STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315257		02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	Census: 166 Sample: 33 + 3 closed records 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 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582		3/25/22

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

Electronically Signed | 03/03/2022

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

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F 582	Continued From page 1 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to provide residents with the required beneficiary notices for 2 of 3 residents reviewed for Beneficiary Protection Notification (Resident [redacted] and Resident [redacted]. This deficient practice was evidenced by the following: On 2/17/22 at 8:30 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident [redacted]. The SNFBPNR indicated that Resident [redacted]	F 582	1. Residents # [redacted] and [redacted] were immediately provided a Notice of Medicare Non-Coverage Form (NOMNC). 2. All residents receiving skilled services had the potential to be affected. No resident was negatively affected. 3. The Regional Clinician re-educated the Social Services department on the policy and procedures of notifying	

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F 582	Continued From page 2 last covered Medicare day was [redacted] and the resident remained in the building. The SNFBPNR further revealed that a Notice of Medicare Non-Coverage-Form CMS 10123 (NOMNC) was not provided to Resident [redacted] On 2/17/22 at 8:38 AM, the surveyor reviewed the SNFBPNR completed by the facility for Resident [redacted]. The SNFBPNR indicated that Resident [redacted]'s last covered Medicare day was [redacted] and the resident remained in the building. The SNFBPNR further revealed that a Notice of Medicare Non-Coverage-Form CMS 10123 (NOMNC) was not provided to Resident [redacted] During an interview with the surveyor on 2/17/22 at 8:58 AM, the facility Business Office Manager (BOM) acknowledged that the NOMNC forms were not given to Resident [redacted] or Resident [redacted] The BOM added that the facility does not give NOMNC's to residents that remain in the facility.	F 582	residents of the notice of Medicare non-coverage form (NOMNC). A facility wide review was conducted on all residents receiving skilled services to ensure a NOMNC was issued appropriately. Social Services will conduct audits weekly x 1 month then monthly x 3 months on notifying residents of their last covered day and providing the residents with a NOMNC form in accordance with state guidance. 4. The Licensed Nursing Home Administrator will conduct random audits and monitor weekly x 1 month then monthly x 3 months to ensure residents are provided with a notification of their last Medicare cover day and given a NOMNC form. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	
F 637 SS=B	NJAC 8:39-4.1(a)(7) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		3/25/22

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F 637	Continued From page 3 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a Significant Change in Status Assessment Minimum Data Set (SCSA-MDS) using the Resident Assessment Instrument (RAI), an assessment tool, process on a resident who elected [redacted] benefits. This deficient practice was identified for 1 of 2 residents (Resident [redacted] reviewed for [redacted]. This deficient practice was evidenced by the following: According to the most recent Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted] On 2/11/2022 at 11:19 AM during the initial tour of the facility the surveyor observed Resident [redacted] lying in bed. Resident [redacted] appeared clean and neat and no signs or symptoms of [redacted] or [redacted] were observed. Resident [redacted] was [redacted] and stated to the surveyor, "I'm leaving. [redacted] just died." On 2/14/2022 at 2:23 PM the surveyor reviewed the medical record (MR) for Resident [redacted] According to the MR, Resident [redacted] was enrolled on [redacted] care on [redacted] with a facility contracted [redacted] provider, as observed on the Long Term Care Facility - Business Office Notification sheet in Resident [redacted]'s MR. Upon further review of the MR, it was observed that Resident [redacted] was disenrolled from [redacted] services on [redacted], per the Long Term Care	F 637	1. A facility wide audit was conducted on all residents to identify all current residents under hospice services. A notification was sent by the Admissions Director to all hospice service providers to request a list of all residents receiving [redacted] services. No residents were negatively affected. The MDS Coordinator immediately opened a significant change MDS for resident [redacted] Resident [redacted] was not negatively affected. 2. A facility wide audit was conducted on all residents to identify all current residents under hospice services. A notification was sent by the Admissions Director to all [redacted] service providers to request a list of all residents receiving [redacted] services. No residents were negatively affected. 3. The facility educator and assistant director of nursing re-educated MDS, Admission Director, Social Services, Business Office Manager, and nursing unit managers on notification of any resident enrolling/discharging from [redacted] services the day of enrolling/discharging from hospice services. 4. The Regional Clinician will conduct random audits weekly x 1 month then monthly x 3 months to ensure compliance that a significant change MDS has been	

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F 637	Continued From page 4 Facility-Business Office Notification sheet observed in Resident [redacted]'s MR. A review of the Minimum Data Set (MDS) 3.0 Assessment History it was determined that Resident [redacted] did not have a SCSA-MDS completed for [redacted] enrollment until [redacted]. Further review of the MDS assessment history revealed that Resident [redacted] did not have a SCSA-MDS initiated or completed for Resident [redacted] discharge from [redacted] care on [redacted]. During an interview with the surveyor on 2/22/2022 at 10:36 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated, "Yes, he/she graduated from [redacted]. I'm not sure of the date but I can get it for you." The LPN/UM#2 returned at 10:40 AM and told the surveyor, "He/she came of[redacted] on [redacted] of this year [redacted]) according to admissions." During an interview with the surveyor on 2/22/2022 at 10:49 AM, with the facility MDS Coordinator, the surveyor asked the MDS coordinator how they are informed and made aware of significant changes in status of facility residents. The MDS coordinator replied, I created a sheet to ask questions daily at the morning meeting to gather information that may necessitate a significant change in status. The surveyor then questioned the MDS coordinator what types of changes would necessitate a significant change in status MDS, and the time frame involved for the assessment and completion of the significant change in status assessment. The MDS coordinator replied, If there is a significant change in status, I generally open it within the week, generally. The assessment should be completed within 14 days	F 637	completed. All findings will be brought to monthly QAPI meeting to determine if further action is necessary. The MDS coordinator will conduct weekly audits x 1 month then monthly on all resident enrolled on [redacted] services to ensure a significant change in MDS has been completed. .	

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F 637	Continued From page 5 of the date of the significant change in status. I complete change of status assessments for greater than 2 areas of care, like a decline in 2 or more ADL's, a [redacted] with a [redacted], [redacted] initiation or coming off [redacted] On 2/22/2022 at 10:55 AM the surveyor asked the facility MDS coordinator if a significant change in status should have been completed for Resident [redacted] prior to [redacted] The MDS coordinator replied, "[Resident name] should have had a significant change in status completed by [redacted]. [redacted] did not have one until June. It was late." The surveyor then asked the MDS coordinator if she was aware that Resident [redacted] had been disenrolled from [redacted] on [redacted] The MDS coordinator responded, "No. There should have been an additional change of status assessment completed approximately 14 days from [redacted]. I was not aware that he/she was disenrolled from [redacted] in [redacted]. I am going to change it now." The surveyor reviewed the significant change in status assessment guidelines. According to the latest version of the Center for Medicare/Medicaid Services (CMS) - RAI 3.0 Manual (updated October 2019) page 2-23 "SCSA is required to be performed when a [redacted] resident enrolls in a [redacted] program (Medicare-certified or licensed [redacted] provider) or changes [redacted] providers and remains a resident at the nursing home. The ARD (assessment reference date) must be within 14 days from the effective date of the [redacted] election (which can be the same or later than the date of the [redacted] election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was	F 637		

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F 637	Continued From page 6 recently conducted on the resident. This is to ensure a coordinated plan of care between the [redacted] and nursing home is in place." In addition, page 2-23 and 24 revealed the following: "An SCSA is required to be performed when a resident is receiving [redacted] services and then decides to discontinue those services (known as revoking of [redacted] care). The ARD must be within 14 days from one of the following: 1) the effective date of the [redacted] election revocation (which can be the same or later than the date of the [redacted] election revocation statement, but not earlier than); 2) the expiration date of the certification of [redacted]; or 3) the date of the physician's or medical director's order stating the resident is no longer [redacted]	F 637		
F 645 SS=D	N.J.A.C. 8:39-11.2(i) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		3/25/22

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F 645	Continued From page 7 services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this	F 645		

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F 645	Continued From page 8 section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to refer Resident [redacted] to the appropriate state-designated authority for level II Preadmission Screening and Resident Review (PASARR) evaluation and determination. This deficient practice was identified for 1 of 4 residents reviewed for Level II PASARR. On 2/11/2022 at 2:21 PM the surveyor reviewed Resident [redacted]'s electronic and paper record. According to the Admission record Resident [redacted] was admitted to the facility with the following diagnoses: [redacted] A further review of the medical record revealed a positive Level I screen for [redacted]) for the diagnoses of [redacted] and depression documented on PASARR Level I Screen, dated [redacted]. Further review of the Level I screen revealed that within the last 2 years had Resident [redacted] had either/both experienced one [redacted] treatment episode	F 645	1. PASARR level 2 was immediately initiated and completed for resident [redacted] Resident [redacted] was not negatively affected. A facility wide audit was conducted by Social Services on all PASARR level I to ensure all positive level I were sent to the appropriate state departments for PASARR level II approval. 2. A facility wide audit was conducted by Social Services on all PASARR level I to ensure all positive level I were sent to the appropriate state departments for PASARR level II approval. No residents were negatively affected. 3. The Licensed Nursing Home Administrator re-educated the Social Service department on the policy and procedures for PASARR screening for [redacted] and [redacted] disability. All new admissions will be reviewed by Social Services to ensure the PASARR's are completed. 4. The Regional Clinician will conduct random audits weekly x 1 month and monthly x 3 months to ensure compliance	

