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 ______	11/02/2020

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 000	INITIAL COMMENTS Standard Survey 11/2/2020 Census: 83 Sample: 18 plus 2 closed records THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES.	F 000		
F 576 SS=B	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent	F 576		12/7/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/13/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 576	Continued From page 1 with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide privacy when receiving mail. This deficient practice was identified for Exec of Exe residents reviewed for privacy with their mail (Resident Executive O) and was evidenced by the following: The surveyor reviewed Resident #Executive Or 10/19/2020 Annual Minimum Data Set, an assessment tool, which identified that the resident Executive Order 26, 4.b. When interviewed on 10/26/2020 at 12:18 PM, Resident Executive O stated that he/she received packages that were opened and/or staff members asked him/her to open the packages in front of the staff member. On 10/26/2020 at 12:22 PM the surveyor (in the presence of another surveyor) observed 2 large packages in the reception area. Both boxes were addressed to Resident Executive O and one box was open. When interviewed at that time, the payroll	F 576	F-tag 576 1. Resident Executive O was interviewed by the Regional Director and the Regional MDS nurse and assured resident that resident would receive mail unopened. All residents have the right to open his/her own mail and packages. 2. All residents have the potential to be affected by this deficient practice when Resident Rights are no followed. 3. An in-service was done with the Administrative staff who have access to the mail on Resident Rights to open their mail and packages on their own. 4. The Administrator and Nursing Supervisor will monitor daily that packages and mail will be delivered unopened and that residents will not be asked to open the mail/packages in front	

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F 576	Continued From page 2 clerk who was sitting at the reception desk, said she did not know who had opened the package. When interviewed on 10/26/2020 at 12:47 PM, the Social worker Assistant (SWA) stated that she did ask Resident #Executive to open his/her package in front of her on Executive Order 26, 4.b. The SWA acknowledged that the residents' have the right to open mail and packages in private. When interviewed on 10/26/2020 at 1:20 PM, the Administrator stated that whomever delivers the mail or packages to the residents' asks the resident to open the packages because of Covid-19 and the risk of residents' receiving sanitizing or cleaning products. When asked if any resident in this facility had ever received cleaning products, the Administrator said "no." The Administrator stated that Resident #Executive's package was accidentally opened by the payroll clerk. He acknowledged that mail and packages should be delivered unopened. On 10/26/2020 at 1:30 PM the surveyor reviewed the Resident Rights policy provided by the Regional Consultant. The policy included that the residents have the right to communicate in person and by mail, email, and telephone with privacy. During an interview on 10/27/2020 the Regional Director in the presence of the Regional Minimum Data Set staff member stated that mail should not be opened by staff. NJAC 8:39-4.1(a)(19)	F 576	of the staff members. The Administrator will check packages that come in daily to ensure that none have been opened and all findings will be reported at the Quality Assurance meeting x 2 quarters.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		12/7/20

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F 584	Continued From page 3	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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F 584	Continued From page 4 sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain sanitary shower rooms. This deficient practice was identified in 4 of 4 shower rooms on 2 of 2 nursing units and was evidenced by the following: On 10/26/2020 at 8:58 AM Resident #[Executive Order 26, 4.b.] stated [Executive Order 26, 4.b.] On 10/27/2020 at 9:56 AM Resident #[Executive Order 26, 4.b.] stated he/she was concerned about mold in the shower room. On 10/28/2020 at 9 AM the surveyor observed the [Executive Order 26, 4.b.] [Executive Order 26, 4.b.]) "Resident Bath Room" that was across from Resident Room [Executive Order 26, 4.b.]. The surveyor observed a heavy accumulation of a black substance in the corner junctions of the shower area, around the toilet, and along the baseboards. On 10/28/2020 at 8:50 AM the surveyor observed the [Executive Order 26, 4.b.] "Resident Bath Room" that was across from Resident Room [Executive Order 26, 4.b.] The surveyor observed a heavy accumulation of a black substance in the shower corner junctions and a heavy accumulation of a black substance in the grout lines. On 10/29/2020 at 9:45 AM the surveyor observed the [Executive Order 26, 4.b.] that was across from Resident Room [Executive Order 26, 4.b.] The surveyor observed a heavy accumulation of a black substance in the corner junctions of the shower area. The surveyor also observed a heavy accumulation of a black substance in the grout lines in the shower	F 584	F-tag 584 1. The [Executive Order 26, 4.b.] resident bathroom across from resident room [Executive Order 26, 4.b.] the [Executive Order 26, 4.b.] resident bathroom across from room [Executive Order 26, 4.b.] the [Executive Order 26, 4.b.] resident bathroom across from room [Executive Order 26, 4.b.] and the [Executive Order 26, 4.b.] resident bathroom across from room [Executive Order 26, 4.b.] were cleaned with bleach to remove the black like substance in the floor wall juncture as well as the grout lines in the tiles and the seam around the toilet. The rest of the bathroom throughout the facility were all checked to assure that they were free from black like mildew substance. Where necessary, the tiles were replaced as well as the baseboards. The housekeepers were immediately in-serviced by the Corporate Housekeeping Director on the policy and procedure for cleaning and disinfecting all resident areas. 2. All residents are affected by this deficient practice when the policy and procedure for cleaning and disinfecting resident areas are not followed. All residents have the potential to be affected when the facility is not maintained in a clean, comfortable and homelike enviroment. 3. An in-service was done on 10/30/2020 with the Housekeeping Director by the Corporate Housekeeping Director on the Policy and Procedure for cleaning all	

