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F 000	INITIAL COMMENTS Complaint #s: NJ00151595, NJ00159657, NJ00152188, NJ00152300, NJ00152402, NJ00152562, NJ00159269, NJ00160307, NJ00164302 Survey Date: 8/15/23 Census: 92 Sample: 20 (sample) + 3 (Closed Records) + 10= 33 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		9/8/23

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

Electronically Signed | 09/03/2023

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F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to: a) ensure a safe, clean, comfortable, and homelike environment for 2 (two) of 7 (seven) residents, (Residents #69 and #143) and b) ensure that the residents Central Bath (use for shower by the residents) was safe, clean, and not used as a storage room for 2 (two) of 2 (two) Central Baths (CB) observed during environment tour. This deficient practice was evidenced by the following: 1. On 8/02/23 at 9:02 AM, the survey team	F 584	Element#1: 1. Room [NJ Exec.] was thoroughly cleaned by the housekeeping director on 8/8/23. 2. The 2 Central Baths were immediately cleaned, and all items being stored were removed. Resident #143 was [NJ ex order 26.4b1] on [NJ ex order 26.4b] 3. The radiator cover in the shower room was fixed on 8/8/23 and the opening in the ceiling in the 2nd shower room was closed in the presence of the surveyor. Element#2: All residents have the potential to be affected by this deficient practice.	

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F 584	Continued From page 2 entered the facility and there was a posted sign on the door upon entry that there was a COVID case in the facility. The Receptionist instructed the surveyors to use the kiosk (automated health screening for COVID-19 questions). Later on, the Director of Nursing (DON) informed the surveyors that there was a COVID outbreak at the facility, with two residents remained in isolation in room [redacted] The surveyor reviewed the medical records of Resident #69. The Admission Record (AR or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but were not limited to other [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [redacted] revealed that the Section C Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognition [redacted]	F 584	Element #3: 1. The Housekeeping staff were educated on the process for daily cleaning of resident rooms. 2. The Housekeeping staff were educated on the process for deep cleaning resident rooms post discharge or room change. 3. The housekeeping staff will complete a comprehensive checklist for daily room cleaning and submit it to the housekeeping Director and Administrator. 4. The Housekeeping staff will complete a comprehensive cleaning checklist for rooms being deep cleaned after discharges or room changes. 5. All Staff were educated on ensuring items are not stored in shower rooms and to report any items needing repair to maintenance Director. 6. The Housekeeping Director or designee will round on the shower rooms daily to ensure items are not being stored in shower rooms. 7. The Maintenance Director or designee will inspect the Central Bath on each unit daily for items in need of repair, including but not limited to the radiators and ceiling access panels. Element #4: 1. The Director of Housekeeping, or designee, will audit 10 rooms for cleanliness weekly x 4 weeks and then 20 rooms monthly x 4 months. The results of these audits will be submitted monthly to the Administrator for review at the monthly QAPI meeting and quarterly to the QA Committee for review and action, as	

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F 584	Continued From page 3 A review of the provided Detailed Census Report for August 2023 by the Licensed Nursing Home Administrator (LNHA) revealed that Resident #69 was in room [NJ ex order 26.4] (NJ ex order 26.4b1 from NJ ex order 26.4b1 and in room [NJ ex order 26.4] (NJ ex order 26.4b1 from NJ ex order 26.4b1 [redacted] On 8/08/23 at 8:37 AM, the surveyor went to see Resident #69 in room [NJ ex] and the resident was not there. The Registered Nurse (RN) informed the surveyor that she was the assigned nurse of the resident and that Resident #69 was moved back to their room in [NJ ex order] (by the door). The RN further stated that she was unable to remember when the resident was moved. On 8/08/23 at 8:39 AM, the surveyor observed Resident#69 seated on their bed with [NJ ex order 26.4] in use. The resident informed the surveyor that the resident was taken off the isolation from room [NJ ex] last Saturday ([NJ ex order 26.4b] where the resident stayed for a total of 12 days and now returned to their previous room ([NJ ex order 26.4b1] The resident stated that he/she had an "unpleasant experience" in room [NJ ex] because the room was not cleaned for 8 (eight) days by housekeeping staff. The resident further stated that he/she had also seen ants, the garbage was full because no one picked it up, and the floor was dirty. The resident stated that "it seems" the staff was hesitant to enter the room because "they have to gown up (to use PPE or personal protective equipment)." On 8/08/23 at 8:51 AM, the surveyor went back to room [NJ ex] and observed the three residents inside the room. Beds A, B, and C were occupied. Bed D was unoccupied (this was the bed where Resident #69 came from). Certified Nursing	F 584	appropriate. 2. The Unit Managers or designee will audit shower rooms weekly for 8 weeks and then monthly to ensure items are not being stored and there is nothing needing repair. The results will be submitted monthly to the Administrator for review at the monthly QAPI meeting and quarterly to the QA Committee for review and action, as appropriate. 3. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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Aide#1 (CNA#1) was inside the room, left, and later came back. CNA#1 informed the surveyor that she was the regular aide of room [NJ Exempt] and "just came back" for personal reasons. Both the surveyor and CNA#1 observed the environment inside room [NJ Exempt] CNA#16 stated that the room "needs cleaning."

The following were observed in each bed in room [NJ Exempt] in the presence of CNA#1:

Bed A=surrounding the flooring area had a brown substance and an accumulation of dust. The top closet with an accumulation of dust and had one pillow with no pillowcase cover. CNA#1 stated that the pillow was considered dirty, otherwise, it should not be on top of the closet. The privacy curtain was not properly installed, some hooks were out of the railing. The overhead light with dust accumulation.

Bed B=scattered pieces of paper and tissues, a wet floor and the two garbage receptacles both uncovered near the bathroom were almost full of garbage.

Bed C=the surrounding bed and environment with an accumulation of dust on the floor and some scattered pieces of small papers and tissues. The privacy curtain was not properly installed, some hooks were out of the railing.

Bed D=there was a basin under the bed, the bed was made (with a bed sheet, linen, and blanket) with two pillows, one pillow with a pillowcase, and the other one had no pillowcase. On top of the bed a magazine and one sock with Resident#5's name on it, a plastic bag, towel, and gown.

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At that time, the CNA stated that "I don't know why it was there," and that if the bed was clean there should be no magazines and other things on top of the bed and the basin should not be below the bed. CNA#1 informed the surveyor that Resident #5 was the one in Bed A.

On that same date and time, the surveyor asked the CNA to open the bed D nightstand table, CNA#1 showed the surveyor the open nightstand table with small pieces of paper and an accumulation of dust. The CNA used her bare hand to wipe the inside drawer and the CNA stated that the table should have been cleaned. The CNA also confirmed and acknowledged the high dusting on the head part light of bed D and the top of bed D closet.

Then the CNA opened bed D's closet and found two crumpled diapers and a pack of wipes, on top of the closet was a wheelchair cushion brown in color and a splint. The CNA stated that it (crumpled diapers, pack of wipes, wheelchair cushion, and the splint) should not be there. The inside closet was observed with accumulation of dust as confirmed by the CNA.

Furthermore, the floor around bed D had scattered pieces of paper and brownish discoloration. The side wall of the window with a brownish scattered dried lumpy substance which the CNA acknowledged and stated "It should have been cleaned."

The vent inside the room with an accumulation of dust. The room[NJ Exec] bathroom's garbage receptacle was also almost full and the vent inside the bathroom with an accumulation of dust which CNA#1 confirmed.

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On 8/08/23 at 9:12 AM, the surveyor interviewed the Housekeeping Director (HD) in the housekeeping office; who informed the surveyor in the presence of the District Manager (DM) that she's been working for two months as a contracted employee. The HD stated that the housekeeping department was all contracted employees. The HD further stated that there were two housekeepers in the 7-3 shift, one for North and one for South, and the two housekeepers split the West wing. In addition, the HD stated that there was another housekeeper who comes in for the 12 PM-8 PM shift.

On that same date and time, the HD informed the surveyor that the isolation rooms were the last to be cleaned every day. The HD stated that there was a checklist that the housekeepers log after cleaning the room and it was her responsibility as HD to check if rooms were cleaned.

On 8/08/23 at 9:24 AM, the surveyor and the HD went to room [redacted] and both observed the above concerns with dust accumulation, chair cushion and pillows on top of the closets, vents with dust, garbage receptacles, personal belongings on top of bed D, and the curtains in bed A and C. The HD stated that the room needs some cleaning and acknowledged the surveyor's concern.

On 8/08/23 at 01:41 PM, the surveyor reviewed the documents provided by the Regional Director of Operations (RDO) about the [name redacted] Pest Control & Termite report for the service date of 7/31/23 revealed that room [redacted] was inspected and treated for ants. The report also included that "residents stated seeing ants in bathroom and by windows. Two small odorous ants (also called

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sugar ants, are one of the most common types of ants found trailing through kitchens; this ant is especially attracted to sweets, such as fruit juices and pastries, but it will also eat a variety of foods, including meats and pastries) were seen crawling in bathroom ....."

On 8/09/23 at 01:24 PM, the surveyor interviewed the HD and the DM in the presence of another surveyor regarding the environmental concerns in room [NJ Exec.]. The HD acknowledged that the room was not clean and the HD agreed that the floor was not cleaned well when both the surveyor and the HD saw room [NJ Exec.]. The HD stated that according to the cleaning checklist that was provided to the surveyor, it showed that the housekeepers went to room [NJ Exec.] to clean, "Now I know we should be checking when the housekeeper cleaned the room because they probably cleaned the room but not properly."

At that same time, the HD informed the surveyors that she knew the room needed to be cleaned on Monday (8/07/23) which was why she asked the Housekeeper (HK) to clean room [NJ Exec.] as part of the HK's responsibility.

On 8/09/23 at 01:48 PM, the surveyor in the presence of another surveyor and HD interviewed the HK. Later on, HD left the conference room and had to call CNA#2 to translate because HK speaks [NJ Exec. Order 2].

Afterward, the surveyor in the presence of another surveyor and CNA#2 interviewed the HK. The HK informed the surveyors via translator CNA#2 that on Monday (8/07/23) that she knew that she had to clean room [NJ Exec.] as part of her assignment. The HK stated that she cleaned

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room [NJ Exec] beds A, B, and C environment except for bed D. She further stated that she did not check bed D's nightstand table and closets because she thought it was clean already because there was no resident on bed D.

At that same time, the HK informed the surveyors that whoever moved the resident last week should have cleaned the room. The HK stated that she knew that Resident #69 was moved from room [NJ Exec. Order 26:4.b] to [NJ Exec. Order 26:4.b.1] She further stated that also on Monday (8/07/23) that she saw beds A and C's privacy curtain hooks were not properly installed to the railing, and it was been like that since last week.

2. On 8/02/23 at 11:06 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the DON in the presence of the RDO the whereabouts of Resident #143 and the RDO informed the surveyor that the resident was [NJ ex order 26.4b1] (d/c) on NJ ex order 26.4b1.

The surveyor reviewed the medical records of Resident #143 as follows:

The AR reflected that the resident was [NJ ex order 26.4b1]

[redacted]

The admission MDS with an ARD of [NJ ex order 26.4b1] revealed the Section C BIMS score of [NJ ex o] out of

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15 which indicated that the resident's cognition [NJ Exec. Order 26:4.b].

A review of the provided Detailed Census Report for [NJ ex order 26.4b1] by the LNHA revealed that Resident #143 was in room [NJ ex order 26.4b] ([NJ ex order 26.4b1]) from [NJ ex order 26.4b1] and in room [NJ ex order 26.4b1] from [NJ ex order 26.4b1]

A review of the [NJ Exec. Order 26:4] attached document to the phone interview of another surveyor to the resident's Power of Attorney (POA) revealed that according to the POA, the facility shower was used as storage.