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F 645	Continued From page 9 that was more intensive than routine follow-up care and/or due to [redacted], experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community or intervention by housing or law enforcement officials. On 2/15/22 at 8:54 AM the surveyor requested a copy of the Level II PASARR evaluation and determination screen for Resident [redacted] from the facility Assistant Director of Nursing. The facility Acting Director of Social Work (ADSW) at 10:27 AM explained to the surveyor, "We do not have the Level II screen for Resident [redacted]. It was determined that he/she did not have their level II screen on the third week of [redacted]) when we audited the [redacted] unit medical records for PASARR completion. The ADSW further explained, "Social services is responsible for contacting the particular agency for positive Level I screens. I'm here on contract for the facility since August. I've been in and out because they haven't been able to retain staff. The department has been bad, that is why our audits are bad. It's due to staffing. We have 1 full time person and me part time." On 2/17/2022 at 9:23 AM the facility social worker provided the surveyor with a fax transmittal of the PASARR Level II [redacted] Evaluation, dated 2/17/2022 at 17:10 (5:10 PM) to the New Jersey Division of Mental Health and Addiction Services for Resident [redacted]. On 2/23/2022 at 10:09 AM the surveyor conducted a follow-up interview with the facility ADSW. The ADSW explained, "The State Agency has not come to the facility at this time to	F 645	with PASARR screening for mental [redacted] I disability. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months. Social Services will conduct audits weekly x 1 month and then monthly x 3 months on all PASARR level I to ensure all positive level I are identified and submitted to the appropriate state agencies for PASARR level IIs.	

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F 645	Continued From page 10 evaluate the resident. I made the referral prior to vacation but they haven't been here yet." The surveyor reviewed the facility provided Pre-Admission Screening Resident Review (PASARR), Policy No. -NP-123, date revised: November 01, 2021. The following was revealed: Purpose: To ensure that all Facility applicants are screened for mental illness and/or intellectual disability prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated. Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. III. Screening Results A. If the Level I screening results indicate that the applicant should receive the Level II screening, the Facility shall contact the appropriate state agency for additional screening.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		3/25/22

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F 656	Continued From page 11 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan (CP) or develop a person-centered comprehensive care plan in a timely manner a) addressing the placement and care of [redacted] on [redacted]	F 656	1. The Care plans for the resident #s [redacted] and [redacted] were immediately reviewed and revised to ensure that a person-centered comprehensive care plan was in place. Resident [redacted]s care plan was revised to include the [redacted] that are utilized. Resident [redacted] care plan	

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F 656	Continued From page 12 [redacted] (Resident [redacted] b) addressing the use, care, cleaning and storage of a [redacted] (Resident # [redacted]), and c) failure to develop a [redacted] care plan in a timely manner for a resident enrolled and disenrolled in [redacted] services (Resident [redacted]. This deficient practice was observed for [redacted] of [redacted] residents reviewed and was evidenced by the following: a) On 2/11/2022 at 11:14 AM, the surveyor observed Resident [redacted] in bed, on a ventilator with a tracheostomy in place. At that time, the surveyor noted a [redacted] in place, ([redacted] are used to help protect patients who are prone to disrupting medical treatment or [redacted]). According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included but not limited to; [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool, dated [redacted], indicated "daily use" under Section [redacted], the [redacted] section. A review of the February 2022 Order Summary Report for Resident [redacted] revealed a Physician Order (PO) dated [redacted], to "[redacted] on [redacted] check skin every 2 hours, for [redacted] pulling." A review of Resident [redacted]'s Care Plan provided to the surveyor on 2/17/2022 at 10:10 AM did not include a care plan for [redacted] or [redacted].	F 656	was revised to include the discontinuation of the [redacted]. Resident [redacted] care plan was revised to include the discontinuation of [redacted] services. 2. A facility wide audit was conducted on all residents to ensure a person-centered comprehensive care plan was in place. No further issues were identified, and no residents were negatively affected. All residents had the potential to be affected. 3. All unit managers, supervisors and department heads have been re-educated by the facility educator/assistant director of nursing on developing and implementing a person-centered comprehensive care plan in a timely manner. All re/new admissions will be reviewed daily, Monday through Friday at our clinical meeting to ensure appropriate care plans are in place. Care plans will be reviewed quarterly by the interdisciplinary care team during care conference. 4. The Unit Managers will conduct weekly audits X1 month and monthly X 3 months to ensure a person-centered comprehensive care plan is in place. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with developing person-centered comprehensive care plan timely. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 656	Continued From page 13 During an interview with the surveyor on 2/22/2022 at 10:32 AM, the Assistant Director of Nursing (ADON) reviewed the comprehensive care plan for Resident [redacted] The ADON acknowledged that the care plan did not include a plan for the use of [redacted] for Resident [redacted] b) On 2/11/2022 at 11:20 AM, during the initial tour of the [redacted] Unit, the surveyor observed a [redacted] connected to [redacted] and medication cup resting on the resident's four drawered dresser. During an interview with the surveyor at that time, resident [redacted] acknowledged the [redacted] was his/hers and that he/she took it "[redacted]." According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included but not limited to; [redacted] ([redacted].) A review of an Admission MDS, dated [redacted], revealed that Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident's [redacted]. A review of the resident's Order Summary Report revealed an order dated [redacted] for [redacted] [redacted]) A review of Resident [redacted] [redacted] Medication Administration Record (MAR)	F 656		

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F 656	Continued From page 14 reflected the above physician's order and was documented as administered. A review of Resident [redacted] Care Plan provided to the surveyor on 2/17/22 at 12:40 PM, did not include a Care Plan for the [redacted] use, care, cleaning, or storage. During an interview with the surveyor on 2/22/22 at 09:35 AM, the ADON reviewed Resident [redacted]s Care Plan and acknowledged that the Care Plan did not include the [redacted]. c) During a review of the medical record (MR) on 2/14/2022 at 9:56 AM, the quarterly MDS dated [redacted], revealed that Resident [redacted] had a BIMS score of [redacted], indicating [redacted] In addition, section O of the MDS revealed that resident [redacted] received [redacted] care while a resident in the facility. In addition, the Order Summary Report had an order for [redacted]", dated [redacted]. According to the Admission Record, Resident [redacted] was admitted to the facility with the following diagnoses: [redacted] On 2/15/2022 at 11:32 AM the surveyor reviewed the electronic MR. According to the [redacted] document titled [redacted] name] Long Term Care Facility-Business Office Notification, Resident [redacted] was admitted to [redacted] services on [redacted]. A further review of facility documentation revealed that Resident [redacted] was discharged from [redacted]	F 656		

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F 656	Continued From page 15 care on [redacted], per the [redacted] name] Long Term Care Facility-Business Office Notification sheet. On 2/15/22 at 12:02 PM the surveyor reviewed Resident [redacted]s comprehensive care plan via the electronic MR. The surveyor observed a care plan addressing the following: "Resident is on [redacted] Care [redacted] name) on [redacted] only [redacted] Date Initiated: [redacted]." The care plan initiation date for [redacted] occurred approximately 6 months from [redacted] enrollment for Resident [redacted] On 2/22/2022 at 2:06 PM the surveyor conducted an interview in the presence of the facility Director of Nursing (DON), ADON, Administrator and Regional Clinical Service Director (RCSD). The surveyor asked when the care plan should have been developed after Resident [redacted] was enrolled on [redacted] care. The DON and RCSD responded, "Nursing would definitely collaborate with [redacted] to develop the care plan which should have occurred within 24-48 hours." The surveyor reviewed the facility policy titled Care Planning," Date Revised: April 03, 2021. The following was revealed under the heading Policy: II. The Care Plan serves as a course of action where the resident ...resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. III. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with	F 656		

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F 656	Continued From page 16 OBRA/NDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgement on an as needed bases. (sic) The following was revealed under the heading Procedure: VIII. A comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. V. (page 3) The IDT will revise the Comprehensive Care Plan as needed at the following intervals: A. Per RAI schedules. B. As dictated by changes in the resident's condition. C. In preparation for discharge. D. To address changes in behavior and care, and E. Other times as appropriate or necessary. A review of an undated facility policy titled, [redacted]," revealed the following under the Care Planning section: Care plans for residents with [redacted] will reflect: A. The type of [redacted] to be used B. The medical symptoms requiring the use of [redacted] C. The treatment team's goals in using the [redacted] D. Interventions that address the immediate medical symptom(s) and the	F 656		

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F 656	Continued From page 17 underlying problems that may be causing the symptom(s) E. Systematic and gradual approaches for minimizing or eliminating the concerning behavior and [redacted] use F. Frequent observation and release every 2 hours for toileting and/or repositioning and checking the condition of skin and impaired circulation if indicated G. The use of postural support and the method of application will be specified in the resident's Care Plan. NJAC 8:39-27.1(a)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		3/25/22

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F 657	Continued From page 18 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to revise a care plan when there was a change in the medication regime for [redacted] sampled residents, (Resident # [redacted]). This deficient practice was evidenced by the following: During the initial tour of the ventilatory unit on 2/11/22 at 10:40 AM, Resident [redacted] was observed lying in bed with their [redacted] connected to a [redacted] with their eyes closed. A review of the Admission Record revealed Resident [redacted] was admitted to the facility with diagnoses including but not limited to: [redacted] A review of an Order Summary Report dated active orders as of [redacted] did not include an order for [redacted] medication [redacted]. On 2/14/22 at 1:35 PM, the surveyor reviewed Resident [redacted] Care Plan that revealed a focus area of "I am at risk for [redacted] secondary to the use of [redacted] for [redacted]) with a Date Initiated of: [redacted] and Revision on: [redacted]	F 657	1. The care plan for resident [redacted] was immediately reviewed, revised, and updated to include the discontinuation of the [redacted] A facility wide care plan audit was conducted on all residents to ensure their care plans are comprehensive and includes their current medication regime. 2. A facility wide care plan audit was conducted on all residents to ensure their care plans are comprehensive and includes their current medication regime. No further issues were identified, and no residents were negatively affected. All residents had the potential to be affected. 3. All unit managers, supervisors and department heads have been re-educated by the facility educator/assistant director of nursing on developing/revising a person-centered comprehensive care plan in a timely manner. All residents with a change in condition will be reviewed daily, Monday through Friday at our clinical meeting to ensure appropriate care plans are in place and the revision occurred. Care plans will be reviewed quarterly by the interdisciplinary care team during care conference.	