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F 584	Continued From page 5 floor and a heavy accumulation of a black substance around the toilet area. On 10/29/2020 at 11:08 AM the surveyor observed the Executive Order 26, 4.b." that was across from Resident Room Execu. The surveyor observed a black substance in the corner junctions of the shower area and in the grout lines on the floor. When interviewed on 10/30/2020 at 12:33 PM the Director of Housekeeping and Laundry (DHK/L) stated he had a staff of three girls, two guys (floor technicians) and two laundry technicians. He stated one of the housekeeping staff cleaned the WW short/long hallway and resident bath (shower rooms). Another housekeeping staff cleaned EW long hallways and the resident bath (shower rooms). The DHK/L stated the toilets, tubs, shower area and shower bed all needed to be cleaned by the housekeeping staff when they were assigned to the EW or WW. The DHK/L stated he had nothing in writing or a policy to provide to the surveyor. The DHK/L stated "It's mostly a verbal procedure, I tell them what to do and then I check behind them to make sure they do what I told them. I make rounds every day and when I've not here I have an alternate supervisor who makes rounds." The DHK/L stated after the showers and shower beds are cleaned, they disinfect them." The DHK/L stated "I look in the showers every day." When the surveyor asked the DHK/L if he thought the showers were clean, he stated "They could be better, the tiles need to be changed." The DHK/L stated he had discussed changing the tiles with the prior Administrator but he hadn't discussed it	F 584	resident areas to maintain a clean, comfortable and homelike enviroment. A review of all housekeeping job discriptions was done by the Corporate Housekeeping Director with the facility Housekeeping Director and all housekeeping staff members. 4. The Housekeeping Director and Administrator will conduct daily rounds to inspect resident areas to assure that these deficient practices do not reoccur ongoing. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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F 584	Continued From page 6 with the current Administrator. NJAC 8:39-31.2	F 584		
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 observation, interview, and record review, it was determined that the facility failed to: a.) follow acceptable standards of clinical practice with following their policy on completion of monthly [Executive Order 26, 4.b.] medication summaries for [Exec] of [Exec] residents reviewed for unnecessary medications (Residents #[Executive], [Executive], [Executive] and [Executive]) and b.) ensure accuracy of physician's orders for [Exe] of [Exe] residents reviewed during the medication pass observation (Resident [Execu]). This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	F tag 658 1.[Executive Order] summaries were completed for all residents on [Executive Order 26, 4.b.] for the month of [Executive Order 26, 4] Resident [Execu] [Executive Order 26, 4.b.] order was immediately clarified and the MAR and POS were updated to reflect the correction. 2. All residents have the potential of being affected when monthly reviews are not done on [Executive Order 26, 4.b.] medications. An audit was to ensure [Executive Order] summaries were completed for October and ongoing. All residents on [Executive Order 26, 4.b.] were audited to ensure correct dosage of [Executive Order 26, 4.b.] was on the MAR and POS. 3. An in-service was done with the nursing staff on completing monthly [Executive Order] summaries on a timely basis. The Nurses were also in-serviced on checking [Executive Order 26, 4.b.] orders with each pick up to ensure the dose did not change and that	12/7/20