3. On 8/08/23 at 9:30 AM, the surveyor and the HD went to West CB (WCB), and later on, the DM followed. The surveyor, HD, and DM both observed inside the WCB that there were two black covered bins (used as garbage disposal inside the resident's room on isolation) one with plastic inside and one without. The black covered bin with plastic inside had a white paper on top with information "should be retained inside the resident's room." Inside the black covered bin were multiple soiled towels and gowns. Also, there was one wheelchair inside the WCB.

On that same date and time, the surveyor asked the HD and the DM if it was appropriate for the used COVID-19 test kit garbage to be inside the WCB and stored in two black covered bins and a wheelchair, and both the HD and the DM did not respond.

On 8/08/23 at 9:35 AM, the surveyor, HD, and DM went to South CB (SCB) and observed in one area inside the SCB next to the shower room

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there were two wheelchairs (w/c), two commodes, one hoyer lift, overflow of soiled personal clothing of residents inside a big receptacle and unable to close due to overflow, there was a stuffed toy on top of one commode. The HD informed the surveyor that the two w/c were considered dirty and once clean should be moved to the clean utility room. The DM acknowledged that the soiled personal clothing of the residents was overflowing from the receptacle and should have been picked up by the laundry staff.

On that same date and time, the surveyor, HD, and DM observed in the shower area that a radiator cover was not properly installed and was open. The DM stated that he will call Maintenance to fix it and that "it should not be like that." In the second shower room observed the ceiling open area and the DM stated that was a small panel access that was next to a vent. The DM stated that it should not be left open. The surveyor observed the DM immediately screwed the small panel area.

At this time, the surveyor asked the HD and the DM who was responsible for the central baths, and the HD stated that it should have been checked by the assigned housekeeper.

On 8/08/23 at 12:38 PM, the survey team met with the RDO, LNHA, and DON and were made aware of the above findings and concerns.

On 8/09/23 at 12:03 PM, the survey team meet with facility LNHA, DON, and RDO. The RDO stated that there should be no equipment in the CB, everything now was removed except for the commode, and should not be used as a storage

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room.

On 8/14/23 at 11:18 AM, the surveyor and the Maintenance Director went inside the SCB. During an interview of the surveyor with the Maintenance Director, the Maintenance Director stated that he was aware of the surveyor's concern regarding the cover of the radiator and the small panel near the vent in the shower areas. The Maintenance Director informed the surveyor that it was not the first time because it happened "maybe" two months ago and had to fix it because the CNA who provided the shower to the resident accidentally bumped it with the shower chair and the cover came out. He stated that when the surveyor saw it on 8/08/23, he was not notified by the staff, not until the surveyor's inquiry. He further stated that staff should notify him immediately if that happen because it was considered a hazard to staff and residents.

On that same date and time, the Maintenance Director informed the surveyor that it was his fault that the small panel was left open near the vent because two days ago he was fixing something on it and "probably I did not close it the right way." The surveyor asked Maintenance Director why is it important the small panel be closed at all times. The Maintenance Director stated that it was considered a hazard because any animals can get inside. He further stated that the cover was for the water valves in the ceiling.

A review of the provided facility's 5-Step Daily Patient Room Cleaning dated 01/01/2000 the DM included that 5-Step Patient Room Cleaning Procedure:
a. Empty Trash=collect trash from all rooms as first priority.....

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F 584	Continued From page 12 d. Dust Mop=the entire floor must be dust mopped-especially behind dressers and beds... e. Damp Mop=the most important area of a patient's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily.... A review of the Discharge Room Cleaning protocol that was provided by the DM included the following: Purpose: To have a system that ensures that once a patient is discharged, the room is disinfected on a timely basis. This will allow the admission of the next resident to a clean and sanitized room. Discharge Cleaning Procedure: .... disinfect all high dusting areas and walls using germicide solution; completely clean the bed, including mattress, frame, springs, headboard, and handrails; damp wipe and disinfect dressers (inside and out), bedside tables; be sure the closet is emptied and disinfected... Items for discussion: if the patient is simply being moved to another room, many times moving the bed and dresser with the patient is a better solution. On 8/15/23 at 12:54 PM, the survey team met for an Exit Conference with LNHA, DON, and RDO. The facility management had no additional information provided.	F 584		
F 641 SS=C	NJAC 8:39-31.3, 31.4(a,c,f), 31.8(c)(13) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		9/8/23

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F 641	Continued From page 13 resident's status. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 1 (one) of 20 residents, (Resident #7) reviewed, and was evidenced by the following: 1. On 8/14/23 at 10:11 AM, the surveyor reviewed Facility Task generated Resident Assessment sampled resident for MDS discrepancy that included Resident #7's MDS for admission on NJ ex order 26.4b1 The surveyor reviewed Resident #7's medical records. The resident's Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility and had a diagnosis of NJ ex order 26.4b1 A review of the resident's MDS showed that on NJ ex order 26.4b1 NJ ex order 26.4b1 (DRNA) Section A Identification Information included that the resident's NJ ex order 26.4b1 (d/c) was NJ ex order 26.4b1 Further review of the MDS revealed that on NJ ex order 26.4b1 an Entry MDS was done and Section A	F 641	Element 1: The MDS Coordinator corrected the MDS assessment for Resident #7 on NJ ex order 26.4b. Element 2: Residents who discharge with return to facility anticipated have the potential to be affected by this deficient practice. Element 3: 1. MDS coordinator was educated on ensuring correct coding of MDS for Discharge residents. 2. MDS coordinator conducted audit Discharge MDS Assessments for accuracy. 3. MDS coordinator will review discharge MDSs with DON and Administrator in morning clinical meeting prior to submitting MDSs. Element 4: 1. The MDS Coordinator, or designee, will keep a log of all Discharge MDS assessments x 20 weeks. The log will be submitted monthly to the Administrator for review at the monthly QAPI meeting and quarterly to the QA Committee for review and action, as appropriate. 2. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element 5: Completion Date: 9/8/2023	

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included that the resident was readmitted to the facility from the acute hospital.

On 8/15/23 at 9:37 AM, the surveyor in the presence of the survey team interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) regarding the MDS of Resident#7 when the resident was d/c on NJ ex order 26.4b1 (DRNA) and an Entry MDS on 1 NJ ex order 26.4 and the other succeeding MDS. The surveyor showed the electronic medical records of the resident and immediately the MDSC/RN stated that "I know what happened, the resident was NJ ex order 26.4b1 and that the resident was NJ ex order 26.4b1 and the NJ ex order 26.4b1 DRNA should have been Discharge Return Anticipated (DRA) because the resident was NJ ex order 26.4b1 with a plan to be NJ ex order 26.4b1 . She further stated that it was an error on my part." The MDSC/RN stated that DRNA was not appropriate because the resident NJ ex order 26.4b1 or another place. The MDSC/RN acknowledged that the NJ ex order 26.4b1 MDS was not coded accurately.

On that same date and time, the MDSC/RN informed the surveyor that there was no facility policy and procedure for MDS and that she follows the RAI (Resident Assessment Instrument) Manual when completing the MDS.

On 8/15/23 at 12:16 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Operations (RDO) and were made aware of the above findings.

On 8/15/23 at 12:54 PM, the survey team met for an Exit Conference with LNHA, DON, and the RDO. The facility management had no additional

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F 641	Continued From page 15 information provided. NJAC 8:39-33.2(d)	F 641		
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: Complaint # NJ00159269 Based on interview, record review, and review of other pertinent facility documents, it was determined that facility failed to ensure: a) staff consistently and accurately documented that residents received showers or the reason why residents did not receive a shower for 1 (one) of 2 (two) residents reviewed for Activities of Daily Living (ADLs), (Resident #16) according to the standards of clinical practice and b) an [NJ ex order 26.4b1] had the appropriate indication and was identified during the admission medication review. This deficient practice was identified during the medication reconciliation review for 1 (one) of 5 (five) residents observed for medication administration (Resident #293). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse	F 658	Element #1: 1. The CNAs for Resident #16 were educated by the DON regarding proper documentation of showers to accurately reflect if a shower was given or to document the reason a shower was not given. 2. The nurse who wrote the medication order with an inappropriate diagnosis for Resident #293 was educated by the DON regarding how to determine the correct diagnosis for an ordered medication by reviewing the resident□s medical record and reviewing the indications for a medication. Element #2: 1. All residents have the potential to be affected by this deficient practice. 2. Residents with new medication orders have the potential to be affected by this deficient practice. Element #3: 1. The ADON, or designee, will educate	9/8/23

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F 658	Continued From page 16 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 physical and emotional health problems, through such services as casefinding, 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 casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 8/03/23 at 9:34 AM, the surveyor observed Resident #16 seated in a [redacted] wheelchair at a table in the North wing unit dayroom and there was a book opened on the table. The resident's eyes were closed. The resident did not respond to surveyor. On 8/10/23 at 9:24 AM, the surveyor reviewed Resident #16's medical record. Resident #16's Admission Record (AR; or face sheet; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to	F 658	nursing staff on how to consistently and accurately document that residents received showers or the reason why residents did not receive a shower. 2. The ADON, or designee, will educate licensed nurses about the importance of documenting the correct diagnosis for each medication ordered, including how to determine the correct diagnosis for an ordered medication by reviewing the resident□s medical record and reviewing the indications for a medication. 3. UM conducted audit of all current residents to ensure there is Task and order triggered for scheduled showers. 4. UM or designee will review Point of care documentation daily for previous day to ensure residents received scheduled showers or documentation is in place if they did not. 5. The Unit manager or designee will review new admission charts within 24 hours for medication orders to ensure appropriate diagnosis is listed in the order and correct as needed. 6. Pharmacy consultant will conduct 24-hour MMR review on admissions and forward results to administrator and DON. 7. Pharmacy consultant will review residents monthly to ensure each medication has an appropriate diagnosis. Results will be reviewed with DON and administrator. Element #4: 1. Unit Manager, or designee, will audit documentation of showers for 5 residents weekly x 4 weeks and then 10 residents monthly x 4 months for consistent and	

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F 658	Continued From page 17 NJ ex order 26.4b1 [redacted] A review of Resident #16's quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b1 reflected that the resident had a Staff Assessment for Mental Status, which indicated that Resident #16's NJ ex order 26.4b1 [redacted] A review of Resident #16's Documentation Survey Report for NJ ex order 26.4b1 indicated that Resident #16's CNA (Certified Nursing Aide) Task included that the resident was to receive a Shower/Bath on Tuesday and Friday. The Report included the question of "Did the resident get a shower?" to be answered by the CNA with a Y-Yes or N-No. On the bottom of the report there was additional responses available for all questions which included RR-Resident Refused. Further review included the following: Tuesday 1 NJ ex order 26.4b1 Y Friday NJ ex order 26.4b1 N Tuesday NJ ex order 26.4b1 N Friday NJ ex order 26.4b1 Y Tuesday NJ ex order 26.4b1 Y Friday NJ ex order 26.4b1 N Tuesday NJ ex order 26.4b1 N Friday NJ ex order 26.4b1 Y Resident #16 received a shower one time a week during the 4 (four) week period reviewed.	F 658	accurate documentation. 2. DON will audit 5 new admission residents' medications weekly x 4 weeks and then 5 new admission medication orders monthly x 4 months for appropriate diagnoses. The results of these audits will be submitted monthly to the Administrator for review at the monthly QAPI meeting and quarterly to the QA Committee for review and action, as appropriate. 3. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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Further review of the Documentation Survey Report for [NJ ex order 26.4b1] indicated that Resident #16 was documented to have the behavior of resisting care on the shower day of [NJ ex order 26.4b1]. The other remaining shower days did not document that the resident resisted care.

The surveyor reviewed Resident #16's Progress Notes for [NJ ex order 26.4b1]. There was no documentation that the resident refused the showers on the days that were answered with a "N" (no).

On 8/10/23 at 10:29 AM, the surveyor interviewed the CNA#1 assigned to Resident #16 regarding showers. CNA #1 stated that residents received showers two times a week. He added that sometimes the unit was short staffed and that he might do the shower on another day then what was the assigned day. He also added that if a resident refused that he would try to do it on another day. The surveyor asked CNA #1 if the showers were documented. CNA #1 stated that he documented them in the computer system when they were done.