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F 657	Continued From page 19 During an interview with the surveyor on 2/16/22 at 10:39 AM, the Registered Nurse Unit Manager (RNUM #2), revealed when a new admission comes, a standard care plan is done and individualized with medications and treatments. RNUM #2 said we do skin risk, pain, falls, Activities of Daily Living's then based on history and diagnosis and medications. She also said we start the care plan within 24 hours of admission, and we meet every 3 months for care plan review. RNUM #2 went on to say the Unit Manager is responsible to do care plans and if medications are discontinued, the Unit Manager is responsible to make sure care plan is revised as needed. She went on to say that yes, it is my responsibility to resolve or revise care plan. During an interview with the surveyor on 2/16/22 at 10:54 AM, the Assistant Director of Nursing (ADON) said ultimately the Unit Manager is responsible for updating and revising the care plans. During an interview with the surveyor on 2/22/22 at 1:50 PM, the Director of Nursing (DON) said her expectations of care plan revisions is they are to be done whenever there is a resident change in condition, quarterly, upon admission and readmissions and as needed. A review of a facility policy titled Care Planning with a revised date of April 03, 2021, revealed under the IDT section V. The IDXT will revise the Comprehensive Care Plan as needed at the following intervals: D to address changes in behavior and care ... NJAC 8:39-11.2(i)	F 657	4. The Unit Managers will conduct weekly audits X 1 month and monthly X 3months to ensure a person-centered comprehensive care plan is in place and/revised timely. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with developing/revising a person-centered comprehensive care plan timely. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and other facility documentation it was determined that the facility failed to follow acceptable standards of clinical practice in accordance with the New Jersey Board of Nursing Statutes by not maintaining medication records that were complete with staff signatures for [redacted] residents reviewed (Resident #[redacted] and Resident [redacted]). 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 states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical 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	F 658	1. The physician and responsible parties for residents #s[redacted] and [redacted] were notified of the missing documentation in the medication and treatment administration record. No new orders were obtained. The residents were not negatively affected. A facility wide audit was conducted of all residents□ medication and treatment administration records to ensure the facility followed appropriate clinical practice in accordance with the New Jersey Board of Nursing Statutes. 2. A facility wide audit was conducted of all residents' medication and treatment administration records to ensure the facility followed appropriate clinical practice in accordance with the New Jersey Board of Nursing Statutes. No further issues were identified, and no residents were negatively affected. All residents had the potential to be affected. 3. All licensed nursing staff have been re-educated by the assistant director of nursing and facility educator on following the acceptable standards of clinical practice in accordance with the New Jersey Board of Nursing Statutes by	3/25/22

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F 658	Continued From page 21 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." A. According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included arthritis. A review of the "Order Summary Report" with active orders as of [redacted], revealed a physician's order dated [redacted] for the resident to receive [redacted] UNIT/GM ... every morning and at bedtime for [redacted] A review of the MAR and TAR for [redacted] and [redacted] revealed that on the following dates and times, there was no documentation to indicate that the medication was administered as ordered on: 1/2/2022 at 2100 1/3/2022 at 0900 and 2100 1/7/2022 at 2100 1/13/2022 at 0900 and 2100 1/16/2022 at 2100 1/17/2022 at 0900 1/18/2022 at 0900 and 2100 1/21/2022 at 0900 1/29/2022 at 0900 1/30/2022 at 0900 1/31/2022 at 0900 and 2100 2/3/2022 at 0900 and 2100 2/5/2022 at 2100 2/7/2022 at 2100	F 658	maintaining medication and treatment record completed with staff signatures. The MAR's and TAR's will be reviewed during our daily clinical meeting by the Unit Managers and nurse Administration, Monday through Friday, to ensure appropriate documentation has occurred. Any/all issues will be addressed with the licensed nurse. 4. The unit managers and nursing supervisors will conduct weekly audits x 1 month and monthly x 3 months to ensure appropriate documentation is completed in the medication and treatment administration record of the residents. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with acceptable standards of clinical practice in maintain the medication and treatment records with appropriate documentation. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 658	Continued From page 22 2/8/2022 at 2100 2/9/2022 at 2100 2/10/2022 at 2100 2/11/2022 at 2100 2/12/2022 at 0900 2/14/2022 at 0900 2/15/2022 at 2100. During an interview with surveyor #2 on 2/17/22 at 12:36 PM, the Licensed Practical Nurse (LPN #1) stated there should not be blanks on the MAR or TAR. The surveyor and LPN #1 reviewed the [redacted] TAR. She stated those should not be blank. B.A review of the Admission Record revealed Resident [redacted] was admitted with the diagnosis including, but not limited to, [redacted] On 2/17/22 at 01:14 PM the surveyor reviewed the [redacted] Medication Administration Record (MAR), Treatment Administration Record (TAR), and Order Summary Report with active orders as of [redacted] for Resident [redacted] and the following was revealed: 1. [redacted] mg give 1 tablet by mouth one time a day for [redacted] which was ordered on [redacted]. There was no documentation to indicate that the medication was administered as ordered on: 2/3/22 at 2200, 2/10/22 at 2200, 2/14/22 at 2200. 2. [redacted] give [redacted] mg by mouth every 12 hours for [redacted]	F 658		

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F 658	Continued From page 23 which was ordered on [redacted]. there was no documentation to indicate that the medication was administered as ordered on: 2/3/22 at 2100 2/14/22 at 2100. 3. [redacted] mg ([redacted]) give 1 capsule by mouth bedtime for [redacted] which was ordered [redacted] There was no documentation to indicate that the medication was administered as ordered on: 2/3/22 at 2200 2/14/22 at 2200. 4. [redacted] mg give 1 tablet by mouth one time a day for [redacted] was ordered on [redacted] There was no documentation to indicate that the medication was administered as ordered on: 2/11/22 at 0600. 5. Administer [redacted] continuous every shift for [redacted] which was ordered on [redacted]. There was no documentation to indicate that the medication was administered as ordered on: 2/3/22 Day and Night Shift 2/5/22 Night Shift 2/7/22 Night Shift 2/10/22 Day Shift and Night Shift 2/14/22 Day Shift 6. physician order to obtain [redacted] of [redacted] is a	F 658		

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F 658	Continued From page 24 [redacted] that measures the amount of [redacted] in the [redacted] every day and night shift which was ordered [redacted]. There was no documentation to indicate that the medication was administered as ordered on: 2/3/21 Day and Night Shift 2/5/22 Night Shift 2/7/22 Night Shift 2/10/22 Night Shift 2/11/22 Night Shift During an interview with surveyor #7 on 2/17/2022 at 01:45 PM, the surveyor asked if there is ever to be an empty space in a MAR or TAR. Licensed Practical Nurse (LPN #1) replied, "no". A review of the policy titled Administering Medications with a revision date of April 2021, revealed under the heading Policy Interpretation and Implementation: The individual administering the medication signs/initials the resident's EMAR/MAR on the appropriate space/line after giving each medication and before administering the next ones.	F 658		
F 677 SS=D	NJAC 8:39-27.1(a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 677	1. Residents #[redacted] and [redacted] were provided	3/25/22