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F 658	Continued From page 7 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in 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. Resident Executive had diagnoses that included Executive Order 26, 4.b. . The resident's Executive Order 26, 4.b. medications included the Executive Order 26, 4.b. medication Executive Order 26, 4.b. the Executive Order 26, 4.b. medication Executive Order 26, 4.b. , and the Executive Order 26, 4.b. medication and Executive Order 26, 4.b. The resident had also been receiving the Executive Order 26, 4.b. medication Executive Ord which was tapered and then discontinued when Executive Order 26, 4.b. was started. The resident was being followed by a Executive Order 26, 4.b. Executive Order 26 consultant group who were making periodic changes with the resident's medications. A Executive Order 26, 4.b. noted a "plan" to change the Executive Order 26, 4.b. A Executive Order 26, 4.b.Executive O eval noted to change Executive Ord to Executive Order 26, 4.b. A Executive Order 26, 4.b. noted to change Executive Order 26, 4.b. A Executive Order 26, 4.b. noted to discontinue Executive Ord	F 658	the POS/MAR are correct. 4. The Director of Nurses and Assistant Director of Nurses or Unit managers will check monthly to ensure all summaries are done timely. The Director of Nurses, Assistant Director of Nurses and Unit Managers will check all Executive Order 26, 4.b. orders when it is picked up from the Executive Order 26, 4.b. clinic to ensure no changes have occured with dosage prior to distributing to the medication Nurse. The two items above will be reviewed at the Quality Assurance meeting x 4 quarters.	

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F 658	Continued From page 8 and Executive Order 26, 4.b. And also to do a Executive Order 26, 4.b. An Executive Order 26, 4.b. eval noted to change Executive Order 26, 4.b. an Executive Order 26, 4.b. eval noted to start Executive Order 26, 4.b. Executive Order 26, 4.b.. The surveyor reviewed the resident's medical record (paper chart) and observed only one "Executive Order 26, 4.b. Monthly Evaluation" that was dated Executive Order 26, 4.b. for "month reviewed September." When interviewed on 11/2/2020 at 8:50 AM, the Director of Nursing (DON) said they had looked through the medical record and were unable to find additional monthly summaries. 2. Resident # Execu had diagnoses that included Executive Order 26, 4.b.. The resident's medications included the Executive Order 26, 4.b. medication Executive Order 26, 4.b. and the Executive Order 26, 4.b. medication Executive Order 26, 4.b. The resident's careplan included a Executive Order 26, 4.b. of Executive Order 26, 4.b." and noted the resident had received Executive Order 26, 4.b. used to treat Executive Order 26, 4.b. the Executive Order 26, 4.b. medication Executive Order 26, 4.b. Executive Order 26, 4.b.. The careplan also noted that Executive Order 26, 4 had been Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. , Executive Order 26, 4.b. and Executive Order 26, 4.b.. The surveyor reviewed the resident's medical record and observed the following monthly Executive Order 26, 4.b. Monthly Evaluation" forms:	F 658		

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F 658	Continued From page 9 Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. NOT completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - NOT completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - NOT completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - NOT completed Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - NOT completed Executive Order 26, 4.b. for the month of Executive Order and Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. - both completed. When interviewed on 11/2/2020 at 8:50 AM, the Director of Nursing (DON) said they had looked through the medical record and were unable to find any additional monthly summaries. 3. Resident #51 had diagnoses that included Executive Order 26, 4.b., Executive Order 26, 4.b., Executive Order 26, 4.b. . The resident's medications included Executive Order 26, 4.b., the Executive Order 26, 4.b. and the Executive Order 26, 4.b. medication Executive Order 26, 4.b. . A Executive Order 26, 4.b. "Interdisciplinary Care Conference Summary" noted the resident had received the Executive Order 26, 4.b. medication Executive Order 26, 4.b. . The surveyor reviewed the Executive Order 26, 4.b. and observed on Executive Order 26, 4.b. the "Plan" included a Executive Order 26, 4.b. the Executive Order 26, 4.b. included another	F 658		