On 8/14/23 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #16 regarding showers. The LPN stated that residents received showers two times a week unless the family requested the resident to have more showers than that. The surveyor then asked the LPN if the showers were documented. The LPN stated that she was not sure how it worked in the computer system for the CNAs to document but that the showers should be documented. She then added if the CNA did not give the shower, then the CNA would tell the nurse and the nurse would document that the

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shower was not given and the reason would probably be that the resident refused.

On 8/14/23 at 10:43 AM, the surveyor asked CNA #1 how the showers were documented in the computer system. CNA #1 stated that there was a yes, not available or refused to choose from. He added that if a resident refused that he would tell the nurse and that he would try to give the resident a shower another day.

On 8/14/23 at 10:49 AM, the surveyor interviewed the North wing Unit Manager/Registered Nurse (UM/RN) regarding showers. The UM/RN stated that showers were given two times a week unless the family requested more days. The surveyor asked the UM/RN what "N" documented for shower meant. The UM/RN stated that "N" meant no and that the resident did not get a shower. She added that the resident's regular CNA might give the shower on another day. The surveyor asked if the shower was given on a different day then what was in the computer system if the CNA was able to document it on another day. The UM/RN stated that she was not sure. She then stated that the CNA would tell the nurse if the resident refused and that usually the nurse would document it, especially if the resident had behaviors.

On 8/14/23 at 10:56 AM, the surveyor interviewed CNA #2 who had documented "N" for Resident #16's showers on NJ ex order 26.4b1. CNA #2 stated that "N" meant the resident refused. She added that if a resident refused that she would tell the nurse. The surveyor asked CNA #2 why Resident #16 did not receive a shower on those days. CNA #2 stated that she did not remember.

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On 8/14/23 at 11:06 AM, the surveyor interviewed the Director of Nursing (DON) regarding showers. The DON stated that residents received showers two times a week or more frequently if requested. She added that it was documented in the computer system and that the staff would click if the resident received the shower or refused it. The surveyor then asked the DON what "N" would mean. The DON viewed the computer system and then stated that "N" was no and that if the resident did not receive the shower then the staff would document the reason and tell the nurse. The surveyor then asked the DON how someone would know why the resident did not receive the shower when the staff documented "N". The DON stated that there would have to be a note for the reason the shower was not given.

On 8/14/23 at 01:36 PM, in the presence of the survey team, the surveyor notified the Regional Director of Operations (RDO) and DON, the concern that Resident #16 did not receive showers two times a week according to the documentation in the resident's medical record.

On 8/15/23 at 10:54 AM, in the presence of the survey team, Licensed Nursing Home Administrator (LNHA) and DON, the RDO stated that stated that there was an order for the nurse to give Resident #16 a shampoo in the shower for that time period. She added that the nurse could not just write a no and that the nurse would have to explain why it was not given. The RDO stated that the resident had the showers. The surveyor reviewed the document that the facility provided which included the following:
Sched (Schedule) for Oct (October) 2022;
Bath/shower and skin check 7-3 shift twice weekly. Initials of LN indicates completion of

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Bath/Shower and Skin check one time a day every Tue (Tuesday), Fri (Friday).

The surveyor notified the LNHA, DON and RDO that they did not provide the order for the shampoo and that the document they provided did not indicate if Resident #16 received a shower.

On 8/15/23 at 12:15 PM, in the presence of the survey team, LNHA and DON and RDO the surveyor asked if the documentation for the showers should be the same when two different staff members were documenting if a shower was given. The RDO stated that the documentation should reflect the same. The surveyor then asked if the order indicated that it was a shower that was given. The RDO stated that the order did not indicate if it was a shower. The surveyor then asked if a resident refused a shower, should the refusal be documented as refused or no. The RDO stated that it should be documented as "R" for refused. The RDO stated that Resident #16 NJ ex order 26.4b1 that the nurses administered when the resident was in the shower. The surveyor asked the RDO to provide the document.

On 8/15/23 at 12:40 PM, the RDO stated that she was wrong and that the order for Resident #16's NJ ex order 26.4b1 and that it would have been administered in the bed.

A review of the facility provided policy titled, "Bathing and Showering" with an updated date of June 1, 2023, included the following:
Policy Statement
The facility will offer showers and tub baths to residents in accordance with their preferences.

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Policy Interpretation and Implementation
1. The facility will offer showers and tub baths to residents at least twice per week ...
5. Provision and refusals of showers and/or tub baths will be documented in the medical record by the certified nursing assistant and/or licensed nurse.

2. A review of the manufacturer's specifications for Flomax (tamsulosin), under section 1. Indication and Usage included an indication for the treatment of the signs and symptoms of benign prostatic hyperplasia (non-cancerous enlargements of the prostate glands which potentially slows or blocks the urine).

The surveyor reviewed the medical record for Resident #293.

The resident's AR reflected that Resident #293 was admitted to the facility with diagnoses that NJ ex order 26.4b1 [redacted]

According to the admission MDS dated [redacted] Resident #293 was documented as having a Brief Interview for Mental Status (BIMS) score of [redacted] (three) out of 15, indicating that the resident had a NJ ex order 26.4b1 [redacted]

A review of the 8/07/23, Order Summary report revealed a physician's order (PO) dated [redacted]

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fo NJ ex order 26.4b1 Take with dinner.

The Discharge Summary dated NJ ex order 26.4b1, revealed the resident had some NJ ex order 26.4b1 . NJ ex order 26.4b was started and was to be assessed for the ability to NJ ex order 26.4b1 .

A review of the pharmacy consultant progress note dated NJ ex order 26.4b, revealed the admission medication regimen review was conducted and no irregularities was identified by the Consultant Pharmacist (CP #1)

On 8/07/23 at 11:04 AM, the surveyor and CP #2 reviewed the medical record for Resident #293.

At that time, CP #2 confirmed that CP #1 reviewed the admission record and did not identify an irregularity. The CP #2 stated she would have questioned the incorrect indication for the NJ ex order 26.4b as it was not used for NJ Exec. Order 26:4.b.1

At that time, the surveyor asked CP #2 if NJ ex order 26.4b indication was appropriate. CP #2 stated NJ ex order 26.4b was an off-label use and would look for data to support it but that would be after confirming the documented/reviewed indication of NJ Exec. Order 26:4.b.1. No additional information was received.

On 8/07/23 at 11:07 AM, during an interview with the surveyor, the Registered Nurse (RN) stated the resident was evaluated and was aware of who they were and where they were. The resident had NJ ex order 26.4b1, NJ ex order 26.4b1 ith the assistance of one person. The

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F 658	Continued From page 24 RN stated the resident was NJ ex order 26.4b1 [redacted] On 8/07/23 at 02:16 PM, during a meeting with the surveyors, the surveyor discussed the concern regarding the failure of the CP #1 to identify the irregularity upon the admission medication review with the RDO, LNHA, and the DON. A review of the facility provided policy; Reconciliation of Medication on Admission dated/revised July 2017 included: General Guidelines 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that included the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. A review of the undated facility provided policy; Pharmacy Services - Role of Consultant Pharmacist included: Policy Interpretation and Implementation 2. The facility will give the consultant pharmacist a current rosed and will inform the consultant pharmacist of all new admissions and readmissions to the facility. 5. The consultant pharmacist will provide specific activities related to medication regimen review including: b. appropriated communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities ...	F 658		

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F 658	Continued From page 25 On 8/08/23 a 12:38 PM, during a meeting with the surveyors, the RDO stated the order for Flomax was clarified after surveyor inquiry. N.J.A.C. 8:39-11.2 (b), 29.3(a)1	F 658		
F 686 SS=D	. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to ensure a) that a physician's [redacted] order was followed and clarified, b) provide [redacted] in accordance with the facility's policy and professional standards of clinical practice and Centers for Disease Control and Prevention (CDC) guidance for 1 (one) of 2 (two) residents	F 686	Element #1: 1. The Unit Manager [redacted] for resident #27 with the physician on [redacted]. 2. The Unit Manager educated the nurse for resident #27 on 8/12/23 on the facility policy and professional standards of clinical practice for [redacted], including hand hygiene, PPE use and following	9/8/23

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F 686	Continued From page 26 (Resident #27) NJ ex order 26.4b1 . This 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 state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimen 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 state: "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 U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 01/08/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents, before moving from work on a soiled	F 686	treatment orders. Element #2: Residents with a wound have the potential to be affected by this deficient practice. Element #3: 1. The ADON educated licensed nurses on facility policy for wound care, including reviewing physician orders and clarifying as necessary. 2. IP educated nursing staff on the policy for enhanced barrier precautions. 3. IP conducted competencies on nursing staff for hand hygiene. 4. ADON conducted wound care competency on licensed nurses. 5. The unit manager audited current residents with wounds to ensure there were no duplicate orders and made corrections as warranted. 6. UM or designee will review the new order listing report daily for new wound care orders and ensure no duplicate orders in place. Element #4: 1. Unit Managers will conduct 2 wound competencies weekly x 4 weeks then 4 wound competencies monthly x 4 months for compliance with facility wound care policy. IP will conduct 4 hand hygiene competencies weekly x 4 weeks and then 4 hand hygiene competencies monthly x 4 months for compliance with hand hygiene. The results of these audits will be submitted monthly to the DON for review at the monthly QAPI meeting and quarterly to the QA Committee for review	

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F 686	Continued From page 27 body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. In addition, wear gloves, according to Standard Precautions, when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur; gloves are not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment, and after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. On 8/02/23 at 10:58 AM, the surveyor observed Resident # 27's room was closed with an NJ ex order 26.4b1 [redacted]; involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a NJ Exec. Order 26:4.b.1 [redacted]] as well as those at increased risk of [redacted] acquisition (e.g., residents with NJ Exec. Order 26:4.b.1 [redacted]) sign outside the room. There was with PPE (personal protective equipment) box outside the room with a gown and gloves. On that same date and time, the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that the resident was on [redacted] because	F 686	and action, as appropriate. 2. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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the resident NJ ex order 26.4b1, an NJ ex order 26.4b1 and facility acquired NJ ex order 26.4b1. The RN/UM stated that the NJ ex order 26.4b1 and unsure what stage now because the NJ Exec. Order 26 doctor came yesterday NJ ex order 26.4b1 and "I have to read the NJ Exec. Order 26:4.b.1 notes" on what NJ Exec. Order 26:4.b.1 was. The RN/UM further stated that the resident used to have a behavior of refusing meds and care but now managed and has no behavior.

The surveyor reviewed Resident #27's medical record.

The resident's Admission Record (or face sheet; an admission summary) reflected that the resident was NJ ex order 26.4b1 with a NJ ex order 26.4b1

The resident's most recent comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 which indicated the resident's cognition was NJ ex order 26.4b1. Further review of the CMDS Section M Skin Conditions, indicated the resident was at risk for developing NJ ex order 26.4b1 and NJ ex order 26.4b1 Section M also included that the resident

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had a total of NJ Exec. Order 26:4.b.1 present.

A review of the facility provided a personalized care plan, with a focus and dated NJ ex order 26.4b1 for a NJ ex order 26.4b1 A goal was to show NJ Exec. Order 26:4.b.1 by/through the review date. Interventions dated NJ ex order 26.4b1 included but were not limited to administer treatments as ordered and monitor effectiveness, continue evaluations by NJ Exec. Order 26:4.b.1 and report s/s (signs/symptoms) of NJ Exec. Order 26:4 as appropriate.

A review of the NJ ex order 26.4b1 electronic Treatment Administration Record (eTAR) included and revealed the following:

1. Enhanced Barrier Precautions every shift for wound. Start date NJ ex order 26.4b1
2. NJ ex order 26.4b1
3. NJ ex order 26.4b1

On 8/07/23 at 10:55 AM, the surveyor observed outside the resident's door a posted sign NJ Exec. Order 26 that included instructions to "STOP" Everyone Must:

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1. Clean their hands, including before entering and when leaving the room.
2. Providers and Staff Must also: wear gloves and a gown for the following high-contact resident care activities including Wound Care: any skin opening and requiring a dressing.