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F 677	Continued From page 25 and other pertinent facility documentation, the facility failed to ensure residents who are unable to carry out activities of daily living (ADL) received the necessary nail care to maintain proper grooming and personal hygiene. The deficient practice was observed for [redacted] residents reviewed for Activities of Daily Living, (Resident #[redacted] and Resident [redacted]). The deficient practice was evidenced by the following: A) During the initial tour of the facility on 2/11/22 at 10:13 AM, surveyor #6 observed Resident [redacted] in their room. At that time, the surveyor observed Resident #[redacted] on his/her [redacted] The [redacted] were chipped, long, and had unidentified matter underneath the [redacted]. On 2/14/22 at 9:19 AM, surveyor #6 observed Resident [redacted] in their room and the [redacted] on his/her [redacted] remained uncut and still contained matter underneath the [redacted]. At that time, surveyor #6 observed that the [redacted] also had unidentified matter underneath. Surveyor #6 also observed Resident [redacted]t which was exposed. His/her [redacted] appeared long and uncut. On 2/14/22 at 11:45 AM, surveyor #6 observed Resident #[redacted] in their room. His/her [redacted] remained uncut and still contained matter underneath the [redacted] On 2/15/22 at 10:18 AM, surveyor #6 observed Resident [redacted] in their room. His/her [redacted] remained uncut and still contained matter underneath the [redacted]	F 677	appropriate nail care immediately. Residents #[redacted] were not negatively affected. A facility wide audit was conducted on all residents to ensure appropriate [redacted] care was provided. No residents were negatively affected. 2. A facility wide audit was conducted on all residents to ensure appropriate nail care was provided. No further issues were identified. All residents had the potential to be affected. and no residents were negatively affected. 3. All nursing staff have been re-educated by the assistant director of nursing and facility educator on necessary [redacted] care to maintain proper grooming and personal hygiene. Resident [redacted] care has been added to the C.N.A. tasks in electronic medical record to trigger as weekly and as needed. 4. The unit managers will conduct weekly audits x 1 month and monthly x 3 months to ensure proper grooming and personal hygiene is completed. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with proper grooming and personal hygiene is maintained. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 677	Continued From page 26 2/16/22 at 9:54 AM, surveyor #6 observed Resident [redacted] in their room. His/her [redacted] remained uncut and still contained matter underneath the [redacted]. A review of the Electronic Medical Record revealed under "Medical Diagnosis" that Resident [redacted] was diagnosed with, but not limited to [redacted]). A review of the most recent Minimum Data Set dated [redacted], revealed that Resident [redacted] was totally dependent on one person to physically assist in his/her personal hygiene which includes [redacted] care. A review of Resident [redacted]s Care Plan initiated on [redacted] and revised on 10/9/20, revealed that he/she requires assistance with ADL functions. During an interview with surveyor #6 on 2/16/21 at 9:56 AM, Temporary Nurse Aide (TNA #1) stated that residents receive [redacted] care about every two days. She confirmed that cleaning the [redacted] and [redacted] clippers can be used. During an interview with surveyor #6 on 2/16/21 at 10:21 AM, the Licensed Practical Nurse Unit Manager #1 (LPNUM #1) said that resident [redacted] care is done by the nurse aides as needed. She confirmed that [redacted] care consists of clipping, filing, and cleaning. B) On 2/15/2022 at 09:17 AM, surveyor #7 observed dirty and long [redacted] on Resident [redacted]. The [redacted] observed to be	F 677		

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F 677	Continued From page 27 long with reddish/brown material under [redacted] On 2/16/2022 at 01:04 PM, surveyor #7 observed dirty and long nails on Resident [redacted] with reddish/brown debris under [redacted]. The [redacted] appeared to be at the same length as prior observation. According to the admission record, Resident [redacted] was admitted to the facility with diagnoses including but not limited to; [redacted] A review of Resident # [redacted] care plan revealed that he/she is dependent with ADL functions related to cognitive impairment. The interventions included provide me with total assist of 1 for grooming personal hygiene, dressing, bathing and incontinent care needs, and total assist of 1 for bed mobility. During an interview with surveyor #7 on 2/17/2022 at 12:28 PM, Registered Nurse Unit Manager (RNUM #1), stated that resident nails are to be completed by the certified nursing assistance (CNA) as part of their shower schedule. The surveyor reviewed the facility provided CNA Shower and Rounds Sheet and which showed a column titled '[redacted] Clipped". RNUM #1 stated that [redacted] are to be inspected daily. During an interview with the survey team on	F 677		

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F 677	Continued From page 28 2/22/2022 at 01:35 PM, the Director of Nursing (DON) reported that CNAs should be completing resident [redacted] care routinely. Review of facility policy titled Activities of Daily Living (ADLs), Supporting revised November 2021 revealed under Policy Statement that, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. N.J.A.C. 8:39-27.2(g)	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		3/25/22

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F 690	Continued From page 29 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure a resident had physician's orders for ongoing care and protocols for a [redacted]) for [redacted] residents reviewed for a [redacted] (Resident [redacted]). The deficient practice was evidenced by the following: During the initial tour of the facility on 2/11/22 at 10:34 AM, the surveyor observed Resident [redacted] in bed. A [redacted] was on the floor with a [redacted] ascending towards the resident. A review of Resident [redacted] Electronic Medical Record (EMR) revealed under, "Medical Diagnosis" that he/she had a diagnosis of but not limited to, [redacted] A review of the 5-Day Minimum Data Set (an	F 690	1. Resident # [redacted]'s orders were immediately updated to include the [redacted]. The [redacted] bag was immediately placed in a [redacted] and the [redacted] was anchored off the floor. Resident [redacted] was not negatively affected. A facility wide audit was conducted on all residents with [redacted] to ensure appropriate documentation is in place including physician orders and [redacted] are in place with [redacted] anchored off the floor. No residents were negatively affected. 2. A facility wide audit was conducted on all residents with [redacted] to ensure appropriate documentation is in place including physician orders, [redacted] are in place with [redacted] anchored off the floor. All residents with [redacted] had the potential to be affected, no residents were negatively affected. 3. All nursing staff was re-educated on	

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F 690	Continued From page 30 assessment tool) dated for [redacted], revealed Resident [redacted] had an [redacted]. A review of the EMR under, "Orders" did not include any physician's orders for the [redacted] A review of Resident [redacted]'s care plan revealed that he/she had a [redacted] for [redacted]. During an interview with the surveyor on 2/16/22 at 10:21 AM, the Licensed Practical Nurse Unit Manager #1 said residents with [redacted] should have orders and a care plan. She further revealed the orders should consist of [redacted], and size of the [redacted]. During an interview with the surveyor on 2/23/22 at 9:32 AM, the Assistant Director of Nursing confirmed Resident [redacted] had no orders for a [redacted]. A review of the facility policy titled, [redacted] of" with a revision date of August 2021, revealed under "Policy" subsection "I.", "[redacted]s provided under the direction of a physician's order, which will include the medical necessity for use, the size of the [redacted]" N.J.A.C. 8:39-23.2(a)	F 690	appropriate documentation needed and care of residents with [redacted] to include [redacted] and appropriate [redacted] placement. During daily clinical rounds all residents with [redacted] will be monitored to ensure [redacted] are in place and [redacted] is properly anchored. 4. The unit managers will conduct weekly audits x 1 month and monthly x 3 months on all residents with [redacted] to ensure compliance. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with documentation and care of resident with [redacted]. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693		3/25/22

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F 693	Continued From page 31 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to accurately and consistently monitor an [redacted] administration [redacted] in accordance with physician's orders. This deficient practice was observed for [redacted] residents (Resident [redacted]) reviewed for [redacted] and was evidenced by the following: On 2/11/2022 at 10:50 AM, during the initial tour of the facility, the surveyor observed Resident [redacted] lying in bed with the head of bed elevated. The surveyor observed the following from the [redacted] screen: Resident [redacted] was actively receiving a [redacted]	F 693	1. Resident [redacted] was immediately corrected to the prescribed auto [redacted]. The physician was immediately notified, and no new orders were obtained. Resident #[redacted] was not negatively affected. A facility wide audit was conducted on all residents receiving [redacted] to ensure physician orders are being followed. 2. A facility wide audit was conducted on all residents receiving [redacted] to ensure physician orders are being followed. No further issues were identified, and no residents were negatively affected.	

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F 693	Continued From page 32 [redacted] In addition, Resident [redacted] was receiving an [redacted] q (every) hour. The [redacted] was labeled [redacted]" and had a hang time of "6 PM." On 2/14/2022 at 8:49 AM, the surveyor observed Resident [redacted] in progress [redacted]. The [redacted] and the [redacted] was observed to be infusing at [redacted] and the [redacted] bag had a hang time of 6 PM and dated [redacted] On 02/15/2022 at 9:03 AM, the surveyor observed Resident [redacted] of [redacted]. [redacted] was set at [redacted]. In addition, on 2/16/2022 at 9:29 AM the surveyor observed Resident [redacted] of [redacted] and an [redacted] set at [redacted] According to Resident [redacted] most recent Admission Record he/she was admitted to the facility with diagnoses of [redacted]. A review of the medical record documentation did not identify any adverse consequences for Resident # [redacted] having more [redacted] than was prescribed. According to a significant change Minimum Data Set (MDS), an assessment tool, Resident [redacted] had a Brief Interview for Mental Status score of [redacted] indicating [redacted]. Section [redacted] of the MDS indicated Resident [redacted] was total dependence for eating and required one-person physical assist to eat. Section [redacted] revealed that Resident [redacted] had a [redacted]	F 693	3. All licensed nursing staff was re-educated on accurately and consistently monitoring the [redacted] and [redacted] in accordance with physician orders. During daily clinical rounds all residents receiving [redacted] will be monitored to ensure [redacted] reflects the current physician□s order. 4. The unit manager will conduct weekly audits x 1 month and monthly x 3 months on all residents received enteral tube feedings. The DON/ADON will conduct weekly audits x 1 month and monthly x 3 months to ensure compliance with residents receiving [redacted] All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 693	Continued From page 33 and had [redacted]% or more of total calories received through [redacted] and [redacted] or more average [redacted] per day via [redacted]. According to the Order Summary Report, dated [redacted] Resident [redacted] had the following physician's orders: [redacted] diet ([redacted]), order date [redacted] [redacted] one time a day [redacted] via [redacted], order date [redacted]. Change [redacted] Administration Set (spike, cap, bag) one time a day, order date [redacted] A review of the comprehensive care plan identified Resident [redacted] had a care plan that addressed the following: "I [redacted] r/t (related to) [redacted] status and [redacted] with history of dependence on [redacted]." Care planned interventions included the following: "Provide [redacted]" date initiated: [redacted] and Revision on: [redacted]. The surveyor reviewed the [redacted] Medication Administration Record (MAR). The MAR revealed that on [redacted], [redacted], and [redacted] nursing staff documented that Resident [redacted] received the following: [redacted] Order one time a day [redacted]	F 693		