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F 658	Continued From page 10 Executive Order 26, 4.b. On Executive Order 26, 4.b. the Executive Order 26, 4.b. the Executive Order 26, 4.b. had not been Executive Order 26, 4.b. The surveyor reviewed the resident's medical record and observed only Executive Order 26, 4.b. Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. Executive Order 26, 4.b. for the month of Executive Order 26, 4.b. When interviewed on 11/2/2020 at 8:50 AM, the Director of Nursing (DON) said they had looked through the medical record and were unable to find additional monthly summaries. 4. Resident Executive was admitted to the facility on Executive Order 26, 4.b. An initial careplan, dated Executive Order 26, 4.b. noted a Executive Order 26, 4.b. " of "Resident has a Executive Order 26, 4.b. Executive Order 26, 4.b. prior to admission and recently Executive Order 26, 4.b. " A Executive Order 26, 4.b. was initiated and the surveyor observed the resident in a Executive Order 26, 4.b. On 7/16/2020 a Executive Order 26, 4.b. was completed and noted diagnoses that included Executive Order 26, 4.b. Executive Order 26, 4.b. . The Executive Order was to start the Executive Order 26, 4.b. medication Executive Ord Executive Order 26, 4.b. for Executive Order 26, 4.b. , Executive Order 2 and Executive Order 26, 4.b. On Executive Order 26, 4.b. a Executive Order 26, 4.b. noted diagnoses of Executive Order 26, 4.b. with the Executive Orde to start Executive Order 26, 4.b. On Executive Order 26, 4 a Executive Ord eval noted to Executive Order 26, 4.b. the Executive Order 26, 4.b. . On Executive Order 26, 4.b. a Executive Order 26, 4.b. noted to Executive the	F 658		

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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 658	Continued From page 11 Executive Order 26, 4.b. The surveyor reviewed the resident's medical record and observed only one Executive Order 26, 4.b. form: Dated Executive Order 26, 4.b. for the month of Executive Order 26, 4.b.. When interviewed on 11/2/2020 at 8:50 AM, the Director of Nursing (DON) said they had looked through the medical record and were unable to find additional monthly summaries. On 10/29/20 at 9:20 AM the surveyor interviewed the Nursing Supervisor and DON. The Nursing Supervisor stated "the monthly Executive Orde summary sheets are in the charts and stated "each nurse is responsible for completing the monthly psych summaries, there is an assignment sheet to follow. When the surveyor mentioned being unable to find consistent completion of monthly summaries in the charts, the DON stated "if they aren't in the charts, they probably weren't done." The surveyor reviewed the facility's policy "Monthly Executive Order 26, 4.b. Summaries", undated, and observed it included "Licensed staff will be assigned to monthly behavioral charting for each resident on Executive Order 26, 4.b. medications. They are due by the 15th of the month." 5. On 10/26/2020 at 9:15 AM the surveyor observed a Licensed Practical Nurse (LPN) administer medications to Resident Executi The resident received Executive Order 26, 4.b. Executive Order 26, 4.b.) as per the order on	F 658		

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	315149	A. BUILDING ______ B. WING ______	11/02/2020

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F 658	Continued From page 12 the Medication Administration Record (MAR). During review of the medical record, the surveyor observed 5/20/2020 Physician's Orders (PO) that included a Physician's order for the resident to receive Executive Order 26, 4.b. Executive Order 26, 4.b.. The surveyor then observed that the order had been changed to Executive Order 26, 4.b. The new order was changed on the MAR, however, there was no verbal physician's order documented to reflect the change in dosage. During an interview on 10/26/2020 at 9:47 AM, the LPN said Resident Executive should have received Executive Order 26, 4.b. not Executive Order 26 The LPN said if the medication order was changed, a verbal order should have been written. During an interview on 10/26/2020 at 10:10 AM the Director of Nursing in the presence of the facility's Regional Consultant stated that Resident Executi did not receive the correct dose of Executive Order 26, 4.b. according to the PO. The facility did not provide a policy and procedure that contained information on documenting physician orders. (The resident had no adverse reaction.) NJAC 8:39-11.2(b) 29.2(d)	F 658		
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	F 756		12/7/20

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F 756 Continued From page 13
licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending 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 and record review, it was determined that the facility failed to ensure that the Consultant Pharmacist (CP) completed

