offers incentive bonuses for CNA staffing and has also reached out to several CNA schools without success, due to decreased registration of individuals in such programs. Finally, the Administrator indicated that she was aware of required staffing ratios of CNAs to residents as follows: 1:8 during the day, 1:10 during the evening, and 1:14 on overnight shifts, respectively. NJAC 8:39-5.1(a)	S 560		