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F 693	Continued From page 34 [redacted] During an interview with the surveyor on 2/16/2022 at 10:48 AM, the Registered Nurse/Supervisor (RN #2) assigned to take care of resident [redacted] on this day, was questioned regarding what the current [redacted] was for Resident [redacted]. RN #2 responded, "They get an [redacted] of [redacted]." The surveyor then accompanied RN #2 to Resident #[redacted] room to assess the current and active [redacted] setting on the [redacted] According to RN #2, "The [redacted] is set to deliver [redacted]. It should be set at [redacted]r. He/she is being delivered an extra [redacted] per day. The [redacted] was already on when I started my shift today. I'm going to check the order and then I'm going to contact the physician/nurse practitioner to let them know and see how they want to proceed." On 2/16/2022 at 11:05 AM, RN #2 went to check Resident [redacted] order to see if there had been a change from [redacted]. RN #2 checked the order via the electronic medical record and responded, "There was no change from [redacted]. I'm going to talk to the nurse practitioner now. I'll be right back." RN #2 at 11:07 AM responded to the surveyor, "The nurse practitioner is going to assess him/her. I'm going to monitor him/her for any [redacted] issues, and I will report them to the nurse practitioner. The nurse practitioner said she may order [redacted]) if there are any [redacted] issues." RN #2 had adjusted the [redacted] in the presence of the surveyor to deliver the ordered dose of water [redacted]. A review of the medical record documentation did not identify any adverse consequences for	F 693		

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F 693	Continued From page 35 Resident [redacted] having more [redacted] than was prescribed. On 2/23/2022 at 9:50 AM, the surveyor in the presence of the facility administrator and Assistant Director of Nursing (ADON), asked the ADON what the facility practice is concerning the initiation of an [redacted]. The ADON responded, "The assigned nurse needs to ensure that [redacted] is programmed according to the physician's order and ensure that the [redacted] is set accurately prior to initiating the [redacted] and [redacted] The surveyor reviewed the facility provided policy titled [redacted]-Safety Precautions, reviewed November 2021. The following was revealed under the heading Purpose: "To ensure the safe administration of [redacted] nutrition." Under the Preparation heading the policy revealed: 1. "All personnel responsible for preparing, storing and administering [redacted] nutrition formulas will be trained, qualified and competent in his or her responsibilities." In addition to the above the policy further revealed the following under General Guidelines: Preventing errors in administration 1. Check the entire nutrition label against the order before administration. Check the following information: a. Resident name, ID, and room number. b. Type of formula. c. Date and time formula was prepared. d. Route of delivery. e. Access site. f. Method (pump, gravity, syringe); and g. Rate of Administration (ml/hour).	F 693		

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	315257		02/23/2022

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F 693	Continued From page 36 2. On the formula label document initials, date, and time the formula was hung, and initial that the label was checked against the order. N.J.A.C. 8:39-27.1(a)	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced 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 [redacted] equipment was stored properly when not in use, to reduce the risk of infection for 1 of 2 residents reviewed for [redacted] equipment, (Resident [redacted] The deficient practice was evidenced as follows: On 2/11/2022 at 11:20 AM, during the initial tour of the [redacted] Unit, the surveyor observed a [redacted] on top of Resident [redacted]'s four drawered dresser. The [redacted]k was exposed, connected to the dry medication cup, and the [redacted] was connected to the [redacted]. The [redacted] was resting on top of a TV remote control, and a tan rolled bandage. The equipment	F 695	1. Resident # [redacted], medication cup and [redacted] were immediately changed, dated and appropriately stored as per policy and procedure. Resident [redacted] was not negatively affected. A facility wide audit was conducted on residents receiving [redacted] treatments to ensure [redacted] equipment was stored appropriately. 2. A facility wide audit was conducted on residents receiving [redacted] treatments to ensure [redacted] equipment was stored appropriately. No further issues were identified, and no residents were negatively affected.	3/25/22

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F 695	Continued From page 37 was unlabeled and undated. During an interview at that time, the resident stated the [redacted] was for [redacted] to use "when [redacted] got [redacted] " The resident further stated that the nurse placed the [redacted] on the dresser. On 2/15/2022 at 09:42 AM, the surveyor observed a [redacted] machine on top of the resident's four drawered dresser. The dry [redacted] was exposed, connected to the dry medication cup, and the [redacted] was connected to the [redacted] machine. The [redacted] was resting against an adjacent closet. The equipment was unlabeled and undated. According to the Admission Record, Resident [redacted] was admitted with a diagnosis which included, but was not limited to; [redacted] ([redacted]). A review of an Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated Resident [redacted] 6 was [redacted] A review of the resident's Order Summary Report revealed an order dated [redacted] for [redacted] rally via [redacted] every 4 hours as needed for [redacted]) A review of Resident [redacted] s [redacted] Medication Administration Record (MAR) reflected the above physician's order and was documented as administered.	F 695	3. All licensed nursing staff was re-educated on the proper procedure on storage of [redacted] equipment, labeling and dating. During daily clinical rounds all residents receiving [redacted] treatments will be monitored to ensure the [redacted] equipment has been changed, dated and stored appropriately. 4. The unit manager will conduct weekly audits x 1 month and monthly x 3 months on all residents received [redacted] treatments. The DON/ADON will conduct weekly audits x 1 month and monthly x 3 months to ensure compliance with residents receiving [redacted] treatments and proper storage, labeling and dating. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 695	Continued From page 38 On 2/16/22 at 11:09 AM, the surveyor brought the assigned Licensed Practical Nurse (LPN #1) to Resident [redacted]'s room. The [redacted], medication cup, and [redacted] were bagged, and the [redacted] was connected to the [redacted]. LPN #1 removed the [redacted] from the bag revealing the [redacted] was dated [redacted]. LPN #1 acknowledged the [redacted] was ordered PRN (as needed) and stated that the process after the [redacted] medication was administered was that the medication cup would have been opened and allowed to dry on a paper towel. Then once it was dry it would then get stored in a bag. LPN #1 further stated that if the [redacted] or the bag had no date it would have been thrown away and replaced. During an interview with the surveyor on 2/16/22 at 12:43 PM, the Registered Nurse/Unit Manager (RNUM #1) stated that when the [redacted] was ordered it was the nurse's responsibility to set up the [redacted], date the [redacted], and store the [redacted] in a plastic bag labeled with resident's name. The RNUM #1 stated that the process for cleaning and sterilizing a [redacted] was to wash it with water and let it air dry and that if a [redacted] was found out of a bag that it would have been replaced. During an interview with the surveyor on 2/17/22 at 01:04 PM, the Assistant Director of Nursing (ADON) stated that it was the nurse's responsibility to date the [redacted] and attachment and store it in a bag. Also, after the medication was administered through the [redacted] the [redacted] and medication cup should be run under tap water and air dried, then replaced into the bag. The ADON further stated	F 695		

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F 695	Continued From page 39 that Resident #[redacted] should not have been resting on the dresser unbagged and that it was an infection control issue because [redacted] products go directly into the [redacted] Review of the facility policy "Administering Medications through a [redacted]) [redacted]" with a revision date of December 2021, revealed Steps in the Procedure: 24. When treatment is complete, turn off [redacted] and disconnect [redacted], and medication cup. 28. Store equipment in clean, dry plastic bag. Review of the facility policy "Medication [redacted] (AARC #2720)," undated, revealed Procedure: 16. If mouthpiece or [redacted] is visibly soiled or debris present may wipe with alcohol wipe to clean. Store in zippered or drawstring bag.	F 695		
F 697 SS=D	NJAC 8:39-15.1(a) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to document that [redacted] medication was administered as ordered by the	F 697	1. Resident #[redacted]s physician was immediately notified of missing documentation from the medical administration record. The physician	3/25/22

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F 697	Continued From page 40 physician. This deficient practice was identified for 1[redacted] residents reviewed for pain management, (Resident [redacted]) and was evidenced by the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted] A review of review the "Order Summary Report" revealed a physician's order dated [redacted] for the resident to receive [redacted] (a [redacted] medication) Apply to [redacted] topically two times a day for [redacted] A review of the electronic Treatment Administration Record (eTAR) for Resident [redacted] for [redacted], revealed the [redacted] medication [redacted] with scheduled administration times of 0900 (9:00 AM) and 2100 (9:00 PM). On the following dates and times, there was no documentation to indicate that the medication was administered as ordered on: 1/2/2022 at 2100 1/3/2022 at 0900 and 2100 1/7/2022 at 2100 1/13/2022 at 0900 and 2100 1/16/2022 at 2100 1/17/2022 at 0900 1/18/2022 at 0900 and 2100 1/21/2022 at 0900 and 2100 1/29/2022 at 0900 1/30/2022 at 0900 1/31/2022 at 0900 and 2100 2/3/2022 at 0900 and 2100 2/5/2022 at 2100	F 697	discontinued the medication due to the resident's request. Resident [redacted] was not negatively affected. 2. A facility wide audit was conducted of all residents' medication administration records to ensure the facility followed appropriate clinical practice in accordance with the New Jersey Board of Nursing Statutes. No further issues were identified, and no residents were negatively affected. All residents had the potential to be affected. 3. All licensed nursing staff have been re-educated by the assistant director of nursing and facility educator on following the acceptable standards of clinical practice in accordance with the New Jersey Board of Nursing Statutes by maintaining medication record completed with staff signatures. 4. The unit managers and nursing supervisors will conduct weekly audits x 1 month and monthly x 3 months to ensure appropriate documentation is completed in the medication and treatment administration record of the residents. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance with acceptable standards of clinical practice in maintain the medication records with appropriate documentation. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X	

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F 697	Continued From page 41 2/7/2022 at 2100 2/8/2022 at 2100 2/9/2022 at 2100 2/10/2022 at 2100 2/11/2022 at 2100 2/12/2022 at 0900 2/14/2022 at 0900 2/15/2022 at 2100. There was no documented evidence in the medical record that the resident experienced a negative reaction/harm from the late administration of the medications. During an interview with the surveyor on 2/17/22 at 12:36 PM, the Licensed Practical Nurse (LPN #1) stated there should not be blanks on the Medication Administration Record or TAR. The surveyor and LPN #1 reviewed the [redacted] and [redacted]. She stated those should not be blank. A review of a facility policy titled "Administering Medications" with a revised date of April 2021, included 22. The individual administering the medication signs/initials the resident's EMAR/MAR on the appropriate space/line after giving each medication and before administering the next ones. A review of a facility policy titled Pain Management with a revised date of February 2022, included A. The Licensed Nurse will administer [redacted] medication as ordered and document medication administered on the Medication/Treatment Administration Record. NJAC 8:39-27.1(a)	F 697	3 months.	

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to consistently communicate with a contracted [redacted] facility according to facility policy and procedure. This deficient practice was observed for 1 of 1 residents (Resident [redacted]) reviewed for [redacted] This deficient practice was evidenced by the following: A review of an Admission Minimum Data Set (MDS), an assessment tool dated [redacted] revealed Resident [redacted] had a Brief Interview for Mental Status score of [redacted], indicating that he/she was [redacted]. According to section [redacted] of the MDS, Resident [redacted] had an active diagnosis of [redacted] and section [redacted] revealed that Resident [redacted] received [redacted] while a resident. According to the Order Summary Report, Active Orders As Of: [redacted], Resident [redacted] had an order, dated [redacted] for: [redacted] treatment 3 times a week on [redacted] Pick-up at 800 am." On 2/17/2022 at 11:17 AM, the surveyor reviewed Resident [redacted] communication book for the period of [redacted] up to and including [redacted] Review of the communication binder	F 698	1. The contracted [redacted] facility for Resident #[redacted] was contacted to gather the communication sheets for [redacted], and [redacted]. The communications sheet for [redacted] was filed in the patient's chart. No new recommendations were made from the dialysis facility during those 4 dates. Resident [redacted] was not negatively affected. 2. Any residents receiving [redacted] have the potential to be affected, no residents were negatively affected. 3. All licensed nursing staff have been re-educated by the assistant director of nursing and facility educator on ensuring the receipt of [redacted] facility communication sheet when resident returns to the facility. Nursing will contact the [redacted] Center when the communication sheets are not completed to obtain missing communication sheets. 4. The unit managers will conduct weekly audits x 1 month and monthly x 3 months to ensure [redacted] communications sheets were received	3/25/22

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F 698	Continued From page 43 revealed that communication sheets were not completed by the facility or the [redacted] facility on the following dates: [redacted] and [redacted] The facility was unable to provide a [redacted] communication sheet for 4 of 24 [redacted] visits by Resident [redacted] in this time frame. During an interview with the surveyor on 2/17/2022 at 11:29 AM, the Licensed Practical Nurse/Unit Manager (LPNUM #2) assigned to the [redacted] Unit. The surveyor asked the LPNUM #2 what the facility procedure was for the dialysis communication book. LPNUM #2 responded, "We are responsible for documenting the vitals prior to the resident leaving the facility and any other pertinent information that is important to communicate with the [redacted] center Upon return to the facility the [redacted] center is responsible for providing the facility with pertinent information including pre and post weights, medications provided during treatment, vital signs and other pertinent information." The surveyor asked the LPNUM #2 what staff would be expected to do if the dialysis facility failed to fill out the Nurses [redacted] Communication Record. The LPN/UM responded, "If the [redacted] center does not fill out the appropriate information the receiving nurse assigned to that resident would be responsible for contacting the [redacted] center by phone during their shift to obtain information for that resident from the [redacted] staff." The surveyor reviewed the facility policy titled '[redacted] Care"; date revised: November 01, 2021. The following was revealed under the Procedure heading:	F 698	and reviewed by the licensed nursing staff. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure [redacted] communication sheets have been received and reviewed by nursing. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 698	Continued From page 44 III. Communication and Collaboration A. The Nursing Staff, Dialysis Provider Staff, and the Attending Physician [redacted] Staff) will collaborate on a regular basis concerning the resident's care as follows: i. Nursing staff will communicate pertinent information in writing to the [redacted] staff which may include: a. any medication changes b. Any recent changes in condition c. The resident's tolerance of [redacted] procedures ii. The [redacted] Provider will communicate in writing to the Facility: a. The resident's current vital signs b. Pre and Post dialysis weight; and c. Any problems encountered while the resident was at the [redacted] provider. v. Nursing Staff may use NP-225-Form A-Nurses [redacted] Communications Record to convey information to the [redacted] Provider (or equivalent). N.J.A.C. 8:39-27.1 (a)	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).	F 730		3/25/22

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F 730	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to ensure that all Certified Nursing Assistants (CNA) received 12 hours of mandatory education training, annually as required. This deficient practice was identified for 1 of 5 CNA files reviewed and was evidenced by the following: On 02/17/22 at 10:09 AM, the surveyor obtained and reviewed the performance evaluations and continuing education (CE) records of five randomly selected CNA staff members from the Assistant Director of Nursing (ADON). Upon review of the records, the surveyor noted the following: 1 of 5 Certified Nursing Assistants had no annual education for 2021. On 02/17/22 at 12:30 PM, the Infection Prevention Nurse (IPN) stated they did not have the required annual education for 1 of the 5 CNA's the surveyor requested for 2021. When asked who was responsible to make sure the required yearly education was completed, she stated she and the ADON were responsible to make sure it was completed. On 02/18/22 at 08:53 AM, the surveyor interviewed the ADON regarding the continuing education credits (CE) for CNA staff. She confirmed that CE credits for CNA staff were counted in terms of a calendar year, from January 1 through December 31 of a given year after their first year of employment. She also confirmed the CNA who was missing the required education	F 730	1. All areas contained in the 12 hours of mandatory annual education was reviewed with the identified CNA to ensure continued competency. The 2022 12-hour mandatory training was completed. No issues were identified. 2. A facility wide audit was conducted on all CNAs to ensure their 2021 12-hour annual mandatory education was completed. All C.N.A.'s had the potential No further issues were identified. 3. The facility educator/ADON was re-educated by the Regional Clinical Service Director on the 12-hour CNA mandatory annual education. 4. The DON/ADON will conduct weekly audits x 1 month and monthly x 3 months to ensure compliance with mandatory education for CNAs. All findings will be brought to monthly QAPI meeting to determine if further action is necessary x 3 months.	

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F 730	Continued From page 46 hours was hired on [redacted] and had been employed at the facility since that date. The ADON then confirmed that the facility was not able to locate this CNA's required 12 hours of training for 2021. She then stated she as well as the IPN were currently responsible to make sure the CNAS have their yearly education. According to the policy titled, "In-Service Training Program, Nurse Aide" all nurse aide personnel should participate in regularly scheduled in-service training classes... "...4. Annual in-services: a. ensure the continuing competence of nurse aides; b. are no less than 12 hours per employment year..." On 02/22/22 at 02:10 PM, during an interview with the survey team, the Director of Nursing acknowledged the facility did not follow their policy to ensure all their CNAs have the required yearly education.	F 730		
F 756 SS=D	NJAC 839-43.17(b) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		3/25/22

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F 756	Continued From page 47 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to follow the recommendation identified by the Consultant Pharmacist. This deficient practice was identified for 1 of 5 Residents (Resident [redacted] reviewed for unnecessary medications, [redacted] medications, and medication regimen review and was evidenced by the following:	F 756	1. The physician for resident # [redacted] was notified to obtain clarification of [redacted] order to include the number of grams to be applied. The [redacted] l was discontinued by the physician per resident's request. Resident # [redacted] was not negatively affected. 2. A facility wide audit was conducted on	

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F 756	Continued From page 48 According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted] A review of the "Order Summary Report" with active orders as of [redacted], revealed a physician's order dated [redacted] for the resident to receive [redacted] (a [redacted] medication) Apply to [redacted] topically two times a day for [redacted] A review of the Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking Final Response dated [redacted], indicated please update [redacted] order with number of grams to be applied. Upon review of the [redacted] and [redacted] Treatment Administration Record of Resident # [redacted] the facility did not address this recommendation. On 02/17/22 at 11:50 AM, the Director of Nursing verified that the nurse manager should have followed up with a clarification for the grams for [redacted] During an interview with the surveyor on 2/17/22 at 01:09 PM, the Registered Nurse/Unit Manager #1 stated that she completed the rest of the recommendations that were required but she must have forgot to complete the recommendation for the [redacted] dosage. According to the Drug Regimen Review with a revised date of November 1, 2021, the pharmacist will report any irregularities to the attending physician and the facility medical director and director of nursing, and these reports	F 756	all residents receiving [redacted] l to ensure the order contains number of grams to be applied. Any order identified were immediately clarified and updated. Any resident receiving [redacted] has the potential to be affected. No residents were negatively affected. 3. All licensed nursing staff have been re-educated by the assistant director of nursing and facility educator on the proper documentation needed for residents receiving [redacted] to include grams to be applied. The monthly pharmacy consultant report will be reviewed during the daily clinical meetings to ensure all areas have been addressed. 4. The unit managers will conduct weekly audits x 1 month and monthly x 3 months to ensure all [redacted] orders received contain appropriate dosing. The director of nursing/assistant director of nursing will conduct random weekly audits x 1 month and monthly x 3 months to ensure [redacted] orders contain grams to be applied. All findings will be brought to monthly QAPI meeting to determine if further action is necessary X 3 months.	