F 756

F-tag 756

1. A new Pharmacy Consultant was hired

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F 756	Continued From page 14 monthly medication regimen reviews as required. This deficient practice was identified for Exe of Exe residents reviewed for unnecessary medications (Residents Executive, Executive, Executive, Executive, and Executive Or and was evidenced by the following: 1. The surveyor reviewed the medical record of Resident Executive and observed the resident was receiving multiple medications that included Executive Order 26, 4.b. Executive Order 26, 4.b., Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.). During further review of the medical record the surveyor noted one CP review dated Executive Order 26, 4.b. completed prior to Executive Order 26, 4.b.. There was no CP review of the resident's medication regimen when admitted on Executive Order 26, 4.b. or a CP review done for the month of Executive Order 26. 2. The surveyor reviewed the medial record of Resident Executive and observed the resident was receiving multiple medications that included Executive Order 26, 4.b. this resident to Executive Order 26, 4.b.), Executive Order 26, 4. (a medication being used with this resident for Executive Or Executive Order 26, 4.b., Executive Order 26, 4.b. (a medication used to treat a Executive Order 26, 4.b.), Executive Order 26, 4.b.), Executive Order 26, 4.b.), Executive Order Executive Order 26, 4.b.), Executive Order 26, 4.b. Executive Order 26, 4.b.. During further review of the medical record, the surveyor noted that the last CP review of the resident's medications had been done on Executive Order 26, 4.b.. There were no further CP reviews found for April, May, June or July. After 3/12/2020	F 756	and started August of 2020. There is a system in place whereby the Pharmacy Consultant can access via remote access all medication records of all residents. This allows all residents to continue to have there medications reviewed monthly as well as new admissions and readmissions. 2. All residents have the potential to be affected when medications are not reviewed on a timely basis. 3. An in-service was done with the Nursing staff on ensuring the Pharmacy consultants are reviewing medications monthly. 4. The Director of Nurses and Assistant Director of Nurses will ensure all resident medication reviews are done by auditing the reports monthly to ensure compliance ongoing. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

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F 756	Continued From page 15 the next CP review was completed in August 2020. 3. The surveyor reviewed the medical record of Resident Execu 1 and observed the resident was receiving multiple medications that included Executive Order 26, 4.b. (a Executive Order 26, 4.b. medication), Executive Order 26, 4.b. (a medication used to treat Executive Order 26, 4.b.), Executive Order (an Executive Order medicaition), Executive Order 26 (an Executive Order 26, 4.b. medication), Executive Order 2 and Executive Order 26, (medications used to Executive Order 26, 4.b. and Executive Order 26, (used to treat Executive Order 26, 4.b., During further review of the medical record, the surveyor noted that the last CP review of the resident's medications had been done on Executive Order 26, 4.b. There were no further CP reviews found for April, May, June or July. After 3/12/2020 the next CP review was completed in Executive Order 2 Executive Ord 4. The surveyor reviewed the medical record of Resident Executive and observed the resident was receiving multiple medications that included Executive Order 26, 4.b. (an Executive Order 26, 4.b.), Executive Order 26, 4.b. (medications used to treat Executive Order 26, 4.b.), Executive Order 26, 4.b. (a medication being used with this resident for Executive Order 26, 4.b.), Executive Order 26, 4.b. (Executive Order 26, 4.b. used in the treatment of Executive Order 26, 4.b.), Executive Order 26, 4.b. (a Executive Order 26, 4.b.) Executive Order 26, 4.b. and Executive Order 26, 4.b. medications), Executive Order 26, 4.b. (a medication used to treat Executive Order 26, 4.b., a Executive Order 26, 4.b. Executive Order 26, 4.b., Executive Order 26, 4.b. (a medication used with this resident to treat Executive Order 26, and Executive Order 2 (a Executive Ord Executive Order 26, medication). During further review of the medical record, the	F 756		

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F 756	Continued From page 16 surveyor noted that the last CP review of the resident's medications had been done on Executive Order 26, 4.b. There were no further CP reviews found for March April, May, June or July. After Executive Order 26, 4.b. the next CP review was completed in Executive Order 26, 4.b. 5. The surveyor reviewed the medical record of Resident Executive and observed the resident was receiving multiple medications that included Executive Order 26, 4.b. (medications to treat Executive Order 26, 4.b.), Executive Order 26 (used in the treatment of Executive Order 26, 4.b.), Executive Order 26, 4.b. (used with this resident to Executive Order 26, 4.b.), Executive Order 26, 4.b. (used to Executive Order 26, 4.b. Executive Order 26, 4.b. During further review of the medical record, the surveyor noted that the resident had been admitted to the facility on Executive Order 26, 4.b. The surveyor observed there had been no CP review of the resident's medication regimen upon admission or during the month of Executive Order 26 On 10/29/2020 at 9:20 the surveyor interviewed the Nursing Supervisor (NS) and the Director of Nursing (DON) regarding the absense of Consultant Pharmacist reviews. The Nursing Supervisor said "they (the CP group) weren't coming into the building due to covid so there probably is a big gap." The NS said a new CP company took over in August. The DON stated she had started working at the facility in September and she had not found anything from the CPs. The DON stated "I don't think they did any after March." When interviewed on 10/29/20 at 11:06 AM, the Regional Director (RD) stated there was no	F 756		

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F 756	Continued From page 17 system put in place to do the CP reviews electronically when they weren't coming into the facility. The surveyor reviewed the facility's policy "Pharmacy Services-Role of the Consultant Pharmacist", revised April 2019, which included "A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines." NJAC 8:39-29.3 (a)1	F 756		
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 record	F 812	f-tag 812	12/7/20

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F 812	Continued From page 18 review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 10/23/2020 from 8:26 to 9:13 AM the surveyor, accompanied by the Director of Dietary (DOD), observed the following in the kitchen: 1. In the emergency food supply room, a can of Executive Order 26, 4.b. (canned beans) on an upper shelf had a significant dent on the upper seam of the can. On interview the DOD stated "That should have been put with the dented cans." The DOD moved the can to the designated dented can area. 2. In the dry storage room on a lower shelf, a can of sliced apples had a significant dent on the upper seam. The DOD stated "That's no good it has a dented seam." The DOD moved the can of apples to the designated dented can area. In addition a 46 Fl oz can of 100% Tomato Juice on an upper shelf had significant dents on the lower and side seams. The DOD moved the can of tomato juice to the designated dented can area. 3. On a lower shelf of a multi-tiered rack in the dry storage room a can of Mashed Potatoes (powdered) was rusted on the lid and had no date or manufacturer use by date. The DOD stated "We had a leak from the pipe and it probably got water on it." The DOD threw the can of mashed potatoes in the trash. 4. In the meat freezer on an upper shelf a plastic style grocery bag contained 3 hot Italian sausage links. The sausage was exposed to the air as the	F 812	1. On 10/23/2020 the can of beans, can of sliced apples, can of 100% tomato juice were removed to the specific dented can area, and the can of mashed potatoes was thrown out immediately. The rest of the Store room was inspected for any other dented cans. None were found. All cans were checked for dates. The sausage links in question were immediately discarded and the rest of the freezer was checked for all frozen items to assure that they were properlty sealed and dated. A thermometer was immediately installed in the dessert refrigerator/white refrigerator. The other refrigerators/freezers were checked to assure that they all had thermometers. The October 2020 temperature log was reviewed and corrected with the proper temperatures logged. All other logs in the kitchen were examined to assure they were up to date. The exhaust fan above freezer number two and freezer number three were immediately cleaned. The rest of the kitchen was inspected to assure that there was no other dirty fans and/or equipment. 2. All residents have the potential to be affected by this deficient practice if food contents in dented cans are compromised, food not stored and dated properly, temperatures not monitored and soiled fans/equipment. This can potentially cause harm to the residents by causing foodborne illness. 3. On 10/24/2020,an in-service was done	

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F 812 Continued From page 19

sausage was uncovered and the bag was not sealed shut. The sausage was covered with ice crystals. The bag had no date or use by date. When interviewed, the DOD stated "They're from staff. I'm throwing them away." The sausage was thrown in the trash.

5. The surveyor was unable to find an internal thermometer in the dessert refrigerator/white refrigerator. When interviewed, the DOD stated "that should have a thermometer." The surveyor requested to see the October 2020 temperature logs for the refrigerators and freezers in the kitchen. The surveyor reviewed the "White Fridge Temperature Log Oct 2020 and observed no temperature had been recorded on 10/23 at breakfast time for the white refrigerator.

On 10/29/2020 from 10:00 to 10:32 AM the surveyor, accompanied by the Regional Director of Dietary (RDOD), observed the following in the kitchen:

1. The surveyor observed the wall mounted fan above reach-in freezer 2 and reach-in freezer 3. The fan had a black, unidentifiable, dust-like substance attached to the wire covering and on the fan blades. When interviewed at that time, the RDOD stated "That is supposed to be on our daily cleaning schedule. I am going to tell them to clean it and cover it up if they are not using it." The RDOD provide the surveyor with a copy of the "Dietary Aides Weekly/Daily Cleaning Schedule" and a copy of the "Cook Weekly/Daily Cleaning Schedule", both undated. The surveyor observed there was no dietary aide or cook assigned to clean the fan on a weekly/daily schedule.

F 812

by the Corporate Director with the Food service Director and all dietary staff on the Policy and procedure for dented cans and storage of these cans. The Corporate Director in-serviced the Food Service Director and all dietary staff on the policy and procedure for proper storage of frozen and refrigerated foods as well as the necessity of having thermometers visible in the refrigerator/freezer and logging temperatures. An in-service was done by the Corporate Director with the Food Service Directtor and dietary staff on the policy and procedure for keeping all kitchen equipment free of dust and debris.

4. The Food Service Director and the Administrator will inspect the kitchen storage area, temperature logs, and kitchen equipment daily to assure that these deficient practices do not reoccur ongoing. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.

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F 812	Continued From page 20 The surveyor reviewed the facility policy titled "Broadway Nutritional Services", undated. The policy included the following under the Frozen Food Items heading: "All frozen products will be left in original box that indicates the date of delivery. If product needs to be stored outside of the original box, product must be securely sealed and labeled with date open or date taken out of original box. No frozen item stored without original box will be held longer than 90 days." The policy also included the following under the heading "Canned Goods": "All canned items stored in the stock room will be dated when stock is delivered and put away. No canned items will be stored longer then (sic) one year of this date. 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." The Food Service Manager is responsible for providing a list of the dented cans that includes date it was received along with product brand to purchasing department. Once received from the purchasing department you will be notified to either throw out the product or return to the vendor." NJAC 8:39-17.2(g)	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		12/7/20

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F 867	Continued From page 21 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide documented evidence of Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings. This deficient practice was evidenced by the following: On 10/29/2020 at 12:00 PM the surveyor reviewed the QAA/QAPI plan and observed the facility was working on discrepancies with meal plan tickets and physician ordered diets. When interviewed at that time, the Director of Nursing (DON), who was new to the facility as of 9/1/2020, stated she found multiple errors in the dietary meal orders vs. the physician's orders. Upon further review the surveyor found no tracking, goals or performance measures identified in the documentation. In addition there were no audits completed of dietary orders and no documented evidence of corrective action put into place. At that time the Regional Director stated "We are behind because of the pandemic." When interviewed on 10/29/2020 at 12:12 PM, the DON stated "We are working on a lot of things but we have nothing formal in place right now. I have a list of audits I want the nurses to do and some plans in place, but nothing as formal as the one I gave you." On 10/30/2020 at 10:55 AM the surveyor interviewed the Administrator and the DON about QAA/QAPI quarterly meetings. The	F 867	F-tag 867 1. On 10/30/2020, the Regional Director in-serviced the Administrator and Director of Nurses on the regulation for QAA/QAPI. A QAPI meeting was scheduled for 11/17/2020. All department heads as well as the medical director and consultants were notified. 2. All residents have the potential to be affected by this deficient practice when QAPI/QAA meetings are not scheduled and resident issues are not addressed on a consistent basis. 3. All Department Heads were in-serviced by the Administrator on the QAPI policy and procedure. 4. The Administrator and Director of Nurses will ensure that QAPI/QAA meetings are scheduled each Quarter. The Administrator will provided notice to all consultants as to the time and date of the QAPI/QAA meeting as well as the current Medical Director. All findings will be discussed at the Quality Assurance meeting x 4 quarters.	

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F 867	Continued From page 22 Administrator, who was new to the facility as of 4/22/2020, stated the last quarterly meeting was July 15, 2020. The Administrator stated "There was no QAPI initiated at that time." The Administrator and the DON both stated they did not know if any QAPI meetings had been held or QAPI plans initiated prior to their employment with the facility. The DON stated she initiated the current QAPI on 10/22/2020 after she discovered the dietary orders were not accurate. When asked if the DON had knowledge of the regulation for the QAA/QAPI, the DON stated "I've printed the regulation out, but I haven't looked through the whole thing yet. I'm a little rusty on doing QAPI plans, it's been a while." NJAC 8:39-33.1 (a)(e)	F 867		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315149 (Y1)	A. Building B. Wing (Y2)	4/5/2021 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0576 Reg. # 483.10(g)(6)-(9) LSC	Correction Completed 11/23/2020	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 11/24/2020	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 11/19/2020
ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 11/23/2020	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 11/19/2020	ID Prefix F0867 Reg. # 483.75(g)(2)(ii) LSC	Correction Completed 11/19/2020
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/2/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO