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 _____	C 01/25/2024

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 Complaint #s: NJ: 161818, 163153, 163899, 164283, 165180, 165492, 165742, 168168, 168204, 168425, 168432, 168784, 168983, 168987, 169922, 169973, 169965, 169972, 170340, and 170605. Census: 100 Sample Size: 28 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. F610L Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 12/11/23, 12/12/23, 12/14/23, and 01/12/24, it was determined that the facility failed to a.) ensure resident safety by not initiating an investigation when visitors, on two different occasions, attempted to bring in alleged NJ EX Order: 264b1 into the facility, b.) conduct a complete and thorough investigation of a Resident to Resident abuse, c.) conduct a complete and thorough investigation of an incident of possible neglect, and d.) follow the facility's "Accidents/Incidents" policy. The deficient practices were identified for 5 of 7 residents (Resident #1, Resident #2, Resident #7, Resident #27, and Resident #28) reviewed for abuse. This placed Resident #27 and Resident #28, as well as all other residents at risk for drug abuse and/or overdose while at the facility, in an Immediate Jeopardy (IJ) situation. The Assistant	F 000		

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

Electronically Signed | 02/14/2024

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Director of Nursing (ADON) was notified of the IJ on [redacted] at 6:15 PM and was provided the IJ template. The IJ began on 01/06/24 and continued thru [redacted] when the facility implemented their Accidents/Incidents policy for Resident #27 and Resident #28.

The facility provided an acceptable Removal Plan on [redacted] at 3:16 PM. On 1/25/24, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on [redacted] at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

On 01/16/24, the facility implemented the Removal Plan, which included the following:
-On [redacted], investigations were initiated into Resident #27's and Resident #28's family members attempting to bring [redacted] into the facility on [redacted] 4.
-On [redacted], unusual occurrences reports were completed for Resident #27 and Resident #28 recording family members attempting to bring [redacted] into the facility on [redacted]
-On [redacted] Resident #27 and Resident #28's Care Plans (CP) were updated to address family members attempting to bring [redacted] into the facility.
-On [redacted], Resident #27 and Resident #28 were educated on facility [redacted] abuse policy. [redacted], the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Medical Director (MD) reviewed the Resident [redacted] Abuse and Resident with [redacted] policies.
-On [redacted] staff education was started on the Resident [redacted] Abuse and Resident with

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NJ EX Order. 264b1 policies.
-A new Rapid Response/Trigger Call policy was written and implemented to ensure proper reporting and timely investigation for unusual occurrences.
-On NJ EX Order. 264b1, staff education was stated on the Rapid Response/Trigger Call policy.

F657L

Based on interviews, medical records review, and review of other pertinent facility documentation on 12/11/23, 12/12/23, 12/14/23, 12/27/23, and 01/12/24, it was determined that the facility failed to a.) update, revise, and implement care plan (CP) interventions for a resident who had NJ EX Order. 264b1 incidents while at the facility. Resident #3, with a known history of NJ EX Order. 264b1 and NJ EX Order. 264b1, who on NJ EX Order. 264b1 23, and NJ EX Order. 264b1 3 exhibited NJ EX Order. 264b1 symptoms required NJ EX Order. 264b1 liquid NJ EX Order. 264b1 milligram (mg)/ NJ EX Order. 264b1 milliliter (ml) NJ EX Order. 264b1), a medication used to treat NJ EX Order. 264b1 in an emergency situation. The facility did not update the resident's CP or implement interventions to manage the resident's NJ EX Order. 264b1 abuse after Resident #3's NJ EX Order. 264b1 NJ EX Order. 264b1 and NJ EX Order. 264b1 incidents., b.) update, revise, and implement CP interventions for residents involved in a resident-to-resident abuse incident. The facility did not update the residents' CP or implement interventions to prevent further NJ EX Order. 264b1t abuse incidents., and c.) follow the facility's policy titled "Comprehensive Care Plan." The deficient practice was identified for 3 of 28 residents (Resident #1, Resident #2, and Resident #3) reviewed for CP.

This placed Resident #1, Resident #2, and

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Resident #3, as well as all other residents at risk for NJ EX Order. 264b1 and/or NJ EX Order. 264b1 and NJ EX Order. 264b1, in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on NJ EX Order. 264b1 at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 264b1 and continued thru NJ EX Order. 264b1 when the facility updated Resident #1, Resident #2, and Resident #3's CP with interventions that addressed the aforementioned incidents.

The facility provided an acceptable Removal Plan on NJ EX Order. 264b1 at 3:16 PM. On NJ EX Order. 264b1, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order. 264b1 at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

On NJ EX Order. 264b1 the facility implemented the Removal Plan, which included the following:

-On 01/17/24, Resident #3's CP was updated to include interventions that addressed the history of NJ EX Order. 264b1 while in the facility.
-On NJ EX Order. 264b1 Resident #1's CP was updated to include interventions on NJ EX Order. 264b1 altercations, specifically NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order. 264b1.
-On NJ EX Order. 264b1, Resident #2's CP was updated to include interventions on NJ EX Order. 264b1 altercations that addressed the potential for NJ EX Order. 264b1 and NJ EX Order. 264b1 by another resident.
-On NJ EX Order. 264b1, all members of the Interdisciplinary Team began education on the facility's

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"Comprehensive Care Plan" policy and the timely implementation of interventions for risk mitigation related to changes in resident condition, accident and incidents, and unusual occurrences.

F689L
Based on observations, interviews, medical records review, and review of other pertinent facility documentation on NJ EX Order. 264b1 and NJ EX Order. 264b1 it was determined that the facility failed to: a.) consistently monitor and/or supervise residents for safety to prevent NJ EX Order. 264b1 and/or NJ EX Order. 264b1 while at the facility. Resident #3, with a known history of NJ EX Order. 264b1 and NJ EX Order. 264b1, who on NJ EX Order. 264b1, and 0 NJ EX Order. 264b1 exhibited NJ EX Order. 264b1 symptoms required NJ EX Order. 264b1 NJ EX Order. 264b1 milligram (mg)/ NJ EX Order. 264b1 milliliter (ml) NJ EX Order. 264b1. This is a medication used to treat NJ EX Order. 264b1 in an emergency situation. The facility did not take steps to increase monitoring or implement interventions to manage the resident's NJ EX Order. 264b1 after Resident #3's NJ EX Order. 264b1 incidents. b.) follow the facility's policy titled "Resident NJ EX Order. 264b1 Policy," and c.) ensure resident safety by not consistently monitoring and/or supervising residents, with known history of NJ EX Order NJ EX Order. 264b1 in order to prevent NJ EX Order from entering the facility. The deficient practice was identified for 5 of 9 residents (Resident #3, Resident #23, Resident #24, Resident #25, and Resident #26) reviewed for NJ EX Order. 264b1.

This placed Resident #3, Resident #23, Resident #24, Resident #25, and Resident #26 as well as all other residents at risk for NJ EX Order. 264b1 and/or NJ EX Order. 264b1, in an Immediate Jeopardy (IJ)

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situation. The Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) were notified of the IJ on [redacted] at 6:54 PM and were provided the IJ template. The IJ began on [redacted] and continued thru [redacted], when the facility implemented their Resident NJ EX Order. 264b1 Policy.

The facility provided an acceptable Removal Plan on [redacted] at 2:10 PM. On [redacted], the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on [redacted] at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

On [redacted] the facility implemented the Removal Plan, which included the following:

-On [redacted], Resident #23 signed out of the facility "NJ EX Order. 264b1).
-On [redacted], the facility implemented 24-hour security service to secure safety of all residents. Duties to include but not limited to checking and searching any visitors' person and/or belongings coming in the facility for a visit with residents, daily rounds throughout facility three times per shift to ensure resident safety and checking any packages for any resident entering the facility to eliminate transmission of any NJ EX Order. 264b1 from entering facility.
-On [redacted], all residents' room were checked for any NJ EX Order. 264b1 . The [redacted] that were [redacted] were [redacted] or [redacted] by maintenance staff. Maintenance will check residents' room window [redacted] weekly to ensure that they are not being tampered with.

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-On [redacted] changes were made to the facility's [redacted] policy to aid in the elimination of transmission of any NJ EX Order. 264b1 that may occur during late nights outside [redacted] sessions. [redacted] sessions will now end at 11:00 PM and will be supervised by staff. Staff are responsible for identifying any signs or symptoms of NJ EX Order. 264b1 [redacted] and will immediately notify nursing. Nursing will notify administration and an investigation will begin to ensure residents' safety.
-On [redacted] Resident #3's was educated on the NJ EX Order. 264b1 or [redacted] Use Policy."
-On [redacted], Resident #3's Care Plan (CP) was updated, and the resident was placed on two-hour checks for NJ EX Order. 264b1.
-On [redacted], the Medical Director, LNHA and DON reviewed the "Resident NJ EX Order. 264b1," Resident with NJ EX Order. 264b1," and the "Resident Out on Pass" policies.
-On [redacted], all staff were immediately in-serviced on the "Resident NJ EX Order. 264b1 "Resident with NJ EX Order. 264b1," and the "Resident Out on Pass" policies.
-On [redacted], Resident #3's had their room checked for NJ EX Order. 264b1. No [redacted] was found as a result of the search.
-On [redacted] Resident #3's had their personal belongings and their person searched. No [redacted] was found as a result of the search.
-All residents with a history with NJ EX Order. 264b1 or who have [redacted] in the facility will have continuous supervised visits, new belongings (if given during visit) will be checked, and their person will also be checked upon resident going back into facility after visit.
-Any resident returning from OOP [out on pass] will be subject to the security screening listed within the security duties.

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F835L
Based on interviews, record review, and review of other pertinent facility documentation on NJ EX Order. 264b1 NJ EX Order. 264b1 and NJ EX Order. 264b1, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being, by failing to a.) consistently monitor and/or supervise residents, with known history of NJ EX Order. 264b1, to prevent NJ EX Order from entering the facility, and/or NJ EX Order. 264 incidents while in the facility, b.) ensure that the Resident NJ EX Order. 264b1 Abuse policy was implemented, c.) initiate and an investigation when visitors, on two different occasions attempted to bring allegedly NJ EX Or into the facility, d.) conduct a complete and thorough investigation of a NJ EX Order. 264b1 abuse and an incident of possible neglect, e.) ensure that residents' care plans were updated, revised, and that interventions were implemented for a resident, with a history of NJ EX Order. 264b1, who had NJ EX Order. 264b1 while at the facility and for residents involved in a NJ EX Order. 264b1 incident, f.) ensure that the facility-wide assessment addressed the resident population and identified the resources needed to provide the necessary care and services for residents admitted with a history of NJ EX Order. 264b1 and/or who NJ EX Order. 264b1 while at the facility, g.) ensure that the Quality Assessment and Performance Improvement (QAPI) committee develop and implement an action plan that addressed the concerns they identified, which were the NJ EX Order. 264b1 NJ EX Order. 264b1 at the facility and the NJ EX Order entering

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the building, and h.) report to the New Jersey Department of Health (NJDOH) incidents of resident NJ EX Order: 264b1 NJ EX Order. 264b1, and incidents where visitors attempted to bring illicit NJ EX Order. 264b1 into the facility.

This placed all residents at risk and in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on NJ EX Order. 264b1 at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 264b1 and continued thru NJ EX Order. 264b1 when the facility LNHA was replaced.

The facility provided an acceptable Removal Plan on NJ EX Order. 264b1 at 3:16 PM. On 1/25/24, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order. 264b1 at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

On NJ EX Order. 264b1, the facility implemented the Removal Plan, which included the following:
-On NJ EX Order. 264b1, the LNHA was replaced.
-On NJ EX Order. 264b1, the new LNHA was educated by the corporate supervisor on the roles and responsibilities of the LNHA and facility policy and procedures.

F838L
Based on interviews and review of pertinent facility documentation on NJ EX Order. 264b1, and NJ EX Order. 264b1, it was determined that the facility failed to: a.) ensure that the facility-wide assessment (FA) evaluated its resident population and b.) identify the resources needed to provide the necessary care

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and services required for residents admitted with a history of NJ EX Order. 264b1 and/or who overdose while at the facility.

This placed all residents with a history of NJ EX Order. 264b1, as well as all other residents at risk for NJ EX Order. 264b1 and/or NJ EX Order. 264b1 while at the facility, in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on NJ EX Order. 264b1 at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 264b1 and continued thru NJ EX Order. 264b1 when the facility reevaluated and revised the facility assessment to address the resident population with a history of NJ EX Order. 264b1 and NJ EX Or NJ EX Order. 264b1 while at the facility.

The facility provided an acceptable Removal Plan on NJNJ EX Order. 26 at 3:16 PM. On NJ EX Order. 26, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order. 264b1 at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

On NJ EX Order. 264b1, the facility implemented the Removal Plan, which included the following:
-On NJ EX Order. 264b1, the facility assessment was reevaluated and revised to include an evaluation of the care required by residents with NJ EX Order. 264b1 NJ EX Order disorder and residents with a history of NJ EX Order. 264b1.
-On NJ EX Order. 264b1, a Quality Assurance & Performance Improvement meeting was held, and the revised facility assessment was introduced and accepted.

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F865L
Based on interviews, record review, and review of the Quality Assessment and Performance Improvement (QAPI) on NJ EX Order. 264b1 , NJ EX Order. 264b1 and NJ EX OnOrder. 26, it was determined that the facility failed to ensure that the QAPI committee developed and implemented an action plan that addressed the concerns they identified for high-risk residents with a history of NJ EX Order. 264b1 , repeated NJNJ EX Order. 264b1 at the facility, and bringing NJ EX Order. 264b1 into the facility.

The facility was aware of NJ EX Order. 264b1 that happened at the facility and was aware of NJ EX Or NJ EX Order. 264b1 that were entering the facility and being used by residents. Specifically, the QAPI committee failed to develop an action plan that addressed the concerns identified, which were the repeated NJ EX Order. 264b1 at the facility and the NJ EX Order entering the building.

These deficient practices placed all residents with a history of substance abuse at risk for an Immediate Jeopardy situation. On NJ EX Order. 264, an Immediate Jeopardy (IJ) Federal citation was identified and reported to the facility's Assistant Director of Nursing (ADON) on NJ EX Order. 264b at 6:15 PM. The ADON was provided with the IJ template. The IJ began on NJ EX Order. 264b when the facility's QAPI committee held its first meeting after the initial NJ EX Order. 264b but failed to address the issues, and it continued through NJ EX Order. 264b when the facility had the QAPI meeting to address the issues.

The facility emailed an acceptable Removal Plan to the New Jersey Department of Health on

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F 000	Continued From page 11 NJ EX Order: 26450 at 3:16 PM. On 1/25/24, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order: 26450 at a level F for "no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. On NJ EX Order: 26450, a QAPI meeting was held, the QAPI Committee addressed the "Performance Improvement Project Plan," which included the facility's failure to initiate and execute comprehensive investigations of unusual occurrences, and failure to initiate and implement relevant, timely interventions for risk mitigation. According to the plan, the following steps are to be implemented: Unusual occurrences will be thoroughly investigated in a timely manner, leading to risk mitigation and improved outcomes. Creation and implementation of a new rapid response/ trigger call protocol to provide enhanced communication and real-time incident management. Timely implementation of risk mitigation strategies and care plan interventions. The facility also provided education on the QAPI program to all staff.	F 000		
F 610 SS=L	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		2/27/24

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F 610	Continued From page 12 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ 161818; 168784; 168987; 170340, and 170605 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on NJ EX Order. 264b1 3, and NJ EX Order. 264b1, it was determined that the facility failed to a.) ensure resident safety by not initiating an investigation when visitors, on two different occasions, attempted to bring alleged NJ EX Order. 264b1 into the facility, b.) conduct a complete and thorough investigation of a Resident-to Resident abuse, c.) conduct a complete and thorough investigation of incident of possible neglect, and d.) follow the facility's "Accidents/Incidents" policy. The deficient practices were identified for 5 of 9 residents (Resident #1, Resident #2, Resident #7, Resident #27, and Resident #28) reviewed for abuse. This placed #27 and Resident #28, as well as all other residents at risk for NJ EX Order. 264b1 and/or NJ EX Order. 264b1 while at the facility, in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on NJ EX Order. 264b1 at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 264b1 and continued thru NJ EX Order. 264b1 when the facility	F 610	F 610 Immediate Action 1. Investigations were initiated and completed for residents #27 and #28 on 1/16/24. 2. On NJ EX Order. 264b1, resident #27□s care plan was revised to include family attempt to bring NJ EX Order. 264b1 into the building on NJ EX Order. 26 3. Resident #27 NJ EX O was placed on a restricted visitor list on NJ EX Order. 4. Resident #28 On NJ EX Order. 26, resident #28□s care plan was revised to include family attempt to bring NJ EX Order. 264b1 into the building on NJ EX Order. 264 5. On NJ EX Order. 264b1, an interdisciplinary meeting was held to review occurrence and resident□s #27 and #28 was re-educated on facility policies/ Resident with NJ EX Order. 264b1 and NJ EX Order. 264b1 policy. 6. Resident #28 NJ EX Order was placed on a restricted visitor list on NJ EX Order. 26 7. Resident #2-On NJ EX Order. 264b1 care plan was revised to include a focus of potential for abuse related to NJ EX Order. 264b1 8. Resident # 2 had NJ EX Order prevention interventions added to care plan on NJ EX Order. 264b1	

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F 610	Continued From page 13 implemented their Accidents/Incidents policy for Resident #27 and Resident #28. The facility provided an acceptable Removal Plan on NJ EX Order. 264b1 at 3:16 PM. On 1/25/24, the Surveyors conducted a revisit to verify that the Removal Plan was implemented. The facility implemented the Removal Plan. So, the noncompliance remained on NJ EX Order. 264b1 as a level F for "no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy," On NJ EX Order. 264b1 the facility implemented the Removal Plan, which included the following: -On NJ EX Order. 264b1, investigations were initiated into Resident #27's and Resident #28's family members attempting to bring NJ EX Order. 264b1 into the facility on NJ EX Order. 264b1 -On NJ EX Order. 264b1, unusual occurrences reports were completed for Resident #27 and Resident #28 recording family members attempting to bring NJ EX Order. 264b1 into the facility on NJ EX Order. 264b1 -On NJ EX Order. 264b1 Resident #27 and Resident #28's Care Plans (CP) were updated to address family members attempting to bring NJ EX Order. 264b1 into the facility. -On NJ EX Order. 264b1 Resident #27 and Resident #28 were educated on facility NJ EX Order. 264b1 policy. -On NJ EX Order. 264b1 the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Medical Director (MD) reviewed the Resident NJ EX Order. 264b1 and Resident with NJ EX Order. 264b1 NJ EX Order. 264b1 policies. -On NJ EX Order. 264b1, staff education was started on the Resident NJ EX Order. 264b1 and Resident with NJ EX Order. 264b1 policies. -A new Rapid Response/Trigger Call policy was written and implemented to ensure proper	F 610	9. Resident #1 care plan was updated on NJ EX Order. 264 NJ EX Order. 264 to other residents. 10. Resident #1 care plan interventions were updated on NJ EX Order. 26 related to the potential to be NJ EX Order. 264 to other residents. 11. On 1/2/24, the licensed Nursing Home Administrator, Director of Nursing and Medical Director reviewed the Resident NJ EX Order. 264b1 Policy and Resident with NJ EX Order. 264b1 Policies. 12. A policy was written for rapid response/trigger calls on NJ EX Order. 264 to ensure proper reporting and timely investigation for unusual occurrences. 13. The staff was educated on the rapid response/trigger call policy on NJ EX Order. 264 14. Policy on Restricted Visitors was revised on 2/6/24. 15. Inservice education on New Restrictive Visitor Policy was initiated on 2/2/24 by DON/Designee to Security staff and to clinical staff and will be completed by 2/27/24. 16. Resident # 7 was transferred to the hospital on NJ EX Order. 264b1 NJ EX Order. 264 for further medical intervention. 17. RN #2 was terminated and no longer works at the facility. 18. Resident #7 care plan was updated on NJ EX Order. 264b1 with NJ EX O interventions. Identification of Others All residents residing in the facility have the potential to be affected by the deficient practice. Systemic Changes	

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F 610	Continued From page 14 reporting and timely investigation for unusual occurrences. -On [redacted], staff education was started on the Rapid Response/Trigger Call policy. The deficient Practice was evidenced by the following: Reviewed of the facility's undated policy titled, "Accidents/Incidents" indicated that it was the policy of the facility to provide a safe and healthful work environment and therefore all accident and incidents occurring on the premised must be reported to the administrator. The policy also indicated that the charge nurse and/or department director or supervisor must conduct an immediate investigation of the accident or incident. The following data must be included on the Accident and Investigation Report form to include: -Date and time the incident took place. -Circumstances surrounding the accident/incident. -Where the incident took place. -Names and any witnesses and their account of the accident/incident. -The injured person's account of the incident. -The date and time the injured person's next of kin was notified. -The condition of the injured person to include vital signs. -Corrective action taken. -Signature and title of the person preparing the report. -Investigative Report to be submitted to the DON no later than 12 hours after the occurrence. 1.) During an interview with the surveyor on	F 610	1. All accidents incidents, unusual occurrences, injuries of unknown origin will be documented on the 24-hour report. The 24-hour report will be reviewed by the IDT at the daily clinical meeting to ensure compliance with facility policy. 2. The accident/incident and unusual occurrence policy was revised. 3. Education by the DON/designee was started on 2/3/24 and will be completed on 2/27/24. 4. The Accident and Incident, Unusual Occurrence Tracker was implemented on [redacted] as a daily audit tool to check timely interventions of safety, risk mitigation strategies and care plan interventions and is brought daily to morning clinical meeting. 5. Education to the Interdisciplinary team and clinical line staff was started on 2/5/24 by DON/designee and focused on the incident report process and will be completed by 2/27/24. 6. [redacted] nursing assessment and intervention education was started on 1/24 by DON/designee and completed by 2/27/24. Quality assurance monitoring 1. The director of nursing/designee will audit weekly all alleged and actual incidents to ensure proper handling in accordance with facility policy and federal regulations. Negative audit results will be corrected immediately. Audit results will be reported to IDC team weekly and the full QAPI committee monthly x 6 months.	