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F 756	Continued From page 49 must be acted upon.	F 756		
F 880 SS=D	NJAC 8:39 - 29.3 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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	F 880		3/25/22

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F 880	Continued From page 50 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined the facility failed to A.) ensure a used syringe left in a plastic cup on a bedside table was placed into a puncture proof container, B.) ensure a [redacted]	F 880	1. The used [redacted] that was placed in a plastic cup in resident #[redacted] room was immediately discharged in the sharp's container on the unit. Nurse stated she was rushing due to another patient requesting medications. Nurse was	

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F 880	Continued From page 51 (access to administer) had a protective plastic device) applied when it was not in use to prevent exposing the access device to the environment and C.) failed to maintain contact isolation for residents reviewed for Infection Control (Resident #, Resident # and Resident #). The deficient practice was evidenced by the following: A.) During the initial tour of the facility on 2/11/22 at 10:40 AM, surveyor #6 observed a used with a depressed plunger placed inside a plastic cup on the bedside table in Resident 's room. During an interview with surveyor #6 on 2/16/22 at 10:21 AM, Licensed Practical Nurse Unit Manager Nurse (LPNUM #2) revealed that each medication cart has a puncture proof container where should be disposed of. B.) During the initial tour of the facility on 2/11/22 at 10:19 AM, surveyor #6 observed Resident in his/her room. At that time, the surveyor observed that Resident # had a in his/her The surveyor observed that the access device was not covered with a protective exposing it to the environment. On 2/14/22 at 1:03 PM, surveyor #6 observed Resident in his/her room. At that time, the surveyor observed that Resident s was not covered with a protective exposing it to the environment.	F 880	immediately educated on the protocols of handling/discarding sharps after usage. Resident # PVC was immediately covered with a protective . Nurse stated she was not aware of placing a on the needless connector. Nurse was immediately educated on the protocols regarding needleless connectors. CNA number one was immediately reeducated by the unit manager on appropriate PPE required in resident # s room. CNA number one stated she was in a rush due to family concerns at home. 2. The facility educator immediately conducted re-education with all nursing staff to include proper disposal of syringes after uses, protective needed on devices, and appropriate PPE needed for residents on contact isolation. 3. The facility educator immediately conducted re-education with all nursing staff to include proper disposal of after uses, protective needed on access sterile devices, and appropriate PPE needed for residents on contact isolation. A LTC self-assessment was completed by the Director of Nursing and the Assistant Director of Nursing. A root cause analysis with the outcome identified was completed. All topline staff and infection preventionist completed Module 1 "Infection Prevention & Control Program", Module 4 "Infection Surveillance", Module 5 "Outbreaks", and	

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F 880	Continued From page 52 On 2/16/22 at 9:17 AM, surveyor #6 observed that Resident #1[redacted] was not covered with a protective [redacted] exposing it to the environment. A review of the EMR revealed under "Medical Diagnosis" that Resident [redacted] was diagnosed with but not limited to [redacted] A review of Resident #[redacted] 5-Day Minimum Data Set (an assessment tool) dated [redacted] revealed he/she received [redacted] medications before and during his/her stay in the facility. A review of Resident #[redacted]s Electronic Medical Record (EMR) under "Orders" revealed an order for [redacted]). During an interview with surveyor #6 on 2/16/22 at 10:21 AM, LPNUM #2 revealed her expectation from nurses is after using the [redacted] for medication administration, they "cap it." The surveyor clarified if she was referring to the protective [redacted]. The LPNUM #2 replied, "Yes." During an interview with surveyor #6 on 2/23/22 at 9:32 AM, the Assistant Director of Nursing confirmed that the [redacted] access device has to have a protective [redacted] when it is not in use.	F 880	Module 11A "Reprocessing Reusable Resident Care Equipment". All staff including topline staff and infection preventionist completed/educated on Module 6A "Principles of Standard Precautions", Module 6B "Principles of Transmission Based Precautions", and Module 11B "Environmental Cleaning and Disinfection". All front-line staff viewed "Keep COVID-19 out!" and "Closely Monitor Residents" videos. The unit managers and nursing supervisor will conduct weekly audits x 1 month and monthly x 3 months to monitor a[redacted] access devices to ensure appropriate caps are in place, monitor staff wearing appropriate PPE in contact isolation rooms and proper disposal of [redacted] 4. The facility infection control nurse will conduct random audits weekly x 1 month and monthly x 3 months to monitor all [redacted] access devices to ensure appropriate caps are in place, monitor staff wearing appropriate PPE in contact isolation rooms and proper disposal of [redacted]. All findings will be brought to monthly QAPI meeting to determine if further action is necessary.	

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F 880	Continued From page 53 C.) On 2/14/22 at 1:32 PM, surveyor #2 observed signage outside Resident # [redacted]s door reflecting that resident is on contact precautions which includes use of gloves and gowns. The surveyor also observed a 3-drawer clear plastic container with gloves and gowns outside of the room. According to the electronic medical record Resident [redacted] had diagnoses which included [redacted] a[redacted] infection. A review of an Order Summary Report with active orders date of [redacted], revealed a Physician Order (PO) for CONTACT ISOLATION: [redacted] every shift. On 2/15/22 at 11:22 AM, surveyor #2 observed a Certified Nursing Assistant (CNA #1) in Resident # [redacted] room with no gown. When interviewed CNA #1 stated she should have donned (put on) a gown prior to entering the resident room. During an interview with surveyor #6 on 02/16/22 at 12:53 PM, the Infection Prevention Nurse (IPN) acknowledged that Resident [redacted] was on contact isolation for [redacted] She stated that gloves and gowns are required to enter the room. She stated that CNA #1 should have been wearing a gown while in Resident [redacted] room. A review of the facility policy titled, "7.0 Sharps, Needles and Syringe Procedure" revised April 2018 under the section titled, "Procedure" subsection, "B." revealed, "Immediately after use, discard intact sharps, syringes and needles into the prominently labeled puncture proof container..."	F 880		

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F 880	Continued From page 54 Review of the facility policy titled, "4.0 Intermittent Infusion Administration" with a revised date of April 2018 under the section "Policy" revealed, "A protective [redacted] is to be applied to the distal end of the [redacted] when it is disconnected from the resident." The policy further revealed under the section, "Procedure" subsection, "P.", "After completion of infused medication disconnect tubing from the resident and apply a sterile protective cap to the end..." A review of a facility policy titled Resident Isolation-Categories of Transmission-Based Precautions with a Revised/Reviewed date of 01/2022 indicated, iii. Contact Precautions ...C. Gloves and Handwashing i. gloves are worn when entering the room ...iii Gloves are removed before leaving room and hands are washed immediately with an antimicrobial agent or a waterless antiseptic agent. Under D. Gown i. a (clean, non-sterile) gown is worn for interactions that may involve resident contact with the resident or potentially contaminated items in resident's environment. NJAC 8:39 - 19.4(a)(1)(2) N.J.A.C 8:39-27.1(a)	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program	F 881		3/25/22

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F 881	Continued From page 55 that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to A.) implement a system to review antibiotic (medicine used against bacteria) use with the consultant pharmacist by failing to obtain monthly reports documenting potential areas of improvement, irregularities, and recommendations and B.) failed to implement ongoing education on the Antibiotic Stewardship Program (program to improve clinical outcomes and minimize harms by improving antibiotic prescribing). The deficient practice was evidenced by the following: During an interview with the surveyor on 2/16/22 at 10:21 AM, the Licensed Practical Nurse Unit Manager (LPNUM #2) revealed she is not sure what Antibiotic Stewardship is. LPNUM #2 revealed that when the facility obtains a new order for an antibiotic, there is nothing specific to do. During an interview with the surveyor on 2/16/22 at 1:01 PM, the Infection Prevention Nurse (IPN) stated she could not provide the consultant pharmacist monthly report. When the surveyor asked if the consultant pharmacist should be providing a monthly report, the Assistant Director of Nursing (ADON) replied, "Yes, they should be." On 2/17/22 at 10:30 AM, the facility provided an undated signature document with a handwritten	F 881	1. The LPN UM #2 was immediately re-educated on the facility antibiotic stewardship program that included antibiotic usage protocol and a system that monitors antibiotic usage. The monthly antibiotic pharmacy report was obtained and reviewed by the assistant director of nursing and infection prevention nurse to ensure accuracy. 2. All/any residents receiving antibiotics have the potential to be affected. No residents were negatively affected. 3. The assistant director of nursing and Infection prevention nurse re-educated all licensed nursing staff and medical staff on the facility antibiotic stewardship program. The IPN will receive and review the monthly antibiotic report from the pharmacy. 4. The infection prevention nurse will conduct weekly audits x 1 month and monthly x 3 months on the antibiotic stewardship program to include antibiotic usage protocol, the system that monitors antibiotic usage. The assistant director of nursing will conduct random audits weekly x 1 month and monthly x 3 months to monitor the antibiotic stewardship program and compliance with pharmacy monthly reports and medical providers following the facility antibiotic stewardship	

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F 881	Continued From page 56 title that read, "Antibiotic Stewardship" presented by the IPN. The signatures on the document were representing staff who allegedly participated in education about Antibiotic Stewardship. The signatures appeared to be photocopied. During an interview with the surveyor on 2/17/22 at 11:10 AM, the ADON and IPN were unable to provide the original signature document. At this time, the ADON confirmed that the Antibiotic Stewardship education did not happen. During a follow-up interview with the surveyor on 02/23/22 at 09:32 AM, the ADON reaffirmed the signature document was fraudulent and the education represented never occurred. She further acknowledged that the Consultant Pharmacist will adhere to facility policy moving forward. A review of the facility policy titled, "Antibiotic Stewardship Program" with a revised date of April 28, 2021, under section "I. Leadership" subsection "ii" revealed, "The Facility's leadership team will create awareness and culture to promote education, regarding appropriate use of antibiotics, implement quality assurance validation, and monitor the goals of the ASP." Further review of the policy under section "II. Accountability" subsection "D." revealed, "The Consultant Pharmacist will prepare a written report documenting potential areas for improvement, irregularities, and recommendations. This report will be shared with the ICC and/or the Quality Assessment and Assurance Committee (QAC)." §N.J.A.C. 8:39-19.4(a)	F 881	program. All findings will be brought to monthly QAPI meetings to determine if further action is necessary X 3 months.	

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F 888	Continued From page 57	F 888		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct	F 888		3/25/22

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F 888	Continued From page 58 contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff	F 888		

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	315257		02/23/2022

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F 888	Continued From page 59 COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section	F 888		

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F 888	Continued From page 60 are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to A) develop and implement a policy to track facility staff vaccination status to ensure all eligible staff were vaccinated by the required dates and B) follow their own policy for contingency plans by not ensuring unvaccinated staff wore an N 95 mask to mitigate the potential spread of COVID-19. This deficient practice was evidenced by the following: On 2/11/22 during entrance conference, the facility was asked to provide a matrix of the vaccination status of all their staff. The facility provided a sheet of paper, separated by department, and listed the number of total vaccinated and unvaccinated staff. The paper did not identify or specify which facility staff were vaccinated or unvaccinated. A.) A review of the facility provided matrix on 2/16/22, revealed 25 new hire employees from November of 2021 to February 2022. Of those 25 new hire employees, 8 are no longer on the schedule, 6 have pending exemptions, and 11 were unvaccinated. During an interview with surveyor #1 on 2/17/22 at 10:05 AM, the Director of Nursing (DON) said the Infection Prevention Nurse (IPN) and	F 888	1. All unvaccinated staff were immediately re-educated to wear N95 masks in the facility until fully vaccinated. The COVID-19 vaccination tracker was immediately revised to include a separate sheet for the unvaccinated and exemptions. 2. A facility wide audit was conducted on all staff to determine accurate COVID-19 vaccination status. Employee employment status was determined based on the facility Vaccination Policy. 3. All staff have been re-educated on the COVID-19 vaccination policy and procedures and requirements for vaccination, timelines and appropriate PPE required. 4. The IPN will conduct weekly audits x 1 month and monthly x 3 months on all staff and their vaccination status to achieve compliance. The ADON will conduct audits weekly x 1 month and monthly x 3 months on staff COVID-19 vaccine compliance. All findings will be brought to monthly QAPI meetings to determine if further action is necessary X	

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F 888	Continued From page 61 Assistant Director of Nursing (ADON) were responsible for maintaining their COVID-19 vaccine policy. The DON acknowledged staff could have received the vaccine in the community or in house at their monthly clinic. When asked how long an employee could work without being vaccinated the DON said, "I will get you that answer." Surveyor #1 asked for clarification since the completed vaccination matrix revealed 3 pending exemptions and the IPN submitted employee documentation for 17 exemptions. The IPN also provided dates of hire for the 25 new employees, however, only 23 new hires were listed. The DON responded, "I know. I think it was confusing how it was on that form (Matrix)." During an interview with surveyor #1 on 02/17/22 at 12:30 PM, the IPN explained a new hire probationary period is 3 months. The IPN also stated, "First dose of the vaccine should have been by January 27th, 2022, I believe, and the 2nd by February 27, 2022. The IPN confirmed to surveyor #1, "I am responsible to track vaccinations as the IPN." During an interview with surveyor #3 on 2/17/22 at 12:40 PM, the Temporary Nursing Assistant (TNA #2), who was one of the 11 documented unvaccinated employees, said she was vaccinated at a community pharmacy with the first dose of a 2-dose vaccine in January of 2022. TNA #2 stated, "Administration made me verbally aware that to continue employment that I would need to be fully vaccinated." During a follow up interview with surveyor #1 on 2/17/22 at 1:25 PM, the IPN said she was not given a deadline for vaccines or exemption completion dates. The IPN further said she was	F 888	3 months.	

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F 888	Continued From page 62 not familiar with the vaccination requirements and had not had time to read the most recent guidance. During an interview with surveyor #5 on 2/17/22 at 1:43 PM, TNA #3 said upon hire she was told by Human Resources that she had until 2/25/22 to get vaccinated or lose her job. She went on to say she scheduled her 1st vaccination on 2/22/22 to be received during the facility vaccination clinic. Surveyor #2 went to the unit to speak with TNA #4 on 2/17/22 at 1:42 PM and was told TNA #4 had been sent home because she did not have her vaccine. During an interview with surveyor #6 on 2/17/22 at 1:54 PM, TNA #1 denied being vaccinated and filled out a non-medical exemption form. She went on to say that when she was first hired, "they told me I had to be vaccinated. They never really pushed for it." During an interview with surveyor #1 on 2/22/22 at 10:29 AM, the IPN said the tracking process for staff vaccines is, "I have a log to track dates of vaccines, boosters, and a swabbing log." She went on to say she puts the unvaccinated in there as well and checks every time there is a clinic. The IPN continued, I send out a voice print (electronic voice mail) to staff regarding updating me on if they have received the vaccine. The IPN said she asks during orientation, who is vaccinated, and they will submit me their card [...] If unvaccinated I will offer them a clinic and if they want to sign up, they can, or I offer them the community option for vaccines. The IPN said, "If they give me a card, I will update the list [...] I don't have a time frame for when they need to get vaccinated by." The ADON added, "We don't	F 888		

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F 888	Continued From page 63 have a way to track the unvaccinated and will need to come up with something." During an interview with the surveyor on 2/22/22 at 1:52 PM, the DON and the Regional Clinical Service Director (RCSD) said the reviews for exemptions "should not take long." There was no specific timeframe provided to the surveyor. The RCSD went on to say that at this time all unvaccinated staff are unable to work until they provide proof of vaccination or file for an exemption. The RCSD further stated that moving forward staff must be fully vaccinated before they start here and/or file for an exemption. B.) On 2/17/22 at 12:40 PM, TNA # 2 was observed by surveyor #3 to be wearing a surgical mask. When asked if she had been instructed by Administration to wear an N-95 level mask while working in the facility TNA #2 said, "I was not made aware that I was to wear N-95 mask due to my vaccination status." TNA #2 said she had been fit tested (specific test performed under a hood using sweet/sour smell to ensure correct fit of the mask). On 2/17/22 at 1:43 PM, TNA #3 was observed by surveyor #5 wearing a surgical mask and full-face shield. When asked about what mask she should be wearing she said she wears an N-95 in the yellow zone (area for persons under investigation/ PUI for Covid). On 2/17/22 at 1:54 PM, TNA #1 was observed to be wearing a surgical mask and eye protection. When asked by surveyor #6 about her use of an N-95 mask she said, "No, not really. I did use it in the subacute covid area. I wear just a surgical mask."	F 888		

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F 888	Continued From page 64 During an interview with surveyor #1 on 2/17/22 at 1:25 PM, when asked about mitigation, the IPN said mitigation was nasal swab twice a week, staff should wear PPE in green zone (no covid or PUI) consisting of face shield and surgical mask. The IPN went on to say, "No, staff does not need to wear N-95 at all times." During an interview with surveyor #1 on 2/17/22 at 2:13 PM, the DON was asked what mitigation process was utilized for unvaccinated or partially vaccinated staff. The DON replied, "It should be an N-95 mask and face shield." The DON went on to say that the ADON or IPN should have told them (unvaccinated/partially vaccinated new employees) during orientation of the requirement. The DON also said the Unit Managers or Supervisors are responsible for monitoring staff on the units to ensure they are compliant with their N-95 mask usage. A review of a facility policy titled (Company Name) Covid-19 Vaccine Policies and Procedures, updated 1/26/2022 revealed under the Staff Vaccine Requirements section "All facility staff are required to have received at least one dose of an FDA authorized Covid-19 vaccine by January 27, 2022, and the second dose by February 28, 2022, and any booster shots for which they are eligible. In addition, the policy revealed the following under the Additional Precautions and Contingency Plans for Unvaccinated Staff: Require use of a NIOSH-approved N-95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct acre to or otherwise interacting with patients."	F 888		

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F 888	Continued From page 65 NJAC 8:39-5.1(a)	F 888		