STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315110	A. BUILDING _____ B. WING _____	02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW REHABILITATION AND CARE CENTER	130 TERHUNE DRIVE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey: 2/23/22 Census: 78 Sample Size: 21 The facility is 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.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of clinical practice by failing to document [redacted] sites on the electronic Medication Administration Record (eMAR) for 1 of 18 residents (Resident [redacted]) reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential	F 658	1. How the corrective actions will be accomplished for those residents found to have been affected: • The nurses were in-serviced by the Assistant Director of Nursing on documenting injection sites when applicable • The involved residents had no negative effect from above. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All other records of residents receiving [redacted] medications were checked to ensure they are all	3/1/22

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

Electronically Signed | 03/28/2022

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F 658	Continued From page 1 physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and 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." On 2/11/22 at 10:15 AM, the surveyor observed Resident #[redacted] in [redacted] room, the resident was in bed listening to music on their electronic tablet. The surveyor reviewed Resident #[redacted]'s electronic medical records that revealed the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses which included [redacted] The [redacted] Physician's Orders report revealed an order dated [redacted] for [redacted] route daily at bedtime for [redacted] The [redacted] eMAR revealed an order	F 658	documented appropriately. • All nurses were immediately re-educated on proper documentation. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: • All nursing staff have been re-in-serviced on proper documentation by the Assistant Director of Nursing. • A QAPI was started. • The Director of Nursing/Designee will review medication administration documentation weekly. • The Director of Nursing /Designee will report the trends from these observations to the Administrator monthly and the QAPI team quarterly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • The Director of Nursing nurse will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly. • The Director of Nursing /Designee will report trends and any make any necessary changes or follow up actions to the QAPI team quarterly.	

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F 658	Continued From page 2 dated [redacted] for [redacted] to [redacted] once daily at bedtime for [redacted]. The eMAR contained slots for medication to be administered at 9:30 AM and a slot for the site of the [redacted] to be documented. The [redacted] eMAR revealed that the nurses documented the [redacted] site only two days (2/11 and 2/12) out of 16 days. On 2/17/22 at 1:30 PM, the surveyor met with the Licensed Nursing Home Administrator, the Assistant Director of Nursing, Regional Clinical Specialist and Regional Administration to discuss the above concerns. No further information was provided by the facility. A review of the facility's policy for Administering Medications dated 1/22/22, indicated the following: "As required of indicated for a medication, the individual administering the medication records in the resident medical record: d. The injection site (if applicable)." NJAC: 8-39-27.1 (a)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		3/1/22

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F 695	Continued From page 3 by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that [redacted] therapy was administered to a resident in accordance with physician's orders. This was found with 2 of 6 residents reviewed, Resident [redacted] and Resident [redacted]. The deficient practice was evidenced by the following: 1. On 2/11/22 at 11:00 AM, the surveyor observed Resident [redacted] walking from the bathroom to sit on bed. The surveyor observed Resident [redacted] putting on a [redacted] over the [redacted] (a [redacted]). The [redacted] delivered the [redacted] to the resident via the [redacted]. The resident stated that he/she was encouraged to keep the [redacted] on. The surveyor reviewed the electronic medical record (EMR) of Resident [redacted] which revealed the following: According to the Resident Face Sheet, Resident [redacted] was admitted with diagnoses that included [redacted]. The Annual Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS) which the resident scored a [redacted]. The [redacted] Physician's Orders form revealed there was no order for the [redacted] that the resident was currently receiving. However, on the [redacted] electronic Resident	F 695	1. How the corrective actions will be accomplished for those residents found to have been affected: • The nurses and [redacted] therapists were in-serviced by the assistant director of nursing on following the facilities policy and procedure on [redacted] administration. • The orders and care plans were updated for both residents. • The involved residents had no negative effect from above. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All resident charts were reviewed to ensure [redacted] orders were entered correctly and facility was following physician's orders. • All nurses and respiratory therapists were immediately re-educated on the facilities policy on [redacted] administration. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: • All nursing staff and [redacted] therapists have been re-in-serviced on the [redacted] administration policy by the assistant director of nursing. • A QAPI was started. • The [redacted] therapy director will review all [redacted] orders weekly and observe the residents to ensure orders are being followed appropriately. • The [redacted] therapy director will	

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F 695	Continued From page 4 [redacted] Therapy Administration Record (eRRTAR) indicated a physician's order dated [redacted] the following: "[redacted] Q-Shift and PRN if [redacted] on [redacted], give [redacted] PRN". Further review of the eRRTAR revealed that there was no documentation that the [redacted] was being administered to the resident as needed. The care plan titled [redacted] Post Admit initiated on [redacted] did not have interventions that addressed how the [redacted] would be delivered to the resident whether to given as needed or continuously. On 2/11/22 at 11:06 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to the resident. LPN stated that she assesses the resident's [redacted] (Indicates the amount of [redacted] level and she stated, "the [redacted] was ok." On 02/15/22 at 12:43 PM, the surveyor interviewed the [redacted] Therapist [redacted] who was assigned to the resident. RT stated Resident [redacted] was encouraged to always wear the [redacted] to prevent [redacted] [redacted] T #1 went over the resident's equipment and [redacted] settings, and stated the resident uses [redacted] and [redacted] as needed. [redacted] T stated that the [redacted] was usually greater than [redacted] On 2/16/22 at 11:45 AM, the surveyor interviewed with [redacted] Therapist Director [redacted] about [redacted] therapy order for Resident [redacted]. The [redacted] stated the [redacted] Ts would follow the [redacted] therapy	F 695	report the trends from these observations to the Administrator monthly and the QAPI team quarterly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • The [redacted] therapy director will review and analyze trends based on the data and her observations and report findings and any necessary follow up actions to the Administrator monthly. • The [redacted] therapy director will report trends and any make any necessary changes or follow up actions to the QAPI team quarterly.	

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F 695	Continued From page 5	F 695		

orders and further stated the [redacted] Ts can adjust the [redacted] settings upon the resident's needs.

2. On 2/11/22 at 1:24 PM, the surveyor observed Resident [redacted] in bed receiving [redacted] via a [redacted] at [redacted] from an [redacted].

On 2/14/22 at 10:45 AM, the surveyor observed Resident [redacted] lying in a recliner receiving [redacted] via a [redacted] from an [redacted].

On 2/16/22 at 10:38 AM, the surveyor observed Resident [redacted] lying in their bed receiving [redacted] a [redacted] at [redacted] from an [redacted].

The surveyor reviewed the EMR of Resident [redacted] which revealed the following:

According to the Resident Face Sheet, Resident [redacted] was admitted with diagnoses that included [redacted] and [redacted].

The Quarterly MDS, dated [redacted], indicated that the facility assessed the resident's cognitive status using BIMS which the resident scored [redacted] that indicated the resident's cognition is [redacted].

The [redacted] Physician's Order form revealed there was an order dated [redacted] for oxygen to be administered via [redacted] as needed for [redacted] for [redacted].

The [redacted] electronic Medication Admission Record (eMAR) revealed there was an order dated [redacted] for monitoring: [redacted];

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F 695	Continued From page 6	F 695		

and [redacted]. The documentation on the eMAR revealed that Resident [redacted] was under [redacted] once on 2/15/22 7-3 shift from 2/1/22 to 2/17/22.

The [redacted] electronic Treatment Administration Record (eTAR) revealed there was an order dated [redacted] for [redacted] at [redacted] as needed for [redacted] The was no documentation by the nurses for three shifts on the eTAR showing that Resident [redacted] was receiving [redacted]

The Care Plan Activity Report revealed there was no comprehensive care plan for Resident [redacted]'s need for [redacted]

On 2/17/22 at 9:55 AM, the surveyor interviewed the facility [redacted] Therapist [redacted] who stated that Resident [redacted] was receiving [redacted] via a [redacted] at [redacted] as needed for an [redacted] The surveyor informed the RT that the resident was observed on multiple occasions receiving [redacted] and when the the surveyor reviewed the [redacted] levels, the resident's level went under [redacted] once from 2/1/22 to 2/17/22.

The [redacted] T stated that if the resident wasn't receiving [redacted] that their [redacted] level would have been below [redacted] The [redacted] T further stated that the resident should be on continuous [redacted]. The surveyor inquired about the lack of a comprehensive care plan to address the resident's need for [redacted]. The [redacted] T stated that it's the responsibility of the [redacted] T to review [redacted] orders and to create an [redacted] care plan. The [redacted] T was also unable to find an [redacted] care plan for Resident [redacted]

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F 695	Continued From page 7 On 2/17/22 at 1:42 PM, the survey team met with the Administrator, Assistant Director of Nursing, Regional Clinical Specialist and Regional Administrator to discuss the above concerns. There was no additional information provided. A review of the facility's policy and procedure titled [redacted] Administration revised 2022. The Policy Statement read "[redacted] will be administered as per MD order to aid in breathing. Emergency [redacted] may be administered by licensed nurse without an M.D. order. The M.D. will be consulted as soon as possible and order [redacted] if continuation is required." Under Procedure #9 indicated "Document initiation of [redacted] in nursing notes including time, indications and method: [redacted]. Document use and resident reaction to [redacted]." NJAC 8:39-25.2(b)(c)4	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to consistently assess a resident upon return from the [redacted] center. The deficient practice was observed for 1 resident, [redacted], of 1 reviewed for dialysis and is evidenced by the following.	F 698	1. How the corrective actions will be accomplished for those residents found to have been affected: " The nurses were in-serviced by the assistant director of nursing on proper [redacted] assessments and documentation.	3/1/22

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F 698	Continued From page 8 On 2/11/22 at 1:08 PM, the surveyor observed the resident in bed with eyes closed. The resident was discharged from the facility on [redacted]. On 2/15/22 at 9:54 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN). The LPN stated the [redacted] resident assessment was documented on the top of the Nursing Facility/[redacted] Center Communication Record (a paper which travels with the resident to and from the dialysis clinic). She stated the post [redacted] assessment is documented in the electronic medical record nursing progress notes. On 2/15/22 at 10:07 AM, the surveyor interviewed the Registered Nurse Unit Manager (RNUM). The RNUM stated "there is no hard documented" resident assessment performed after the resident returned from the [redacted] center. There is no specific place for it on the electronic record." The RNUM stated "the nurses definitely do an assessment, but it is not hard documented." A review of the hybrid medical record revealed the following information: The Resident Face Sheet included the following diagnoses present at the time of admission: [redacted] The [redacted] Physician's Orders report included the following orders related to [redacted]: "Ensure dressing is in place at all times to [redacted] every [redacted] and [redacted], pick up at 5 am; [redacted] every [redacted], pick up time at 5:30 am; ensure the [redacted] communications form goes with the	F 698	" The involved resident had no negative effect from above. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: " Any patient on [redacted] has the potential to be affected. " All nurses were immediately re-educated on proper assessments and documentation for [redacted] patients. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: " All nursing staff have been re-in-serviced on proper documentation by the Assistant Director of Nursing. " A QAPI was created. As soon as we have another [redacted] patient, the qapi will be started. " When we have a [redacted] patient, the director of nursing/designee will perform observations on residents pre and post [redacted] assessments and documentation three times a week for the duration of the patients stay. " The director of nursing/designee will report the trends from these observations to the administrator monthly and the QAPI team quarterly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: " The director of nursing nurse will	

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F 698	Continued From page 9 resident to and from [redacted] and is completed with the most recent vital signs; 7-3 shift nurse to ensure to check the dialysis communication sheet when resident returns from the [redacted] session." The [redacted] quarterly Minimum Data Set assessment tool indicated the resident had [redacted] as evidenced by a score [redacted] on the Brief Interview for Mental Status. Additionally, the resident was noted to have received [redacted] prior to admission and while a resident at the facility. The 2/15/2022 care plan addressing [redacted] included an intervention for nursing staff - "my [redacted] ([redacted] site will be monitored for [redacted] and dressing in place every shift." The [redacted] and [redacted] Treatment Administration Record section regarding assessment of the [redacted] was not documented as having been checked during the period of [redacted] through [redacted] during all of the three shifts. Nursing Progress Notes reviewed for the period of [redacted] through [redacted] failed to reveal an assessment of the resident's [redacted] site upon return from [redacted] On 2/15/22 at 01:13 PM, the surveyor discussed the post [redacted] assessment omissions with Administrator, Assistant Director of Nursing, Regional Clinical Specialist, and Regional Administrator. On 2/16/22 at 09:25 AM, the Administrator provided the facility policy for [redacted] Additionally, the Administrator stated there was a	F 698	review and analyze trends based on the data and observations. They will report findings and any necessary follow up actions to the administrator monthly. " The director of nursing/designee will report trends and any make any necessary changes or follow up actions to the QAPI team quarterly.	

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F 698	Continued From page 10 [redacted] progress note template in the electronic software program which was not being utilized by nursing. The [redacted] Policy and Procedure indicated staff will assess the [redacted] access site every hour for four hours after return from the [redacted] center. Documentation would include assessing for bleeding, pain, redness, and swelling. NJAC 8:39-27.1(a)	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §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	F 755		3/1/22

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F 755	Continued From page 11 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation interview and review of facility records, it was determined that the facility failed to ensure an accurate inventory of controlled medications (narcotic medications) dispensed from the facility's automated medication dispensing system (AMDS). The deficient practice was observed on the automatic medication dispensing system located on the [redacted] nursing office and evidenced by the following: On 2/18/22 at 10:05 AM, the surveyor reviewed the facility's DEA 222 forms and asked the Regional Clinical Specialist (RCS) a Registered nurse if he could provide the surveyor signed off logs showing that narcotics are being accounted for in the facility's AMDS. On 2/18/22 at 11:55 AM, the Licensed Nursing Home Administrator (LNHA) told the surveyor team that the Assistant Director of Nursing (ADON) were unable to locate the accountability form for the controlled medications accountability for the month of [redacted] On 2/18/22 at 12:05 PM, the surveyor in the presence of the LNHA was brought to the Nursing office on the [redacted] nursing unit which contained the facility AMDS. The surveyor observed the ADON and a [redacted] Registered	F 755	1. How the corrective actions will be accomplished for those residents found to have been affected: • No residents were affected. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: • The process was immediately changed and nursing staff in-serviced on the process. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: • The process was immediately changed to ensure the outgoing 11-7 nurse and incoming 7-3 nurse are to sign off on the controlled substances. • All nursing staff have been in-serviced by the Assistant Director of Nursing. • A QAPI was started. • The Director of Nursing/Designee will monitor sign off sheets 5 days a week, until there are 4 consecutive weeks with no omissions. Weekly until there are 4 weeks with no omissions, and monthly thereafter. • The Director of Nursing /Designee will	

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F 755	Continued From page 12 Nurse Unit Manager (RNUM) checking the narcotic count in the AMDS. The surveyor interviewed the ADON who stated that the narcotic counts are done daily, and they don't have a specific time, but it's usually done on the 11-7 shift with the 7-3 shift nurse. She informed the surveyor that she's unable to find the February 2022 accountability form and that the form was hung on a clip board that's located on the side of the AMDS. She showed the surveyor the clip board that also contained the facility AMDS policy and procedures. The surveyor observed that there was no February accountability form on the clipboard. The ADON and RNUM could not explain why the accountability form for February wasn't on the clipboard. The ADON stated that the previous months accountability forms were kept by the Director of Nursing (DON). On 2/18/22 at 12:30 PM, the surveyor interviewed the RCS who told the surveyor that he would provide the survey team with the previous months accountability forms. The surveyor asked the RCS, ADON and RNUM who was responsible to ensure that the narcotic counts were being done daily. All three stated the DON was responsible. The surveyor was informed that the DON was on leave. The surveyor asked both ADON and RNUM if the facility had the ability to print out a report showing which controlled medications were being dispensed from the AMDS. The ADON and RNUM stated that the facility does not have the ability to print out a controlled medication usage report. They were unable to explained to the surveyor how controlled medications are being	F 755	report the trends from these observations to the Administrator monthly and the QAPI team quarterly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • The Director of Nursing nurse will review and analyze trends based on the data and observations and report findings and any necessary follow up actions to the Administrator monthly. • The Director of Nursing /Designee will report trends and any make any necessary changes or follow up actions to the QAPI team quarterly.	

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F 755	Continued From page 13	F 755		

accounted for inside the AMDS.

On 2/18/22 at 12:45 PM, the surveyor interviewed the RSC who stated that the facility did not have the ability to print out reports from the [AMDS]. He told the surveyor that the Provider Pharmacy was responsible for the [AMDS].

On 2/18/22 at 12:50 PM, the surveyor interviewed the Provider Pharmacy Account Manager (PPAM) via telephone. The PPAM informed the surveyor that the Provider Pharmacy was responsible for filling the machine with non-controlled medications.

The PPAM stated that the facility was responsible for all the controlled medications inside the [AMDS]. The PPAM stated that only designated nursing staff, such as DON, ADON or Nursing Supervisor have the authority to fill the [AMDS] with controlled medications. The PPAM further stated that the facility does not have the ability print out any reports from the [AMDS]. The facility would be able to request a report to be printed out by the Pharmacy Provider and the Pharmacy Provider would email the report to the facility.

The RCS provided the surveyor with the December 2020 through December 2021 accountability forms but stated that he couldn't find the January 2022 and February 2022 accountability forms. The RCS, LNHA and ADON confirmed there was no January and February 2022 forms available for review.

Upon review of the narcotic count accountability forms, the surveyor observed the following dates that were missing nurse signatures: 10/11/21,

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10/12/21, 10/14/21, 10/16/21, 10/17/21, 10/18/21, 10/19/21, 10/20/21, 10/21/21, 10/23/21, 10/24/21, 10/25/21, 10/28/21, 10/30/21, 10/31/21, 11/1/21, 11/2/21, 11/4/21, 11/5/21, 11/6/21, 11/7/21, 11/11/21, 11/13/21, 11/14/21, 11/15/21, 11/16/21, 11/17/21, 11/18/21, 11/20/21, 11/21/21, 11/22/21, 11/26/21, 11/27/21, 11/28/21, 11/29/21, 11/30/21, 12/2/21, 12/3/21, 12/4/21, 12/5/21, 12/6/21, 12/7/21, 12/8/21, 12/10/21, 12/11/21, 12/12/21, 12/13/21, 12/14/21, 12/15/21, 12/16/21, 12/17/21, 12/18/21, 12/19/21, 12/20/21, 12/21/21, 12/22/21, 12/23/21, 12/24/21, 12/25/21, 12/26/21, 12/27/21, 12/28/21, 12/29/21, 12/30/21 and 12/31/21.

On 2/18/22 at 1:45 PM, the survey team met with the LNHA, ADON, RCS and Regional Administrator about the above concern. No additional information was provided.

A review of the facility's policy for [AMDS] Station Policies and Procedures that was undated and was provided by the LNHA indicated the following:
Under Reports "Controlled Substance Activity Report-Both pharmacy and the facility will retain the report as required by federal and/or state regulations."
Under [AMDS] Quality Assurance-monitoring by the pharmacy "To assure compliance with policy and procedures and appropriate use of the [AMDS] system the following items are to be monitored by the pharmacy [AMDS] manager:" This included reviewing the Narcotic Inventory Reports.

The surveyor requested the facility's Controlled Substances Policy which was not provided by the facility

NJAC 8:39-29.4(n)

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 3 of 6 medication carts inspected. This deficient practice was evidenced by the following: On 2/11/21 at 10:20 AM, the surveyor inspected the [redacted] medication cart [redacted] in the presence	F 761	1. How the corrective actions will be accomplished for those residents found to have been affected: " The [redacted] solution and [redacted] were labeled and dated based on investigation to determine when they were opened. " The expired vial of [redacted] medication was discarded appropriately. " An investigation was immediately	3/1/22

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F 761	Continued From page 16 of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened bottle of [redacted] solution and an opened [redacted] that were not dated. The surveyor interviewed LPN #1 who stated that once a bottle of [redacted] solution and an [redacted] are opened they should have been dated. On 2/11/22 at 11:15 AM, the surveyor inspected the [redacted] medication cart [redacted] in the presence of LPN #2. The surveyor observed an opened [redacted] vial that had an opened date of 1/4/22 and was expired. The surveyor also observed a [redacted] pen that was in a bag with another resident's name and that was label for [redacted] pen. The surveyor also observed a [redacted] pen that was in a plastic bag with a different resident's name and was labeled for [redacted] pen. The surveyor also observed that narcotic box inside the medication cart was unlocked. The surveyor interviewed LPN #2 who stated that the [redacted] vial was expired and should have been removed from the medication cart. LPN#2 also noted that both the [redacted] and [redacted] pens were in the wrong bag. She told the surveyor that the evening nurse should have double check the name and medication on the bag before placing the [redacted] pens inside the bag. She told the surveyor that when she administers [redacted] that she will always check the name on the vial or pen. LPN #2 also stated that the narcotic box was opened, and it should have been lock. On 2/14/22 at 11:25 AM, the surveyor inspected the [redacted] medication cart [redacted] in the presence of LPN #3. The surveyor observed an	F 761	started with regards to the [redacted] pen and [redacted] pen. It was determined they were put in the wrong residents bags when being replaced. No resident received the wrong medication. Both medications were discarded appropriately and new medications were ordered. " All narcotic boxes on the med carts were locked immediately " The nurses were in-serviced by the Director of Nursing on labeling and dating medication and proper storage " The nurses were in-serviced on proper storage of narcotics and ensuring the narcotic boxes stay locked. " The involved residents had no negative effect from above. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: " All residents have the potential to be affected by this deficient practice. " All medications were checked to ensure they are all label and dated appropriately. " All medications were checked to ensure they weren□t expired. " All medication carts were checked to make sure narcotic boxes were locked. " The Director of Nursing re-educated the entire staff on labeling and dating medications and proper storage. 3. What measures will be put into place or systemic changes made to ensure the	

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F 761	Continued From page 17 unlocked narcotic box inside the medication cart. The surveyor interviewed LPN #3 who stated that the narcotic box should have been lock. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. [redacted] Solution once opened have an expiration date of 90-days 2. [redacted] once opened have an expiration date of 42-days. 3. [redacted] vial once opened have an expiration date of 28-days. On 2/14/22 at 1:30 PM, the surveyor met with the Administrator, Assistant Director of Nursing, Regional Clinical Specialist and Regional Administrator. No further information was provided by the facility. A review of the facility's policy for Labeling of Medication Containers that was undated and was provided by the LNHA indicated the following: 3. "Labels for individual resident medications include all necessary information, such as:" h. "The expiration date when applicable." A review of the facility's policy for Storage of Medications that was undated and was provided by Administrator indicated the following: "4. "Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." 8. "Schedule II-V controlled medications are stored separately locked, permanently affixed compartments."	F 761	deficient practice will not recur: " All nursing staff have been re-in-serviced on medication labeling/storage by the Director of Nursing. " The Director of Nursing/Designee will perform three observations of three different med carts weekly until there are four consecutive weeks with no issues observed. " The Director of Nursing /Designee will report the trends from these observations to the Administrator monthly. " The Director of Nursing/Designee will report the trends from these observations to the QAPI team quarterly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: " The Director of Nursing nurse will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly. " The Director of Nursing /Designee will report trends and any necessary follow up actions quarterly to the Quality Assurance Committee.	

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F 761	Continued From page 18 NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to sanitize and air-dry steam table pans in a manner to prevent microbial growth and c.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following:	F 812	1. How the corrective actions will be accomplished for those residents found to have been affected: • All wet and dirty pans were put back in the dishwasher to be washed and dried. • All dishes/pans were checked to ensure there were no other dirty/wet items in the kitchen. • The sprinkler caps above the cook top area were cleaned immediately. • All dented cans were moved to the “dented can storage” to be discarded.	3/1/22

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F 812	Continued From page 19 On 2/14/22 at 9:47 AM, in the presence of the Dietary Supervisor and Regional Food Service Director, the surveyor observed the following: 1. In the food preparation area, on a shelf over top of the convection ovens, the surveyor observed three full sized sheet pans which were stacked with water between them. 2. The surveyor observed two of three red sprinkler caps and fire suppression poles above the cook top area, which were soiled with gray colored dust-like particles. 3. In the dry storage area, the surveyor observed a random sampling of dented cans which were in rotation for use. The surveyor observed the following: - A #10 sized can of chili con carne with two separate 2-inch sized dents on the body of the can, - A #10 sized can of green beans with a 1-inch sized dent on the upper lip of the can and a 1-inch sized dent on the lower lip of the can, -A #10 sized can of diced pears with a 1/2-inch sized dent on the body of the can. On 2/14/22 at 1:55 PM, the surveyor discussed the above concerns with the Administrator, the Assistant Director of Nursing, Regional Clinical Specialist and Regional Administrator. The surveyor reviewed the facility's policy with a revised date of 2/2022 titled, "Sanitation." The policy indicated that the food service area shall be maintained in a clean and sanitary manner and to clean after each task before proceeding to the next assignment.	F 812	• Residents had no negative effect from above. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • The food service director immediately re-educated the staff on proper cleaning protocols and dented can policy. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: • All staff have been re-in-serviced on the dish washing/drying policy by the Food Service Director. • The Food Service Director will perform observations twice a week of all dishes and sprinkler caps on each shift at least once per month • The food service director will check dented cans weekly after the food delivery. • The Food Service Director will report the trends from these observations to the Administrator, with follow up as necessary • The food service director will report the trends from the observations to the QAPI team quarterly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • The Food Service Director will review	

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F 812	Continued From page 20 The surveyor reviewed the facility's policy and procedure titled "Dented Cans," with a revised date of 2/2022. The policy indicated to identify unacceptable dented cans and placed the dented can in a designated area. NJAC 8:39-17.2(g)	F 812	and analyze trends based on the observations and report findings and any necessary follow up actions to the Administrator monthly. • The Food Service Director will report trends and any necessary follow up actions quarterly to the QAPI team.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		4/1/22

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F 880	Continued From page 21 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 880	1. How the corrective actions will be	

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F 880	Continued From page 22 review it was determined the facility failed to follow accepted standards of infection control to reduce the spread of infection as observed for 2 of 2 Licensed Practical Nurses (LPN #1 and LPN #2) and 3 of 3 Housekeepers (HK #1, HK #2, and HK #3). The deficient practice is evidenced by the following. 1. On 2/16/22 at 11:00 AM the surveyor observed LPN #1 perform a [redacted] treatment on Resident [redacted] The surveyor and LPN #1 reviewed the physician's order on the electronic record - cleanse [redacted] with [redacted] solution, pat dry, pack wound with [redacted] and cover with a dry dressing daily and as needed if soiled, initiated [redacted]. LPN #1 stated the resident had a [redacted] LPN #1 performed hand hygiene, donned gloves, and sanitized the over bed table with an antiseptic wipe. LPN #1 removed her gloves and, without performing hand hygiene, assembled supplies for the treatment. LPN #1 entered the resident's room, donned gloves, and began the treatment. LPN #1 removed the resident's soiled dressing, removed her gloves, and performed hand hygiene. LPN #1 donned gloves and cleansed the [redacted] according to the physician's order. She removed her gloves and left the bedside to perform hand hygiene. During the time away from the resident's bedside, the uncovered and cleansed [redacted] touched the inside of the [redacted].	F 880	accomplished for those residents found to have been affected: " The two nurses that did not use proper hand hygiene and infection control protocols were immediately re-in-serviced by the Assistant Director of Nursing. " The three housekeepers that did not follow infection control protocols were immediately re educated by the Infection Prevention nurse and Housekeeping director " The involved residents had no negative effect from above. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: " The Assistant Director of Nursing and infection prevention nurse immediately re-educated the entire staff on proper hand hygiene and infection control practices. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: " All staff have been re-in-serviced on the hand hygiene and infection control protocols by the Infection Prevention nurse and Assistant Director of Nursing. " An RCA was done and indicated the need to limit distractions during in-servicing, increase hours of education for all staff on hand hygiene, and proper infection control protocols, and added use of black light competencies, which are being purchased.	

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F 880	Continued From page 23 LPN #1 completed the treatment as ordered by the physician and wearing the same gloves, bundled the trash in a plastic bag and exited the room. LPN #1 walked to the soiled utility room, obtained the key to the door, and entered the room while wearing the gloves worn during the treatment. LPN #1 then removed her gloves and performed hand hygiene. The surveyor spoke with LPN #1 on 2/16/22 at 11:25 AM regarding failure to perform hand hygiene after removing gloves, allowing the open [redacted] to touch the [redacted], and wearing soiled gloves outside of the resident's room and touching the key and door to the soiled utility room with the soiled gloves. She verbalized understanding. The surveyor spoke with the Administrator, Assistant Director of Nursing, and corporate staff on 2/16/22 01:21 PM and explained the breaches in infection control practices. 2. On 2/17/22 at 9:59 AM, the surveyor observed the LPN #2 perform a [redacted] treatment to the [redacted] of Resident #21. LPN #2 cut the resident's soiled bandage from around the [redacted], with a pair of scissors she removed from her jacket pocket. LPN #2 did not sanitize the scissors before or after cutting off the soiled bandage. Following the removal of the soiled dressing, LPN #2 used a pile of gauze that she moistened with [redacted] to clean the [redacted] LPN #2 used the full surface area of the open gauze to wipe around the [redacted] multiple times and then discarded the pile. LPN #2 repeated with another pile of gauze wiping around the	F 880	i. In-services will be monitored by the DON/Administrator or designee on a monthly basis to ensure distractions are limited. ii. Increased education on hand hygiene. Will be done monthly for 3 months, quarterly after. iii. Black light competencies will be done monthly for 3 months, and quarterly after. " A QAPI was started. " The Infection Prevention Nurse/Designee will perform the following hand hygiene observations until every staff member is monitored at minimum twice: i. A dietary staff member three times a week ii. Two housekeeping/laundry staff members three times a week iii. Three nursing staff three times a week " After all staff are monitored at minimum twice, ten staff members will be monitored monthly for three months. Based on the outcomes, the monitoring schedule will be amended as necessary. " The Infection Prevention Nurse/Designee will report the trends from these observations to the Administrator, with follow up as necessary " The infection prevention nurse/designee will report the trends from these observations to the QAPI team quarterly. " As per the DPOC, all topline staff as well as the infection preventionist viewed the following: i. Module 1: Infection prevention and control program	

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F 880	Continued From page 24 [redacted]. When LPN #2 finished the [redacted] treatment she removed her gloves, tied the trash bag, and carried the trash bag out of the resident's room. LPN #2 stopped at the nurses' station, picked up a key from the unit clerk, opened the soiled utility room and put the trash bag in the garbage receptacle. She handed the key back to the unit clerk. LPN #2 did not perform hand hygiene until she returned to the resident's room. On 2/17/22 at 10:45 AM, the surveyor interviewed LPN #2 about the surveyor's observation regarding using scissors she removed from her pocket without sanitizing them before and after use. The surveyor also inquired of LPN #2 the process of cleaning a [redacted]. LPN #2 acknowledged that she did not sanitize the scissors before or after using them to cut the soiled bandage and she wasn't aware of how she cleansed the [redacted] On 2/17/22 at 1:20 PM, the surveyor informed the Administrator and Assistant Director of Nursing (ADON) of the above concerns. The Administrator provided the surveyor with the policy as requested. The surveyor reviewed the undated facility's policy and procedure titled [redacted] Management. The policy did not address handling of scissors and wound cleaning technique. In addition, the Administrator provided the surveyor with a sample Treatment Competency that revealed under Performance Criteria #17 "Cleanse the [redacted] from inner to outer." The surveyor reviewed the facility's policy and	F 880	ii. Module 5: Outbreaks iii. Module 7: Hand Hygiene iv. Module 6A: Principles of Standard precautions v. Module 6B: Principles of Transmission based precautions vi. Module 11A: Reprocessing reusable resident care equipment " As per the DPOC, all frontline staff viewed the two in-services mandated: i. Keep Covid out! ii. Clean Hands iii. And Use PPE correctly for COVID-19 iv. Module 7: Hand Hygiene v. Module 6A: Principles of Standard precautions vi. Module 6B: Principles of Transmission based precautions 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: " The Infection Prevention nurse will review and analyze trends based on the observations and report findings and any necessary follow up actions to the Director of Nursing monthly. " The Infection Prevention Nurse/Designee will report trends and any necessary follow up actions quarterly to the Quality Assurance Committee. " A root cause analysis was done and corrective actions were taken based on the RCA. Follow up with the RCA will continue through the QAPI process.	

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procedure dated 1/28/22 titled "Dressings, Dry/Clean", provided by the Administrator. Under Procedure, it read: "2. Place the clean equipment on the clean field. Arrange the supplies so they can be easily reached., 15. Cleanse the [redacted] with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward)." The policy and procedure provided did not address the cleansing and storage of the scissors.

The surveyor reviewed the facility's policy and procedure dated 2022 titled Handwashing/Hand Hygiene. Under Policy Interpretation and Implementation, it read: #7 "Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. before and after direct contact with residents, g. before handling clean or soiled dressings, gauze pads, k. after handling used dressings, contaminated equipment ... m. after removing gloves."

3. On 2/16/22 at 12:00 PM, the surveyor observed personal protective equipment (PPE) hanging on Resident [redacted]'s door and a STOP sign on the door which indicated "Contact Precautions: To prevent the spread of infection, anyone entering this room must wear: gloves, mask and an isolation gown." The surveyor also observed two additional signs on the door which indicated "Donning (putting on) PPE: 1. Gown, 2. Respirator mask, 3. Goggles or face shield and 4. Gloves" and a sign which indicated "Doffing (taking off) PPE: 1. Gloves, 2. Hand hygiene, 3. Goggles or face shield, 4. Gown, 5. Hand

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hygiene, 6. Respirator mask and 7. Wash hands."

The surveyor reviewed Resident [redacted]'s medical records which revealed the following:

According to the Resident Face Sheet, Resident [redacted] was admitted to the facility with diagnoses that included [redacted]. There was a Physician's Order dated [redacted] for "Contact precautions for [redacted]."

On 2/17/22 at 9:45 AM, the surveyor observed a Housekeeper (HK #1) put on gloves, a respirator mask, a gown and did not put on eye protection. HK #1 entered into Resident #[redacted]'s room in the [redacted] unit, took the garbage bag out of the resident's garbage can, placed it on the floor. The HK #1, with his soiled gloves and gown still on, walked into the hallway, opened the PPE bin drawer, took out a whole roll of new garbage bags, grabbed one new garbage bag, placed the roll inside the drawer, closed the drawer, and went back inside the resident's room.

HK #1 placed the new garbage bag into the resident's garbage can and removed and discarded his soiled gloves and gown into the garbage. The HK #1 took the garbage bag from the resident's floor, walked into the hallway and without any hand hygiene, he opened the soiled utility room door and threw out the garbage bag. The HK #1 then put on a new pair of gloves to pick up something from the floor. The HK#1 removed and discarded those gloves and then closed the soiled utility room door without performing any hand hygiene. HK #1 proceeded to walk down the hallway when the surveyor stopped and asked what should have been done. HK #1 stated that he should have worn eye

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protection and he forgot to put them on. HK #1 also stated that he should have done hand hygiene before and after glove usage.

At 9:55 AM, the surveyor observed HK #2 in a recently discharged resident's room in the [redacted] unit wearing a gown, gloves, respirator mask and no eye protection. HK #2 was observed cleaning the room. HK #2 was observed removing a pair of goggles and a face shield from a bin labeled "used eye protection." HK #2 walked into the hallway wearing his gown and gloves and placed the two used eye protection equipment onto a box that was on the floor in the hallway. HK #2 shut the resident's door.

At 10:09 AM, the surveyor interviewed HK #2 who stated that he should have worn eye protection in the room and did not know where he should have put the two used eye protection equipment that he removed from the "used eye protection" bin.

At 11:40 AM, the surveyor observed HK #3 in a resident's room wearing a respirator mask and gloves on her hands. HK #3 removed the garbage bag from the resident's garbage can, placed it on the floor and then removed and discarded her gloves in another garbage. HK #3 did not perform hand hygiene and was observed grabbing a new pack of paper towels which she placed into the paper towel dispenser in the resident's room.

HK #3 picked up the garbage bag from the resident's floor, walked down the hallway, opened the soiled utility room door and placed the garbage bag inside the room. HK #3 closed the soiled utility room door and walked down the hallway back toward the south unit when the

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surveyor interviewed HK #3. HK #3 stated that she should have performed hand hygiene after removing her gloves and forgot to do so.

At 12:05 PM, the surveyor interviewed the Housekeeping Director (HKD), who stated that eye protection is to be worn in every resident's room in the facility and that the staff should have followed appropriate infection control techniques. The HKD stated that all the staff were recently educated regarding infection control.

The surveyor reviewed the policy and procedure titled "Isolation," which was reviewed on 1/28/22. The policy and procedure indicated that gloves are to be removed before leaving the room and to perform hand hygiene.

The surveyor reviewed the policy and procedure titled "Hand Washing/Hand Hygiene," which was reviewed on 1/28/22. The policy and procedure indicated that hand hygiene is the final step after removing and disposing of personal protective equipment and specifically after removing gloves.

On 2/17/22 at 1:47 PM, the surveyor discussed the above concerns with Administrator, Assistant Director of Nursing, Regional Clinical Specialist and Regional Administrator who agreed that these breaches in infection control should not have occurred.

NJAC 8:39-19.4 (a)

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S 000	Initial Comments 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 DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	1. How the corrective actions will be accomplished for those residents found to have been affected: " Efforts to hire facility staff will continue until there is adequate staff to serve all residents. " Facility will utilize staffing agencies to fill open positions. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: " Continuous efforts will be made to hire	3/1/22

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S 560	Continued From page 1 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the	S 560	and fill open positions so no residents will be affected. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: " A QAPI was started to address ongoing staffing challenges " Contracts with additional staffing agencies have been secured to supplement facility staff. " Hiring and recruitment efforts continue, including wage increases, sign on bonuses, referral bonuses, perfect attendance bonuses. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: " The director of nursing will review staffing schedules weekly to ensure adequate staffing is maintained for all shifts. " The results of the director of nursing reviews will be brought to the QAPI team quarterly	

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S 560	Continued From page 2 midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 1/23/22 and 1/30/22 revealed the following: The facility was deficient in CNA staffing for residents on 12 of 14 day shifts and deficient in CNAs to total staff on 3 of 14 evening shifts as follows: - 01/23/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. - 01/24/22 had 9 CNAs for 76 residents on the day shift, required 10 CNAs. - 01/25/22 had 9 CNAs for 76 residents on the day shift, required 10 CNAs. - 01/26/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. - 01/26/22 had 5 CNAs to 11 total staff on the evening shift, required 6 CNAs. - 01/27/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. - 01/28/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. - 01/28/22 had 6 CNAs to 13 total staff on the evening shift, required 7 CNAs. - 01/29/22 had 5 CNAs for 76 residents on the day shift, required 10 CNAs - 01/30/22 had 7 CNAs for 76 residents on the	S 560		

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S 560	Continued From page 3 day shift, required 10 CNAs. - 01/31/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. - 02/01/22 had 5 CNAs to 12 total staff on the evening shift, required 6 CNAs. - 02/03/22 had 9 CNAs for 78 residents on the day shift, required 10 CNAs. - 02/04/22 had 6 CNAs for 76 residents on the day shift, required 10 CNAs. - 02/05/22 had 8 CNAs for 76 residents on the day shift, required 10 CNAs. On 02/18/22 at 1:00 PM, the surveyor interviewed the Administrator and the Assistant Director of Nursing regarding minimum direct care staff-to-resident ratios and CNA shortages on day and evening shifts. The Administrator stated she was aware of the most current staff to resident ratios. She further stated the facility is utilizing multiple methods to recruit additional staff.	S 560		