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NJ EX Order. 264b1 at 11:22 AM, the Licensed Nursing Home Administrator (LNHA) stated that on Saturday, 01/06/24, he received calls from the security guard (SG) about family members attempting to bring NJ EX Order. 264b1 into the facility. The LNHA further stated that the SG informed him that while checking in family members, NJ EX Order. 264b1 were found in NJ EX Order. 264b1 being delivered to the residents. At which time, the LNHA confirmed that there had been two separate incidents on NJ EX Order. 264b1, where a family member attempted to drop off NJ EX Or NJ EX Order. 264b1 to the resident. The LNHA stated that one family member attempted to drop off a NJ EX Order for a resident. Upon inspection of the cereal box, the SG observed that the bottom of the cereal box had been opened and a package of NJ EX Order. 264b1 inserted inside. At that time, the SG confiscated the package of NJ EX Order. 264b1 The LNHA continued that another resident's family member attempted to drop off a NJ EX Order. 264b1 to the resident. Upon inspection of the bagel, the SG observed a NJ EX Order. 264b1 or some other NJ EX Order. 264b1, placed inside of the NJ EX Order with NJ EX Order. 264b1 At that time, the SG confiscated the NJ EX Order. 264b1 that was hidden inside of the NJ EX Order. 264b1. The LNHA stated that he instructed the SG to "stash away" the NJ EX Order. 264b1 in a lock box located at the reception area until his return to the facility on NJ EX Order. 264b1 He removed the NJ EX Order. 264b1 from the reception area on NJ EX Order. 264b1 and placed them in his office. The LNHA stated that he brought the NJ EX Order. 264b1 to the police station on NJ EX Order. 264 . He was provided a case number and was informed that the NJ EX Order. 264b1 were going to be destroyed. The surveyor asked why the NJ EX Order. 264b1 were not brought to the police station on NJ EX Order. 264b1 to which he responded,

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"No reason, I had got caught up with the day-to-day work and that it was secured in the office." The surveyor asked if the residents' family members had visited the facility before. The LNHA responded that he did not know and would have to double check with the SG. The surveyor then asked the LNHA for the residents' names that were supposed to receive the packages. The LNHA stated that he did not know "off head" the residents' names involved or if the aforementioned family members had previously visited the facility. The surveyor asked the LNHA to explain his investigation process into the [redacted] incidents. The LNHA stated that he was not sure if the SG had questioned the family members attempting to bring in the [redacted] and that the SG checked the bags per the new policy that had been implemented. The family members did not stay with the [redacted] and had just dropped them off and left. The LNHA further stated he had not followed up or spoken with the residents who were supposed to receive the [redacted] "The [redacted] were just confiscated." The surveyor asked if there was any other staff present during the [redacted] incidents to which the LNHA responded that he believed the evening receptionist (Receptionist #1) was present. The surveyor asked if the SG informed the manager or supervisor on duty that day about the confiscated [redacted] The LNHA responded that he was not sure if the SG relayed to the staff on duty that he found [redacted]. The LNHA continued that an incident report was not completed and that he did not initiate an internal investigation into the incidents. The LNHA continued that the [redacted] were confiscated, did not get back to the residents, and were brought to the police station. The LNHA explained the investigation

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process the facility followed for accidents/incidents. The LNHA explained that an 'Incident Report" would be completed and that he would gather all the facts. He would meet with the individuals involved, collect statements, and then a summary and conclusion would be completed. The LNHA stated that the purpose of this process was to try to curtail any issues and prevent it from happening again. The LNHA further stated that it was a first for him and that he never had to deal with [redacted] in a facility before. The surveyor asked who was responsible for completing the investigation of the aforementioned incidents. The LNHA responded that he was responsible for conducting the investigation.

The LNHA was unable to provide the any documentation about the [redacted] incidents.

During a telephone interview with the surveyor on 01/12/24 at 1:05 PM, Receptionist #1 stated that she did not work on [redacted] and that Receptionist #2 was on duty that day. Receptionist #1 stated she received the full report on the incidents. She stated that Resident #27's son brought in the [redacted] and Resident #28's [redacted] brought in the [redacted] on [redacted] Receptionist #1 further stated that Resident #27's [redacted] visited frequently and always brought "stuff" for the resident.

The surveyor attempted to call Receptionist #2 and left a voicemail the receptionist to call the surveyor back. The surveyor did not receive a return call.

During a telephone interview with the surveyor on [redacted] at 1:29 PM, the SG stated that, on

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, Resident #27's brought a package in for the resident that consisted of and The SG continued that he noticed that the resident's kept on pushing on the bottom of the . Upon inspection of the cereal box, the SG observed that the of the was open. He opened the and observed a package containing inside the The SG added that Resident #27's would normally wait to make sure the resident received the package, but that day dropped the package off and left. The SG and Receptionist #2 called the LNHA and informed him of the incident. The LNHA instructed him to lock the package of in the lock box located at the receptionist desk until his return on . The SG continued that on Resident #28 came to the door and informed him that his/her was coming to drop off and that he/she had twenty dollars to give to her. When the resident's came into the facility, she came with a " bag and indicated that brought Resident #28 a handed him the package and "bolted out" out of the facility. Upon inspection of the package, the SG stated that he noticed that the plastic wrapping on the was not sealed properly. He opened the bagel and observed possibly containing inside. He called the LNHA again to informed him of the incident and was instructed to lock the in the lock box located at the receptionist desk until his return on . He asked the LNHA if Resident #27's and Resident #28's would be placed on the "Do Not Visit" list (list) and the LNHA responded that they were going to place them on the list. The SG further stated that he did not write statements for the

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aforementioned incidents and that he explained the incidents to the LHNA over the phone that night.

Review of the "Restricted Visitors" sheet, provided by Receptionist #3 on [redacted] at 2:24 PM, did not include Resident #27's [redacted] and Resident #28's [redacted] names.

During an interview with the surveyor on 01/12/24 at 1:54 PM, the ADON stated that she heard about the [redacted] incidents "after the fact." The ADON stated that she heard "chatter" about [redacted] in a [redacted] but that they caught it. The ADON further stated that she had not heard anything about the NJ EX Order. 264b1 " incident. The ADON explained that the SG would converse with the LNHA, they would call the police, and the LNHA would go and speak with the residents involved. The ADON added that nursing really wasn't involve with the [redacted] incidents and that the packages did not enter the building. During that same interview, the DON stated she was not aware of the incidents and that she heard about the [redacted] incidents today, [redacted].

According to the Admission Record, Resident #27 was admitted to the facility in NJ EX Order. 264b1 with diagnoses that included but not limited to NJ EX Order. 264b1 [redacted].

Review of Resident #27's CP revealed a "Focus," initiated on [redacted], that Resident #27 had "a history of NJ EX Order. 264b1 and has potential for complications such as recurrence of [redacted] "

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During an interview with the surveyor on 01/12/24 at 2:38 PM, Resident #27 stated that he/she usually gets food delivered from family. Resident #27 added that he/she had [redacted] delivered to the facility, but they did not give it to him/her. Resident #27 further stated that he/she has had family deliver[redacted] to the facility and that it was only done one time.

According to the Admission Record, Resident #28 was initially admitted to the facility in [redacted] with diagnoses that included but not limited to [redacted].

Review of Resident #28's CP revealed a "Focus," initiated on [redacted] that Resident #28 had "a history of [redacted] and has potential for complications such as recurrence [redacted]

2.) According to the Face Sheet (FS), Resident #1 [redacted] was admitted to the facility with the diagnoses which included but not limited to, [redacted] The quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate resident care, dated [redacted], reflected that Resident #1 was [redacted] and scored a [redacted] on the Basic Interview for Mental Status (BIMS). The MDS also indicated that the resident had no behaviors and required supervision with activities of daily living (ADL's).

According to the FS, Resident #2 [redacted] was admitted to the facility with the diagnoses which included but not limited to, [redacted]

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NJ EX Order. 264b1. The annual MDS dated [redacted], reflected that the resident scored a [redacted] on the BIMS which indicated that resident was NJ EX Order. 264b1. The MDS also indicated that Resident #2 had no behaviors and required supervision with ADLs.

The surveyor reviewed the Facility Reportable Event (FRE) dated [redacted]. The FRE indicated that on [redacted], Resident #1 came into Resident #2's room and NJ EX Order. 264b1 the front of his/her NJ EX Order. 264b1 The residents were separated, and the police were notified. The FRE also indicated that Resident #1 was [redacted] by the police and was placed on [redacted].

The surveyor reviewed the facility Incident Report (IR) dated [redacted] at 09:00 AM, which indicated that Resident #1 [redacted] into Resident #2's [redacted] to take a [redacted]. According to the IR, the residents were separated, evaluated for injury (none noted), and the police were called. The IR also indicated that neither resident needed to go to the hospital.

The surveyor reviewed Resident #1's behavior progress note (PN) dated [redacted] at 09:31 AM, which indicated that the nurse was notified by another resident that Resident #1 NJ EX Order. 264b1 the front of Resident #2's [redacted] and took a [redacted] The note also indicated that the residents were separated, psychiatrist was notified to conduct an evaluation on the resident. The noted also reflected that [redacted] intervention was called the [redacted] center however the center was unable to assist because Resident #1 did not have a [redacted] diagnosis. The note also reflected that the resident was put on [redacted].

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The PN dated [redacted]3 at 07:59 AM, reflected a Psychiatric Progress Note (PPN) that the Resident #1 allegedly had inappropriate [redacted] with another resident and that when the [redacted] interviewed Resident #1, the resident stated that there was no [redacted] contact and that he/she only went to the other resident's room to retrieve a [redacted]. The note also indicated that the resident was put on [redacted] precaution for own [redacted] and others. The PPN reflected that the plan for Resident #1 was non-pharmacologic intervention to include [redacted]. The note also indicated that [redacted] precaution was no longer necessary at this time.

The surveyor reviewed Resident #2's PN dated [redacted] at 08:44 AM which indicated that the Resident #2 reported to the nurse that Resident #1 had went into his/her [redacted] and took a [redacted]. There was no further documentation that the resident was evaluated or that any further abuse preventions interventions were implemented on the resident's Care Plan.

On 12/11/23 at 10:05 AM, the surveyor interviewed Resident #1 who was sitting in his/her room in the wheelchair on the [redacted] Wing. The surveyor did not observe that the Resident #1 had behaviors at this time. The resident was calm and cooperative and stated that he/she was "ok". The surveyor attempted to conversate with the resident regarding the incident that occurred on [redacted], however the resident stated he/she did not want to discuss the incident with the surveyor.

On 12/11/23 at 10:10 AM, the surveyor interviewed Resident #1's Certified Nursing

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Assistant (CNA #1) who stated that Resident #1 fed himself/herself and could wash and dress independently. CNA #1 stated that Resident #1 moved from the [redacted] Wing to the [redacted] Wing because he/she was not getting along with others on the [redacted] Wing. CNA #1 stated that she was not sure what happened and that Resident #1 had no behaviors or incident since the move to the [redacted] Wing.

On 12/11/23 at 10:15 AM, the surveyor interviewed a Registered Nurse (RN #1) who stated that she had been employed in the facility for approximately [redacted]. The RN #1 explained that Resident #1 was [redacted] most times but had behaviors such as [redacted], not letting staff [redacted] his/her [redacted] m, and episodic behaviors such as [redacted] and becoming [redacted] with staff and other residents. She stated that the resident exhibited these behaviors [redacted] a week. She stated that she was not aware that the resident had any physical altercations while on the [redacted] Wing. She stated that Resident #1 had an incident with another resident on the [redacted] Wing but was not able to give specifics. RN #1 added that the resident could be easily redirected when exhibiting behaviors.

On 12/11/223 at 10:30 AM, the surveyor interviewed Resident #2 who stated that he/she felt "good". Resident #2 agreed to speak about the incident with Resident #1. The resident stated that they had no further interactions with Resident #1 and felt safe in the facility. Resident #2 further stated that Resident #1 was moved to another unit and did not see him/her much. The resident added that when he/she does see Resident #1, the resident continued to want to

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apologize to him/her. Resident #2 also stated that there had been no altercations with Resident #1 prior to this incident and that he/she had never known or seen Resident #1 have any altercations with any other resident in the facility. Resident #2 stated the facility handled the altercation well and that he/she felt safe living there. The resident stated that he/she was never physically injured and there was no need for any first aid. The care was good and he/she was doing well since the incident with the cell phone.

The surveyor reviewed a PN dated [redacted] at 6:04 PM which indicated that Resident #1 was on [redacted] precautions and was in his/her room watching television.

On 12/11/23 at 11:55 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #1) who documented a PN on [redacted] at 18:04 (06:04 PM). LPN clarified with the surveyor what she meant when she documented that Resident #1 was on [redacted] precautions". LPN #1 stated that it meant that the resident was on [redacted] minute checks. She also added that Resident #1 was [redacted] after the incident and that no further incident had occurred.

On 12/11/23 at 12:20 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who explained the investigative process regarding Resident-to-Resident abuse that the staff was to follow. The LNHA explained that if resident had an altercation with another the resident the residents were separated, rooms were changed, statements would be acquired by residents involved and staff statements going back 24 hours. He also stated that during the investigative

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process, interventions would be put in place and documented on the residents' CPs to include interventions to prevent further incident and to assure resident safety. The surveyor requested the investigation for the incident between Resident #1 and Resident #2 to include statements and interventions to prevent further reoccurrence on NJ EX Order. 264b1 and the LNHA stated that he would obtain any information pertaining to the incident and would provide to the surveyor.

On 12/13/23 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) who explained that if an incident occurred regarding NJ EX Order. 264b1 abuse, the residents would be separated, escorted back to their rooms, and assessed for injury. She continued to explain that statements would be obtained from the residents involved and reason why the incident happened. She stated that statements would also be obtained going back 1 shift from the nurse and CNAs. She stated that documentation would include NJ EX Order. 264b1, NJ EX Order. 264b1 if required. She also added that physician and family would be notified. She then confirmed that the resident's CP would be updated immediately following the incident. She stated that safety interventions would be implemented on the CP to prevent further reoccurrence.

The surveyor reviewed both Resident #1's and Resident #2's CPs and there was no mention of the incident, and no interventions were implemented regarding interventions to prevent further reoccurrence.

On 12/14/23 at 09:20 AM, the surveyor

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interviewed the DON who stated that she was not able to provide the full investigation related to the NJ EX Order. 264b1 altercation of [redacted]. The only documentation that the DON could provide was the incident/accident report.

On 12/14/23 at 09:25 AM, the surveyor interviewed LPN #2 who stated that the supervisor and the DON were responsible to obtain statements from the staff and residents regarding any NJ EX Order. 264b1 altercations. She also stated that the DON was responsible to conduct investigations and to update the CPs with new interventions to prevent reoccurrence.

On 12/14/23 at 10:52 AM, the surveyor interviewed that MDS Coordinator/Floor nurse (RN/MDSC) who stated that when there was a NJ EX Order. 264b1 t altercation in the facility, the nurse assigned to the residents was responsible to complete the incident accident report and would document the occurrence in the residents' medical record. She continued to explain that the DON was responsible for the investigations and to assure that the interventions were appropriate and implemented on the resident's CPs.

On 12/14/23 at 12:46 PM, the surveyor interviewed the LNHA who stated that he could not provide the investigation regarding the altercation with Resident #1 and Resident #2 on [redacted]. He stated that all incidents and accidents should be immediately reported to the LNHA. He stated that he could not speak to where the investigation was, as he was not the LNHA at the time the incident occurred. The LNHA also confirmed that there was no mention or documentation regarding the incident in either residents' CP. He also reviewed Resident #1 and

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Resident #2s CP, in the presence of the surveyor, and confirmed that the residents CPs were not updated to include new interventions to prevent reoccurance. The LNHA continued to explain that the nurse assigned to the resident was to initiate the investigation, however the LNHA/Designee were responsible to assure that the investigation was complete. He stated that a complete investigation would include statements, conclusion summary and implementation of safety interventions on the CP. He stated that safety interventions on the CPs main purpose was prevent recurrences of further altercations.

3.) On NJ EX Order. 264b1 at 10:05 AM, the surveyor observed Resident #7 lying in bed. The resident stated that on NJ EX Order. 264b1 he/she NJ EX O out of bed trying to NJ EX Or his/her wheelchair. The resident further stated that it took approximately NJ EX Order. 2 NJ EX Order. 264b1 for someone to come to his/her room after the NJ EX Or and when the nurse arrived, the nurse did not assess him/her or take vital signs. When asked about the resident's level of consciousness during the incident, the resident stated he/she was NJ EX Order. 264b1

According to the Admission Record, Resident #7 had diagnoses which included, but were not limited to, NJ EX Order. 264b1

Review of the significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ EX Order. 264b1, included the resident had a Brief Interview for Mental Status score of NJ EX Order. 264b1 which indicated the resident's NJ EX Order. 264b1 . Further review of the MDS included the resident had NJ EX Order. 264b1 to the NJ EX Order. 264b1 and was NJ EX Order. 264b1 on staff for NJ EX Order. 264b1.

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Review of the resident's Care Plan, revised [redacted] included focus areas that the resident had limited [redacted] and ADL (activities of daily living) care, was [redacted] towards others, and was a high risk for [redacted] related to [redacted]

Review of the Progress Notes included a nursing note written by Registered Nurse (RN) #2, dated [redacted] at 10:56 PM, which included that, "Around 7:30 pm, staff/CNA [Certified Nursing Assistant] reported found resident sitting on the floor close to bed side. Resident assessed noted [redacted], and [redacted] (name) and [redacted]. Assessed noted with no visible injury from f[redacted] assessment] noted with no deficit ...Vital sign noted ... [physician] notified with new order for ER [emergency room] visit. Paramedics came took resident to [hospital] ER for further evaluation at 8:10 pm."

Review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) by the Director of Nursing (DON), dated [redacted], included that, "On [redacted] approximately 7:30 PM, [Resident #7] was found on the floor in [his/her] room next to [his/her] bed. Informed also that resident was [redacted] with [redacted] 911 dispatched and physician made aware." Further review of the FRE included, "Facility wide in-service r/t [related to] prompt reporting of all accidents and incidents," and, "Attending nurse terminated."

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Included in the FRE submitted by the DON were witness statements from the following staff: CNA #2, CNA #3, Nurse Aide (NA), and Security. There were no statements from any staff nurse present during the incident.

Review of the witness statement written by CNA #2, dated [redacted], included, "On [redacted] y, [redacted] I [CNA #2] saw [Resident #7] about 5:15 on [his/her] bed. At around 7:30, [RN #2] said [Resident #7] never called for [his/her] 6:00 pm medications, so I said I was going to check on [Resident #7]. RN #2 told me, no he will go in at 8:00 pm, so I grabbed my co-worker [CNA #3] and we went down there. As soon as we opened the door, we saw [Resident #7] on the floor. I ran and got the nurses."

Review of the witness statement written by CNA #3, dated [redacted], included, "[CNA #2] came to me to ask me to come down to [Resident #7's] room to help check on [him/her]. We walked down and knocked and entered the room and saw [Resident #7] on the floor and immediately notified both nurses."

Review of the witness statement written by the NA, dated [redacted] included, "At approximately 7:15, [CNA #2] come finds me, says she needs my help to approach [Resident #7's] room to find [him/her] on the floor. I ask what happen, [he/she] says [he/she] had [redacted] I inform them to call the nurses before we touch [him/her] and [CNA #1] say [RN #2] has insisted we leave [him/her] there. As I get deeper into convo [conversation] I find out [RN #2] did not go to give [Resident #7] [his/her] 6:00 pm medicine, that he would at 8:00. As the incident is going on, I have to ask why 911 has yet to be called, it had been

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NJ EX Order. 264b1 to my knowledge that resident has been on the floor. The nurses inform us that they are waiting for a doctor. So I waited another NJ EX minutes and called [VP of Clinical Services], my boss, to inform her of the situation. Now the ambulance is called because I asked [Resident #7] if [he/she] wanted to go to hospital. Paramedics come and get the resident off the ground."

Review of the FRE submitted to the NJDOH by the VP of Clinical Services (VPCS), dated NJ EX Order. 264b1, for the same incident, included a statement from the VPCS.

Review of the VPCS' statement included, "On NJ EX Order. 264b1, NJ EX Order. 264b1 at approximately 7:55-8:00 pm, I received a call from [NA] at Sterling Manor Nursing Center, reporting that [Resident #7] was found on the floor in [his/her] room next to [his/her] bed. He reported that [Resident #7] 'NJ EX Order. 264b1 is NJ EX Order. 264b1 NJ EX Order. 264b1 [hospital].'"

Further review of the statement included, "I asked [NA] if the resident was still on the floor and he reported yes, that the nurse did not move the resident, and that the nurse was waiting to hear back from the doctor regarding sending [him/her] to the hospital. I informed the NA to stay with the resident and make sure [he/she] was comfortable. I asked the NA if the nurse had been in yet to do vital signs and he replied not yet. I informed the NA to keep me posted and we hung up."

Further review of the statement included, "Approximately NJEX minutes later, the NA called me back again. He informed me that he felt I

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should come to the facility and that the resident was still lying on the floor. I asked if 911 was called and he informed me that he was not sure, but that nobody still had come to the resident's room. He again stressed that the resident did not [redacted] and that [his/her] NJ EX Order. 264b1 [redacted] the resident. I informed the NA that I was already on my way and for 911 to be called if it had not already been."