On that same date and time, the Licensed Practical Nurse/Supervisor (LPN/S) that he will be the one to do [NJ Exec. Order 26:4.b.1] of Resident#27 and will be assisted by the RN/UM and Certified Nursing Aide (CNA).

During the [NJ Exec. Order 26:4.b.1] observation, the LPN/S did not read an order for [NJ Exec. Order 26:4.b.1], did not perform hand hygiene, immediately donned (applied) a new pair of gloves, and entered the resident's room and assessed resident [NJ Exec. Order 2]. The LPN/S was wearing a surgical mask. The LPN/S went outside the room, took his keys from his uniform pocket then went inside the resident's room again, took the side table, removed the drinking cup and other personal belonging of the resident, and disinfected the table.

At that same time, the CNA took an isolation gown from the PPE box outside the resident's room without performing hand hygiene, donned gloves, and immediately entered the resident's room to reposition the resident towards the left side, facing the window.

At that time, the RN/UM informed the surveyor that she will help the LPN/S for [NJ Exec. Order 26:4.b.1] and the CNA. The RN/UM did not perform hand hygiene and entered the resident's room without donning an isolation gown.

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Afterward, the LPN/S removed gloves, performed handwashing inside the resident's room, then went outside the room to get an isolation gown from the PPE box and donned the gown, entered the resident's room, set up treatment supplies that were taken from the treatment cart: [redacted] and placed on top of the side table with liner and next to it was a plastic. There was a mounted ABHR (alcohol base hand rub) on the resident's room wall towards the foot part.

Later on, the LPN/S donned gloves without performing hand hygiene. Then the LPN/S removed the [redacted], doffed off (removed) gloves, and then performed handwashing. The LPN/S donned gloves and [redacted] that LPN/S [redacted] The LPN/S immediately took the [redacted] from the [redacted] area after [redacted] without performing hand hygiene and and did not change gloves. At that time, the RN/UM and CNA were present in the room. When the LPN/S was about to get the [redacted], the RN/UM took it from the LPN/S and instructed the LPN/S to change gloves. The LPN/S doffed off gloves and did not perform hand hygiene and immediately donned a new pair of gloves. The LPN/S took the [redacted] was poured by the RN/UM, LPN/S applied the [redacted] discard the [redacted] another [redacted] and the RN/UM poured towards the [redacted] the [redacted], and the LPN/S applied it to the surrounding [redacted]d. Afterward, the LPN/S applied the [redacted] without dating and

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signing the [NJ Exec. Order 26:4]. After the LPN/S removed gloves and gown and performed handwashing, he informed the surveyor that the [NJ Exec. Order 26:4.b.1] was finished.

During an interview of the surveyor with the LPN/S outside the resident's room, the LPN/S informed the surveyor that the posted [NJ Exec. Or] sign outside the resident's door was because the resident had [NJ Exec. Order 26]. The LPN/S stated that the [NJ Exec. O] sign should be followed by all staff and other people before entering and before exiting the room who will perform direct care like [NJ Exec. Order 2] The surveyor then asked the LPN/S if he performed hand hygiene before entering the room for [NJ Exec. Order 26:4.b.1], and the LPN/S did not respond. Then the surveyor asked the LPN/S if he performed hand hygiene when the RN/UM instructed him to change gloves after he cleansed the resident's [NJ Exec. Order 2] and the LPN/S stated "I can't remember." The surveyor asked the LPN/S if he should perform hand hygiene after cleaning the [NJ Exec. Order] and removing gloves and he stated "yes," he should wash his hands. The surveyor then asked the LPN/S where to donn gown before entering the room or inside the room, the LPN/S stated that staff should donn gown before entering the room and remove the used gown inside the room before exiting the room then perform hand hygiene before exiting the room according to facility practice and protocol.

At that same time, the surveyor asked the LPN/S what was the order for the [NJ Exec. Order 26:4.b.1] and why he did not read an order for the [NJ Exec. Order 26:4.b.1] that was done for the [NJ Exec. Order 26:4.b.1] before beginning the [NJ Exec. Order 26:4.b.1]. The LPN/S informed the surveyor that the resident's [NJ Exec. Orde] was a [NJ Exec. Order 26:4.b.1] and that he

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read the order for the [NJ Exec. Order 26:4.b.1] before the surveyor came. At that time, the treatment cart that was used for [NJ Exec. Order 26:4.b.1] did not have a computer where the orders can be read. The surveyor then asked the LPN/S why there were two different orders in the eTAR for the [NJ Exec. Orde] one was ordered on [NJ Exec. Order 26:4] for [NJ Exec. O], and on [NJ Exec. Order 26] for [NJ Exec. Orde] and [NJ Exec. Order 26:4.b.1] for [NJ Exec. Order 26:4.b.1]. Immediately the LPN/S checked the eTAR from the medicine cart that was parked in the next resident's room, and informed the surveyor that the order for [NJ Exec. Order 26:4] should have been discontinued (d/c) when the new order on [NJ Exec. Order 26] was obtained and "I don't know why it was not d/c." He acknowledged that the orders for [NJ Exec. Orde] should have been clarified because there were two order existing at that time, one order dated for [NJ Exec. Order 26:4] and the other one was dated [NJ Exec. Order 2].

Afterward, the surveyor interviewed the RN/UM outside the resident's room in the presence of the LPN/S and CNA regarding her instructions to the LPN/S to change gloves after [NJ Exec. Order 26:4.b.1] the [NJ Exec. Order 26:4.b.1], the surveyor asked the RN/UM if she saw the LPN/S performed hand hygiene after NJ Exec. Order 26:4.b.1 and removed used gloves, the RN/UM stated "no, I did not see him," performed hand hygiene. The RN/UM acknowledged that the LPN/S should have removed gloves and performed hand hygiene after NJ Exec. Order 26:4.b.1. The surveyor asked also the RN/UM why she did not perform hand hygiene before entering the resident's room, the RN/UM responded that she came out the restroom room before going to the resident's room and that she had performed hand hygiene prior to leaving the restroom.

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F 686	Continued From page 34 On 8/07/23 at 11:25 AM, the surveyor interviewed the CNA. The surveyor asked the CNA about the [NJ Exec. Ord] posted sign outside the resident's room and what it meant about hand hygiene before entering the resident's room. The CNA informed the surveyor that she came from another resident's room but was unable to remember what room. The CNA stated that she should have washed her hands before entering the [NJ Exec. O] room. She acknowledged that she should followed the instructions from outside the door because she entered the room to provide direct care which was assisting the nurses with [NJ Exec. Order 26:4.b.1]. On 8/07/23 at 11:33 AM The surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Regional Director of Operations (RDO) regarding the above findings and concerns with the [NJ Exec. Order 2] observation of Resident #27. The surveyor asked the facility management when staff should donn PPE. The RDO informed the surveyor that the gown should be donned outside, before entering the resident's room. The RDO stated also that hand hygiene should be done in [NJ Exec. Ord] before entering the room, remove gloves and gowns inside the room and dispose of them inside the room into the covered bin. On 8/07/23 at 01:46 PM, the RDO to the surveyor showed the camera surveillance in the South unit from 10:55 AM onwards. The RDO stated that according to the video/camera surveillance, the LPN/S should have performed hand hygiene prior to entering the resident's room for [NJ Exec. Order] She further stated that the staff should perform hand hygiene according to the [NJ Exec. Ord] posted sign outside the resident's room. The RDO also stated that the video surveillance	F 686		

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showed that the RN/UM came out of the restroom which was in front of the nursing station, then walked until the RN/UM reached the resident's room.

On 8/08/23 at 12:38 PM, the survey team met with the RDO, LNHA, and DON. The RDO stated that the LPN/S followed the NJ Exec. Order 26:4.b.1 order on 8/03/23 order for NJ Exec. Order 26:4.b.1. She further stated that the RN/UM failed to discontinue the previous order on NJ Exec. Order 26:4.b, and should have been clarified the order for NJ Exec. Orde when the new order obtained on NJ Exec. Order 26.

A review of the undated facility's Wound Care Policy that was provided by the LNHA included that the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation included verify that there is a physician's order for this procedure, and review the resident's order and care plan for the special needs of the resident. Steps in the procedure included to mark the dressing label or tape with the date, time, and initials. Also included in the steps is to apply a prepared label with the date, time, and initial to dressing.

A review of the facility's Medication and Treatment Orders Policy that was provided by the RDO with a revised date of July 2016 included that orders for medications and treatments will be consistent with principles of safe and effective order writing.

A review of the undated facility's Personal Protective Equipment Policy that was provided by the RDO revealed that soiled or contaminated PPE clothing and equipment must be removed and discarded at the location where the soiling or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 36 contamination occurred. The policy did not include information on when and where to donn PPE, if it is before entering the room or inside the room. On 8/09/23 at 12:03 PM, the survey team meet with the LNHA, DON, RDO. There was no additional information provided by the facility management.	F 686		
F 688 SS=D	NJAC 8:39-11.2(b), 19.4(a), 27.1(a), 29.2(d) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure that the [redacted] NJ Exec. Order 26:4.b.1 was	F 688	Element #1: 1. Physician for Resident #57 was notified that resident was NJ ex order 26.4b1 [redacted] and ordered to re-apply.	9/8/23

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F 688	Continued From page 37 consistently applied according to the physician's order. This deficient practice was identified for 1 (one) of 2 (two) residents reviewed for NJ ex order 26 [redacted], Resident #57, and was evidenced by the following: During the initial tour on 8/02/23 at 10:36 AM, the surveyor observed Resident #57 in bed, with a NJ ex order 26.4b1 that appeared stained with yellow and brown discoloration. The resident had NJ ex order 26.4b1 [redacted]. There was not a date or initials on the NJ Exec. Order [redacted]. On 8/03/23 at 10:31 AM, the surveyor observed the resident, in bed, with a NJ ex order 26.4b1 that was visibly stained with yellow and brown discoloration. The resident had NJ Exec. Order 26:4.b.1 of the NJ Exec. Order 26:4.b [redacted]. The NJ Exec. Order [redacted] was not dated or initialed. On 8/08/23 at 10:31 AM, the surveyor observed the resident, in a reclining chair, the NJ ex order 26.4b1 [redacted] The surveyor asked the resident what had happened to the NJ Exec. Order 26:4 [redacted], and the resident replied, "I took it off because it was dirty." On 8/10/23 at 9:33 AM, the surveyor observed the resident in bed, the NJ ex order 26.4b1 [redacted] The surveyor asked the resident what had happened to the NJ Exec. Order 26:4 [redacted], and the resident replied, "Oh, that thing? It was dirty." The surveyor reviewed the medical records of Resident #57. According to the Admission Record (admission summary), Resident #57 was NJ ex order 26.4b1 [redacted] with medical diagnoses which included but	F 688	2. Unit Manager NJ ex order 26.4b1 to resident # 57 NJ ex order 26.4b1. 3. The Nurses assigned to resident #57 on NJ ex order 26 [redacted] and NJ ex order 26 [redacted] were educated on ensuring the NJ ex order 26.4b1 is in place and proper documentation of non-compliance with orders. Element #2: All residents who have splint orders have the potential to be affected by this deficient practice. Element #3: 1. The ADON educated licensed nurses on the facility splint policy, including the correct procedure to follow if the splint is removed and the importance of updating a resident□s care plan to address non-compliance with orders. 2. The Unit Manager audited residents with orders for splints to ensure they were in place and there is an order in place. 3. Unit manager or designee will check residents with splints orders daily to ensure splint is in place as ordered. Element #4: 1. The Unit Manager will audit 5 residents with splints weekly for 4 weeks to ensure splint is in place or there is documentations to why it is not, and then monthly for 4 months. The results of these audits will be submitted monthly to the DON for review at the monthly QAPI meeting and quarterly to the QA Committee for review and action, as appropriate. 2. The QAPI Committee will make	

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F 688	Continued From page 38 not limited to; NJ ex order 26.4b1 [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b1 revealed a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 which indicated that the resident's NJ ex order 26.4b1 A review of the Physician Orders (PO) in the Electronic Medical Record (EMR) revealed active orders for: . NJ ex order 26.4b1 [redacted] Active NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted]. Active NJ ex order 26.4b1 A review of the Treatment Record for NJ ex order 26.4 [redacted] evealed that the nurses signed "NJ ex order 26.4b1 [redacted] "with a start date of NJ ex order 26.4b1 or day shift (7 am -PM) on NJ ex order 26.4b1 day shift, evening shift (3 PM-11 PM), and night shift (1-7 am) on NJ ex order 26.4. The surveyor had observed NJ Exec. Order 26.4 not in place since NJ ex order 26.4b1 . A review of radiology results for NJ ex order 26.4b1 [redacted] at 7:49 PM, findings revealed NJ ex order 26.4b1 [redacted]. NJ ex order 26.4b1 [redacted]. A review of radiology results for NJ ex order 26.4b1 2 (two) views, dated NJ ex order 26.4b1 at 4:31 PM, findings	F 688	recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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NJ ex order 26.4b1 [redacted]

The ongoing Care Plan revealed a "focus"; resident has a NJ ex order 26.4b1 r/t (related to) NJ ex order 26.4b1 with interventions that included-I will remain free of complications NJ ex order 26.4b1 [redacted]

The consultation report dated NJ ex order 26.4b [redacted] by orthopedic provider. Which listed recommendation that included to keep NJ Exec. Order 26:4.b [redacted] can change as needed (which was not seen as an order on the PO).

A review of general Progress Notes (PN) dated NJ ex order 26.4b [redacted] at 2:49 PM showed "NJ ex order 26.4b1 [redacted]".

Further review of general (PN) revealed that the last nursing progress note was written on NJ ex order 26.4b [redacted] at 11:11 PM. The facility was not able to provide additional general progress notes for NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted]

A review of the occupational therapy treatment encounter notes dated NJ ex order 26.4b1 showed under precautions: "NJ Exec. Order 26:4.b.1) pending medical doctor (MD) clearance." Further review revealed, under 97535: "NJ ex order 26.4b1 [redacted]."

On 8/15/23 at 12:16 PM, the survey team met

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with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO). The surveyor asked the facility management if there will be additonal information regarding Resident #57's concerns and findings. The facility management did not provide an additional information.

A review of the facility's Policy: ROM Devices with a reviewed date of March 2023. The policy read as follows:
Residents with limited ROM may be candidates for the use of orthotic devices such as splints and braces. When used, these devices will be maintained to increase and/or prevent a further decrease in ROM and to reduce the risk for complications.
Procedure
1. Physical and occupational therapists may make recommendations for the use of ROM devices within their scope of practice.
a. The primary physician will review the therapist's recommendations and provide orders for use of the ROM device, as appropriate.
2. When a ROM device is to be utilized, the primary physician or consulting physician will provide orders specifying the type of device, the frequency of application, and the duration of application.
a. If applicable, the physician's order will specify the don and doff times for the device to be applied and removed.
3. The physician's orders will include the type and frequency of monitoring for potential complications of the device to be used (e.g., presence of pain, indications of impaired skin integrity, impaired circulation).
4. The licensed nurse will document in the medical record the type, duration, and frequency

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F 688	Continued From page 41 that the device was donned and doffed. 5. The licensed nurse will document in the medical record the completion of monitoring for potential complications as ordered by the physician. a. In the event that a complication or potential complication is observed, the nurse will document details of the observation in the medical record. i. The physician will be notified of the licensed nurse's observations and the nurse will obtain and carryout any new orders, if applicable. ii. The resident (or resident representative) will be notified of the change in condition and any follow-up actions. NJAC 8:39-27.1 (a)	F 688		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		9/8/23

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F 725	Continued From page 42 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ00159269, NJ00160307, NJ00164302, NJ00152188 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey (NJ) and b.) ensure that 7 AM-3 PM and 3-11 PM shifts were staffed to provide the ADLs (activities of daily living) with regard to toileting need and assistance in distribution of meal trays for 2 (two) of 4 (four) residents, (Residents#143 and #7) according to facility practice, required minimum direct care staff-to-shift ratios as mandated by the state of NJ, and facility assessment. 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,	F 725	Element #1: 1. Resident # 143 was [redacted] on [redacted] 2. Resident # 7 was interviewed by Dietician, Dietary manager and VP of Dining Services on [redacted] to discuss concerns regarding Cold food. Element #2: All residents have the potential to be affected by this deficient practice. Element #3: 1. The Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for the next day, and staffing for the upcoming week. Trends identified from these meetings will be presented during the monthly QAPI meeting. 2. The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes Job fairs, Flexible scheduling, Increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need	

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F 725	Continued From page 43 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 CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. On 8/02/23 at 9:00 AM, the surveyors entered the facility and observed that the Nursing Home Resident Care Staffing Report that was posted at the reception desk for the staffing of the facility included the following: 8/02/2023-Day Shift; Current Resident Census: 92; Certified Nurses Aide (CNA) # of Staff-10; Staff to Resident Ratio-1 CNA:9.2 Residents. The facility staffing did not meet the required minimum direct care staff-to-shift ratios as mandated by the state of NJ. On 8/02/23 at 9:53 AM, the surveyor toured the North wing unit of the facility which was a locked unit for cognitively impaired residents. The surveyor interviewed the North wing Unit Manager/Registered Nurse (UM/RN) regarding the staffing for that unit. The UM/RN stated that the resident census was 43 and that 4 (four) CNAs were working on the unit. The surveyor	F 725	arises),Implementation of advanced staffing management software system, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. 3. The facility has developed a Culture Committee focused on recruitment and retention of staff by enhancing the employee experience, some of the committee's activities include a weekly event for staff where food is provided, as well as bi-monthly large fun event with food and prizes with 2 employees of the Month chosen. The facility also has seasonal holiday parties, gives all employees gifts during each holiday season and celebrates all employee's birthday's once a month. 4. The facility has implemented the Care Champion Program to mentor new employees where the champions/mentors (senior CNA staff) receive a bonus if the new employee stays for a certain period of time. 5. The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open positions, recruitment tactics, and changes to improve outcomes. 6. The facility has implemented processes to increase communication with employees through monthly Townhall meetings and a Digital Suggestion Box. 7. The facility conducts an exit interview with any employee who resigns to better improve the employee experience and	

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F 725	Continued From page 44 calculated the staff-to-resident ratio and it was 1 (one) CNA to 10.8 residents. The North wing unit was not staffed to meet the minimum direct care staff-to-shift ratios as mandated by the state of NJ. On 8/03/23 at 12:31 PM, the surveyor toured the North wing unit of the facility. The surveyor interviewed the North wing UM/RN regarding the staffing for that unit. The UM/RN stated that the resident census was 43 and that 4 (four) CNAs were working on the unit. The surveyor calculated the staff-to-resident ratio and it was 1 (one) CNA to 10.8 residents. The North wing unit was not staffed to meet the minimum direct care staff-to-shift ratios as mandated by the state of NJ. On 8/08/23 at 01:24 PM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) to provide the CNA assignment sheets for the North wing unit for the weeks of 02/13/22, 02/27/22, 10/23/22, 10/30/22, 11/6/22 and 5/14/23. On 8/10/23 at 01:12 PM, in the presence of another surveyor, the surveyor interviewed the Staffing/Ancillary Coordinator (S/AC) regarding staffing. The S/AC stated that she did the staffing, ordered supplies, and sometimes worked as a CNA. She stated that she staffed the building according to the mandated ratio depending on the facility census. The S/AC stated the correct ratios for each shift and was aware of the day shift ratio of 1 (one) CNA to 8 (eight) residents. The surveyor then asked the S/AC if she staffed the CNAs for the census of the building or the census for each unit. The S/AC stated that she normally staffed the CNAs for the census of the building.	F 725	help with retention. Element #4: Starting on 9/15/23 the Administrator/designee will review the minutes from monthly resident council meetings for 3 months to determine whether there are any concerns regarding care and services. Starting on 9/15/23 the Administrator/designee will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements. The Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 3 months to determine if needs are being met. The results of the audits will be reviewed during QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/2023	

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She added that some days the facility met the ratio and sometimes they did not.

On that same date and time, the surveyor then asked how the North wing unit would be staffed. The S/AC stated that if the census would be 48 then there would be 6 (six) CNAs. The surveyor notified the S/AC that the North wing unit had 4 (four) CNAs on 8/02/23 and 8/03/23. The S/AC stated that she was not sure why the unit was short of the mandated ratio. The surveyor then asked the S/AC if she notified anyone if the staffing for a day did not meet the minimum direct care staff-to-shift ratios as mandated. The S/AC stated that she would let the Director of Nursing (DON) know.

A review of the facility provided CNA assignment sheets and census report for the North wing unit included the following for the day shift:

On 02/13/22 there were 3 CNAs with a census of 45. The ratio was 1 CNA to 15 residents.
On 02/19/22 there were 3 CNAs with a census 46. The ratio was 1 CNA to 15.3 residents.
On 10/23/22 there were 3 CNAs with a census 45. The ratio was 1 CNA to 15 residents.
On 10/27/22 there were 3 CNAs with a census 45. The ratio was 1 CNA to 15 residents.
On 10/29/22 there were 3 CNAs with a census 45. The ratio was 1 CNA to 15 residents.
On 10/30/22 there were 3 CNAs with a census 45. The ratio was 1 CNA to 15 residents.
On 11/01/22 there were 3 CNAs with a census 45. The ratio was 1 CNA to 15 residents.
On 11/6/22 there were 3 CNAs with a census 47. The ratio was 1 CNA to 15.7 residents.
On 12/27/22 there were 3 CNAs with a census 46. The ratio was 1 CNA to 15.3 residents.

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On 12/30/22 there were 3 CNAs with a census 46. The ratio was 1 CNA to 15.3 residents.
On 12/31/22 there were 2 CNAs with a census 44. The ratio was 1 CNA to 22 residents.
On 5/11/23 there were 3 CNAs with a census 42. The ratio was 1 CNA to 14 residents.
On 5/15/23 there were 3 CNAs with a census 43. The ratio was 1 CNA to 14.3 residents.
On 5/16/23 there were 3 CNAs with a census 41. The ratio was 1 CNA to 13.7 residents.
On 5/17/23 there were 3 CNAs with a census 43. The ratio was 1 CNA to 14.3 residents.
On 5/19/23 there were 2 CNAs with a census 43. The ratio was 1 CNA to 21.5 residents.
On 5/20/23 there were 3 CNAs with a census 43. The ratio was 1 CNA to 14.3 residents.

On 8/14/23 at 11:03 AM, the surveyor interviewed the North wing UM/RN regarding the staffing of the unit. The UM/RN stated that the North wing unit was usually staffed with 4 (four) or 5 (five) CNAs depending on the census. She added that for a census of 46, there would be 5 (five) CNAs and a census of 41 or 42 might have 4 (four) CNAs. The surveyor then asked the UM/RN if she was aware of the minimum direct care staff-to-shift ratios as mandated by the state of NJ. The UM/RN stated that the day shift was 1 (one) CNA to 8 (eight) residents.

On that same date and time, the surveyor then asked the UM/RN if she was aware that the facility was not meeting the ratio for her unit. She stated that she was aware. The surveyor then asked the UM/RN if she notified anyone when the unit did not meet the ratio. She stated that she would let S/AC, DON, and Human Resources know. She added that they were trying to hire more CNAs.

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On 8/14/23 at 11:12 AM, the surveyor interviewed the DON regarding if she was involved with staffing the facility. The DON stated that she was involved to a certain extent and that she was aware of the staff-to-resident ratios. The surveyor then asked the DON if the facility was meeting the ratios. The DON stated that the facility generally met the ratio for the building. The surveyor then asked if she was aware that the North wing unit was not meeting the ratio. The DON stated that she looked at the schedule and that she would have extra staff help on the unit. The surveyor asked if those "extra staff" would help with direct care. The DON stated that they could help with direct care but that they would not be listed on the assignment sheet.

On 8/14/23 at 01:34 PM, in the presence of the survey team, the surveyor notified the Regional Director of Operations (RDO) and DON the concern that the North wing unit was not sufficiently staffed.

On 8/14/23 at 01:46 PM, in the presence of the survey team and DON, the RDO stated that it was a challenge. She stated that the facility met the acuity for nurses but that they did not always meet the CNA ratio.

2. On 8/02/23 at 11:06 AM, the surveyor asked the LNHA and the DON in the presence of the RDO the whereabouts of Resident #143 and the RDO informed the surveyor that the resident was NJ ex order 26.4b1 (d/c) on NJ ex order 26.4b1 NJ ex order 26.4b1
The surveyor asked for the closed record, grievances, incidents/accident reports, and reportable events since the last recertification and

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the facility management stated that they will get back to the surveyor.

The surveyor reviewed the medical records of Resident #143 as follows:

The Admission Record (or face sheet; an admission summary) reflected that the resident NJ ex order 26.4b1 with a diagnosis that included but was not limited to NJ ex order 26.4b1 [redacted].

The admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed that the Section C Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 which indicated that the resident's NJ ex order 26.4b1. The aMDS in Section G NJ ex order 26.4b1 was coded NJ ex (extensive assistance with one person physical assist). The aMDS in Section NJ ex order 26.4b1 (NJ ex order 26.4b1).

A review of the NJ ex order 26.4b1 at 3:42 PM phone interview of another surveyor to the resident's Power of Attorney (POA) revealed that according to the POA, the resident NJ ex order 26.4b1 and NJ ex order 26.4b1 .

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Also, the POA was not sure if staff members were present during [NJ Exec. Order 26:4.b] because the resident had to wait to be [NJ Exec. Order 26]

A review of the provided Detailed Census Report for [NJ ex order 26.4b1] by the LNHA revealed that Resident #143 was in room [NJ ex order 26.4b1] from [NJ ex order 26.4b1] through [NJ ex order 26.4b1] and in room [NJ ex order 26.4b1]) from [NJ ex order 26.4b1]

A review of the Full QA Report (Investigation Report) dated [NJ ex order 26.4b1] that was provided by the RDO revealed that Resident #143 had a [NJ ex] at 3:00 PM, was found next to the toilet lying on the resident's right side by a staff member (Occupational Therapist). The investigation also showed that the full body assessment was done with [NJ ex order 26.4b1] noted and that the resident was educated on the use of the [NJ ex order 26.4] and not to use the toilet by himself/herself. The assigned caregiver was CNA#1.

A review of the provided nursing schedule for [NJ Exec. Order 26:] by the RDO showed the following information:
CNA#2 called off for the 7 AM to 3 PM South CNA shift,
The total assigned CNA for the 7 AM-3 PM shift was 8.0,
West wing with 1.0 CNA that included CNA#1's name,
South wing with 3.0 CNAs that included Nurse Aide#1 (NA#1), NA#2, and CNA#3

Further review of the above nursing schedule for 01/14/22 showed that no one called off from the 7 AM to 3 PM shift for West wing and was originally

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scheduled for one CNA (CNA#1).

A review of the provided West Wing CNA Assignment (7 AM-3 PM/Morning Shift) by the RDO showed Post 1 was CNA#1 had a total of 14 residents that included Resident #143, Post 2 was crossed out (no assigned CNA, and residents were divided to Post 1 and Post 3), and Post 3 was NA#1 had a total 15 residents.

Further review of the provided West Wing CNA Assignment (3 PM-11 PM/Evening Shift) showed Post 1 was CNA#2 had a total of 14 residents that included Resident #143, Post 2 was crossed out, and Post 3 was CNA#3 had a total of 15 residents.

Review of the requested staffing for the weeks of 01/09/2022 to 01/15/2022 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 2 of 7 overnight shifts as follows:

-01/09/22 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-01/09/22 had 6 total staff for 93 residents on the overnight shift, required at least 7 total staff.
-01/10/22 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-01/11/22 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-01/12/22 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-01/12/22 had 6 total staff for 93 residents on the overnight shift, required at least 7 total staff.
-01/13/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs.

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F 725	Continued From page 51 -01/14/22 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -01/15/22 had 6 CNAs for 99 residents on the day shift, required at least 12 CNAs. On 8/14/23 at 11:07 AM, the surveyor interviewed the Registered Nurse (RN) at West wing 1 (one) unit. The RN informed the surveyor that she's been working in the facility as a full-time nurse in the West unit for NJ Exec. Order 26:4. She further stated that there were 2 (two) units in the West wing; West wing 1 (one) unit from rooms one through nine and West wing 2 (two) unit from rooms 10 through 16. The RN stated that for the day shift (7 AM -3 PM) there should be three CNAs to cover for West 1 and 2 units and "the same way" for the 3 PM-11 PM shift. On that same date and time, the surveyor asked the RN if she knew about the NJ state mandated staffing ratio. The RN stated that she was not aware of the NJ nurse staffing ratio to residents in the facility "but" knew that there should be three CNAs assigned for 7 AM-3 PM and 3 PM-11 PM shifts because that was the practice in the facility. She further stated that there was short staff in the unit. The RN also stated that in the morning it was hard and CNA needs to attend to more residents. The RN was unable to determine which shift and if it was on weekdays or weekends the most short staff, "but it happens." At that same time, the surveyor asked the RN if she remembered Resident #143. The RN stated that she was unable to remember Resident#143 because it was over a year and unable to remember the NJ Exec. Order 26:4.b.1. The RN acknowledged that she was the assigned nurse on that day for the 7 AM-3 PM shift.	F 725		

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Later on, the surveyor then showed the West Wing CNA Assignment (7 AM-3 PM/Morning Shift) on [NJ Exec. Order 26:4] where she was assigned as the nurse and CNA#1 with 14 residents on Post 1 (one). The RN confirmed that was her name and that the CNA had 14 residents because Post 2 (two) had no CNA and had to divide the assignment on Post 2 (two) between Post 1 (one) and Post 3 (three) CNA.

On 8/14/23 at 11:28 AM, the surveyor interviewed CNA#1 who was assigned on Post 1 (one), and the caregiver on the [NJ ex order 26.4b1] [NJ ex order 26.4b1] The CNA informed the surveyor that she was a regular aide in the South unit for the 7-3 shift. The CNA stated that she was aware of the NJ Nurse Staffing ratio of CNA to resident which was 1 (one) CNA to 8 (eight) residents for the 7 AM-3 PM shift. She further stated that it was not being followed for some time and there was a short staff at the facility and was unable to specify specifics (weekdays, weekends, and what shift), she added, "It's happening." The surveyor then asked the CNA if care was affected due to short staff in the facility and the CNA did not respond.

On that same date and time, the surveyor asked CNA#1 if she had worked in the West unit, and CNA#1 stated she can not remember. Then the surveyor showed the CNA the West Wing CNA Assignment (7 AM-3 PM/Morning Shift) on [NJ Exec. Order 26:4...] where she was assigned as the CNA with 14 residents on Post 1 (one). The CNA confirmed that was her name and she had 14 residents because Post 2 (two) had no CNA and had to divide the assignment on Post 2 (two) between Post 1 (one) and Post 3 (three) CNA.

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The CNA acknowledged that it was "probably short staff" which was why she was assigned to the West wing because she "normally" work at the South wing.

At the same time, the surveyor asked the CNA to describe the West wing and the residents. CNA#1 stated that the West unit was considered subacute and "of course, residents wanted to be toileted and helped all at the same time." The surveyor then asked the CNA if she remembered Resident#143 and the NJ ex order 26.4b1 on that same date that she was assigned on NJ ex order 26.4b1 when the resident was found on the floor in the bathroom in the resident's room when the resident toileted self. The CNA stated that she can not remember the NJ ex order 26.4b1 incident.

On 8/14/23 at 01:02 PM, the survey team met with RDO and DON. The surveyor notified the facility management of the above findings with regard to the short staff and discussed the Facility assessment. The RDO stated that for the 7-3 shift, the facility follows the NJ mandates for staff to resident ratio of 1 (one) CNA to 8 (eight) residents. The RDO further stated that staffing was a challenge in the facility and acknowledged the concerns.

A review of the Quality Assurance Performance Improvement (QAPI) Audit Review agenda for the month of January, February, and March 2023 that was provided by the LNHA revealed that in concern/problem, staffing compliance was included and that the compliance goal (# or percentage) for meeting the state regulations regarding staffing was left blank.

Attached to the QAPI above was the QAPI Action

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Plan (QAPI/AP) dated 5/01/23 with a goal to meet the state staffing requirements while reducing the need for agency nursing staff. Included in the QAPI/AP was tabulated information that included:
Tasks=to evaluate the current amount of nursing staff wherein to plot all nurse and CNA schedule templates based on assigned shifts
Discipline (who will be involved)=LNHA, DON, HR Director, and Staffing Coordinator
Target Date=started 5/01/23
Intervention/Progress/Resolution=was left blank

3. On 8/02/23 at 11:01 AM, Resident #7 was observed sitting in a wheelchair, ambulating within their room and was conversant.

At that time, the resident informed the surveyor about previous concerns and stated there weren't enough aids to pass the meal trays that food was received cold at times.

The surveyor reviewed the medical record for Resident #7.

A review of the AR reflected the resident was NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1 [redacted].

The MDS dated NJ ex order 26.4b showed a BIMS score of NJ ex out of 15, indicating the resident was NJ Exec. Order 26:4.b.1.

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Review of the requested staffing for the weeks of 01/23/2022 to 01/29/2022 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-01/23/22 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/24/22 had 7 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/25/22 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/26/22 had 7 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/27/22 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.
-01/28/22 had 7 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-01/29/22 had 5 CNAs for 96 residents on the day shift, required at least 12 CNAs.

Review of the requested staffing for the weeks of 11/20/2022 to 11/26/2022 showed that the NJDOH Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-11/20/22 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-11/21/22 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-11/22/22 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-11/23/22 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-11/24/22 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.

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-11/25/22 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-11/26/22 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs.

A review of the facility provided policy titled, "Staffing, Sufficient and Competent Nursing" with a reviewed date of March 2023, included the following:
Policy Statement
Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.
Policy Interpretation and Implementation
Sufficient Staff
1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including:
a. assuring resident safety;
b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident;
c. assessing, evaluating planning and implementing resident care plans; and
d. responding to resident needs ...
4. Licensed nurses are required to supervise nurse aides/nursing assistants and are scheduled in such a way that permits adequate time to do so.
5. "Nurse aides/nursing assistants" are individuals providing nursing or related services to resident in the facility, including those who provide services through an agency or under a contract with the facility. Licensed health professionals, registered dieticians, paid feeding assistants and individuals who volunteer to

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F 725	Continued From page 57 provide nursing or related services without pay are not considered nursing assistants and are not posted or reported as "direct care" staff. 6. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment. 7. Factors considered in determining appropriate staffing ratios and skills include an evaluation of the diseases, conditions, physical or cognitive limitations of the resident population, and acuity. 8 Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing. On 8/15/23 at 12:54 PM, the survey team met for an Exit Conference with LNHA, DON, and RDO. The facility management had no additional information provided. N.J.A.C. 8:39-27.1(a)	F 725		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		9/8/23

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F 806	Continued From page 58 by: Complaint # NJ00151595 and NJ00159657 Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident's dietary preferences were honored. The deficient practice was identified for one (1) of two (2) residents reviewed for dietary concerns (Resident #7) and was evidenced by the following. On 8/02/23 at 11:01 AM, the surveyor observed Resident #7 within their room and conversant. Resident #7 stated, they were supposed to be on NJ ex order 26.4b1 because of their NJ ex order 26.4b1. The resident stated they had informed the dietician of their preferences but there were still no available choices for their needs. On 8/02/23 at 12:46 PM, Resident #7 informed the surveyor that he/she had fettuccine alfredo for lunch today and the food was not bat. The resident further stated that lunch was still all carbohydrates. The surveyor reviewed the medical record for Resident #7. The Admission Record (or face sheet; an admission summary) reflected the resident was admitted to the facility with diagnoses that included NJ ex order 26.4b1 NJ ex order 26.4b1),	F 806	Element #1: Food Service Director and Registered Dietician met with resident # 7 on 8/8/23 to review and correct Resident #7□s dietary preferences. Element #2: All residents who select their menu have the potential to be affected by this deficient practice. Element #3: 1. Food Service Director and Dietician audited current residents on 8/8/23 for preferences. 2. Regional Dietician educated facility dietician on obtaining residents preferences while following therapeutic diets on admission and at least quarterly. 3. Dietary staff were educated on the importance of following residents□ preferences and diets. 4. Food Service Director or designee will monitor tray line daily to ensure dietary staff are following preferences and diet. 5. Dieitican will assess reisdents preferences on admission and document on care plan and in dietary software to ensure they appear on tray ticket. 6. Food Service Director will distribute select menus individually to each resident weekly per their physician ordered diet and retrieved so preferences can entered into Dietary system. 7. Administrator will attend reisednt council meeting to determine if residents are receiving their preferences. Element #4: 1. Administrator will interview 5 residents	

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F 806	Continued From page 59 NJ ex order 26.4b1 [redacted] A review of the Minimum Data Set, an assessment tool used to facilitate the management of care dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating the resident was NJ ex order 26.4b1 [redacted] A review of the Resident's Care Plan (CP) revealed a focus that the resident had [redacted] related to NJ Exec. Order 26:4.b.1, NJ ex order 26.4b1 [redacted] he interventions included food preferences will be recorded and updated as needed, initiated on [redacted] The resident's Orders Summary Report that included a diet order dated [redacted], for a [redacted] regular texture, thin consistency and consistent, constant, or NJ ex order 26.4b1 [redacted]). A review of the Week at a Glance menu, dated 7/30/23 to 8/05/23, included the lunch meal for 8/02/23, which was fettuccine alfredo with mushrooms, broccoli florets, bread roll with butter or margarine and the alternative was egg salad sandwich with three bean salad. The corresponding therapeutic menu for [redacted] revealed that a NJ ex order 26.4b1 [redacted] were served items on a regular diet and NAS was achieved by removing saltshaker and salt packets. Further review of the sampled therapeutic diet	F 806	weekly x 4 weeks and then monthly for 4 months to determine if they are receiving their preferences for meals. All findings will be reported to QAPI team on a monthly basis and quarterly to QA Committee for review. Interventions will be put in place as needed. 2. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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from [NJ ex order 26.4b] through [NJ ex order 26.4b1] reflected the same information.

The Registered Dietician's (RD's) Nutritional Risk Assessment (NRA) dated [NJ ex order 26.4], under recommendation and plan did not include the resident's diet preference.

Further review of the RD's NRA dated [NJ ex order 26.4], under recommendation and plan did not include the resident's diet preference.

On 8/07/23 at 9:36 AM, the surveyor interviewed the Registered Dietician (RD) who stated she was responsible for the dietary, appropriate goals, interventions, and food preferences which she included into the resident's CP. The resident's food preferences were updated quarterly, yearly or upon significant change.

At that time, the RD stated the resident had never communicated their diet preference to her but confirmed the resident's preference should have been obtained within 48 hours of admission.

On 8/07/23 at 01:24 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) assigned to resident stated that Resident #7 was [NJ ex order 26.4b1]. The resident had the ability [NJ Exec. Order 26:4.b.1].

On 8/07/23 at 01:47 PM, during an interview with the surveyor, the Food Service Director stated that the resident's preferences were the responsibility of the dietician to obtain and document.

On 8/07/23 at 02:16 PM, the survey team met

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with the Regional Director of Operations (RDO), Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns regarding Resident #7's food preferences that were not collected, documented, and honored.

On 8/08/23 at 12:38 PM, during a meeting with the surveyors, the RDO acknowledged that the RD should have gathered and updated the resident's dietary preference to be more specific and resident centered.

At that time, The RDO informed the surveyors that the resident was ordering from the select menu as opposed to the therapeutic diet menu. The menus were available at the main lobby. The resident placed meal orders and did not receive all the choices from select menu because it would have been replaced with therapeutic diet. The RDO informed the surveyor that moving forward the resident's menu would be delivered to their room.

Furthermore, the RDO stated that the facility conducted a facility wide audit to ensure all resident's preferences were included into their care plan. The RDO further acknowledged that the RD should have recommended appropriate diet to the physician based on the resident's health condition and laboratory values.

A review of the facility provided policy Resident Food Preferences revised July 2017, included under policy statement that individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the

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F 806	Continued From page 62 residents or representative's consent. Under policy interpretation and implementation: 1. Upon the residence admission the dietitian or nursing staff will identify a resident's food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan. 4. The dietitian and the nursing staff assisted by the physician will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. 7. The resident has the right not to comply with the therapeutic diets. 8. If the resident refuses or is unhappy with his or her diet the staff will create a care plan that the resident is satisfied with. A review of the undated Clinical Dietician Job Description under responsibilities and duties included consult with physician and other health care personnel to conduct independent assessment as to the dietary restrictions and nutritional needs of the residents. Communicate with residents to assess overall nutrition and provide individualized assessments. NJAC 8:39-17.4 (c), (e)	F 806		
F 880 SS=D	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	F 880		9/8/23

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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 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

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F 880	Continued From page 64 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 review of the facility provided documents, it was determined that the facility failed to ensure: a) used COVID test kits were not stored inside the Central Bath (where staff provides showers to residents) and b) sharp container was sealed and replaced with a new container when reached the full line (75% to 80% full) according to the standard of practice and facility policy. This deficient practice was evidenced by the following: On 8/02/23 at 9:02 AM, the survey team entered the facility and there was a posted sign on the door upon entry that there was a COVID case in	F 880	Element #1 1. The used garbage receptacle with the used COVID-19 test kits were removed from the shower room on 8/8/23. 2. The sharps container was replaced on 8/8/23. Element #2: Residents utilizing any of the Central Baths have the potential to be affected by these deficient practices. Element #3: 1. The Maintenance Director audited all sharps containers to ensure no more than 3/4ths full and replaced where applicable. 2. IP rounded on Central shower rooms	

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F 880	Continued From page 65 the facility. The Receptionist instructed the surveyors to use the kiosk (automated health screening for COVID-19 questions). Later on, the Director of Nursing (DON) informed the surveyors that there was a COVID outbreak at the facility, with two residents remained in isolation. On 8/08/23 at 9:30 AM, the surveyor and the Housekeeping Director (HD) went to West Central Bath (CB), and later on, the District Manager (DM) followed. The surveyor, HD, and DM both observed inside the West CB that there was one covered garbage receptacle with a red plastic bag inside, and inside the red plastic bag were multiple used COVID-19 test kits. On that same date and time, the surveyor asked the HD and the DM if it was appropriate for the used COVID-19 test kit garbage to be inside the CB, and both the HD and the DM did not respond. On 8/08/23 at 9:35 AM, the surveyor, HD, and the DM went to South Central CB and observed the sharp container attached to the wall was above the full line (the line where the sharp container should have been replaced for safety). Inside the sharp container were multiple different colors of used razors and different kinds of used syringes. The surveyor asked the HD who was responsible for replacing the sharp container with a new one once reached the full line, and the HD stated that she was not sure but it was not their responsibility (Housekeeping Department). The HD stated that it was "probably" Nursing's responsibility to replace the sharp container when full.	F 880	on 8/8/23 to ensure used test kits were not disposed of in shower rooms. 3. The Infection Preventionist educated all staff on proper disposal of biohazard materials. 4. The IP educated the Maintenance director on importance of replacing sharps containers when ¿ full. 5. The Maintenance Director or designee will make daily rounds to inspect the sharps containers in each Central Bath in the facility. 6. IP or designee will make rounds in shower rooms daily to ensure biohazard material is nt being stored there. Element #4: 1. The administrator or designee will round on shower rooms weekly for 4 weeks and then monthly to ensure biohazard material is not being stored and sharps containers are not overflowing. The results of the rounds will be submitted monthly for review at the monthly QAPI meeting and quarterly to the QA Committee for review and action, as appropriate. 2. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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On that same date and time, the HD called the Unit Manager/Registered Nurse (UM/RN). The UM/RN went to South CB and saw the sharp container. The UM/RN acknowledged that the sharp container should have been replaced because it was full. The UM/RN informed the surveyor that she did not know who was responsible for replacing the sharp container and will have to call the Supply Clerk (SC) who also had the key to remove the full sharp container. Later on, the UM/RN stated that it was "probably" the Infection Preventionist Nurse (IPN) responsibility to check and replace the sharp container.

At 9:46 AM, the SC with a key to the sharp container met with the surveyor, UM/RN, and HD in South CB. The SC also stated that it was the IPN's responsibility to check the sharp container and replace it.

Furthermore, the surveyor asked the UM/RN why it was important to replace the sharp container when it was above the full line (above 75% to 80%). The UM/RN stated that it was important because it was for the safety of the staff and infection control prevention.

On 8/08/23 at 11:48 AM, the surveyor in the presence of another surveyor interviewed the IPN. The IPN informed the surveyors that she was not responsible for replacing the sharp containers, "but when I do rounds for infection control and observe it full, I notify the nurse." The IPN stated that part of her responsibility was to rounds for infection control at the facility which included the Central Baths. She further stated that "I don't remember the last time I did rounds for the bath area for south and west stations."

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On that same date and time, the surveyor notified the IPN of the above findings regarding the sharp container and the used COVID-19 test kits garbage receptacle in the CB.

On 8/08/23 at 12:06 PM, the surveyor and the IPN went to West CB and observed the garbage container with a red plastic bag with multiple used COVID-19 test kits inside. The surveyor asked the IPN if the used COVID-19 test kits should be inside the West CB, and the IPN stated that she will get back to the surveyor because she was not sure.

On that same date and time, the IPN stated that it was not her responsibility to replace the sharp container. She further stated that it was an expectation that when it was above the line (full line), whoever put the last one beyond the full line should be the one to report to the nurse and the nurse should replace it with a new one (new sharp container). She acknowledged that it was the Certified Nursing Aides (CNAs) and nurses who use the sharp container in the CB and they (nurses and CNAs) were responsible for the sharp container to prevent bloodborne pathogens (microorganisms such as viruses or bacteria that are carried in the blood and can cause disease in people) related infections.

On 8/08/23 at 12:38 PM, the survey team met with the Regional Director of Operations (RDO), Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON). The surveyor notified the facility management of the above findings.

On 8/09/23 at 12:03 PM, the survey team meet

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F 880	Continued From page 68 with the LNHA, DON, and RDO. The LNHA stated that according to the facility's policy, the Maintenance designated person was responsible to check and replaced full sharp containers. The RDO stated that the Maintenance Director was the designated Maintenance person who "missed it," and it should have been replaced because it was full. On 8/15/23 at 12:16 PM, the survey team met with the LNHA, DON, and RDO. The surveyor followed up facility's response concerning the used COVID-19 test kits inside the West CB. The RDO stated that the used COVID kits "should not be there," and not to be stored inside the CB. A review of the facility's Sharps Disposal Policy that was provided by the RDO with a revised date of January 2012 included that during use, containers for contaminated sharps will be handled as follows: designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container. On 8/15/23 at 12:54 PM, the survey team met for an Exit Conference with LNHA, DON, and RDO. The facility management had no additional information provided.	F 880		
F 921 SS=D	NJAC 8:39-19.4 Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		9/8/23

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F 921	Continued From page 69 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a safe and sanitary environment in 1 (one) of 1 (one) laundry room in accordance with the facility procedures. This deficient practice was evidenced by the following: On 8/15/23 at 8:47 AM, the surveyor toured the laundry room in the presence of the Housekeeping Director (HD), District Manager (DM), and Laundry Staff (LS). The surveyor observed in the drying area and folding area of the laundry room an electric fan that was on the wall that was in use and vent#1 above the ceiling with an accumulation of white substance and dust wherein below were folded clean towels, linens, blankets, and house gowns. There was also a cable wire connected to a wall with an accumulation of dust. The surveyor asked the housekeeping management and LS what was above the folded clean towels, linens, blankets, and gowns, and the DM stated that was the vent with lint. The surveyor asked if it was appropriate that the electric fan was in use while there was an accumulation of lint above the cleaned supplies, and both housekeeping management and LS did not respond. On that same date and time, the surveyor observed the laundry room floor with brown and black scattered discoloration of dried substances and an accumulation of dust. The surveyor also observed in the presence of the HD, DM, and LS	F 921	Element #1: The laundry room was immediately cleaned thoroughly on 8/15/23 by the housekeeping director. Element #2: All residents have the potential to be affected by this deficient practice. Element #3: 1. The regional Director of Housekeeping educated the House keeping Director and housekeeping staff on cleaning of laundry room to include electric fan and vents. 2. The laundry staff will complete a checklist daily for the laundry room cleaning to include high dusting to include ceiling/wall corners, dust cable wires, dust/mop surfaces. sweeping, wiping surfaces, and cleaning vents. 3. The Housekeeping Director or designee will check laundry room vents daily for dust accumulation. Element #4: 1. The administrator will audit the laundry room, including vetns and fans, weekly x 4 weeks and then monthly x 4 months. The results of these audits will be submitted weekly x 4 weeks to the Administrator for review. Results will also be submitted during the monthly QAPI meeting and quarterly to the QA Committee for review and action as applicable. 2. The QAPI Committee will make	

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F 921	Continued From page 70 the second and third vents near the exit door next to the drying area with an accumulation of dust. On 8/15/23 at 10:29 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified the facility management of the above findings. A review of the facility's Complete room clean checklist that was provided by the DM revealed that high dusting included ceiling/wall corners. Room cleaning should also include dust cable wires and dust/mop floors. On 8/15/23 at 12:16 PM, the survey team met for an Exit Conference with the LNHA, DON, and Regional Director of Operations (RDO). The facility management had no additional information provided. NJAC 8:39-31.4(a)	F 921	recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date 9/8/23	

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	062008	A. BUILDING: _____ B. WING _____	C 08/15/2023

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00151595, NJ00152188, NJ00152300, NJ00159269, NJ00159657, NJ00160307, NJ00164302 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: 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	S 560	Element #1: No residents were identified Element #2: All residents have the potential to be affected by this deficient practice. Element #3: 1. The Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for the next day, and staffing for the upcoming week. Trends identified from these meetings will be presented during the monthly QAPI meeting. 2. The facility has implemented a multifaceted approach for recruitment and	9/8/23

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

Electronically Signed | 09/03/23

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S 560	Continued From page 1 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 CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 01/09/2022 to 01/15/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -01/09/22 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs. -01/09/22 had 6 total staff for 93 residents on the overnight shift, required at least 7 total staff. -01/10/22 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.	S 560	retention of employees, which includes Job fairs, Flexible scheduling, Increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises),Implementation of advanced staffing management software system, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. 3. The facility has developed a Culture Committee focused on recruitment and retention of staff by enhancing the employee experience, some of the committee's activities include a weekly event for staff where food is provided, as well as bi-monthly large fun event with food and prizes with 2 employees of the Month chosen. The facility also has seasonal holiday parties, gives all employees gifts during each holiday season and celebrates all employee's birthday's once a month. 4. The facility has implemented the Care Champion Program to mentor new employees where the champions/mentors (senior CNA staff) receive a bonus if the new employee stays for a certain period of time. 5. The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open positions, recruitment tactics, and changes to improve outcomes. 6. The facility has implemented processes to increase communication with	

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S 560	Continued From page 2 -01/11/22 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs. -01/12/22 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -01/12/22 had 6 total staff for 93 residents on the overnight shift, required at least 7 total staff. -01/13/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -01/14/22 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -01/15/22 had 6 CNAs for 99 residents on the day shift, required at least 12 CNAs. 2. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 01/23/2022 to 01/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/23/22 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/24/22 had 7 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/25/22 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/26/22 had 7 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/27/22 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -01/28/22 had 7 CNAs for 96 residents on the day	S 560	employees through monthly Townhall meetings and a Digital Suggestion Box. 7. The facility conducts an exit interview with any employee who resigns to better improve the employee experience and help with retention. Element #4: Starting on 9/15/23 the Administrator/designee will review the minutes from monthly resident council meetings for 3 months to determine whether there are any concerns regarding care and services. Starting on 9/15/23 the Administrator/designee will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements. The Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 3 months to determine if needs are being met. The results of the audits will be reviewed during QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Element #5: Completion Date: 9/8/23	

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S 560	Continued From page 3 shift, required at least 12 CNAs. -01/29/22 had 5 CNAs for 96 residents on the day shift, required at least 12 CNAs. 3. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 01/30/2022 to 02/05/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/30/22 had 5 CNAs for 98 residents on the day shift, required at least 12 CNAs. -01/31/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/01/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/02/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/03/22 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/04/22 had 7 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/05/22 had 7 CNAs for 96 residents on the day shift, required at least 12 CNAs. 4. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 02/13/2022 to 02/19/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/13/22 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 4 -02/14/22 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -02/15/22 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -02/16/22 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -02/17/22 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -02/18/22 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -02/19/22 had 6 CNAs for 100 residents on the day shift, required at least 12 CNAs. 5. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 02/27/22 to 3/05/22, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/27/22 had 6 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/28/22 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -3/01/22 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -3/02/22 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -3/03/22 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 5 -3/04/22 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -3/05/22 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. 6. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 10/23/2022 to 10/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/23/22 had 6 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/24/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/25/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/26/22 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -10/27/22 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/28/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/29/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. 7. As per the "Nurse Staffing Report" completed by the facility for the weeks of staffing from 11/06/2022 to 11/19/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/06/22 had 7 CNAs for 101 residents on the	S 560		

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S 560	Continued From page 6	S 560		

day shift, required at least 13 CNAs.

-11/07/22 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.

-11/08/22 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.

-11/09/22 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.

-11/10/22 had 8 CNAs for 102 residents on the day shift, required at least 13 CNAs.

-11/11/22 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs.

-11/12/22 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.

-11/13/22 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs.

-11/14/22 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs.

-11/15/22 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs.

-11/16/22 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.

-11/17/22 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.

-11/18/22 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs.

-11/19/22 had 10 CNAs for 98 residents on the day shift, required at least 11 CNAs.

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S 560	Continued From page 7 8. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 11/20/2022 to 11/26/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/20/22 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs. -11/21/22 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. -11/22/22 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/23/22 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/24/22 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/25/22 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -11/26/22 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. 9. As per the "Nurse Staffing Report" completed by the facility for the weeks of staffing from 12/18/2022 to 12/31/2022, the facility was deficient in CNAs staffing for residents on 13 of 14 day shifts as follows: -12/18/22 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs. -12/19/22 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs.	S 560		

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S 560	Continued From page 8 -12/20/22 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -12/22/22 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -12/23/22 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/24/22 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/25/22 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/26/22 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/27/22 had 7 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/28/22 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/29/22 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/30/22 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -12/31/22 had 7 CNAs for 94 residents on the day shift, required at least 12 CNAs. 10. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 5/14/2023 to 5/20/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -5/14/23 had 8 CNAs for 91 residents on the day	S 560		

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S 560	Continued From page 9 shift, required at least 11 CNAs. -5/15/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -5/16/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -5/17/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -5/18/23 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -5/19/23 had 6 CNAs for 89 residents on the day shift, required at least 11 CNAs. -5/20/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. 11. As per the "Nurse Staffing Report" completed by the facility for the weeks of staffing from 7/16/2023 to 7/29/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -7/16/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -7/17/23 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -7/18/23 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -7/19/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -7/20/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 10 -7/21/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -7/22/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -7/23/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -7/24/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -7/25/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -7/26/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. On 8/10/23 at 01:12 PM, in the presence of another surveyor, the surveyor interviewed the Staffing/Ancillary Coordinator (S/AC) regarding staffing. The S/AC stated that she did the staffing, ordered supplies and sometimes worked as a CNA. She stated that she staffed the building according to the mandated ratio depending on the facility census. The S/AC stated the correct ratios for each shift. The surveyor then asked the S/AC if she staffed the CNAs for the census of the building or the census for each unit. The S/AC stated that she normally staffed the CNAs for the census of the building. She added that some days the facility met the ratio and sometimes they did not. The surveyor then asked the S/AC if she notified anyone if the staffing for a day did not meet the minimum direct care staff-to-shift ratios as mandated. The S/AC stated that she would let the Director of Nursing (DON) know. On 8/14/23 at 11:12 AM, the surveyor interviewed	S 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 11	S 560		

the DON regarding if she was involved with staffing of the facility. The DON stated that she was involved to a certain extent and that she was aware of the staff to resident ratios. The surveyor then asked the DON if the facility was meeting the ratios. The DON stated that the facility generally met the ratio for the building.

On 8/14/23 at 01:46 PM, in the presence of the survey team and DON, the Regional Director of Operations (RDO) stated that staffing was a challenge. She stated that the facility met the acuity for nurses but that they did not always meet the CNA ratio.

A review of the facility provided policy titled, "Staffing, Sufficient and Competent Nursing" with a reviewed date of March 2023, included the following:
Policy Statement
Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.
Policy Interpretation and Implementation
Sufficient Staff
1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including:
a. assuring resident safety;
b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident;
c. assessing, evaluating planning and implementing resident care plans; and
d. responding to resident needs ...
5. "Nurse aides/nursing assistants" are individuals providing nursing or related services to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062008	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALTHCARI	144 GALES DRIVE NEW PROVIDENCE, NJ 07974

(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 560	Continued From page 12 resident in the facility, including those who provide services through an agency or under a contract with the facility. Licensed health professionals, registered dieticians, paid feeding assistants and individuals who volunteer to provide nursing or related services without pay are not considered nursing assistants and are not posted or reported as "direct care" staff ... 8 Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing.	S 560		

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
315005 Y1	A. Building B. Wing Y2	9/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALTHCARE CENTER	144 GALES DRIVE NEW PROVIDENCE, NJ 07974

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 F0584	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	09/08/2023	LSC	09/08/2023	LSC	09/08/2023
ID Prefix F0686	Correction	ID Prefix F0688	Correction	ID Prefix F0725	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	09/08/2023	LSC	09/08/2023	LSC	09/08/2023
ID Prefix F0806	Correction	ID Prefix F0880	Correction	ID Prefix F0921	Correction
Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)	Completed
LSC	09/08/2023	LSC	09/08/2023	LSC	09/08/2023
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	
8/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062008	A. Building B. Wing	9/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALTHCARE CENTER	144 GALES DRIVE NEW PROVIDENCE, NJ 07974

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 09/08/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 8/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315005	A. BUILDING **01** B. WING _____	**08/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING GROVE REHABILITATION AND HEALTHCARE CENTER	**144 GALES DRIVE** **NEW PROVIDENCE, NJ 07974**

(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
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/11/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/11/23 and was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Spring Grove Rehabilitation and Healthcare Center is a one-story building that was built in the 1950's. It is composed of Type II protected construction. The facility is divided into five-smoke zones. The generator does approximately 50 % of the building as per the Regional Maintenance Director. The current occupied beds are 98 of 107. .	K 000		

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

Electronically Signed | 08/25/2023

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