Further review of the statement included, "I arrived at the facility around 8:30 pm and went to the resident's room. Resident was observed at this time laying on [his/her] [redacted] with [redacted] [Emergency Medical Services] were also at the bedside at this time ... Resident was [redacted]. I informed the EMS team that this was not resident's baseline and that [he/she] appears NJ EX Order. 264b1 obtained by facility staff nurse [LPN #3] ... Resident was then stabilized on the stretcher and transferred out of the facility to the hospital."

Further review of statement included, "Spoke with primary nurse [RN #2]. Reported that he called 911 and then notified the provider of the incident. States that earlier in the shift, resident was sleeping and that he had been planning on doing his next check around 8:00 pm, because he noticed the resident did not ask for [his/her] usual PRN [as needed] [redacted] medication at 6:00 pm."

The surveyor attempted to call CNA #2 and left a voicemail for the CNA to call the surveyor back. The surveyor did not receive a return call.

The surveyor attempted to call CNA #3, but the

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phone number was no longer in service.

During a phone interview with the surveyor on 12/13/23 at 10:38 AM, RN #2 stated that the day Resident #7 [redacted], CNA #2 found the resident on the floor and then notified him of the incident. The RN further stated that he went down to the resident's room, assessed the resident, called 911 because the resident was [redacted] and notified the physician. The RN added that he completed an incident report and gave a statement.

During a phone interview with the surveyor on 12/13/23 at 11:30 AM, the VPCS stated that the day Resident #7 [redacted], she received a phone call from the NA who was upset that the resident was on the floor and that he notified the nurse of the situation, but the nurse did not come to the resident's room. The VPCS further stated that when she arrived at the facility, EMS was already in the resident's room and she called LPN #3 down to the room to assist. VPCS added that after the resident was transferred onto the stretcher and transported to the hospital, RN #2 still had not come down to the resident's room. When asked if RN #2 wrote a witness statement, the VPCS stated he completed an incident report and wrote a nursing note in the resident's electronic medical record, but not a statement.

During a phone interview with the surveyor on 12/13/23 at 11:37 AM, the NA reiterated what he wrote in his witness statement and stated RN #2 never came to Resident #7's room to assess the resident after the [redacted]

Review of RN #2's Disciplinary Action Record, dated [redacted] included the RN was terminated

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because he "failed to fulfill duties required of him in a supervisory role during the 3-11 shift." Further review of the Disciplinary Action Record revealed RN #1 refused to sign the form and that it was witnessed by RN/MDSC and signed by the DON.

During an interview with the surveyor on 12/14/23 at 10:43 AM, RN/MDSC stated that it was alleged that RN #2 did not respond immediately to Resident #7's [redacted] and was therefore terminated. RN/MDSC further stated that when there is a resident incident, written statements should be obtained from any staff assigned to the resident or involved in the incident.

During a phone interview with the surveyor on 12/14/23 at 1:15 PM, LPN #3, who assisted during Resident #7's [redacted], stated that the day Resident #7 [redacted], she was not assigned to the resident. She further stated that RN #2 assessed the resident and called 911 while she obtained the resident's [redacted]. The LPN added that there was a lot of commotion at that time, and she went to the resident's room to try to help out as much as possible. When asked if the LPN completed a witness statement for the incident, she stated she was not instructed to provide a statement.

During an interview with the surveyor on 12/13/23 at 3:38 PM, the DON stated that when a resident [redacted], the [redacted] should be reported to the nurse assigned to the resident, the nurse should assess the resident to rule out injuries, notify the physician, and initiate the incident report which includes obtaining witness statements from staff assigned to the resident or who assisted in the incident. The DON further stated that the day

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F 610	Continued From page 34 Resident #7 NJEXS she was not involved in the investigation because the facility staff did not notify her of the incident. The DON added that the VPCS, who is the DON's immediate supervisor, was notified of the incident and therefore conducted the investigation. The DON then stated that she reviewed the completed investigation, along with the camera footage from the resident's hallway which ruled out any delay in the resident's care. When asked about the nurse statements related to the incident, the DON stated RN #2 and the LPN #3 did not provide written statements, but that they should have in order for the investigation to be considered complete. When asked about RN #2's termination, the DON stated that RN #2 was terminated for multiple instances of not notifying the DON of resident incidents. Review of the facility's Residents Rights to Freedom from Abuse, Neglect, and Exploitation policy and procedure, undated, included, "In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall: ... have evidence that all alleged violations are thoroughly investigated." The policy also indicated that altercations from resident to resident as a potential situation of abuse.	F 610		
F 657 SS=L	NJAC 8:39-27.1(a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		2/27/24

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F 657	Continued From page 35 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint # NJ 161818, 168784, and 168987. Based on interviews, medical records review, and review of other pertinent facility documentation on NJ EX Order. 264b1 it was determined that the facility failed to a.) update, revise, and implement care plan (CP) interventions for a resident who had NJ EX Order. 264b1 NJ EX Order. 264b1 incidents while at the facility. Resident #3, with a known history of NJ EX Order. 264b1 and NJ EX Order. 264b1 who on NJ EX Order. 264b1 and NJ EX Order. 264b1 exhibited overdose symptoms that required NJ EX Order. 264b1 milligram (mg)/ NJ EX O milliliter (ml) NJ EX Order. 264b1, a medication	F 657	F 657 Immediate action 1. Resident #3 had their care plan updated on 1 NJ EX Order. and NJ EX Order. 3 with NJ EX Order. 264b1 Prevention interventions which include: NJ EX Order. 26, discussed behavioral limits and expectations with Resident and be very clear. On NJ EX Order. 264 discussed with resident any instances that may lead to NJ EX Order. 264b1, NJ EX Order. 26, educate on effects of medication in NJ EX Order. 264b1, explore alternative methods NJ EX Order. 264b1. NJ EX Order. 26, notify MD if resident appears to	

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F 657	Continued From page 36 used to treat NJ EX Order. 264b1 in an emergency situation. The facility did not update the resident's CP or implement interventions to manage the resident's NJ EX Order. 264b1 after Resident #3's NJ EX Order. 264b1 incidents., b.) update, revise, and implement CP interventions for residents involved in a NJ EX Order. 264b1 abuse incident. The facility did not update the residents' CP or implement interventions to prevent further NJ EX Order. 264b1 t abuse incidents., and c.) follow the facility's policy titled "Comprehensive Care Plan." The deficient practice was identified for 3 of 28 residents (Resident #1, Resident #2, and Resident #3) reviewed for CP. The failure to follow their policy and proceedures for Comprehensive Care Plans for Resident #1, Resident #2, and Resident #3, as well as all other residents at risk for NJ EX Order. 264b1 and/or NJ EX Order. 264b1 and NJ EX Order. 264b1 t abuse was in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on NJ EX Order. 264b1 at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 26 and continued thru NJ EX Order. 264b1, when the facility updated Resident #1, Resident #2, and Resident #3's CP with interventions that addressed the aforementioned incidents. The facility provided an acceptable Removal Plan on NJ EX Order. 264b1 at 3:16 PM. On 1/25/24, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order. 264b1 at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.	F 657	NJ EX Order. 264b1 consults as needed. 2. Resident #2 had their care plan updated on NJ EX Order. 264b1 to include potential for abuse related to NJ EX Order. 264b1 3. Resident #1 had their care update for potential to be NJ EX Order. 264b1 to other residents on NJ EX Order. 264b1. 4. LPN #1 was provided education on 2/12/24 on the difference between contact precautions and NJ EX Order minute checks. 5. The LNHA notated in the 2567 is no longer employed at the facility effective NJ EX Order. 264b1 Identification of Others All residents residing in the facility have the potential to be affected by the deficient practice. Systemic changes 1. Changes in resident circumstances, condition, or accident and incidents will be reviewed in clinical meeting for timely care plan updating. When necessary, care plans will be updated in clinical meeting. 2. Clinical staff received education which started on 2/4/24 and will be completed by 2/27/24 regarding timely updating of care plans to address resident change in circumstance, condition or accident and incidents. 3. All accidents incidents, unusual occurrences, injuries of unknown origin will be documented on the 24-hour report. The 24-hour report will be reviewed by the IDT at the daily clinical meeting to ensure compliance with facility policy. 4. The accident/incident and unusual occurrence policy was revised.	

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F 657	Continued From page 37 On NJ EX Order. 264b1 the facility implemented the Removal Plan, which included the following: -On NJ EX Order. 264b1, Resident #3's CP was updated to include interventions that addressed the history of repeated NJ EX Order. 264b1 while in the facility. -On NJ EX Order. 264b1 Resident #1's CP was updated to include interventions on NJ EX Order. 264b1 altercations, specifically theft of property and uninvited NJ EX Order. 264b1. -On NJ EX Order. 264b1 Resident #2's CP was updated to include interventions on NJ EX Order. 264b1t altercations that addressed the potential for abuse related to NJ EX Order. 264b1 and NJ EX Order. 264b1 by another resident. -On NJ EX Order. 264b1, all members of the Interdisciplinary Team began education on the facility's "Comprehensive Care Plan" policy and the timely implementation of interventions for risk mitigation related to changes in resident condition, accident and incidents, and unusual occurrences. The deficient Practice was evidenced by the following: A review of the facility's undated "Comprehensive Care Plan" revealed under the "Procedure" section that "3. The interdisciplinary team must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. 4. The care must describe: -the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. -Identification of specific problems, and highly individualized interventions, to correct the problems. -Interventions will,	F 657	5. Education by the DON/designee was started on 2/4/24 and will be completed on 2/27/24 by DON/designee. 6. The Accident and Incident, Unusual Occurrence Tracker was implemented as a daily audit tool to check timely interventions of safety, risk mitigation strategies and care plan interventions and is brought daily to morning clinical meeting. 7. Education to the Interdisciplinary team and clinical line staff was started on 2/4/24by DON/designee and focused on the incident report process. Quality assurance monitoring 1. Care plans are reviewed daily in clinical meeting by DON/designee to ensure timely updating in response to resident change in circumstances, change in condition and/or accident/incidents. 2. DON/designee will audit weekly care plans related to change in circumstances, change in condition and/or accident/incidents. 3. Tracking tool for tracking monitoring will be completed by DON/designee will be completed weekly and reported to QAPI committee monthly x6 months for review and further recommendations. 4. The director of nursing/designee will audit all alleged and actual incidents to ensure proper handling in accordance with facility policy and federal regulations. Negative audit results will be corrected immediately. Audit results will be reported to the QAPI committee monthly x 6 months for review and further recommendations.	

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wherever possible, reflect the resident's preferences, interest and likes taken from the resident profile on the care plan."

1.) According to the Admission Record (AR), Resident #3 was readmitted to the facility in [redacted] with diagnoses that included but not limited to NJ EX Order. 264b1 [redacted]

Review of Resident #3's Order Summary Report (OSR), for active orders as of [redacted], revealed a physician order (PO), dated [redacted]. The PO instructed to administer one [redacted] alternating [redacted] every [redacted] hours as needed for NJ EX Order. 264b1. May repeat every [redacted]" minutes as needed.

Review of Resident #3's "Progress Notes" (PN) revealed a [redacted] "Nurses Note" (NN) completed by the Licensed Practical Nurse (LPN), that Resident #3 was [redacted]. The resident appeared not to have the NJ EX Order. 264b1 and was NJ EX Order. 264b1 when communicating. Resident #3 was administered [redacted] n at 4:43 PM with good effect. The resident "appeared to recover, became NJ EX Order. 264b1 but [redacted] and did not wish to discuss the matter further."

Review of the PN revealed a 09/21/23 NN that Resident #3 was brought to the nurses' station by the Certified Nurse Assistant (CNA). The resident was assessed by the LPN and noted to be "NJ EX Order. 264b1 [redacted], NJ EX Order. 264b1 [redacted] The LPN administered [redacted] mg NJ EX Order. 264b1 at

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4:43 AM and NJ EX Order. 264b1 was administered when Resident #3's NJ EX Order. 264b1 to NJ EX Order. 264b1. 911 was called and the resident was transferred to hospital for NJ EX Order. 264b1 NJ EX Order. 264b1

Review of the PN revealed a NJ EX Order. 264b1 NN that Resident #3 was lying NJ EX Order. 264b1 in bed with their NJ EX Order. 264b1. The resident was NJ EX Order. 264b1, and the nurse proceeded to do NJ EX Order. 264b1 with ineffective results. The nurse administered the NJ EX Order. 264b1 of NJ EX Order. 264b1 into NJ EX Order. 264b1 at 8:25 AM, with ineffective results. A NJ EX Order. 264b1 of NJ EX Order. 264b1 was administered into the NJ EX Order. 264b1 at 8:28 AM, with effective results. "At 8:31 AM, resident was NJ EX Order. 264b1 ... NJ EX Order. 264b1 minutes afterwards, at 8:56 AM, resident began to experience NJ EX Order. 264b1." The physician was informed, and the resident was sent to the hospital for further treatment.

Review of Resident #3's CP revealed a "Focus," revised on NJ EX Order. 264b1, that Resident #3 had "a history of NJ EX Order. 264b1 and has potential for complications such as NJ EX Order. 264b1 NJ EX Order. 264b1 [suspected] to be NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 administered and effective."

Under the "Interventions," section, revealed the following interventions:
-Administer medications as ordered and monitor side effects, initiated on NJ EX Order. 264b1
-Discuss behavioral limits and expectations with Resident #3 and be NJ EX Order. 264b1, initiated on NJ EX Order. 264b1
-Discuss with Resident #3 any issues which may lead to NJ EX Order. 264b1, initiated on NJ EX Order. 264b1.

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-Education on effects of medications in combination with alcohol, initiated on [redacted].
-Explore alternative methods [redacted] initiated on [redacted].
-Notify MD if observed to be [redacted], initiated on [redacted].
[redacted] consult as needed, initiated on [redacted]
-Administer [redacted] as per physician orders, initiated on [redacted]

Further review of the CP showed no revision or updates to Resident #3's CP for the [redacted] and [redacted] incidents.

During an interview with the surveyor on 12/14/23 at 9:25 AM, the Licensed Practical Nurse (LPN) #1 stated the Director of Nursing (DON) was responsible for conducting investigations and updating the resident's CPs with new interventions to prevent reoccurrence.

During an interview with the surveyor on 12/14/23 at 10:52 AM, the Minimum Data Set Coordinator (MDSC) stated that the DON was responsible for the investigations and to assure that the interventions were appropriate and implemented on the resident's CPs.

During an interview with the surveyor on 12/14/23 at 1:00 PM, the Licensed Nursing Home Administrator (LNHA) stated that Resident #3's [redacted] incidents should be addressed in the resident's CP. The LNHA added that the resident's CP should have been updated after each incident so that the entire team is informed of the incidents and for continuity of care.

During an interview with the surveyor on 12/14/23

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at 4:06 PM, the DON stated that Resident #3's CP should have been updated to address the resident's [redacted] incidents in order to paint a picture of what was going on with the resident. The DON further stated that she was "stretched thin" and that she should have updated the resident's CP.

2.) According to the Face Sheet (FS), Resident #1 [redacted] was admitted to the facility with the diagnoses which included but not limited to, NJ EX Order. 264b1 [redacted] The quarterly Minimum Data Set (MDS) an assessment tool utilized to facilitate resident care dated 1[redacted], reflected that Resident #1 was NJ EX Order. 264b1 and scored a [redacted] on the Basic Interview for Mental Status (BIMS). The MDS also indicated that the resident had no behaviors and required supervision with activities of daily living (ADL's).

According to the FS, Resident #2 [redacted] was admitted to the facility with the diagnoses which included but not limited to, NJ EX Order. 264b1 [redacted]. The annual MDS dated [redacted] reflected that the resident scored a [redacted] on the BIMS which indicated that resident was NJ EX Order. 264b1. The MDS also indicated that Resident #2 had no behaviors and required supervision with ADLs.

The surveyor reviewed the Facility Reportable Event (FRE) dated [redacted]. The FRE indicated that on [redacted], Resident #1 came into Resident #2's room and NJ EX Order. 264b1 the front of his/her [redacted] and stole a [redacted]. The residents were separated, and the police were notified. The FRE also indicated that Resident #1 was [redacted]

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the police and was placed on [redacted] monitoring.

The surveyor reviewed the facility Incident Report (IR) dated [redacted] at 09:00 AM, which indicated that Resident #1 [redacted] into Resident #2's [redacted] to take a [redacted]. According to the IR, the residents were separated, evaluated for injury (none noted), and called the police. The IR also indicated that neither resident needed to go to the hospital.

The surveyor reviewed Resident #1's behavior progress note (PN) dated [redacted] at 09:31 AM, which indicated that the nurse was notified by another resident that Resident #1 reached down the [redacted] of Resident #2's [redacted] and took a [redacted]. The note also indicated that the residents were separated, psychiatrist was notified to conduct and evaluation on the resident. The note also reflected that [redacted] intervention was called; however, the [redacted] was unable to assist because Resident #1 did not have a [redacted] diagnosis. The note also reflected that the resident was put on [redacted].

The PN dated [redacted] at 07:59 AM, reflected a Psychiatric Progress Note (PPN) that the Resident #1 allegedly had inappropriate [redacted] with another resident and that when the [redacted] interviewed Resident #1, the resident stated that there was no [redacted] and that he/she only went to the other resident's room to retrieve a [redacted]. The note also indicated that the resident was put on [redacted] precaution for own [redacted] and others. The PPN reflected that the plan for Resident #1 was non-pharmacologic intervention to include redirection, support/reassurance, comfort measures, [redacted] and family

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involvement. The note also indicated that [redacted] precaution was no longer necessary at this time.

The surveyor reviewed Resident #2's PN dated [redacted] at 08:44 AM which indicated that the Resident #2 reported to the nurse that Resident #1 had went into his/her [redacted] and took a [redacted]. There was no further documentation that the resident was evaluated or that any further abuse preventions interventions were implemented on the resident's Care Plan (CP).

On 12/11/23 at 10:05 AM, the surveyor interviewed Resident #1 who was sitting in his/her room in the wheelchair on the [redacted] Wing. The surveyor did not observe that the Resident #1 had behaviors at this time. The resident was calm and cooperative and stated that he/she was "ok". The surveyor attempted to talk with the resident regarding the incident that occurred on [redacted] however the resident stated he/she did not want to discuss the incident with the surveyor.

On 12/11/23 at 10:10 AM, the surveyor interviewed Resident #1's Certified Nursing Assistant (CNA #1) who stated that Resident #1 fed himself/herself and could wash and dress independently. CNA #1 stated that Resident #1 moved from the [redacted] Wing to the [redacted] Wing because he/she was not getting along with others on the [redacted] Wing. CNA #1 stated that she was not sure what happened, and that Resident #1 had no behaviors or incident since the move to the [redacted] Wing.

On 12/11/23 at 10:15 AM, the surveyor interviewed a Registered Nurse (RN #1) who stated that she had been employed in the facility for approximately one year. The RN #1 explained

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that Resident #1 was calm, pleasant most times but had behaviors such as [redacted], not [redacted] his/her room, and episodic behaviors such as [redacted] with staff and other residents. She stated that the resident exhibited these behaviors [redacted] s a week. She stated that she was not aware that the resident had any physical altercations while on the [redacted] Wing. She stated that Resident #1 had an incident with another resident on the [redacted] Wing but was not able to give specifics. RN #1 added that the resident could be easily redirected when exhibiting behaviors.

On 12/11/23 at 10:30 AM, the surveyor interviewed Resident #2 who stated that she felt "good". Resident #2 agreed to speak about the incident with Resident #1. The resident stated that they had no further interactions with Resident #1 and felt safe in the facility. Resident #2 further stated that Resident #1 was moved to another unit and did not see him/her much. The resident added that when she/he does see Resident #1, the resident continued to want to apologize to him/her. Resident #2 also stated that there had been no altercations with Resident #1 prior to this incident and that he/she never known or seen Resident #1 have any altercations with any other resident in the facility. Resident #2 stated the facility handled the altercation well and that he/she felt safe living there. The resident stated that he/she was never physically injured and there was no need for any first aid. The care was good, and he/she was doing well since the incident with the cell phone.

The surveyor reviewed a PN dated [redacted] at 6:04 PM which indicated that Resident #1 was on

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contact precautions and was in his/her room watching television.

On 12/11/23 at 11:55 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #1) who documented a the PN on [redacted] at 18:04 (06:04 PM). LPN clarified with the surveyor what she meant when she documented that Resident #1 was on [redacted] precautions". LPN #1 stated that it meant that the resident was on [redacted]. She also added that Resident #1 was arrested after the incident and that no further incident had occurred.

On 12/11/23 at 12:20 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who explained the investigative process regarding NJ EX Order. 264b1 abuse that the staff was to follow. The LNHA explained that if resident had an altercation with another the resident the residents were separated, rooms were changed, statements would be acquired by residents involved and staff statements going back 24 hours. He also stated that during the investigative process interventions would be put in place and documented on the residents CPs to include interventions to prevent further incident and to assure resident safety. The surveyor requested the investigation for the incident between Resident #1 and Resident #2 to include statements and interventions to prevent further reoccurrence on [redacted] and the LNHA stated that he would obtain any information pertaining to the incident and would provide to the surveyor.

On 12/13/23 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) explained that if an incident occurred regarding

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resident-to-resident abuse, the residents would be separated, escorted back to their rooms, and assessed for injury. She continued to explain that statements would be obtained from the residents involved and reason why the incident happened. She stated that statement would also be obtained going back 1 shift from the nurse and CNAs. She stated that documentation would include [redacted] if required. She also added that physician and family would be notified. She then confirmed that the resident's CP would be updated immediately following the incident. She stated that safety interventions would be implemented on the CP to prevent further reoccurrence.

The surveyor reviewed both Resident #1's and Resident #2's CPs and there was no mention of the incident, and no interventions were implemented regarding interventions to prevent further reoccurrence.

On 12/14/23 at 09:20 AM, the surveyor interviewed the DON who stated that she was not able to provide the full investigation related to the NJ EX Order. 264b1 altercation of [redacted]. The only documentation that the DON could provide was the incident/accident report.

On 12/14/23 at 09:25 AM, the surveyor interviewed LPN #2 who stated that the supervisor and the DON were responsible to obtain statements from the staff and resident regarding any NJ EX Order. 264b1 altercations. She also stated that the DON was responsible to conduct investigations and to update the CPs with new interventions to prevent reoccurrence.

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F 657	Continued From page 47 On 12/14/23 at 10:52 AM, the surveyor interviewed that MDS Coordinator/Floor nurse (RN/MDSC) who stated that when there was a NJ EX Order. 264b1 altercation in the facility, the nurse assigned to the residents was responsible to complete the incident accident report and would document the occurrence in the residents' medical record. She continued to explain that the DON was responsible for the investigations and to assure that the interventions were appropriate and implemented on the resident's CPs. On 12/14/23 at 12:46 PM, the surveyor interviewed the LNHA who stated that he could not provide the investigation regarding the altercation with Resident #1 and Resident #2 on NJ EX Order. 264b1 He stated that all incidents and accidents should be immediately reported to the LNHA. He stated that he could not speak to where the investigation was, as he was not the LNHA at the time the incident occurred. The LNHA also confirmed that there was no mention or documentation regarding the incident in either residents' CP. He also reviewed Resident #1 and Resident #2s CP, in the presence of the surveyor, and confirmed that the residents CPs were not updated to include new interventions to prevent reoccurance. The LNHA continued to explain that the nurse assigned to the resident was to initiate the investigation, however the LNHA/Designee were responsible to assure that the investigation was complete. He stated that a complete investigation would include statements, conclusion summary and implementation of safety interventions on the CP. He stated that safety interventions on the CPs main purpose was prevent recurrences of further altercations.	F 657		

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F 657	Continued From page 48 NJAC 8:39-11.1	F 657		
F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # NJ 161818; 168784; 168987; 170340, 170340, and 170605 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on NJ EX Order. 264b1 [redacted], and NJ EX Order. 264b1 it was determined that the facility failed to: a.) consistently monitor and/or supervise residents for safety to prevent NJ EX Order. 264b1 and/or NJ EX Order. 264b1 while at the facility. Resident #3, with a known history of NJ EX Order. 264b1, who on NJ EX Order. 264b1 exhibited NJ EX Order. 264b1 symptoms required NJ EX Order. 264b1 liquid [redacted] milligram ([redacted] milliliter (ml) NJ EX Order. 264b1 This medication is used to treat NJ EX Order. 264b1 in an emergency situation. The facility did not take steps to increase monitoring or implement interventions to manage the resident's NJ EX Order. 264b1 after Resident #3's NJ EX Order. 264b1, and NJ EX Order. 264b1 incidents. b.) follow the facility's policy titled "Resident	F 689	F 689 Immediate Action 1. The resident NJ EX Order. 264b1 policy was reviewed and revised on 1/20/24. 2. Staff and resident education were initiated on the NJ EX Order. 264b1 policy on 1/20/24 by the DON/designee and will be completed by 2/27/24. 3. Resident #3 was reassessed for risk of NJ EX Order. 264b1 in the facility on 2/15/24. Changes to care plan include: NJ EX Order. 264b1 risk NJ EX Order. 264b1 assessment completed. Staff to be observant for changes in mental status or s/s of NJ EX Order. 264b1 such as: NJ EX Order. 264b1 [redacted] do not leave along. Remain with resident until no longer at risk for NJ EX Order. 264b1. 4. Resident #3 Interventions on care plan were updated on NJ EX Order. 264b1 [redacted] related to NJ EX Order. 264b1	2/27/24

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F 689	Continued From page 49 NJ EX Order. 264b1 Policy," and c.) ensure resident safety by not consistently monitoring and/or supervising residents, with known history of [redacted], in order to prevent [redacted] from entering the facility. The deficient practice was identified for 5 of 9 residents (Resident #3, Resident #23, Resident #24, Resident #25, and Resident #26) reviewed for NJ EX Order. 264b1 This placed Resident #3, #23, #24 #25 and Resident #26, as well as all other residents at risk for NJ EX Order. 264b1 and/or [redacted]e, in an Immediate Jeopardy (IJ) situation. The Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) were notified of the IJ on [redacted] at 6:54 PM and were provided the IJ template. The IJ began on [redacted] and continued thru [redacted], when the facility implemented their Resident NJ EX Order. 264b1 Policy. The facility provided an acceptable Removal Plan on [redacted] at 2:10 PM. On 1/4/24, the surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on [redacted] at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. On [redacted], the facility implemented the Removal Plan, which included the following: -On [redacted], Resident #23 signed out of the facility "NJ EX Order. 264b1 ". -On [redacted] the facility implemented 24-hour security service to secure safety of all residents. Duties to include but not limited to checking and searching any visitors' person and/or belongings coming in the facility for a visit with residents,	F 689	5. Incident reports were completed for Resident #3 on the [redacted] (completed on NJ EX Order. 264b1 (completed on [redacted] and [redacted] (completed on [redacted] related to [redacted] incidents. 6. A policy was written for Incoming Parcel Search on 1/30/24. 7. Staff and resident education was initiated on the Incoming Parcel Search on 2/6/24 by the DON/designee and will be completed by 2/27/24. 8. A new policy was written on 2/6/24 regarding the ability to search new admission belongings of residents with NJ EX Order. 264b1 diagnosis. 9. A town Hall meeting will be held on 2/19/24 to advise residents on the updated policy changes. 10. [redacted] resident #23 was discharged [redacted]. 11. The Out on Pass and OOP with responsibility policies were revised on 2/2/24. 12. On [redacted], each resident was assessed by the interdisciplinary team including the Medical Director and all residents out on pass orders were updated to reflect their current status and documentation added to medical record. 13. All updated policies were added to the admission packet to initiate with new residents. 14. Security times were changed to reflect 24-hour coverage on 12/27/23. 15. The security policy was updated to reflect that security keeps a log of all occurrences. 16. Resident #24 was reassessed for risk of NJ EX Order. 264b1 in the facility on 2/15/24.	

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F 689	Continued From page 50 daily rounds throughout facility three times per shift to ensure resident safety and checking any packages for any resident entering the facility to eliminate transmission of any NJ EX Order. 264b1 from entering facility. -On 12/27/23, all residents' room were checked for any NJ EX Order. 264b1. The NJ EX Order. 264b1 that were NJ EX Order. 264b1 were repaired or replaced by maintenance staff. Maintenance will check residents' room NJ EX Order. 264b1 weekly to ensure that they are not being tampered with. -On NJ EX Order. 264b1 changes were made to the facility's NJ EX Order. 264b1 policy to aid in the elimination of transmission of any NJ EX Order. 264b1 that may occur during late nights outside NJ EX Order. 264b1 sessions. NJ EX Order. 264b1 sessions will now end at 11:00 PM and will be supervised by staff. Staff are responsible for identifying any signs or symptoms of NJ EX Order. 264b1 or possible NJ EX Order. 264b1 s and will immediately notify nursing. Nursing will notify administration and an investigation will begin to ensure residents' safety. -On NJ EX Order. 264b1, Resident #3's was educated on the 'NJ EX Order. 264b1 or NJ EX Order. 264b1 Policy." -On NJ EX Order. 264b1 Resident #3's Care Plan (CP) was updated, and the resident was placed on NJ EX Order. 264b1 for NJ EX Order. 264b1. -On NJ EX Order. 264b1, the Medical Director, LNHA and DON reviewed the "Resident NJ EX Order. 264b1 Resident with NJ EX Order. 264b1," and the "Resident Out on Pass" policies. -On NJ EX Order. 264b1, all staff were immediately in-serviced on the "Resident NJ EX Order. 264b1," Resident with NJ EX Order. 264b1," and the "Resident Out on Pass" policies. -On NJ EX Order. 264b1, Resident #3's had their room checked for NJ EX Order. 264b1. No NJ EX Order. 264b1 was found as a result of the search. -On NJ EX Order. 264b1, Resident #3's had the personal	F 689	17. Resident #24 investigation completed on 2/16/24. 18. Resident #24 Interventions on care plan were updated on 12/27/23 related to NJ EX Order. 264b1 19. Resident #25 investigation was completed on 2/16/24. 20. Resident #25 was reassessed for risk NJ EX Order. 264b1 in the facility, by the DON, on 2/16/24. 21. A standardized tool for substance use assessment was implemented and DON/designee provided education to clinical staff on 2/17/24 on how to administer assessment and will be. Completed by 2/27/24. 22. Resident #26 was discharged on NJ EX Order. 264b1. Identification of Others 1. All residents residing in the facility have the potential to be affected by the deficient practice. Systemic changes 1. Policies for Out on Pass Restricted Visitors, Incoming Parcel Search, Resident Room and Personal Belonging Search, Resident with NJ EX Order. 264b1 Policy and the Facility NJ EX Order. 264b1 Policy were revised. 2. Don/Designee revised and educated on the incident management policy on 2/4/24. 3. DON/Designee, revised and educated on the Rapid Response and Trigger Policy on 1/20/24. 4. DON/designee will review and track daily- Accident and Incident events via the Incident/accident/unusual occurrence	

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F 689	Continued From page 51 belongings and their person searched. No NJ EX Order. 264b1 was found as a result of the search. -All residents with a history with substance abuse or who have NJ EX Order. 264b1 in the facility will have continuous supervised visits, new belongings (if given during visit) will be checked, and their person will also be checked upon resident going back into facility after visit. -Any resident returning from OOP [out on pass] will be subject to the security screening listed within the security duties. This deficient practice was evidenced by the following: Review of the facility's undated "Resident NJ EX Order. 264b1 Policy" indicated that "Sterling Manor Nursing Center is a NJ EX Order. 264b1 environment and has policies in place to ensure the safety and well-being of all residents. The facility's NJ EX Order. 264b1 policy prohibits residents from using or being in NJ EX Order. 264b1 and/or NJ EX Order. 264b1. Residents note to be in possession of NJ EX Order. 264b1, or related NJ EX Order. 264b1, or those suspected of being NJ EX Order. 264b1 NJ EX Order. 264b1, may be subject to the following actions, as deemed appropriate by the IDC [interdisciplinary care] Team: 1. Report to the local or state police. 2. Restricted from going out on pass independently, or at all. 3. Take a NJ EX Order. 264b1 test. If a resident who is suspected, refuses to be tested, the resident will be advised that one or more of the below ramifications will occur. 4. Room search in the presence of the resident. 5. Supervised or restricted visitations. 6. Deliveries may be opened by facility staff in the presence of the resident. 7. Placed on increased staff supervision. 8. Discharged from the facility. The resident will be educated on the ill effects of	F 689	tracker. Quality monitoring 1. The director of nursing/designee will bring results of the daily monitoring to the Quality Assurance Process Improvement committee. Monthly x 6 months for review and further recommendations.	

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NJ EX Order. 264b1, as well as the interactions that may occur with the residents other medication and offer NA/AA support services. The resident will be assessed by te nurse the attending physician will called to hold all NJ EX Order. 264b1 for a 24-hour period and or have all NJ EX Order. 264b1 discontinued."

1. According to the Admission Record (AR), Resident #3 was admitted to the facility in NJ EX Order. NJ EX Order with diagnoses that included but not limited to NJ EX Order. 264b1 .

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ EX Order. 264b1, revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of NJ EX Order which indicated the resident had NJ EX Order. 264b1. The MDS also indicated Resident #3 required supervision to limited assistance for Activities of Daily Living (ADLs).

Review of Resident #3's physician "Order Summary Report (OSR)," for active orders as of NJ EX Order. 264b1, revealed the following physician orders:
1. A physician order, dated NJ EX Order. 264b1, that Resident #3 NJ EX Order. 264b1
2. A physician order, dated NJ EX Order. 264b1, NJ EX Order. 264b1 NJ EX Order. 264b1, NJ EX Order. 264b1 every NJ EX Order hours as needed for opioid overdose. May repeat every NJ EX Order minutes as needed.
3. A physician order, dated NJ EX Order. 264b1, for NJ EX Order. 264b1 a medication used to NJ EX Order. 264b1

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NJ EX Order. 264b1) NJ EX Order. 264b1 and to administer NJ EX Order [for total of NJ EX Order. 264b1 one time a day for NJ EX Order. 264b1 NJ EX Order. 2

Review of Resident #3's Progress Notes (PN), revealed a NJ EX Order. 264b1 at 11:08 PM "Nurses Note" (NN), written by the Licensed Practical Nurse (LPN), that at around 4:30 PM Resident #3 was NJ EX Order. 264b1 The resident was NJ EX Order. 264b1 what happened and was repeatedly asked with no effect. Resident #3 was administered NJ EX Order. 26 at 4:43 PM with good effect. The resident "appeared to NJ EX Order. 264b1 and did not wish to discuss the matter further."

Review of the NJ EX Order. 264b1 untitled document, digitally signed on NJ EX Order. 264b1 at 4:37 PM by the Nurse Practitioner (NP), revealed that Resident #3 was noted to have NJ EX Order. 264b1 yesterday NJ EX Order. 264b1 and was given NJ EX Order. 264 times two with good response. "[Resident #3] reports using a NJ EX Order. 264b1 ." Under the "Assessment and Plan" section revealed that the NP "spoke with patient regarding NJ EX Order. 264b1 use. [Resident #3] was not aware of what [he/she] NJ EX Order. 264b reviewed facility policy NJ EX Order. 264 ."

Review of the resident's "Lab Note," written by the Director of Nursing (DON), with the effective date of NJ EX Order. 264b1 at 1:02 PM, revealed that the "MD [physician] reviewed with no new orders at this time, resident will continue to be supported by the NJ EX Order. 264b1 director as needed and as appropriate."

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Review of Resident #3's PN, revealed a NJ EX Order. 264b1 at 5:09 PM NN, written by the LPN, that Resident #3 was received from another resident's room NJ EX Order. 264b1 by the Certified Nurse Aide (CNA). The resident was brought to the nursing station. The resident was assessed and noted as being NJ EX Order. 264b1. Resident #3's eyes were NJ EX Order. 264b1, and then NJ EX Order. 264b1 of his/her NJ EX Order. 264b1) was performed but the nurse received no response. NJ EX Order. 264b1 was administered at 4:40AM and 4:43AM. Resident #3's respiratory NJ EX Order. 264b1) and another dose of NJ EX Order. 264b1 was administered. 911 was called and the resident was transferred to hospital for accidental NJ EX Order. 264b1.

Further review of Resident #3's PN revealed that the resident returned to the facility from the hospital on NJ EX Order. 264b1 3, with a diagnosis of 'NJ EX Order. 264b1."

Review of Resident #3's NJ EX Order. 264b1 Panel, NJ EX Order. 264b1" lab results, completed at the hospital, revealed that the resident NJ EX Order. 264b1 for b NJ EX Order. 264b1 (a class of drugs that produce NJ EX Order. 264b1), NJ EX Order. 264b1 l), NJ EX Order. 264b1 (medication used to treat NJ EX Order. 264b1 r), and NJ EX Order. 264b1 used to treat NJ EX Order. 264b1).

Review of Resident #3's PN, revealed a NJ EX Order. 264b1 at 9:00 AM NN, written by the LPN, that at 8:21 AM, she was notified by CNA that the resident needed to be seen because he/she did not appear to look okay. Resident #3 was observed

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lying on their NJ EX Order. 264b1 NJ EX Order. 264b1. The resident was NJ EX Order. 264b1 results. The nurse administered NJ EX Order. 264b1 mg at 8:25 AM with ineffective results. A second dose of NJ EX Order. 264b1 mg was administered at 8:28 AM and was effective after NJ EX Order minutes. At 8:31 AM, Resident #3 was NJ EX Order. 264b1 to staff and at 8:56 AM, the resident began to experience NJ EX Order. 264b1 The resident's physician was informed, and Resident #3 was transferred to the hospital for further treatment.

Further review of Resident #3's PN revealed that the resident returned to the facility from the hospital on NJ EX Order. 264b1 with a diagnosis of NJ EX Order. and NJ EX Order. 264b1."

Review of Resident #3's NJ EX Order. 264b1 hospital "After Visit Summary" revealed that the reason for the visit was "NJ EX Order. 264b1" and the resident's diagnoses were NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1"

Review of Resident #3's PN from NJ EX Order. 264b1 to NJ EX Order. 264b1 revealed no documentation that Resident #3 was reassessed for the risk for NJ EX Order. 264b1 in the facility. The PN also did not revealed any documentation of interventions implemented to prevent Resident #3 NJ EX Order. 264b1 after the NJ ENJ EX Order. 264b1 overdose incidents.

Review of Resident #3's CP revealed a "Focus," revised on NJ EX Order. 264b1, that Resident #3 had "a history of NJ EX Order. 264b1 and has potential for NJ EX Order. 264b1 NJ EX Order. 264b1 and/or NJ EX Order. 264b1. NJ EX Order. 26 [suspected] to be under the NJ EX Order. 264b1 administered and effective."

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Under the "Interventions," section, revealed the following interventions:
-Administer medications as ordered and monitor side effects, initiated on [redacted]
-Discuss behavioral limits and expectations with Resident #3 and be very clear, initiated on 0[redacted]
-Discuss with Resident #3 any issues which may lead to [redacted]e, initiated on [redacted]
-Education on effects of medications in combination with [redacted] initiated on 0[redacted]
-Explore alternative methods [redacted], initiated on [redacted]
-Notify MD if observed to [redacted], initiated on [redacted]
[redacted] consult as needed, initiated on [redacted]
-Administer [redacted] as per physician orders, initiated on [redacted].

Further review of Resident #3's CP showed no evidence that the facility implemented interventions to prevent Resident #3 [redacted] while in the facility. The CP also did not reveal any interventions for increased monitoring when Resident #3's [redacted] was [redacted] and/or [redacted].

During an interview with the surveyor on 12/11/23 at 1:51 PM, the DON stated that she could not find any incident reports for Resident 3's [redacted], and [redacted] incidents. The DON further stated that she would double check and follow up with the surveyor.

During a follow-up interview with the surveyor on 12/12/23 at 10:50 AM, the DON stated they did

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not complete an incident report for Resident #3's NJ EX Order. 264b1 Jer. 264b1 incidents. The surveyor asked how the facility investigated the incidents. The DON stated that she asked the resident where they got the NJ EX Order. and that the resident would not tell them anything about the persons supplying them. Resident #3 also would not allow them to search their belongings or room. The DON added that they try to put in modifications that are safe for the resident but there is a delicate line. The DON stated that the residents have rights, and they have the right to refuse. The DON continued that, if a resident refuses, they could not go through the resident's belongings and that they could not force them to take a NJ EX Order. 264b1. After an incident, she would investigate, and the resident won't say anything because they want to maintain their relationship with the supplier. The DON stated that "they" say there is a lot of drugs in the building, but that her investigations end up as "dead ends." The DON continued that there were residents that indicated that they had the drug on them when admitted and others have said that they were able to obtain drugs in the facility, but that no one discloses who it is. The DON added they all know the "clientele" at the facility and that we all try to be observant. The surveyor asked about interventions implemented for residents who NJ EX Order. 264b1 while at the facility. The DON responded that the resident would be NJ EX Order. 264b1 as needed, at the discretion on the physician. The resident would have supervised lobby visits, no visitors in rooms, no "out on pass" without supervision, and a staff member would accompany the resident during outside appointments.

Review of the undated "Investigation/Conclusion"

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sheet, provided by the DON, indicated that Resident #3 presented with disorientation, NJ EX Order. 264b1 with significant deviation from baseline on NJ EX Order. 264b1. NJ EX Order. 264b1 was administered with positive effect. Resident #3 was questioned regarding the causative factors and any participation in NJ EX Order. 264b1 since admitted to the facility. Resident #3 verbalized that the NJ EX Ord's were brought in on their person from the community at the time of admission. Resident #3 denied search of room and belongings, denied having NJ EX Order. 264b1 and any NJ EX Orde NJ EX Order. 264b1 Resident encouraged to inform staff if additional help is wanted at any time. The investigation was completed on NJ EX Order. 264b1

Review of the undated "Investigation/Conclusion" sheet, provided by the DON, indicated that Resident #3 presented with NJ EX Order. 264b1 on NJ EX Order. 264b1. NJ EX Order. 264b1 was administered multiple times and was ineffective. Resident sent out 911. During the investigation, resident denied obtaining the NJ EX Order within the facility, denied having NJ EX Order on his/her person or room. Resident #3 denied search of room and belongings, denied having additional NJ EX Order. 264b1 and any NJ EX Order. 264b1. Resident encouraged to inform staff if additional help is wanted at any time.

Review of the undated "Investigation/Conclusion" sheet, provided by the DON, indicated that Resident #3 presented with significant deviation from baseline, NJ EX Order. 264b1 NJ EX Order. 264b1 and that NJ EX Order. 264b1 symptoms had been identified on NJ EX Order. 264b1 was administered and 911 was activated. Upon return, Resident #3 refrained from answering any

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investigative questions in addition to declining a search of his/her room, person, or personal belongings. The physician with NJ EX Order. 264b1 and medical director was informed. Resident encouraged to inform staff if additional help is wanted at any time. "The investigation was completed the day of residents return to the facility."

During an interview with the surveyor on 12/12/23 at 12:30 PM, Resident #3 stated he/she could not recall anything that happened during the NJ EX Order. 264b1, and NJ EX Order. 264b1 incidents.

During an interview with the surveyor on 12/27/23 at 4:09 PM, the MDS Coordinator (MDSC) stated that Resident #3 had been NJ EX Order. 264b1 NJ EX Order. 26 r for a long time. The MDSC added that they keep an NJ EX Or" on Resident #3 as much as possible and that staff are aware of the resident. The MDSC further stated that they did not initiate 1 NJ EX Order. 264b1 checks for Resident #3 because that would have to go on forever.

During an interview with the surveyor on 12/27/23 at 6:34 PM, the Assistant Director of Nursing (ADON) stated Resident #3's interventions to the NJ EX Order. 264b1 incidents was that he/she was sent out to the hospital for evaluation. The ADON further stated there were no changes documented in the resident's CP or plan of care.

During an interview with the surveyor on 12/29/23 at 11:16 AM, the Director of Admissions (DA) stated that she or her desginee would provide the resident with the Admission Packet and policies on admission. The policies provided included the following: Resident Out on Pass Policy, Resident NJ EX Order. 264b1 Policy, Resident Outside Fresh

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Air Policy, Smoking Policy, Abuse Policy, and the Resident Rights Policy. The DA further stated they would meet with the resident, go over all the paperwork, and have them sign the "Policy Acknowledgment Form." The DA added that they encourage the resident to sign the "Policy Acknowledgement Form" because signing it meant they they would abide by the rules.

Review of Resident #3's Admission Packet revealed that the "Policy Acknowledgement Form" had been signed by the resident on admission to the facility.

2.) On NJ EX Order. 264b1 at 01:12 PM, the surveyor reviewed Resident #23 admission notes which indicated that the resident was admitted to the facility in NJ EX Order. 264b1 from NJ EX Order. 264b1 facility. The surveyor then reviewed the admission nursing evaluation which revealed that Resident #23 had a history of NJ EX Order. 264b1.

Review of the Admission record revealed that the resident was admitted to the facility with medical diagnoses which included but were not limited to NJ EX Order. 264b1

Review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1 showed that Resident #23 had a Brief Interview of Mental Status of NJ EX, meaning the resident was NJ EX Order. 264b1

On 12/27/23 at 01:34 PM, the surveyor reviewed Resident #23 progress notes which showed that on NJ EX Order. 264b1 at 05:07 PM Resident #23 went out on pass. Further review of the physician orders showed an active out on pass order without supervision that was effective on NJ EX Order. 264b1.

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On 12/27/23 at 2:00 PM, the surveyor reviewed the resident's progress notes which revealed that on [redacted] at 06:04 PM the resident was discovered by another resident on the floor in the hallway of the unit [redacted]. The progress note written by the nurse caring for the resident indicated that the resident was [redacted] and was [redacted]. The nurse documented that she administered [redacted] in an emergency) and the resident didn't respond. The nurse waited [redacted] minutes and administered another dose of [redacted], and the resident [redacted] The nurse notified emergency medical system (911) who arrived at the facility and the resident refused to go to the emergency room. The resident's physician was notified of the incident.

On 12/27/23 at 2:04 PM, the surveyor reviewed progress notes from [redacted], and [redacted]. [redacted] 3, the resident, who was prescribed [redacted] e (medication to treat [redacted]) at the time, requested to come off the [redacted] and start [redacted] (a [redacted] reliever for [redacted]. Review of the physician orders showed that the physician discontinued the [redacted]. Review of the [redacted] progress note showed that the resident was found with [redacted] of [redacted]" in the room. The staff notified the resident's physician of the finding. On [redacted] the resident was awaiting admission to an [redacted] a program to address [redacted] and [redacted] s).

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F 689	Continued From page 62 On 12/27/23 at 02:28 PM, the surveyor reviewed the residents active care plan initiated on NJ EX Order. 264b1 which had a focus of history of NJ EX Order. 264b1 and potential complications such as recurrence of NJ EX Order. 264b1 and NJ EX Order. 264b1. The goal of the care plan was that the resident would not exhibit inappropriate behavior by use of NJ EX Order. 264b1 NJ EX Order. 264b1 unless prescribed by the physician. Interventions of the care plan included notifying the physician if observed NJ EX Order. 264b1 provide NJ EX Order. 264b1 methods, educate resident, medicate as prescribed, and NJ EX Order. 264b1 consult as needed. On 12/27/23 at 02:51 PM, the surveyor reviewed Resident #23 Admission Packet. Included in the packet was the Resident NJ EX Order. 264b1 Policy with a revision date of NJ EX Order. 264b1. The policy read that the facility was a NJ EX Order. 264b1 environment and had policies in place to ensure the safety and well-being of all residents. The facility's NJ EX Order. 264b1 NJ EX Order. policy prohibits residents from using or being in NJ EX Order. 264b1 and/or NJ EX Order. 26. Resident noted to be in possession of NJ EX Order. 264b1 or related NJ EX Order. 264b1 a, or this suspected of being NJ EX Order. 264b1 may be subject to the following actions as deemed appropriate by the Interdisciplinary team: Reported to police, restricted from going out on pass independently or at all, NJ EX Order. 264b1 room search with resident present, supervised or restricted visitation, deliveries opened by the facility staff in presence of the resident, placed on increased staff supervision, or discharged from the facility. The NJ EX Order. 264b1 policy was signed by the resident on admission to the facility.	F 689		

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On 12/27/23 at 03:40 PM, the surveyor then reviewed the resident Out on Pass Policy, an undated policy. The purpose of the policy was to provide residents with the opportunity to participate in family and community life to the fullest extend possible, while ensuring the safety of the specific resident, all other residents in the facility, and residents in the surrounding community. The procedure of the policy was that all residents will have an out of pass order on the chart based on the Interdisciplinary teams' recommendations. It would either be out independently, out with responsible party, restricted from going out on pass, or supervised lobby visits.

Review of Resident #23 out on pass policy showed that the resident signed for all four areas of out on pass on admission to facility. The areas were out on pass independently, out with appropriate responsible party, restricted from going out on pass, and supervised lobby visits. Further review of the policy read violations to the out on pass policy, NJ EX Order. 264b1 policy or other significant concern will result in out on pass restrictions per the Interdisciplinary team recommendations.

On 12/27/23 at 03:45 PM, the surveyor reviewed the Resident Out on Pass Log. Resident #23 signed out of the facility on NJ EX Order. 264b1 two times, NJ EX Order. 264b1, NJ EX Order. 264b1 and a progress note revealed that Resident #23 signed out on pass on NJ EX Order. 264b1.

On 12/27/23 at 03:50 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the Out on Pass policy and building security. The LNHA told the

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surveyor the facility had security from 10 AM to 6 PM and then 11 PM to 7 AM. The surveyor asked the LNHA if security kept a log or report of any incidents and the LNHA responded, "No".

On 12/27/23 at 03:52 PM, the surveyor interviewed unit Licensed Practical Nurse (LPN) regarding Out on Pass policy. The LPN told the surveyor that they would check to make sure there was a physician order before allowing them to sign out and that all residents should "be checked at the door to be sure there is nothing on them they shouldn't have".

On 12/27/23 at 03:55 AM, the surveyor reviewed the physician orders for out on pass. On [redacted] 3 the resident had a physician order for [redacted] s, NJ EX Order. 264b1 in the room, must be accompanied by staff to all appointments, not to go out on pass. On 1[redacted] the order was changed to "May go out on pass with responsibility party". On [redacted] the order was changed to 'NJ EX Order. 264b1, not to have NJ EX Order. 264b1, must be accompanied by staff to all appointments, not to go out on pass without a responsible party to assume responsibility for resident and physically sign them out of the facility". On [redacted] the order changed to 'NJ EX Order. 264b1 visits, [redacted], must be accompanied by staff to all appointments, not to go out on pass". On [redacted] the order changed to "May go out on pass without supervision". The facility did not provide additional information as to why the resident's out on pass status changed on [redacted]

On 12/27/23 at 06:40 PM, the surveyor interviewed the Assistant Director of Nursing

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(ADON) regarding Resident #23 and the [redacted] The ADON said following the [redacted] of the resident, the resident was placed on every [redacted] checks. The surveyor asked for copies of every [redacted] checks and they were not provided to the surveyor. The surveyor asked if a resident with a NJ EX Order. 264b1 history should have their Out on Pass status changed and she responded, "Yes, very much so. They should lose their pass to go out and visitors should even be restricted".

On [redacted] at 09:15 AM, the surveyor went to interview Resident #23. The nursing staff told the surveyor the resident signed out of the facility NJ EX Order. 264b1 and the physician was made aware.

On [redacted] at 09:30 AM, the surveyor interviewed the facility security guard. The security guard told the surveyor that the process for those residents who went out of the facility and had a history [redacted] would have their bags checked when they returned to the facility. The security guard told the surveyor if anything is found on a resident on return, they would call the Director of Nursing and the Administrator. The security guard told the surveyor that "Beginning today we have 24-hour security".

3. According to the AR, Resident #24 was admitted to the facility in NJ EX Order. 264b1 with diagnoses that included but not limited [redacted] and NJ EX Order. 264b1.

Review of the Resident #24's PN, revealed a

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12/25/23 at 8:02 PM NN, written by the LPN, that Resident #24 had a NJ EX Order. 264b1. Resident #24 was NJ EX Order. 264b1, had [redacted], and was suspected of NJ EX Order. 264b1 NJ EX Order. 264b1 was administered and after [redacted] minutes, the resident became NJ EX Order. 264b1 to NJ EX Order. 264b1. Resident #24 was then sent out to the hospital for evaluation.

Further review of Resident #24's PN revealed that the resident returned to the facility, in an [redacted] and with no discharge papers. The resident indicated that he/she was provided with directions and that he/she called [redacted].

During an interview with the surveyor on 12/28/23 at 12:10 PM, the surveyor inquired about his/her [redacted] incident. Resident #24 stated that he/she NJ EX Order. 264b1 and was NJ EX Order. 264b1. Resident #24 did not want to elaborate how or when he/she obtained the [redacted]

4. According to the AR, Resident #25 was admitted to the facility in NJ EX Order. 264b1, with diagnoses that included but not limited [redacted] and other [redacted] NJ EX Order. 264b1.

Review of the Admission MDS, dated [redacted], revealed that Resident #25 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had NJ EX Order. 264b1.

Review of the Resident #25's PN, revealed a [redacted] at 7:13 PM NN, written by the LPN, that Resident #25 was NJ EX Order. 264b1, had

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NJ EX Order. 264b1 and was NJ EX Order. 264b1 NJ EX Order. 264b1. NJ EX Order. 264b1 was administer two times and the resident NJ EX Order. 264b1 NJ EX Order. 264b1. The PN indicated that 911 was called but the resident refused to be sent out to the hospital for evaluation.

During an interview with the surveyor on 12/28/23 at 12:15 PM, the surveyor inquired about his/her NJ EX Order. 264b1 incident. Resident #25 stated that he/she did not want to discuss the incident.

During an interview with the surveyor on 12/28/23 at 1:14 PM, the ADON indicated that Resident #24's and Resident #25's investigations were still in progress.

5. According to the AR, Resident #26 was admitted to the facility in NJ EX Order. 264b1 with diagnoses that included but not limited NJ EX Order. 264b1

Review of the Resident #26's PN, revealed a NJ EX Order. 264b1 at 9:20 AM "Alert Note," written by the DON, that the resident presented with NJ EX Order. 264b1 . The resident was diaphoretic and verbalized that he/she was NJ EX Order. 264b1 s and was NJ EX Order. 264b1 " (NJ EX Order. 264b1). Resident #26 verbalized that they had NJ EX Order. 264b1 but could not state how much." The resident denied having NJ EX Order. 264b1 or NJ EX Order. 264b1 NJ EX Order. 264b1 on [his/her] person or in their room at this time. The NP was present in facility and requested Resident #26 to be sent out 911. The

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Emergency Medical Technicians arrive and was accompanied by the local police. The local police discovered approximately NJ EX Order. 264b1 containing NJ EX Order. 264b1. Resident #26 verbalized that he/she uses NJ EX Order. 264b1 l, NJ EX Order. 264b1 and that NJ EX O brought the NJ EX Order from NJ EX Order. 264b1 prior to admission to the facility. The resident further stated that he/she had not purchased any NJ EX Order since housed in the facility. The police officer confiscated the NJ EX Order. 264b1, containers NJ EX Order. 264b1 NJ EX Order. 264b1 s" bag in which the NJ EX Order. 264b1 pe with a NJ EX Order. 264b1 and containers were housed. Resident #26 was then transferred to the hospital for evaluation.

During an interview with the surveyor on 12/12/23 at 10:50 AM, the DON stated that Resident #26 was NJ EX Order. 264b1. The DON stated that she asked the resident if he/she had used any NJ EX Or to which the resident responded that he/she had NJ EX Order. 264b1. The DON asked if the resident had any additional drug in their possession and Resident #26 indicated that NJ EX O had some in a NJ EX Order. 264b1 The DON further stated that Resident #26 had approximately NJ EX Order. 264b1 in their possession and that the police officer confiscated the NJ EX Order. 264b1.

Review of the facility's "Residents with NJ EX Order. 264b1 Policy and Procedure, with the copyright date of 2022, indicated under the "Purpose" section that the facility would "develop and implement safety policies and procedures to address residents with a history of NJ EX Order. 264b1 NJ EX Order. 264 who may be at increased risk for leaving

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F 689	Continued From page 69 the Facility without notification to staff and/or for NJ EX Order or pNJ EX Order. 264b1 if the resident continues using such NJ EX Order. 264b1 while residing in the Facility." Under the "Policy" section revealed that the "Facility shall be responsible for identifying and assessing resident's risks for leaving the Facility without notification to staff and shall develop interventions to address this risk." Under the "Interventions" section revealed that "If appropriate, the Facility will plan interventions in the resident's comprehensive care plan to prevent NJ EX Order. 264b1 NJ EX in the Facility as well as interventions for when NJ EX Order. 264b1 is suspected or identified. Facility stall will implement care plan interventions when NJ EX Order. 264b1 s is suspected, such as: a. increased monitoring and supervision of resident, b. increased supervision of visitors, and c. notifying the resident's physician and non-physician practitioner."	F 689		
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	F 755		2/27/24

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F 755	Continued From page 70 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- §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: Complaint NJ #00164283 Based on interviews, review of the medical record, and other pertinent facility documentation on 12/11/23, 12/12/23 and 12/14/23, it was determined that the facility failed to maintain professional standards of practice by not signing on the Medication Administration Record (MAR) that a medication was administered according to Physician's Orders (PO). The deficient practice was identified for Resident #3 and #18, 2 of 28 sampled residents and was evidenced by the following:	F 755	F755 Immediate Action: 1. On 8/8/23 and 9/23/23, Resident #3 received medication as ordered by physician, however, was not documented in the MAR. Resident had no negative outcome. 2. LPN #1 was educated on February 16, 2024 and LPN#2 was educated on 2/26/24 3. Resident #18 expired, and the nurse is no longer employed by the company. 4. Medication charting policy was reviewed by DON/Designee and revised on 2/4/24. 5. Licensed nursing staff was educated	

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F 755	Continued From page 71 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." According to the Admission Record (AR), Resident #3 was readmitted to the facility with diagnoses that included but not limited to NJ EX Order. 264b1). Review of Resident #3's Order Summary Report (OSR), for active orders as of NJ EX Order. 264b1, revealed a physician order (PO), dated NJ EX Order. 264b1, for NJ EX Order. 264b1 milligram (mg)/ NJ EX O milliliter (ml) NJ EX Order. 264b1. A medication that is used to treat NJ EX Order. 264b1 in an emergency situation. The PO instructed to administer NJ EX O NJ EX Order. 264b1 every NJ EX O hours as needed for NJ EX Order. 264b1. May repeat every NJ EX O" minutes as needed. Review of Resident #3's Care Plan (CP), initiated NJ EX Order. 264b1, included a focus that Resident #3 had a "history NJ EX Order. 264b1 and has a potential for complications such as NJ EX Order. 264b1 NJ EX Order. 2 suspect to be under the NJ EX Order. 264b1 administered and	F 755	on proper documentation of administering medications on 2/16/24 and will be completed by 2/27/24. Identification of Others 1. All residents residing in the facility have the potential to be affected by the deficient practice. Systemic changes 1. Medication administration record will be monitored daily by DON/designee to assure proper documentation via the PCC dashboard for each shift. Quality monitoring 2. The director of nursing/designee will bring results of the daily monitoring to the Quality Assurance Process Improvement committee Monthly x 6 months for review and further recommendations.	

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effective." Under "Interventions," indicated to administer [redacted] as per MD [physician] orders.

Review of Resident #3's "Progress Notes" (PN) revealed a [redacted] "Nurses Note" (NN) completed by the Licensed Practical Nurse (LPN) #3, that Resident #3 did not have the [redacted] Resident #3 was repeatedly asked what happened with no effect. "Instructions given to [administer] [redacted]." [redacted] was administered at 4:43 PM with good effect. "Patient appeared to NJ EX Order. 264b1 and NJ EX Order. 264b1 and did not wish to discuss the matter further."

Review of the PN revealed a [redacted] NN that Resident #3 was brought to the nurses' station by the Certified Nurse Assistant (CNA). The resident was assessed by the LPN and noted to be NJ EX Order. 264b1 hen patient's NJ EX Order. 264b1. The LPN administered [redacted] mg NJ EX Order. 264b1 at 4:43 AM, NJ EX Order. 264b1 [beats per minute], administered another dose of [redacted] mg [redacted] 911 called."

Review of the PN revealed a [redacted] NN that Resident #3 was NJ EX Order. 264b1 in bed with [redacted] NJ EX Order. 264b1. The resident was NJ EX Order. 264b1, and the nurse proceeded to do NJ EX Order. 264b1 results. The "nurse collected a set of VS [vital signs] from the resident and then retrieved [redacted] The nurse administered the [redacted] dose of [redacted] into [redacted] at 8:25 AM, with ineffective results. A [redacted] dose of [redacted] was administered into the

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NJ EX Order. 264b1 at 8:28 AM, with effective results. "At 8:31 AM, resident was responsive to staff ... NJ EX afterwards, at 8:56 AM, resident began to experience NJ EX Order. 264b1." The physician was informed and the resident was sent to the hospital for further treatment.

Review of Resident #3's NJ EX Order. 264b1 NJ EX Order Medication Administration Record (MAR) revealed the aforementioned NJ EX Order. 264b1 PO for NJ EX Order. 264b1 mg/ NJ EX ml and to administer NJ EX Order. 264b1, NJ EX Order. 264b1 every NJ EX hours as needed and may repeat every NJ EX Ord minutes for NJ EX Order. NJ EX Order. 264b1

The NJ EX Order. 264b1 MAR did not reveal a signature from the nurse that NJ EX Order. 264b1 was administered on NJ EX Order. 264b1 at 4:43 PM for an apparent NJ EX Order. 264b1.

The NJ EX Order. 264b1 MAR did not contain any signatures from the nurses of the multiple doses of NJ EX Order. 264 administered to Resident #3 on NJ EX Order. 264b1 and NJ EX Order. 264 for the apparent NJ EX NJ EX Order. 264b1

On 12/12/23 at 3:35 PM, the surveyor interviewed LPN#3 who stated that she had been employed at the facility for a little NJ EX Order. 264b1. LPN #3 stated that Narcan orders were located under the PRN (as needed) orders and that nurses are supposed to sign the MAR after administering the medication. LPN #3 added that she did not remember if she signed Resident 3#'s MAR on NJ EX Order. 264b1, but that she did write a detailed PN of the incident.

2. According to the AR, Resident #18 was admitted to the facility with the diagnoses that

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included but not limited to NJ EX Order. 264b1

Resident #18's CP indicated that the resident had a history of NJ EX Order. 264b1.

The surveyor reviewed the Facility Reportable Event [FRE] dated NJ EX Order. 264b1 that indicated on NJ EX Order. 264b1 between 12:15 PM-12:20 PM, Resident #18 was found by the Certified Nursing Assistant (CNA) NJ EX Order. 264b1 on the floor with a NJ EX Order. under his/her NJ EX Order. . The FRE indicated that the resident was NJ EX Order. 264b1) was started. The FRE also indicated that the resident was administered the medication NJ EX Order. 264b1 (a medication used for NJ EX Order. 264b1) several times through the event.

Review of the resident's OSR, dated NJ EX Order. 264b1 , reflected a physician's order for NJ EX Order. 264b1 mg/ NJ EX ml. NJ EX Order. 264b1 NJ EX Order. every NJ EX Order. minutes as needed for NJ EX Order. 264b1 and may repeat every NJ EX Order. minutes in NJ EX Order. 264b1 .

The PN, dated NJ EX Order. 264b1 at 1:17 PM, indicated that when Resident #18 was found NJ EX Order. 264b1 e NJ EX Order. was initiated, 911 was called and the resident was administered several doses of the medication NJ EX Order. 264b1 .

The MAR was reviewed by the surveyor and reflected the aforementioned NJ EX Order. 264b1 mg/ NJ EX ml and to administer one NJ EX Order. 264b1 every t NJ EX Order. minutes as needed for NJ EX Order. NJ EX Order. 264b1 and may repeat every NJ EX Order. minutes in NJ EX Order. 264b1 . The MAR did not contain any signatures from the nurse that the multiple doses of NJ EX Order. 264b1 was administered to Resident #18 on

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NJ EX Order. 264b1 for an NJ EX Order. 264b1.

On 12/11/23 at 10:01 AM, the surveyor interviewed the Director of Nursing (DON) who explained the process of NJ EX Order. 26 administration that the facility follows when a resident was suspected of an NJ EX Order. 264b1. The DON stated that if a resident received the medication NJ EX Order. 26 for an NJ EX Order. 264b1 that the nurse would document on the MAR every dose of NJ EX Order. 26 that was administered. She added that NJ EX Order. 26 can be given multiple times until the resident comes out of the s NJ EX Order. 264b1 of an NJ EX Order. 264b1

The DON reviewed Resident #18's MAR and confirmed that there was no documentation on the MAR that the resident received multiple doses of NJ EX Order. 26 on NJ EX Order. 26 for an apparent NJ EX Order. 264b1

On 12/14/23 at 10:35 AM, the surveyor interviewed LPN #1 who worked on the NJ EX Or Wing. LPN #1 stated that when a resident was suspected of an NJ EX Order. 264b1 and recieved the medication NJ EX Order. 264 the nurse would be responsible to document every dose of NJ EX Order. 26 that was administered to the resident. She stated that it would be important to document every administration of the medication to assure proper documentation.

On 12/14/23 at 11:00 AM, the surveyor interviewed the Registered Nurse Minimum Data Set Coordinator who stated that that if NJ EX Order. 26 was administered to a resident, the nurse would document in the PRN (as needed) section of the MAR to indicate that a medication was administered. She added that proper documentation of the MAR was a standard of nursing practice.

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F 755	Continued From page 76 On 12/14/23 at 12:30 PM, the surveyor interviewed LPN#2 who stated that she had been employed in the facility for [redacted]. LPN #2 stated that [redacted] should be administered per the physician order. She stated that if a nurse administered any medication, including prn [redacted], that the nurse would document the administration of the medication on the MAR. On 12/14/23 at 12:46 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who state that if a nurse administered the medication [redacted], the nurse should document the administration of the medication on the MAR and in the progress notes. Review of the facility's undated policy titled, "Medication Charting" indicated that charting of medications shall be kept current and shall be completed as soon as possible following the administration of the medication. Computerized Medication Administration records are provided to facilitate recording of medications administration in a timely and accurate fashion. The policy also indicated that PRN medications shall be recorded in the appropriate section of the MAR in the usual manner. Review of the undated facility policy titled, "Charting and Documentation" indicated that all services provided to the resident or any changes to the resident's medical or mental condition shall be documented in the reisdent's medical record. The policy also indicated that all observations, medications administered, services performed [ect] must be documented in the resident's medical record.	F 755		

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F 755	Continued From page 77 NJAC 8:39-27.1 (a)	F 755		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint # NJ 161818; 164283, 168432, 168784; 168987; 170340, 170340, and 170605. Based on interviews, record review, and review of other pertinent facility documentation on [redacted], and [redacted], it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being, by failing to a.) consistently monitor and/or supervise residents, with known history of drug abuse, to prevent [redacted] from entering the facility, and/or overdose incidents while in the facility, b.) ensure that the Resident [redacted] policy was implemented, c.) initiate and an investigation when visitors, on two different occasions, attempted to bring allegedly [redacted] into the facility, d.) conduct a complete and thorough investigation of a [redacted] abuse and an incident of possible neglect, e.) ensure that a residents' care plan were updated, revised, and that interventions were implemented for a resident, with a history of	F 835	F835 Corrective Action: 1. Licensed Nursing Home Administrator employed at the time of the survey is no longer employed by facility. 2. On 1/15/24, the new LNHA was educated by their corporate supervisor on the roles and responsibilities of the LNHA (job description) as well as facility policy/procedures and IJ templates and plan of correction. 3. Weekly and as needed meetings are scheduled with the corporate LNHA supervisor to ensure that the facilities policies, procedures and systems and plan of correction are developed and implemented in accordance with regulations and facility policies and procedures. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents.	2/27/24

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F 835	Continued From page 78 NJ EX Order. 264b1, who had NJ EX Order. 264b1 while at the facility and for residents involved in a NJ EX Order. 264b1t incident, f.) ensure that the facility-wide assessment addressed the resident population and identify the resources needed to provide the necessary care and services for residents admitted with a history of NJ EX Order. 264b1NJ EX Order. 2 and/or who NJ EX Order. 264b while at the facility, g.) ensure that the Quality Assessment and Performance Improvement (QAPI) committee develop and implement an action plan that addressed the concerns they identified, which were the repeated overdoses at the facility and the NJ EX Order entering the building, h.) immediately investigate two incidents where visitors attempted to bring NJ EX Order. 264b1 into the facility, and g.) report to the New Jersey Department of Health (NJDOH) incidents of resident NJ EX Order. 264b1 a resident NJ EX Ex Order. 264b, and incidents where visitors attempted to bring NJ EX Order. 264b1 into the facility. This placed all residents at risk and in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on NJ EX Order. 264b at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 264b and continued thru NJ EX Order. 264b, when the facility LNHA was replaced. The facility provided an acceptable Removal Plan on NJ EX Order. 264b at 3:16 PM.On NJ EX Order. 26, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order. 264b at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy	F 835	Systemic Changes: 1. The LNHA corporate supervisor will conduct weekly audits on 5 facility policies and Procedures/ week to ensure the administrator's adherence to and compliance of facility policies and procedures as evidenced by correct implementation via, staff interview and observation and pertinent documentation based on the policy being reviewed. How Will These Actions Be Measured: 1. Findings of weekly meetings and audits will be reported to the Quality Assurance & Performance Improvement Committee by the LNHA corporate supervisor monthly x 6 months for analysis and further recommendations. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 835	Continued From page 79 On [redacted], the facility implemented the Removal Plan, which included the following: -On [redacted]4, the LNHA was replaced. -On [redacted], the new LNHA was educated by the corporate supervisor on the roles and responsibilities of the LNHA and facility policy and procedures. The deficient Practice was evidenced by the following: Review of the "SIR Facility Administrator" job description revealed that the "primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times." The "Duties and Responsibilities" included but not limited to the following: -Plan, develop, organize, implement, evaluate, and direct facility's programs and activities. -Meet with department directors to discuss use of departmental policies and procedures and establish a rapport in and among departments so that each can realize the importance of teamwork. -Interpret the facility's policies and procedures to employees, residents, family member, visitors, government agencies, etc., as necessary. -Oversee the facility's marketing and census development plans. -Ensure that public information (policy manuals, etc.) describing the services provided in the facility is accurate and fully descriptive. -Make routine inspections of the facility to assure that established policies and procedures are	F 835		

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being implemented and followed.
-Serve as Chair of the Quality Assurance Committee.
-Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas and/or improvement of services.
-Assure that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents.
-Assure that all residents receive care in a manner and in an environment that maintains or enhance their quality of life without abridging the safety and rights of other residents.
-Assist the Quality Assurance Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies.

1. According to the Admission Record (AR), Resident #3 was admitted to the facility in June [redacted] with diagnoses that included but not limited to [redacted].

Review of Resident #3's Progress Notes (PN) revealed a [redacted] at 11:08 PM "Nurses Note" (NN), that at around 4:30 PM Resident #3 was [redacted]. The resident appeared [redacted] The resident was unable to [redacted] and was repeatedly asked with no effect. Resident #3 was administered [redacted] at 4:43 PM with good effect. The resident "appeared to recover, became [redacted] but [redacted] and did not wish to discuss the

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F 835	Continued From page 81 matter further." Review of Resident #3's PN, revealed a [redacted] at 5:09 PM NN, that Resident #3 was received from another resident's room [redacted]s by the Certified Nurse Aide (CNA). The resident was assessed and noted as being [redacted] which then [redacted] d. [redacted] as ineffective and [redacted] mg was administered at 4:40AM and 4:43AM. Resident #3's [redacted] (BPM) and another dose of [redacted] was administered. 911 was called and the resident was transferred to hospital for [redacted] Review of Resident #3's [redacted] "[redacted]" lab results, completed at the hospital, revealed that the resident tested [redacted] for [redacted] a class of drugs that produce[redacted]), [redacted] with [redacted]), [redacted] (medication used to treat [redacted]), and c[redacted] (a [redacted]c used to treat [redacted] to [redacted]). Review of Resident #3's PN revealed a [redacted] at 9:00 AM NN, that at 8:21 AM, [redacted] was notified by the CNA that the resident needed to be seen because he/she did not appear to look okay. Resident #3 was observed lying on [redacted] with [redacted]. The resident was [redacted] was ineffective. The nurse administered [redacted] 4 mg at 8:25 AM with ineffective results. A second dose of [redacted] mg was administered at 8:28	F 835		

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AM and was effective after NJ EX Orde minutes. At 8:31 AM, Resident #3 was NJ EX Order. 264b1 to staff and at 8:56 AM, the resident began to experience NJ EX Order. 264b1.

Further review of Resident #3's PN revealed that the resident returned to the facility from the hospital on NJ EX Order. 264b1 with a diagnosis of NJ EX Orde NJ EX Order. and NJ EX Order. 264b1."

Review of Resident #3's PN from NJ EX Order. 264b1 to NJNJ EX Order. 264 revealed no documentation that Resident #3 was reassessed for the risk for NJ EX Order. 264b1 in the facility. The PN also did not revealed any documentation of interventions implemented to prevent Resident #3 NJ EX Order. 264b1 after the NJ EX Order. 264b1 and NJ EX Order. 264b1 NJNJ EX Order. 264 incidents.

During an interview with the surveyor on 12/12/24 at 10:50 AM, the Director of Nursing (DON) stated that she did not report Resident #3's NJ EX Order. 264b1 incidents for NJ EX Order. 264b1, and NJ EX Order. 264b1 to the NJDOH.

During an interview with the surveyor on 12/14/23 at 1:00 PM, the LNHA stated he and the DON were responsible for reporting to the NJDOH.

2. Reviewed Resident #23 admission notes, which indicated that the resident was admitted to the facility in NJ EX Order. 264b1 from NJ EX Order. 264b1 facility. The surveyor then reviewed the admission nursing evaluation which revealed that Resident #23 had a history of NJ EX Order. 264b1.

On 12/27/23 at 2:00 PM, the surveyor reviewed the resident's PN which revealed that on NJ EX Order. 264b1

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at 06:04 PM, the resident was discovered by another resident on the NJ EX Order. 264b1 of the unit NJ EX Order. 264b1. The resident was not NJ EX Order. 264b1 or a NJ EX Order. 264b1 and was NJ EX Order. 264b1." NJ EX Ex Order. was administered and the resident didn't respond. The nurse waited NJ EX Or minutes and administered another dose of NJ EX Order 26, and the resident responded. The nurse notified emergency medical system (911) who arrived at the facility and the resident refused to go to the emergency room.

On 12/27/23 at 03:55 AM, the surveyor reviewed the physician orders for an "out on pass" to be given to the resident to leave the facility. On NJ EX Order. 26 3, the resident had a physician's order for NJ EX Order. 264b1, NJ EX Order. 264b1 must be accompanied by staff to all appointments, and not to go out on pass. On NJ EX Order. 2642 the order was changed to "May go out on pass with responsible party". On NJ EX Order. 26 3 the order was changed to NJ EX Order. 264b1, NJ EX Order. 264b1, must be accompanied by staff to all appointments, not to go out on pass without a responsible party to assume responsibility for resident and physically sign them out of the facility". On NJ EX Ex Order. 26 the order changed to "NJ EX Order. 264b1, NJ EX Order must be accompanied by staff to all appointments, not to go out on pass". On NJ EX Order. 2642 the order changed to "May go out on pass without supervision".

The facility did not provide additional information as to why the residents' out on pass status changed on NJ EX Order. 2642.

On 12/27/23 at 06:40 PM, the surveyor

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interviewed the Assistant Director of Nursing (ADON) regarding Resident #23 and the [redacted]. The ADON said following the [redacted] of the resident, the resident was placed on every [redacted] checks. The surveyor asked for copies of every [redacted] checks and they were not provided to the surveyor. The surveyor asked if a resident with a NJ EX Order. 264b1 history should have their Out on Pass status changed and she responded, "Yes, very much so. They should lose their pass to go out and visitors should even be restricted."

3. During an interview with the surveyor on 01/12/24 at 11:22 AM, the Licensed Nursing Home Administrator (LNHA) stated that on [redacted], he received calls from the security guard (SG) about family members attempting to bring NJ EX Order. 264b1 into the facility. At which time, the LNHA confirmed that there had been two separate incidents, on [redacted], where a family member attempted to deliver NJ EX Order. 264b1 to the resident. The LNHA stated that one family member attempted to drop off a [redacted] for a resident. Upon inspection of the [redacted], the SG observed that the bottom of the [redacted] had been opened and a package [redacted] inserted inside. At that time, the SG confiscated the package of [redacted]. The LNHA continued that another resident's family member attempted to drop off a NJ EX Order. 264b1 to a resident. Upon inspection of the [redacted] the SG observed NJ EX Order. 264b1. He explained that this is a NJ EX Order. 264b1 used for holding [redacted] of [redacted] or [redacted]s, such as [redacted] or some other [redacted], placed inside of the NJ EX Order. 264b1. At that time, the SG confiscated the [redacted] that was

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hidden inside of the NJ EX Order. 264b1. The LNHA stated that he brought the NJ EX Ord [redacted] to the police station on the following week on a NJ EX Order. 264b1. The surveyor asked if the residents' family members had visited the facility before. The LNHA responded that he did not know and would have to double check with the SG. The surveyor then asked the LNHA for the residents' names that were supposed to receive the packages and if those family members had prior visits to the facility. The LNHA stated that he did not know the residents' names involved or if the aforementioned family members had previously visited the facility. The surveyor asked the LNHA to explain his investigational process into the NJ EX Order. 264b1 incidents. The LNHA stated that he was not sure if the SG had questioned the family members attempting to bring in the NJ EX Ord [redacted] and that the SG checked the bags per the new policy that had been implemented. The LNHA continued that an incident report was not completed and that he did not initiate an internal investigation into the incidents. The LNHA further stated that it was "a first" for him and that he never had to deal with NJ EX Order. 264b1 in a facility before. The surveyor asked who was responsible for completed the investigation of the aforementioned incidents. The LNHA responded that he was responsible for conducting the investigation. The LNHA further stated that he did not know he was required to report the NJ EX Order. 264b1 incidents to the NJDOH.

The LNHA was unable to provide the any documentation about the NJ EX Order. 264b1 incidents.

4. According to the AR, Resident #1 [redacted] NJ EX Order. 264b1 was admitted to the facility with the diagnoses which included but not limited to, NJ EX Order. 264b1

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NJ EX Order. 264b1

According to the AR, Resident #2 [NJ EX Order. 264b1] was admitted to the facility with the diagnoses which included but not limited to, NJ EX Order. 264b1 NJ EX Order. 264b1).

The surveyor reviewed the facility Incident Report (IR) dated NJ EX Order. 264b1 at 09:00 AM, which indicated that Resident #1 NJ EX Order. 264b1 into Resident #2's NJ EX Order to take a NJ Ex Order. 264b1. According to the IR, the residents were separated, evaluated for injury (none noted), and called the police. The IR also indicated that neither resident needed to go to the hospital.

On 12/14/23 at 09:20 AM, the surveyor interviewed the DON who stated that she was not able to provide the full investigation related to the NJ EX Orde NJ Ex Order. 264b1 altercation of NJ Ex Order. 264b1. The only documentation that the DON could provide was the incident/accident report.

5. According to the AR, Resident #7 had diagnoses which included, but were not limited to NJ EX Order. 264b1

During an interview with the surveyor on 12/13/23 at 3:38 PM, the DON stated that when a resident NJ EX Ord the NJ EX should be reported to the nurse assigned to the resident.Then the nurse should assess the resident to rule out injuries, notify the physician, and initiate the incident report.This report includes obtaining witness statements from staff assigned to the resident or who assisted in the incident. The DON further stated that the day Resident #7 NJ EX, she was not involved in the

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investigation because the facility staff did not notify her of the incident. The DON added that the VP of Clinical Services (VPCS), who is the DON's immediate supervisor, was notified of the incident and therefore conducted the investigation. The DON then stated that she reviewed the completed investigation, along with the camera footage from the resident's hallway, which ruled out any delay in the resident's care. When asked about the nurse's statements related to the incident, the DON stated RN #2 and the LPN #3 did not provide written statements, but that they should have in order for the investigation to be considered complete. When asked about RN #2's termination, the DON stated that RN #2 was terminated for multiple instances of not notifying the DON of resident incidents.

Review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) by the Director of Nursing (DON), dated [redacted], included that, "On [redacted] approximately 7:30 PM, [Resident #7] was found on the floor in [his/her] room next to [his/her] bed. Informed also that resident was [redacted]. [redacted] 911 dispatched and physician made aware." Further review of the FRE included, "Facility wide in-service r/t [related to] prompt reporting of all accidents and incidents," and, "Attending nurse terminated."

Included in the FRE submitted by the DON were witness statements from the following staff: CNA #2, CNA #3, Nurse Aide (NA), and Security. There were no statements from any staff nurse present during the incident.

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6. Review of the facility's website indicated they "specialize in NJ EX Order. 264b1 maintenance and can accept NJ EX Order. 264b1 NJ EX Order. 264b1 patients. Our facilities at Sterling offer a safe, comfortable, and supportive environment where all our residents can focus on their recovery and receive the care and attention they need. Our staff is dedicated to providing high-quality care to individuals, including those struggling with NJ EX Order. 264b1. The team of professionals at Sterling has extensive experience in treating patients with addiction and helping them on the path to recovery. There are unique challenges that come with NJ EX Order. 264b1, and we understand that. Our staff is equipped with the knowledge and resources to support our residents. Whether it's through individual therapy, group (medication to treat NJ EX Order. 264b1) support, or a range of recreational activities, we strive to empower our residents and help them achieve their goals."

Under the "Clinical Specialties" section indicated that they provided addiction management, NJ EX Order. 264b1 medication used to treat NJ EX Order. 264b1) and NJ EX Order. 264b1 (medication to treat NJ EX Order. 264b1) maintenance.

Review of the facility's "Facility Assessment" (FA), revealed that the FA lacked the following required components for the resident population with a history of NJ EX Order. 264b1 and/or who NJ EX Order. 264b1 while at the facility:
- A description of the facility's resident population;
- The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that were present within that population
- The staff competencies that were necessary to

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provide the level and types of care needed for the resident population;
- The physical environment, equipment, and services necessary to care for the resident population; and
- Any ethnic, cultural, or religious factors that could affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

The facility assessment did not include any documentation that addressed the resident population that was admitted to the facility with a history of NJ EX Order. 264b1 and/or who NJ EX Order. 264b1 at the facility.

During an interview with the surveyor on 01/04/24 at 2:36 PM, the LNHA explained the steps taken to develop the FA. The LNHA stated that the facility census was NJ EX O and that there were approximately NJ EX Order. residents in the facility with a history of NJ EX Order. 264b1. The LNHA further stated that based on the challenges that they had in the building, it would be beneficial to address residents with a history of NJ EX Order. 264b1 NJ EX Order. 2 and/or NJ EX Order. 264b1 while at the facility in the FA.

7. During a telephone interview with the surveyor on NJ EX Order. 264b1, the surveyor asked if the facility had developed a Quality Assessment and Performance Improvement (QAPI) plans that addressed the NJ EX Order. 264b1 entering the building and residents who NJ EX Order. 264b1 at the facility. The LNHA stated that the Interdisciplinary Team (team) had discussed the issue. The LNHA further stated that they [team] thought about developing QAPI plans for the aforementioned concerns, but that they never got

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a chance to initiate them.

8. According to the AR, Resident #17 was admitted to the facility in NJ EX Order. 264b1 with diagnoses that included, but were not limited to NJ EX Order. 264b1, NJ EX Order. 264b1 .

Review of Resident #17's physician "Order Summary Report (OSR)," revealed a physician order, dated NJ EX Order. 264b1 of "Ancillary services/Consult. 1) NJ EX Order. 264b1, 2) NJ EX Order. 264b1 in room, 3) Must be NJ EX Order. 264b1 "

Review of the NJ EX Order. 264b1 "Incident Report (IR)," completed by the Licensed Practical Nurse (LPN) #1, indicated that at 11:05 PM, she was notified that Resident #17 had left the facility premises unauthorized by NJ EX Order. 264b1. At 1:30 AM, the resident returned to the facility in a NJ EX Order. 264b1). The staff questioned the resident, who stated that he/she had never left the facility.

Review of the witness statement, written by LPN #2, dated NJ EX Order. 264b1, indicated that she was notified by a staff member that Resident #17 had got out of the building, possibly through a NJ EX Order. 264b1 "This nurse and several staff members searched the entire NJ EX Order. 264b1 Wing and NJ EX Order. 264b1 area." Resident #17 was not able to be located in the facility. Around 1:30 AM, she was informed by staff that the resident was dropped back off to the facility in a NJ EX Order. 264b1. Initially, Resident #17 denied leaving the facility but then stated that he/she had went and "NJ EX Order. 264b1 NJ EX Order. 264b1 ."

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F 835	Continued From page 91 During an interview with the surveyor on 12/14/23 at 1:00PM, the LNHA confirmed that Resident #17 had left the facility unauthorized and had return later on that same night. The LNHA further stated that "allegedly," Resident #17 had got out the facility through the [redacted]. The surveyor asked if he reported the [redacted] incident to the NJDOH to which he responded that they "assumed" that the resident got out. The LNHA further stated that he did not report the [redacted] incident to the NJDOH as an elopement. During an interview with the surveyor on 12/14/23 at 4:06 PM, the DON stated that Resident #17 somehow got out of the facility on [redacted]. The DON further stated that the resident may have gotten the codes and left through the [redacted]. The DON added that the resident left the facility via the [redacted] and not [redacted]. The DON further stated that Resident #17's leaving the building on [redacted] was not reported to the NJDOH, but that she should have reported the incident as an [redacted]t.	F 835		
F 838 SS=L	NJAC 8.39-9.2(a), Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at	F 838		2/27/24

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least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies

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F 838	Continued From page 93 related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Complaint # NJ 161818; 164283, 168432, 168784; 168987; 170340, 170340, and 170605. Based on interviews and review of other pertinent facility documentation on, NJ EX Order. 264b1 it was determined that the facility failed to: a.) ensure that the facility-wide assessment (FA) evaluated its resident population and b.) identify the resources needed to provide the necessary care and services required for residents admitted with a history of NJ EX Order. 264b1 and/or who NJ EX Order. 264b1 while at the facility. This placed all residents with a history of NJ EX Order. 264b1, as well as all other residents at risk for NJ EX Order. 264b1 and/or NJ EX Order. 264b1 while at the facility, in an Immediate Jeopardy (IJ) situation. The Assistant Director of Nursing (ADON) was notified of the IJ on 0 NJ EX Order. 264 at 6:15 PM and was provided the IJ template. The IJ began on NJ EX Order. 264b1 and continued thru NJ EX Order. 264 4 when the facility reevaluated and revised the facility assessment to address the resident population	F 838	F838 Corrective Action: 1. Upon identification, the Facility Assessment was updated on NJ EX Order. 264, to ensure that the facility-wide assessment evaluated its resident population, identified the resources needed to provide the necessary care and services required for residents admitted with a history of NJ EX Order. 264b1 and/or who NJ EX Order. 264b1 while at facility. 2. On NJ EX Order. 264 the Quality Assurance and Performance Improvement Committee meeting was held, and the revised facility assessment was introduced and accepted. 3. On NJ EX Order. 264, the facility assessment was initially reviewed and revised. On NJ EX Order. 264, the facility assessment was reviewed again, and the following areas were added and addressed: " The types of care required for residents based on their diagnosis, physical and cognitive abilities, overall	

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F 838	Continued From page 94 with a history of NJ EX Order. 264b1 and/or who overdose while at the facility. The facility provided an acceptable Removal Plan on NJ EX Order. 264b1 at 3:16 PM. On 1/25/24, the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on NJ EX Order. 264b1 at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy On NJ EX Order. 264b1, the facility implemented the Removal Plan, which included the following: -On NJ EX Order. 264b1, the facility assessment was reevaluated and revised to include an evaluation of the care required by residents with NJ EX Order. 264b1 NJ EX Order. 264b1 and residents with a history of NJ EX Order. 264b1. -On NJ EX Order. 264b1, a Quality Assurance & Performance Improvement meeting was held, and the revised facility assessment was introduced and accepted. This deficient practice was evidenced by the following: Review of the facility's undated "Facility Assessment Policy and Procedures" policy revealed under the "Policy" section that facility "would conduct and document a FA to determine the resources necessary to care for its residents competently, during both the day-to-day operations and emergencies. The facility would review and/or revise the assessment as necessary and as required by law." Under the "Procedure" section indicated that the facility shall made a FA to "determine what resources are necessary to care for its residents competently	F 838	acuity. " Staff competencies required to provide the level and types of care required to care for the residents. " The physical environment, equipment, and services necessary to care for the resident population. " Any ethnic, cultural, or religious factors that could affect the care provided by the facility. 4. Corporate website was reviewed to assure that services provided at the facility were accurately reflected on the company□s website. 1. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 2. Measures Put into Place: The Facility Assessment will be audited monthly by the Administrator and/or designee to assure it is signed and dated commensurate with this document being updated and/or reviewed. 3. How Will These Actions Be Measured: Results of the monthly audit will be completed by the Administrator and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting	

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during both the day-to-day operations and emergencies." The policy further indicated that "B. The assessment must address or include a. The facility's resident population, including, but not limited to ... ii. the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; iii. The staff competencies that are necessary to provide the level and types of care needed for the resident population;"

Review of the facility's website indicated they "specialize in methadone maintenance and can accept NJ EX Order. 264b1 patients. Our facilities at Sterling offer a safe, comfortable, and supportive environment where all our residents can focus on their recovery and receive the care and attention they need. Our staff is dedicated to providing high-quality care to individuals, including those struggling with NJ EX Order. 264b1. The team of professionals at Sterling has extensive experience in treating patients with NJ EX Order. 264b1 and helping them on the path to recovery. There are unique challenges that come with NJ EX Order. 264b1, and we understand that. Our staff is equipped with the knowledge and resources to support our residents. Whether it's through individual therapy, group (medication to treat NJ EX Order. 264b1) support, or a range of recreational activities, we strive to empower our residents and help them achieve their goals."

Under the "Clinical Specialties" section indicated that they provided addiction management, NJ EX Order. 264b1c medication used to treat NJ EX Order. 264b1) and NJ EX Order. 264b1 (medication to treat NJ EX Order. 264b1) maintenance.

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F 838	Continued From page 96 Review of the facility's "Facility Assessment," provided by the Licensed Nursing Home Administer (LNHA), indicated the assessment was reviewed on [redacted]3. Under the "Purpose" section, it stated that "the purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies ...Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require." Further review of the facility's FA, revealed that the FA lacked the following required components for the resident population with a history of substance abuse and/or who overdose while at the facility: - A description of the facility's resident population; - The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that were present within that population - The staff competencies that were necessary to provide the level and types of care needed for the resident population; - The physical environment, equipment, and services necessary to care for the resident population; and - Any ethnic, cultural, or religious factors that could affect the care provided by the facility,	F 838		

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including, but not limited to, activities and food and nutrition services.

The facility assessment did not include any documentation that addressed the resident population that was admitted to the facility with a history of NJ EX Order. 264b1 and/or who NJ EX Order. 264b1 at the facility.

During an interview with the surveyor on 12/28/23 at 1:14 PM, the Assistance Director of Nursing (ADON) stated that there was a physician, from the 'NJ EX Order. 264b1 Program" that comes in and evaluate the residents on NJ EX Order. 264b1 This is a medication used to treat NJ EX Order. 264b1 in NJ EX Order. 264b1 who have agreed to be treated for their NJ EX Order. 264b1. The physician would assess the residents and issue a prescription for NJ EX Order. 264b1 weekly. The surveyor inquired about the care and service available for the residents with a history of su NJ EX Order. 264b1 and/or who overdosed at the facility. The ADON stated that the NJ EX Order. 264b1 program was outsourced to NJ EX Order. 264b1 that provide NJ EX Order. 264b1) and NJ EX Order. 264b1 (a facility that NJ EX Order. 264b1) The ADON further stated that she did not know which residents were enrolled into the programs and that the Director of Admissions (DA) would be able to provide further information about the NJ EX Order. 264b1 and NJ EX Order. 264b1 programs.

During an interview with the LNHA on 12/28/23 at 2:06 PM, the surveyor inquired about the aforementioned advertisement displayed on the facility website. The LHNA stated if the

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aforementioned advertisement was on the website, he never saw it and that "corporate" was responsible for the website. The LNHA stated that they did not provide anything onsite and that "corporate" was responsible for the website. The LNHA continued that "corporate" had a contract with "NJ EX Order. 264b1 and that they did not provide anything onsite. The facility staff did not have the credentials to counsel the residents and that they would assist in setting up the resident with outside resources. The LNHA stated that the in-house staff did not have any special education that addressed the care of residents with NJ EX Order. 264b1 The LNHA added that they "just set them up and hope they stay in the program."

During an interview with the surveyor on 12/29/23 at 11:16 AM, the DA stated the facility had a contract with NJ EX Order. 264b1 and that it was a "NJ EX Order. 264b1 " that provided both outpatient and inpatient services in the community. The DA stated that she connected with the case worker there and that they were looking for placement for residents that required a higher level of care. The residents would be evaluated, if approved, a referral would be initiated. The DA continued that NJ EX Order. 264b1 also had a "virtual program" and that therapy sessions with the resident would be conducted virtually. The DA further stated that the NJ EX Order. 264b1 was a day program for residents with NJ EX Order. 264b1 and NJ EX Order. 264b1 l issues. The resident would be picked up and taken to the day program, located in NJ EX Order. 264b1. The residents would be fed, provided with group counseling sessions, and then brought back to the facility. The surveyor asked if there were any residents actively enrolled in either the NJ EX Order. 264b1 programs to which the DA responded that there was no

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F 838	Continued From page 99 resident actively using the services provided by the programs. During a follow-up interview with the surveyor on 01/04/24 at 2:36 PM, the LNHA explained the steps taken to develop the FA. The LNHA stated that he met with his interdisciplinary team and department heads and went through each department to discuss what issues they had that needed to be resolved. The surveyor asked if resident admitted with a history of NJ EX Order. 264b1 e and/or who NJ EX Order. 264b while at the facility was addressed in the facility assessment. The LNHA responded that he would have to double check. The LNHA stated that he did not think residents with NJ EX Order. 264b1 or NJ EX Order. was addressed in the FA and that he would have to look into it. The LNHA stated that the facility census was NJ EX Or and that there were approximately NJ EX Order. residents in the facility with a history of NJ EX Order. 264b1 r. The LNHA further stated that based on the challenges that they had in the building, it would be beneficial to address residents with a history of NJ EX Order. 264b1 e and/or who NJ EX Order. 264b1 while at the facility in the FA.	F 838		
F 842 SS=D	NJAC 8:39-5.1(a) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		2/27/24

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accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 101 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint NJ #161818, NJ #168784, NJ #168987 Based on interview and review of medical records and other pertinent facility documentation, it was determined that the facility failed to maintain complete and accurate medical records by not documenting a.) every NJ Ex -minute checks for a resident that allegedly NJ EX Order. 264b1 and b.) follow-up NJ Ex Order. 264b1 l evaluations (NJ Ex Order. 264b1) after an NJ EX Order. 264b1 l for 2 of 12 residents (Resident #1 and #7) reviewed for NJ Ex Order and NJ Ex Order. 264b1 This deficient practice was was evidenced by the following:	F 842	F842 Immediate Action: 1. Policy and observation check list for Q 15-minute checks was reviewed and revised on 2/2/24. 2. Activity and nursing staff were educated by the DON/Designee on the revised policy on 2/13/24 and will be completed by 2/27/24 related to resident # 1 and #7□s lack of documentation of NJ Ex Ord minute checks and neuro assessment. 3. Education provided to Clinical Nurses on neuro assessment and documentation on 2/15/24 and will be completed by 2/27/24. Identification of Others 1. The deficient practice has the	

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F 842	Continued From page 102 1.) According to the Face Sheet (FS), Resident #1 was admitted to the facility with the diagnoses which included but not limited to, [redacted]. The quarterly Minimum Data Set (MDS) an assessment tool utilized to facilitate resident care, dated [redacted] reflected that Resident #1 was [redacted] and scored a [redacted] on the Basic Interview for Mental Status (BIMS). The MDS also indicated that the resident had no behaviors and required supervision with activities of daily living (ADL's). The surveyor reviewed the Facility Reportable Event (FRE) dated [redacted]. The FRE indicated that on [redacted], Resident #1 came into Resident #2's room and [redacted] the front of his/her [redacted] and stole a [redacted]. The residents were separated, and the police were notified. The FRE also indicated that Resident #1 was [redacted] by the police and was placed on [redacted] monitoring. The surveyor reviewed Resident #1's behavior progress note (PN) dated [redacted] at 09:31 AM, which indicated that the nurse was notified by another resident that Resident #1 [redacted] the [redacted] Resident #2's [redacted] and took a [redacted]. The note also indicated that the residents were separated, [redacted] was notified to conduct and evaluation on the resident. The note also reflected that [redacted] intervention was called and the [redacted] center was unable to assist because Resident #1 did not have a [redacted] diagnosis. The note also reflected that the resident was put on [redacted]. The PN dated 02/26/23 at 06:39 AM, the nurse documented that Resident #1 was in the	F 842	potential to affect all residents. Systemic changes 1. A revised policy was implemented for [redacted]-minute checks on 2/13/24. 2. Residents on [redacted]-minute checks will have their [redacted]-minute documentation audited daily by the DON/designee. 3. Neuro assessments/neuro-checks will be audited daily by DON/Designee for appropriate documentation. Quality monitoring 1. The director of nursing/designee will bring results of the daily monitoring of Q [redacted]-minute checks and neurochecks/documentation to the Quality Assurance Process Improvement committee monthly x 6 months for review and further recommendations.	

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resident's room and that every [redacted]-minute checks were completed. The surveyor could not locate the form that included the every [redacted] minute checks for Resident #1 after the resident had a altercation with another resident on [redacted] 3.

The surveyor reviewed a PN dated [redacted] at 18:04 (06:04 PM) which indicated that Resident #1 was on [redacted] precautions" and was in his/her room watching television.

On 12/11/23 at 11:55 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #1) who documented the PN on [redacted] at 18:04 (06:04 PM). LPN #1 clarified with the surveyor what she meant when she documented that Resident #1 was on [redacted] precautions". LPN #1 stated that it meant that the resident was on every [redacted] minute checks. She stated that she could not remember if she documented the checks on the every [redacted]-minute check form.

On 12/11/23 at 12:20 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who explained the investigative process regarding NJ EX Order. 264b1t abuse. The LNHA explained that if residents had an altercation with one another the residents were separated, rooms were changed, statements would be acquired by residents involved and staff statements going back 24 hours. He also stated that during the investigative process interventions would be put in place and resident CPs would be updated to include interventions to prevent further incident and to assure resident safety. The LNHA stated that if a resident was put on every(q) [redacted] minute checks or [redacted]-minute checks the nurses would document on every [redacted] minute check form and

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that the form would be included in the resident's medical record.

On 12/13 /23 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) who stated that q [redacted]-minute checks were documented on a form that the nurse completes. She also indicated that q [redacted]-minute checks should also be documented on the resident's Care Plan (CP). The DON stated that every [redacted]-minute checks were a nursing intervention and that a physician's order was not required.

On 12/14/23 at 09:20 AM, the surveyor interviewed the DON who stated that she was not able to locate the documentation for Resident #1 when every [redacted] minute checks were completed. The DON stated she could not locate the form.

On 12/14/23 at 09:25 AM, the surveyor interviewed LPN #2 who indicated that when a resident was put on every [redacted]-minute checks there was a specific form that the nurses complete that include the time the check was done and what type of activity the resident was doing at the time the nurse checked the resident.

On 12/14/23 at 10:52 AM, the surveyor interviewed the Registered Nurse Minimum Data Set Coordinator (RN/MDSC) who stated that the form for every [redacted]-minute checks was not located in the electronic medical record (EMR). She stated that the nurses document that they checked on the resident of a paper form. She added that there was a space on the form that indicated where the resident was at a specific time. She stated that every [redacted]-minute checks should also be documented on the Care Plan as a safety intervention.

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On 12/14/23 at 12:46 PM, the LNHA stated that if DON could not provide the form for Resident #1's q [redacted] minute checks that were to be completed after the resident to resident altercation of [redacted]. He stated that they could not provide it to the surveyor, because they could not find it.

2.) On 12/11/23 at 10:05 AM, the surveyor observed Resident #7 lying in bed. The resident stated that on 1[redacted], he/she [redacted] out of bed trying to [redacted] his/her wheelchair. The resident further stated that it took approximately [redacted] for someone to come to his/her room after the [redacted] and when the nurse arrived, the nurse did not assess him/her or take vital signs. When asked about the resident's level of consciousness during the incident, the resident stated he/she was "[redacted]

According to the Admission Record, Resident #7 had diagnoses which included, but were not limited to, [redacted]

Review of the significant change in status MDS dated [redacted], included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's [redacted] Further review of the MDS included the resident had [redacted]) to the [redacted] and was [redacted] on staff for bed-to-chair transfers.

Review of the resident's Care Plan, revised [redacted], included focus areas that the resident had [redacted] and was a high risk [redacted] related to [redacted] a.

Review of the Progress Notes included a nursing

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note written by Registered Nurse (RN) #1, dated [redacted] at 10:56 PM, which included that, "Around 7:30 pm, staff/CNA [Certified Nursing Assistant] reported found resident sitting on the floor close to bed side. Resident assessed noted [redacted] Assessed noted with no visible injury from [redacted] check noted with no deficit ...Vital sign noted ... [physician] notified with new order for ER [emergency room] visit. Paramedics came took resident to [hospital] ER for further evaluation at 8:10 pm."

Review of a Progress Note, dated [redacted] at 2:49 PM, included, "This writer called [hospital] at patient was admitted to hospital DX [diagnoses] [redacted], and [redacted]."

Review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) by the Director of Nursing (DON), dated [redacted], included that, "On [redacted] approximately 7:30 PM, [Resident #7] was found on the floor in [his/her] room next to [his/her] bed. Informed also that resident was [redacted] checks abnormal with [redacted]. 911 dispatched and physician made aware."

Review of the [redacted] Assessment Flow Sheet for Resident #7, dated [redacted] revealed there was only [redacted] check documented at 7:30 PM.

During a phone interview with the surveyor on 12/13/23 at 10:38 AM, Registered Nurse (RN #1) stated that the day Resident #7 [redacted], the CNA found the resident on the floor and then notified

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him of the incident. The RN further stated that he went down to the resident's room, assessed the resident, called 911 because the resident was [redacted], and notified the physician.

During an interview with the surveyor on 12/14/23 at 10:43 AM, RN/MDS Coordinator (RN/MDSC) stated that when a resident [redacted], the nurse should be notified and a RN should assess the resident by obtaining vital signs and performing [redacted], if the [redacted] was unwitnessed or the resident NJ EX Order: 264b1. RN/MDSC further stated that [redacted] checks are documented on a paper form and it is important to conduct [redacted] checks to make sure the resident does not have a [redacted].

During a phone interview with the surveyor on 12/14/23 at 1:15 PM, LPN #3, who assisted during Resident #7's [redacted], stated that the day Resident #7 [redacted] she was not assigned to the resident. She further stated that RN #1 assessed the resident and called 911 while she obtained the resident's vital signs. When asked about [redacted] checks, the LPN stated that neuro checks should be done [redacted] minutes for the f[redacted] hour after a resident [redacted], but was unsure if the RN conducted [redacted] checks on Resident #7. The LPN stated it is important to conduct [redacted] checks for NJ EX Order: 264b1 to assess for [redacted] y.

During an interview with the surveyor on 12/13/23 at 3:38 PM, the DON stated that when a resident [redacted] the [redacted] should be reported to the nurse assigned to the resident, the nurse should assess the resident to rule out injuries, notify the physician, and initiate the incident report. The DON further stated that the nurse should conduct

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NJ EX Order checks as instructed on the form or until the resident is transferred to the hospital. The DON then verified that if the resident was found on the floor at 7:30 PM and NJ EX Order checks were initiated, there should have been NJ EX Order checks documented every NJ EX minutes before the resident was transferred to the hospital at 8:10 PM. The DON stated the importance of NJ EX Order checks was to assess for any NJ EX Order. 264b1 from baseline and to ensure the resident is n NJ EX Order. 264b1 intact.

Review of the undated facility policy titled, "Charting and Documentation" indicated that all services provided to the resident or any changes to the resident's medical or mental condition shall be documented in the reisdent's medical record. The policy also indicated that all observations, medications administered, services performed [ect] must be documented in the resident's medical record.

Review of the NJ EX Order. 264b1 and Completion of NJ EX Order. 264b1 Flowsheet form, undated, provided by the DON, included, NJ EX Order. 264b1 are to be performed on all NJ EX not witnessed by staff. The NJ EX Order. 264b1 Flowsheet is to be completed per the instructions at the top of the page using the following guidelines:
1st hour = Every 15 minutes
2nd hour = Every 30 minutes
3rd, 4th hour = Every 1 hour, then
Every 4 hours up to 72 hours (3 days)"

Review of the NJ EX Order. 264b1 Assessment policy, undated, included, "The purpose of this procedure is to perform NJ EX Order. 264b1 sign assessment ... when following a NJ EX either witnessed or unwitnessed ... NJ EX Order. 264b1

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F 842	Continued From page 109 assessments are the responsibility of licensed nursing personnel." Further review of the policy included, "The following information should be recorded in the resident's medical record 1. The date and time of the procedure was performed. 2. The name and title of the individual(s) who performed the procedure 3. All assessment data ... obtained during the procedure. Utilize Neurological Assessment Flow Sheet 4. How the resident tolerated the procedure 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data." NJAC 8:39-35.2 (d) 6, 16(e)	F 842		
F 865 SS=L	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development,	F 865		2/27/24

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implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

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F 865	Continued From page 111 §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the	F 865		

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F 865	Continued From page 112 requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ161818, NJ163153, NJ163899, NJ164283, NJ165180, NJ165492, NJ165742, NJ168168, NJ168204, NJ168425, NJ168432, NJ168784, NJ168983, NJ168987, NJ169922, NJ169973, NJ169965, NJ169972, NJ170340, and NJ170605. Based on interviews, record review, and review of the Quality Assessment and Performance Improvement (QAPI) on NJ EX Order. 264b1 NJ EX Order. 264b1 t was determined that the facility failed to ensure that the QAPI committee developed and implemented an action plan that addressed the concerns they identified for high-risk residents with a history NJ EX Order. 264b1 NJ EX Order. 264b1 at the facility, and bringing NJ EX Order. 264b1 into the facility. The facility was aware of NJ EX Order. 264b1 that happened at the facility and was aware of NJ EX Order. 264b1 that were entering the facility and being used by residents. Specifically, the QAPI committee failed to develop an action plan that addressed the concerns they identified, which were the NJ EX Order. 264b1 at the facility and the NJNJ EX Order entering the building. These deficient practices placed all residents with a history of NJ EX Order. 264b1 at risk for an	F 865	F865 1. Corrective Action: 1. A QAPI meeting was immediately scheduled on 1/18/24 to address the facilities systems related to initiating and executing investigations of unusual occurrences and implementing relevant, timely interventions for risk mitigation. 2. On 1/20/24 a rapid response/trigger call protocol was developed and implemented to provide enhanced communication and immediate incident management. 3. Education on the QAPI program was initiated on 1/22/24 by DON/designee. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents with a history of NJ EX Order. 264b1. 3. Measures Put into Place: 1. Daily administrative and clinical meeting information will be reviewed by the DON/designee daily. Areas requiring additional focus will be referred to QAPI for consideration of Performance improvement planning. 4. How Will These Actions Be Measured:	

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F 865	Continued From page 113 Immediate Jeopardy situation. On [redacted]4, an Immediate Jeopardy (IJ) Federal citation was identified and reported to the facility's Assistant Director of Nursing (ADON) on [redacted] at 6:15 PM. The ADON was provided with the IJ template that included information about the issue. The IJ began on [redacted] when the facility's QAPI committee held its first meeting after the initial overdose but failed to address the issues, and it continued through [redacted] when the facility had the QAPI meeting to address the issues. The facility emailed an acceptable Removal Plan to the New Jersey Department of Health on [redacted] at 3:16 PM. On [redacted] the Surveyors conducted a revisit and verified that the Removal Plan was implemented. The noncompliance remained on [redacted] at a level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. On 01/18/24, a QAPI meeting was held, the QAPI Committee addressed the "Performance Improvement Project Plan," which included the facility's failure to initiate and execute comprehensive investigations of unusual occurrences, and failure to initiate and implement relevant, timely interventions for risk mitigation. According to the plan, the following steps are to be implemented: Unusual occurrences will be thoroughly investigated in a timely manner, leading to risk mitigation and improved outcomes. Creation and implementation of a new rapid response/ trigger call protocol to provide enhanced communication and real-time incident management. Timely implementation of risk mitigation strategies and care plan interventions. The facility also provided education on the QAPI program to all staff.	F 865	The results of the daily reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly, comprised of internal idcp staff, for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 865	Continued From page 114 This deficient practice was evidenced by the following: Review of the facility's undated "Quality Assurance & Performance Improvement ("QAPI") Policy and Procedure." Under: Purpose: To ensure that... ("the Facility") implements a comprehensive program which addresses all the care and unique services the Facility provides; to ensure continuous evaluation of the Facility's systems with the objectives of: ensuring that care delivery systems function consistently, accurately, and incorporate current and evidence-based practice standards where available. Under "Policy" I. It is the policy of the facility to develop implement and maintain an effective comprehensive data-driven corporate program that focuses on indicators of the outcomes of care and quality of life. Under "Procedure," The Facility will maintain a QAPI program that will ensure that the Facility obtains feedback, uses data, and takes action conduct structured, systemic investigations and analysis of underlying causes or contributing factors of problems affecting facility wide processes that impacts quality of care, quality of life, and resident safety. The QAPI program will include the following components: A. "Programs Feedback:" a. Facility maintenance of effective system to obtain unused feedback and input from direct use that staff residents and resident representative included such information problems that are high risk high volume or problem opportunities for improvement." B. "Data Collection Systems:" a. Facility maintenance effective system to identify, collect,	F 865		

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and use data and information from all departments, including but not limited to the required facility assessment and including how such information will be used to develop and monitor performance indicators."

Review of the facility's website indicated they "...specialize in methadone maintenance and can accept NJ EX Order. 264b1 patients. Our facilities at Sterling offer a safe, comfortable, and supportive environment where all our residents can focus on their recovery and receive the care and attention they need. Our staff is dedicated to providing high-quality care to individuals, including those struggling with NJ EX Order. 264b1 The team of professionals at Sterling has extensive experience in treating patients with NJ EX Order. 264b1 and helping them on the path to recovery. There are unique challenges that come with substance abuse, and we understand that. Our staff is equipped with the knowledge and resources to support our residents. Whether it's through individual therapy, group NJ EX Order. 264b1 -is a medication to treat NJ EX Order. 264b1 support, or a range of recreational activities, we strive to empower our residents and help them achieve their goals."

The "Clinical Specialties" section indicated that they provided NJ EX Order. 264b1 management, NJ EX Order. 264b1 (a NJ EX Order. 264b1 medication used to treat NJ EX Order. 264b1 NJ EX Order. 264b1 , and NJ EX Order. 264b1 (medication to treat NJ EX Order. 264b1) maintenance.

Review of the facility's "Quality Assurance Improvement," committee meeting minutes provided by the Licensed Nursing Home Administer (LNHA), revealed the meetings were completed on NJ EX Order. 264b1 , and NJ EX Order. 264b1 .

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However, the QAPI meetings did not include any documentation that addressed the resident population that was admitted to the facility with a history of NJ EX Order. 264b1, who NJ EX Order. 264b1 at the facility, and/or NJ EX Order. 264b1 into the facility.

During an interview on 12/28/23 at 1:14 PM, the Assistance Director of Nursing (ADON) stated that there was a physician from the "Cooper NJ EX Order. 264b1" who came in and evaluated the residents on NJ EX Order. 264b1. This is a medication used to treat NJ EX Order. 264b1 in NJ EX Order. 264b1 who have agreed to be treated for their NJ EX Order. 264b1. The physician would assess the residents and issue a prescription for NJ EX Order. 264b1 weekly. The surveyor inquired about the care and service available for the residents with a history of NJ EX Order. 264b1 and/or NJ EX Order. 264b1 at the facility.

The ADON stated that the Narcotics Anonymous (NA) program was outsourced to NJ EX Order. 264b1 (an outside NJ EX Order. 264b1 center that provides virtual meetings with a counselor) and Unity Place (a facility that provides community-based individualized treatment services to individuals NJ EX Order. 264b1 illness, NJ EX Order. 264b1, and/or NJ EX Order. 264b1 disorders.) The ADON further stated that she did not know which residents were enrolled into the programs and that the Director of Admissions (DA) would be able to provide further information about the NJ EX Order. 264b1 and NJ EX Order. 264b1 programs.

During an interview with the LNHA on 12/28/23 at 2:06 PM, the surveyor inquired about the aforementioned advertisement displayed on the facility's website. The LHNA stated if the advertisement above was on the website, he

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never saw it and that "corporate" was responsible for the website. The LNHA stated that they did not provide anything onsite and that "corporate" was responsible for the website. The LNHA continued to say that "corporate" had a contract with [redacted] and that they did not provide anything onsite. The facility staff did not have the credentials to counsel the residents and that they would assist in setting up the residents with outside resources. The LNHA further stated that the in-house staff did not have any special education that addressed the care of residents with NJ EX Order. 264b1 . The LNHA added that they "just set them up and hope they stay in the program."

During an interview with the surveyor on 12/29/23 at 11:16 AM, the DA stated the facility had a contract with [redacted] and that it was a [redacted] center" that provided both outpatient and inpatient services in the community. The DA stated that she connected with the case worker there and that they were looking for placement for residents who required a higher level of care. The residents would be evaluated, and if approved, a referral would be initiated. The DA continued that [redacted] e also had a "virtual program" and that therapy sessions with the resident would be conducted virtually. The DA further stated that the [redacted] was a day program for residents with NJ EX Order. 264b1 and [redacted]. The resident would be picked up and taken to the day program located in another town.

The residents would be fed, then provided with group counseling sessions, and then brought back to the facility. The surveyor asked if any residents were actively enrolled in either the [redacted] or [redacted] programs, to which the

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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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DA responded that no resident was actively using the services provided by the programs.

During a telephone interview with the surveyor on 01/05/24, the surveyor asked if the facility had developed a QAPI plan that addressed the [redacted] entering the building and residents who [redacted] at the facility. The LNHA stated that the Interdisciplinary Team (team) had discussed the issue. The LNHA further stated that they [team] thought about developing QAPI plans for the concerns mentioned above but never got a chance to initiate them.

During an interview with the surveyor on 01/12/24 at 11:22 AM, the LNHA stated that on [redacted], he received calls from the security guard (SG) about family members attempting to bring [redacted] into the facility. The LNHA further stated that the SG informed him that while checking in family members, [redacted] were found in packages being delivered to the residents. At which time, the LNHA confirmed that there had [redacted] separate incidents on [redacted], where a family member attempted to drop off [redacted] to the resident. The LNHA stated that one family member attempted to drop off a [redacted] for a resident. Upon inspection of the cereal box, the SG observed that the bottom of the [redacted] box had been opened, and a package [redacted] was inserted inside. At that time, the SG confiscated the package [redacted]. The LNHA continued that another resident's family member attempted to drop off a [redacted] to a resident. Upon inspection of the [redacted], the SG observed a [redacted] or some other [redacted] placed inside of the [redacted] gel with [redacted]. At that time, the SG confiscated

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the NJ EX Order. 264b1 that was hidden inside of the NJ EX Order. 264b1. The LNHA stated that he instructed the SG to NJ EX Order. 264b1 " the NJ EX Order. 264b1 in a lock box located at the reception area until his return to the facility on NJ EX Order. 264b1 He removed the illicit substances from the reception area on Monday and placed them in his office. The LNHA stated that he brought the NJ EX Order. 264b1 to the police station on NJ EX Order. 264b1. The surveyor asked if the residents' family had visited the facility before. The LNHA responded that he did not know and would have to double-check with the SG. The surveyor then asked the LNHA for the residents who were supposed to receive the packages and if those family members had prior visits to the facility. The LNHA stated that he did not know "off head" the residents' names involved or if the family members mentioned above had previously visited the facility. The surveyor asked the LNHA to explain his investigation process into the NJ EX Order. 264b1 incidents. The LNHA stated that he was not sure if the SG had questioned the family members attempting to bring in the NJ EX Order. 264b1 and that the SG checked the bags per the new policy that had been implemented. The family members did not stay with the packages and had just dropped them off and left. The LNHA further stated he had not followed up or spoken with the residents who were supposed to receive the packages. The surveyor asked if the SG informed the manager or supervisor on duty that day about the confiscated packages. The LNHA responded that he was not sure if the SG relayed to the staff on duty that he found NJ EX Order. 264b1. The LNHA continued that an incident report was not completed and that he did not initiate an internal investigation into the incidents. The LNHA explained the investigation process the facility

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F 865	Continued From page 120 followed for accidents/incidents. The LNHA explained that an 'Incident Report" would be completed and that he would gather all the facts. He would meet with the individuals involved, collect statements, and then a summary and conclusion would be completed. The LNHA stated that the purpose of this process was to try to curtail any issues and prevent it from happening again. The LNHA further stated that it was a first for him and that he never had to deal with [redacted] a facility before. The surveyor asked who was responsible for completing the investigation of the incidents above. The LNHA responded that he was responsible for conducting the investigation. NJAC 8:39-33.1 (b) (e); 33.2 (a)	F 865		

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S 000	Initial Comments Complaint #s: NJ: 161818, 163153, 163899, 164283, 165180, 165492, 165742, 168168, 168204, 168425, 168432, 168784, 168983, 168987, 169922, 169973, 169965, 169972, 170340, and 170605. Census: 100 Sample Size: 28 The facility was 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 deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	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: Complaint # NJ169922 Based on facility document review on 12/14/2023 and on 12/29/2023, it was determined that the facility failed to ensure staffing ratios were met to	S 560	S560 Immediate Action 1. Staffing coordinator was educated on New Jersey state staffing ratio	2/27/24

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

Electronically Signed | 02/14/24

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S 560	Continued From page 1 maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 13 of 22 day shifts and 1 of 21 night shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. The surveyor requested staffing for the weeks of 11/26/2023 to 12/2/2023 and 12/3/2023 to 12/9/2023. The facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:	S 560	requirements on 2/13/24. 2. Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. 3. Facility Administrator worked with Human resources to secure additional staffing agency contracts. 4. Interdisciplinary team met on 2/8/24 to discuss recruitment and retention interventions which included scheduling a job fair to be held on 3/27/24 . Identification of Others All residents have the potential to be affected by the deficient practice. Systemic changes 1. Weekly recruitment, retention and employee appreciation meeting was initiated and will be led by the Director of Human Resources and/or designee. 2. Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. 3. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. 4. The facility administrator/designee will continue to track and document all recruitment and retention efforts weekly. 5. The administrator/designee will review staffing schedules weekly to ensure adequate staffing for all shifts.	

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S 560	Continued From page 2 -11/26/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/01/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/02/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/04/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/05/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/08/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. 2. The surveyor requested staffing for the weeks of 12/17/2023 to 12/23/2023. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -12/17/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/18/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/19/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/20/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/21/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/22/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/22/23 had 6 total staff for 101 residents on the overnight shift, required at least 7 total staff. -12/23/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs.	S 560	Quality monitoring The results of these reviews will be submitted to the Quality Assurance Performance Improvement Committee monthly for 6 months. Based on the audit results, a decision will be made regarding the need for continued submission and reporting.	

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S 885	Continued From page 3	S 885		
S 885	8:39-9.4(e)(4) Mandatory Administration (e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following: 4. All fires, disasters, deaths, and imminent dangers to a resident's life or health resulting from accidents or incidents in the facility. This REQUIREMENT is not met as evidenced by: Complaint #: NJ170605 Based on observation, interview, review of medical records, and review of other pertinent facility documentation on 12/11/23, 12/12/23 and 12/14/23, and 01/12/24, it was determined that the facility failed to a) notify the New Jersey Department of Health (DOH) immediately by telephone and failed to provide written confirmation to the DOH within 72 hours of an imminent danger to a resident's life or health resulting from an accident or incident in the facility. The deficient practice was identified for Resident #3, Resident #17, Resident #27, and Resident #28, 4 of 9 residents reviewed for substance abuse and was evidenced by the following:	S 885	S885 Immediate Action 1. On 1/16/24 the Department of Health was notified of reportable events related to resident #□s #3, #17, #27 and #28. 2. LNHA is no longer employed at the facility. 3. The New LNHA was oriented on 1/17/24 to his job description which included notification to the Department of Health regarding All fires, disasters, deaths, and imminent dangers to a resident□s life or health resulting from accidents or incidents in the facility. Identification of Others	2/27/24

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S 885	Continued From page 4 1.) According to the Admission Record (AR), Resident #3 was admitted to the facility in June 2023 with diagnoses that included but not limited to insomnia, opioid dependence, polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body), and nicotine dependence. Review of Resident #3's Progress Notes (PN) revealed a 08/03/23 at 11:08 PM "Nurses Note" (NN), that at around 4:30 PM Resident #3 was disoriented, confused, and mumbling. The resident appeared not to have the ability to focus their attention and was not making sense when communicating. The resident was unable to recall what happened and was repeatedly asked with no effect. Resident #3 was administered Narcan at 4:43 PM with good effect. This medication is used to treat narcotic overdose in an emergency situation. The resident "appeared to recover, became alert and oriented but agitated and did not wish to discuss the matter further." Review of Resident #3's PN, revealed a 09/21/23 at 5:09 PM NN, that Resident #3 was received from another resident's room unconscious by the Certified Nurse Aide (CNA). The resident was assessed and noted as being incoherent with speech with pinpoint eyes which then rolled to the back of his/her head. A sternum rubbed (a technique to test an unconscious person's responsiveness) was ineffective and Narcan 4mg was administered at 4:40AM and 4:43AM. Resident #3's respiratory rate dropped to 4 breaths per minute (BPM) and another dose of Narcan 4mg was administered. 911 was called and the resident was transferred to hospital for accidental overdose.	S 885	All residents have the potential to be affected by the deficient practice. Systemic changes 1. The Accident and Incident, Unusual Occurrence Tracker was implemented as a daily audit tool to check timely interventions of safety, risk mitigation strategies and care plan interventions and is brought daily to morning clinical meeting. Quality monitoring 1. The director of nursing/Administrator and/or designee will audit all alleged and actual incidents to ensure proper handling and reporting in accordance with facility policy and federal regulations. Negative audit results will be corrected immediately. Audit results will be reported to the QAPI committee monthly x 6 months for review and further recommendations.	

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S 885	Continued From page 5 Review of Resident #3's 09/21/23 "Drug of Abuse Panel, Urine" lab results, completed at the hospital, revealed that the resident tested positive for benzodiazepines (a class of drugs that produce central nervous system depression), cocaine (an intense, euphoria-producing stimulant drug with strong addictive potential), methadone (medication used to treat Opioid Use Disorder), and oxycodone (a narcotic used to treat moderate to severe pain). Review of Resident #3's PN revealed a 09/28/23 at 9:00 AM NN, that at 8:21 AM, she was notified by the CNA that the resident needed to be seen because he/she did not appear to look okay. Resident #3 was observed lying on their back with their arms hanging downwards. The resident was unresponsive, and a sternum rub was ineffective. The nurse administered Narcan 4 mg at 8:25 AM with ineffective results. A second dose of Narcan 4 mg was administered at 8:28 AM and was effective after three minutes. At 8:31 AM, Resident #3 was responsive to staff and at 8:56 AM, the resident began to experience withdrawal symptoms. Further review of Resident #3's PN revealed that the resident returned to the facility from the hospital on 09/28/23, with a diagnosis of "drug abuse and heroin abuse." During an interview with the surveyor on 12/12/24 at 10:50 AM, the Director of Nursing stated that she did not report Resident #3's 08/03/23, 09/21/23, and 09/28/23 overdose incidents to the DOH. 2. According to the AR, Resident #17 was admitted to the facility in August 2023 with	S 885		

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S 885	Continued From page 6	S 885		

diagnoses that included, but were not limited to opioid dependence, anxiety disorder, and attention-deficit hyperactivity disorder.

Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/22/23, revealed that Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS also indicated Resident #3 required supervision for Activities of Daily Living.

Review of Resident #17's Care Plan revealed a "Focus," revised on 08/11/23, that Resident #17 had "a history of substance abuse and has potential for complications such as recurrence of substance abuse, mood and/or behavior disturbance.

Review of Resident #17's physician "Order Summary Report (OSR)," revealed a physician order, dated 09/18/23, of "Ancillary services/Consult. 1) Lobby supervised visits, 2) Not to have visitors in room, 3) Must be accompanied by staff to all appointments, and 4) Can not go out on pass for any reason."

Review of the 09/30/23 "Incident Report (IR)," completed by the Licensed Practical Nurse (LPN) #1, indicated that at 11:05 PM, she was notified that Resident #17 had left the facility premises unauthorized by climbing through a window. At 1:30 AM, the resident returned to the facility in a silver Sports Utility Vehicle (SUV). The staff questioned the resident, who stated that he/she had never left the facility.

Included with the IR submitted by the Director of Nursing (DON) were multiple witness statements

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about Resident #17 leaving the facility on 09/30/23.

Review of the witness statement, written by LPN #2, dated 10/01/23, indicated that she was notified by a staff member that Resident #17 had got out of the building, possibly through a window. "This nurse and several staff members searched the entire East Wing and smoking area." Resident #17 was not able to be located in the facility. Around 1:30 AM, she was informed by staff that the resident was dropped back off to the facility in a silver Rav-4 vehicle. Initially, Resident #17 denied leaving the facility but then stated that he/she had went and "got some candy, vapes (an electronic cigarette), and cigarettes."

The surveyor attempted to call LPN #1 and LPN #2 and left a voicemail for the LPNs to call the surveyor back. The surveyor did not receive a return call.

During an interview with the surveyor on 12/14/23 at 1:00PM, the LNHA confirmed that Resident #17 had left the facility unauthorized and had return later on that same night. The LNHA further stated that "allegedly," Resident #17 had got out the facility through the window. The surveyor asked if he reported the 09/30/23 incident to the DOH to which he responded that they "assumed" that the resident got out. The LNHA further stated that he did not report the 09/30/23 incident to the DOH as an elopement.

During an interview with the surveyor on 12/14/23 at 4:06 PM, the DON stated that Resident #17 somehow got out of the facility on 09/30/23. The DON further stated that the resident may have gotten the codes and left through the front doors. The DON added that the resident left the facility

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via the door and not a window. The DON further stated that Resident #17's leaving the building on 09/30/23 was not reported to the DOH, but that she should have been reported the incident as an elopement.

3.) During an interview with the surveyor on 01/12/24 at 11:22 AM, the Licensed Nursing Home Administrator (LNHA) stated that on Saturday, 01/06/24, he received calls from the security guard (SG) about family members attempting to bring illicit substances into the facility. The LNHA further stated that the SG informed him that while checking in family members, illicit substances were found in packages being delivered to the residents (Resident #27 and Resident #28). The LNHA stated that one family member attempted to drop off a box of cereal for a resident. Upon inspection of the cereal box, the SG observed that the bottom of the cereal box had been opened and a package of marijuana inserted inside. At that time, the SG confiscated the package of marijuana. The LNHA continued that another resident's family member attempted to drop off a bagel with cream cheese to a resident. Upon inspection of the bagel, the SG observed blue baggies. This is a small plastic bag used for holding small amounts of marijuana or powdered drugs, with heroin or some other illicit substance, placed inside of the bagel with cream cheese. At that time, the SG confiscated the illicit substance that was hidden inside of the bagel with cream cheese. The LNHA stated that he instructed the SG to "stash away" the illicit substances in a lock box located at the reception area until his return to the facility on Monday. LNHA further stated he did not report the 01/06/24 incidents to the DOH because he did not know that he was required to report it.

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 _____	C 01/25/2024

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 885	Continued From page 9 Review of the facility's undated "Sterling Manor Nursing Center Reporting " policy indicated that staff would administer Narcan in accordance with Stare Law to a person suffering from opioid overdose to minimize the chance of death. The policy revealed that the facility would complete a Reportable Event Record and submit it to the DOH with 24-48 hours after a complete investigation.	S 885		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060312		3/4/2024

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/27/2024	ID Prefix S0885 Reg. # 8:39-9.4(e)(4) LSC	Correction Completed 02/27/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315149 Y1	A. Building B. Wing Y2	3/4/2024 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 F0610	Correction	ID Prefix F0657	Correction	ID Prefix F0689	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	02/27/2024	LSC	02/27/2024	LSC	02/27/2024
ID Prefix F0755	Correction	ID Prefix F0835	Correction	ID Prefix F0838	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.70	Completed	Reg. # 483.70(e)(1)-(3)	Completed
LSC	02/27/2024	LSC	02/27/2024	LSC	02/27/2024
ID Prefix F0842	Correction	ID Prefix F0865	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. #	Completed
LSC	02/27/2024	LSC	02/27/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO