STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE WEST ORANGE, NJ 07052**

(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		

Survey Date: 3/8/22

Census: 123

Sample: 24 + 2 + 2

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.

During a Standard Survey from 2/23/22 through 3/8/22, the survey team identified that the facility failed to administer *Ex Order 26. 4B1* in accordance with physician's orders and appropriately reconcile *Ex Order 26. 4B1* discharge medications for 2 of 3 residents with a diagnosis of *Ex Order 26. 4B1*. The facility's failure to ensure all residents on *Ex Order 26. 4B1* were ordered and administered as ordered posed a serious and immediate threat for adverse reactions including various types of *Ex Order 26. 4B1* which can result in harm, impairment, or death resulted in an Immediate Jeopardy (IJ) situation for all residents on *Ex Order 26. 4B1*.

The facility was notified of the IJ situation on 3/4/22 at 2:44 PM, which began on 1/31/22 when the resident did not receive the 9:00 PM dose of *Ex Order 26. 4B1*.

The IJ was removed on 3/5/22 at 4:46 PM, upon implementation of an acceptable Removal Plan that was verified on-site by the survey team.

The non-compliance remained on 3/6/22 for no actual harm with the potential for more than

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

Electronically Signed | 03/31/2022

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 000	Continued From page 1 minimal harm that is not immediate jeopardy. F760	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a Registered Nurse completed full body assessments after a fall prior to being moved in accordance with professional standards of practice. This deficient practice was identified for 1 of 4 resident (Resident #50) reviewed for falls. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse	F 658	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. F 658 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ The doctor for Resident #50 was notified post fall in both incidents. ¿ All nurses were in-serviced on proper evaluation post fall and educated on the	4/14/22

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F 658	Continued From page 2 Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows: On 2/23/22 at 11:36 AM, the surveyor observed Resident #50 lying in a low positioned bed with floor mats on either side of the bed. The resident was unable to be interviewed. On 3/1/22 at 12:41 PM, the surveyor interviewed Resident #50's Representative (RR) via telephone who stated that the resident had multiple falls since admission at the facility. The surveyor reviewed the medical record for Resident #50. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included *Ex Order 26. 4B1* [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated *Ex Order 26. 4B1*, reflected a *Ex Order 26. 4B1* [redacted] score of [redacted] out of 15, which indicated *Ex Order 26. 4B1* [redacted].	F 658	requirement for an RN assessment as per professional standards of quality. 2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents that are identified as a risk for falls have a potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ All nurses will be in-serviced at least twice yearly by the DON or ADON or Designee on the requirement of a proper RN assessment post fall as per professional standards of practice. ¿ DON or designee will audit five falls per month for the first three months and quarterly thereafter. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The DON or designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	

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F 658	Continued From page 3 A review of the individualized person-centered Care Plan included a focus area initiated Ex Order 26. 4B1, for at risk for further falls due to a history of falls, Ex Order 26. 4B1 [redacted]. Actual falls on: Ex Order 26. 4B1 with minor injury; Ex Order 26. 4B1 without injury; and Ex Order 26. 4B1 without injuries. Interventions included to anticipate and meet needs; air Ex Order 26. 4B1 [redacted] check proper function every shift; keep bed in lowest position at all times except when giving care; padded side rails are to be maintained at all times; and provide Ex Order 26. 4B1 [redacted] to reduce risk of injury should a fall occur. A review of the fall Incident Report dated 12/23/21, reflected that the resident was found by Ex Order 26. 4B1 nurse on the floor. The incident report included a statement from Registered Nurse (RN #1) that the resident was assessed and found to express Ex Order 26. 4B1 pain, so the resident was transferred to the Ex Order 26. 4B1 for evaluation. A review of the fall Incident Report dated Ex Order 26. 4B1, reflected that the resident was found at 9:30 PM by the writer [Licensed Practical Nurse (LPN #1)] on the floor with no noted injury. The resident with assistance of two Certified Nursing Aides (CNA) was transferred back to bed. The report also included that LPN #1 documented in a Nurse Note dated Ex Order 26. 4B1 at 11:02 PM, that a Ex Order 26. 4B1 assessment was done with no injury noted. The report also included a Fall Risk Assessment dated effective date Ex Order 26. 4B1 at 10:08 PM, was completed by LPN #1. There was no documentation that the resident was assessed by a RN prior to being moved.	F 658		

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F 658	Continued From page 4	F 658		

A review of the fall Incident Report dated [redacted], reflected that the writer [LPN #1] found the resident at 8:40 AM in their room lying on the floor mat. There was no injury noted and the resident was transferred with the assistance of two CNAs. The report included a Nurse Note from LPN #1 dated [redacted] at 11:01 AM, that she was called to the room at 8:40 AM and found the resident lying on the left side of bed on the floor mat; a quick assessment was done with no injury noted and the resident was transferred by two CNAs back to bed. A [redacted] assessment was done with no injury noted. The report also included a Fall Risk Assessment dated [redacted] at 3:43 PM, that was completed by LPN #1. There was no documentation that the resident was assessed by a RN prior to being moved.

A review of the Progress Notes that corresponded with the falls on [redacted], did not include documentation that an RN assessed the resident after the fall prior to being transferred back to bed.

On 3/2/22 at 9:55 AM, the surveyor observed resident in bed asleep. The surveyor observed that the bed was positioned low, side rails were padded and in the up position, and fall mats were on either side of the bed.

On 3/2/22 at 11:02 AM, the surveyor interviewed RN #1 who stated that the resident had multiple falls since admission at the facility with interventions put in place which included bed in lowest position, floor mats to both sides of the bed, and padded side rail in the up position while in bed. RN #1 stated that the resident had only fell once during her shift and she completed the

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F 658	Continued From page 5 assessment for that fall. RN #1 stated that a RN had to complete the assessment when a resident falls. On 3/2/22 at 11:40 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when a resident fell, a Ex Order 26. 4B1 assessment was completed to ensure the resident had no injuries which included vital signs, Ex Order 26. 4B1 , and Ex Order 2 checks. The DON confirmed that in accordance with standards of practice for nursing, only a RN and not a LPN could assess the resident and the assessment was completed prior to be moved from the floor. The DON stated that the RN should also document their assessment in the Progress Notes or in the Incident Repot. The surveyor reviewed the fall Incident Reports for Resident #50 dated Ex Order 26. 4B1 . The DON acknowledged that even though she documented Interdisciplinary Care Plan Summary notes on Ex Order 26. 4B1 , there was no documented RN assessments completed after the fall prior to moving the resident. On 3/4/22 at 10:12 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Assistant Director of Nursing (ADON), Corporate Nurse, and survey team, acknowledged that no RN assessment was completed for the falls on Ex Order 26. 4B1 . A review of the facility's "Incident/Accident Reporting Policy and Procedure" dated updated Ex Order 26. 4B1 , included that it was the responsibility of the Licensed Nurse who first witnessed the incident/accident to initiate and complete the Incident/Accident Report in its entirety utilizing input from the staff present at the time of the	F 658		

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F 658	Continued From page 6 incident/accident. The Nurse evaluates the resident's condition, renders appropriate treatment, i.e. [id est; that is] first aid or calls the Physician who orders specific treatment or decides if the resident is to be transferred to the Emergency Room... the policy did not include/specify that the RN completed the assessment.	F 658		
F 695 SS=E	NJAC 8:39-27.1(a) 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, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) administer *Ex Order 26. 4B1* according to the physician's order and b.) ensure *Ex Order 26. 4B1* was stored and dated properly. This deficient practice was identified for 5 of 7 residents (Resident #35, Resident #51, Resident #57, Resident #69, and Resident #363) reviewed for *Ex Order 26. 4B1* and the evidence was as follows: 1. On 2/23/22 at 11:25 AM, the surveyor observed Resident #35 sitting in a wheelchair in their room	F 695	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION _____ _____ The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard.	4/14/22

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F 695	Continued From page 7 watching television. The resident was being administered [redacted] from a [redacted] alongside their bed that was set to [redacted] via an undated [redacted]. The resident appeared to be in no distress. The surveyor reviewed the medical record for Resident #35. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnosis which included [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a [redacted] score of [redacted] out of 15, which indicated a [redacted]. A further review reflected the resident was not on [redacted] at the time of this assessment. A review of the individualized person-centered Care Plan initiated on [redacted], did not include that the resident received [redacted]. A review of the Order Summary Report included a physician's orders (PO) dated [redacted] for [redacted] at [redacted] via [redacted] as needed for [redacted] or for [redacted] less than 92%. On 2/24/22 at 10:07 AM, the surveyor observed the resident in bed with the [redacted] set to [redacted] being delivered to the resident by an	F 695	F 695 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #35 [redacted] settings were corrected to the correct setting. The [redacted] was changed and dated correctly. Care plan was updated to reflect [redacted] as well. Resident #69 [redacted] was changed and dated correctly. [redacted] was adjusted according to physician order. Resident #363 [redacted] was changed and dated immediately and will be placed in a bag when not in use. Resident #57 [redacted] was changed and dated and will be placed in a bag if not in use. The [redacted] setting was also corrected. Resident #51 [redacted] was changed and the [redacted] removed from the floor and replaced. All tubing will be placed in a bag when not in use. All nurses were in-serviced on proper procedure for labeling, tubing storage and correct concentrator settings per physician orders to ensure residents in need of respiratory care meet professional standards of practice. Education for personalized care plans reflecting	

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F 695	Continued From page 8 undated Ex Order 26. 4B1 . The resident appeared to be in no distress. On 2/24/22 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the resident's Ex Order 26. 4B was checked that morning at 8:05 AM, and it was at 91%. The LPN stated that the PO was to administer Ex Order 26. 4B1 at Ex [redacted] when the Ex Order 26. 4B was less than 92%. The LPN also stated that Ex Order 26. 4B1 was changed once a week and should be dated when changed. At this time, the surveyor accompanied by the LPN observed Resident #35's Ex Order 26. 4B1 [redacted]. The LPN confirmed the Ex Order 26. 4B1 was not dated, and the Ex Order 26. 4B1 was not set to the ordered Ex Order 26. 4. The surveyor observed the LPN replace the Ex Order 26. 4B1 and dated it Ex Order 26. 4B1. On 2/25/22 at 1:04 PM, the surveyor observed the resident's Ex Order 26. 4B1 connected to the Ex Order 26. 4B1 that was not in use was dated Ex Order 26. 4B1 and not the Ex Order 26. 4B1 date observed yesterday. On 2/25/22 at 1:46 PM, the surveyor interviewed the LPN regarding the resident's Ex Order 26. 4B1 who confirmed that she dated the tubing Ex Order 26. 4B1 yesterday, and she was unable to explain why the tubing was now dated Ex Order 26. 4B1. The LPN called the Assistant Director of Nursing/Infection Preventionist (ADON/IP) over to the resident's room. The ADON/IP confirmed that she was aware of the tubing being changed and dated the previous day on Ex Order 26. 4B1, and she confirmed the current tubing was now dated Ex Order 26. 4B1. The ADON was unable to speak to this discrepancy.	F 695	residents respiratory needs were given to all nurses. 2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents with respiratory treatment have potential to be affected by unchanged tubing, incorrect concentrator settings per physician orders, and unclean tubing. ¿ All residents with respiratory treatments will have a personalized care plan reflecting their goals of care. ¿ All residents with respiratory treatment were audited to ensure proper care plans, dated and clean tubing and nebulizers and concentrator settings set per Physician orders. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: . ¿ Unit Manager or designee will audit residents with respiratory treatments weekly for one month and then monthly for two months and quarterly thereafter to ensure tubings are dated and stored properly. ¿ Concentrators will be audited weekly for one month by ADON or designee to be sure of proper settings according to physician order. It will then be audited monthly thereafter for three months.	

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F 695	Continued From page 9 On 3/4/22 at 10:11 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LHNA), ADON/IP, and the survey team, stated that Ex Order 26. 4B1 was changed and dated weekly on Sundays during the 11:00 PM to 7:00 AM shift by nursing staff and as needed if the tubing was on the floor. The DON also acknowledged that Ex Order 26. 4B1 should be administered according to the PO. The DON was unable to speak to the discrepancies in the Ex Order 26. 4B1 dates. 2. On 2/23/22 at 11:14 AM, the surveyor observed Resident #69 in their room resting in bed with no distress. The resident was being administered Ex Order 26. 4B1 from a Ex Order 26. 4B1 alongside their bed that was set to Ex Order 26. 4 via an undated Ex Order 26. 4 . The surveyor reviewed the medical record for Resident #69. A review of the Admission Record reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnosis which included Ex Order 26. 4B1 . A review of the most recent quarterly MDS dated Ex Order 26. 4B1, reflected a Ex Order 26. 4 score of Ex out of 15, which indicated a Ex Order 26. 4B1 . A further review reflected the resident was on Ex Order 26. 4B1 and had Ex Order 26. 4B1 when lying flat.	F 695	¿ ADON will in-service nurses monthly for the first three months and quarterly thereafter on proper procedures for infection control, tubing changes and dates, and concentrator settings. ¿ Care plans will be reviewed quarterly by the DON or designee to ensure personalized plans of care. ¿ 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The DON/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	

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F 695	Continued From page 10 A review of the individualized person-centered Care Plan initiated on [redacted], included a focus area for *Ex Order 26. 4B1* [redacted]. Interventions included to administer *Ex Order 26. 4B1* [redacted] in a timely manner and to position resident with proper body alignment for optimal breathing. A review of the active Order Summary Report included a PO dated [redacted] for [redacted] to be administered at [redacted] via *Ex Order 26. 4B1* [redacted]. On 2/24/22 at 11:06 AM, the surveyor in the presence of the LPN observed the resident in bed with the *Ex Order 26. 4B1* [redacted] set to [redacted] being delivered to the resident via a *Ex Order 26. 4B1* that was dated [redacted]. The LPN confirmed the PO was for the *Ex Order 26. 4B1* to be set at [redacted] but did not make the adjustment at that time. On 2/25/22 at 1:02 PM, the surveyor observed the resident's *Ex Order 26. 4B1* [redacted] was set to [redacted] and the *Ex Order 26. 4B1* was dated [redacted] which contradicted the [redacted] date observed the day before. On 2/25/22 at 1:52 PM, the surveyor interviewed the ADON/IP confirmed the tubing was dated [redacted] and stated that she will "have to look into this issue." On 3/4/22 at 10:11 AM, the DON in the presence of the LNHA, ADON/IP, and the survey team, stated that *Ex Order 26. 4B1* was changed and dated weekly on Sundays during the 11:00 PM to 7:00 AM shift by nursing staff and as needed if the tubing was on the floor. The DON also acknowledged that [redacted] should be	F 695		

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STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE WEST ORANGE, NJ 07052**

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F 695	Continued From page 11	F 695		

administered according to the PO. The DON was unable to speak to the discrepancies in the Ex Order 26. 4B1 dates.

3. On 2/23/22 at 10:50 AM, the surveyor observed Resident #363 in their room resting in bed. The resident was being administered Ex Order 26. 4B1 from a Ex Order 26. 4B1 alongside their bed that was set to Ex Order 26. 4 via an undated Ex Order 26. 4B1.

The surveyor reviewed the medical record for Resident #363.

A review of the Admission Record reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnosis which included Ex Order 26. 4B1 .

A review of the most recent quarterly MDS dated Ex Order 26. 4B1, reflected a Ex Order 26. 4 score of Ex 1 out of 15, which indicated a Ex Order 26. 4B1 . A further review reflected the resident was on Ex Order 26. 4B1 or trouble breathing when lying flat.

A review of the individualized person-centered Care Plan initiated on Ex Order 26. 4B1, included a focus for Ex Order 26. 4B1 related to the diagnosis of Ex Order 26. 4B1 . Interventions included to administer Ex Order 26. 4B1 by Ex Order 26. 4B1 at Ex Order 26. 4 as needed for Ex Order 26. 4B1 .

A review of the active Order Summary Report included a PO dated Ex Order 26. 4B1 for continuous Ex Order 26. 4B1 at Ex Order 26. 4 via Ex Order 26. 4B1

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Ex Order 26. 4B1. An additional PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 at Ex Order 26. 4 as needed for a Ex Order 26. 4B1 less than 92% or Ex Order 26. 4B1.

On 2/25/22 at 12:44 PM, the surveyor observed the resident's Ex Order 26. 4B1 not in use and hanging wedged between the nightstand table and wall with most of the tubing length lying directly on the floor. At this time, the surveyor interviewed the resident who stated that he/she needed the Ex Order 26. 4B1.

On 2/25/22 at 12:49 PM, the DON came to the resident's room and informed the surveyor that the tubing should not be stored like that; it should be in a bag when not in use. The DON also stated that the tubing should not be on the floor like that because it can cause infection control issues and needed to be changed.

4. On 2/23/22 at 11:01 AM, the surveyor observed Resident #57 in bed with an Ex Order 26. 4B1 at their bedside which was turned on and set to Ex Order 26. 4B1. The surveyor observed that the undated Ex Order 26. 4B1 was connected to the Ex Order 26. 4B1 and hanging from the resident's bed side rail with the Ex Order 26. 4B1 lying directly on the floor.

The surveyor reviewed the medical record for Resident #57.

A review of the Admission Record reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1.

A review of the most recent quarterly MDS dated Ex Order 26. 4B1, reflected a Ex Order 26. 4 score of Ex Ord out of 15, which indicated a Ex Order 26. 4B1. A further review reflected the resident was not on

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F 695	Continued From page 13 [redacted] at the time of this assessment. A review of the individualized person-centered Care Plan initiated on [redacted], included a focus area for [redacted] related to the diagnosis of [redacted]. Interventions included to give [redacted] as ordered by the physician. A review of the active Order Summary Report included a PO dated [redacted] for [redacted] to be administered at [redacted] via [redacted] as needed for [redacted] less than 90%. On 2/24/22 at 10:34 AM, the surveyor along with the LPN observed the resident in their room not receiving [redacted]. The LPN stated that the resident received [redacted] as needed for an [redacted] less than 90%. The LPN stated that she checked the resident's [redacted] that morning and the level was above 90% so the resident did not need [redacted]. On 3/4/22 at 10:11 AM, the DON in the presence of the LNHA, ADON/IP, and the survey team, stated that [redacted] should be stored in a bag when not in use. 5. On 2/23/22 at 11:02 AM, the surveyor observed Resident #51 awake lying in bed. The surveyor observed a [redacted] with connected tubing and a face mask lying directly on the floor underneath the resident's bed. The surveyor reviewed the medical record for	F 695		

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F 695	Continued From page 14 Resident #51. A review of the Admission Record reflected that the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included *Ex Order 26. 4B1* [redacted]. A review of the most recent quarterly MDS dated [redacted], reflected a [redacted] score of [redacted] out of 15, which indicated a *Ex Order 26. 4B1* [redacted]. A review of the active Order Summary Report reflected a PO dated [redacted], for [redacted] every six hours every Monday, Wednesday, Friday, Sunday for *Ex Order 26. 4B1* [redacted] on non-[redacted] days. A review of the individualized person-centered Care Plan included a focus area initiated [redacted], for altered *Ex Order 26. 4B1* [redacted] with regards to *Ex Order 26. 4B1* [redacted]. Interventions included to administer medications as ordered; monitor for effectiveness and side effects. On 2/28/22 at 11:05 AM, the surveyor observed Resident #51 awake lying in bed with the *Ex Order 26. 4B1* with the connected tubing and mask lying directly on the floor underneath the resident's bed. On 2/28/22 at 11:05 AM, the surveyor accompanied by the Registered Nurse (RN) entered Resident #51's room and the RN	F 695		

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F 695	Continued From page 15 confirmed that the resident's Ex Order 26. 4B1 with connected tubing and mask was lying directly on the floor underneath the resident's bed. The RN stated that she needed to change the tubing and mask and proceeded to pick up the Ex Order 26. 4B1 with the attached tubing and mask and placed them in bed with the resident. The RN removed the tubing and mask and stated that she needed to grab new tubing and mask since it was on the floor for infection control purposes. The RN changed the tubing and mask, leaving the Ex Order 26. 4B1 in bed with the resident and exited the room. At this time, the surveyor interviewed the RN in the hallway who confirmed that the tubing and mask on the floor would be an infection control concern, so she changed them. When asked about the Ex Order 26. 4B1 that was on the floor and now in bed with the resident was okay, the RN acknowledged that she should have changed the Ex Order 26. 4B1 or wiped it down with alcohol. The RN stated that she would now change the Ex Order 26. 4B1, tubing, and mask. On 2/28/22 at 11:20 AM, the surveyor interviewed the resident who stated that the Certified Nursing Aide (CNA) placed the Ex Order 26. 4B1, tubing, and mask on the floor when they performed care, and the CNA had not placed the Ex Order 26. 4B1 back in bed. The resident confirmed that the Ex Order 26. 4B1 was usually placed in bed with them. On 2/28/22 at 11:30 AM, the surveyor interviewed the CNA who stated that she had not performed care on the resident yet, and she had not placed the Ex Order 26. 4B1 on the floor. On 2/28/22 at 11:38 AM, the surveyor	F 695		

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F 695	Continued From page 16 re-interviewed the resident who confirmed that the CNA had not placed the Ex Order 26. 4B1 , tubing, and mask on the floor, and they were unable to speak to who did. On 3/1/22 at 9:19 AM, the surveyor interviewed the ADON/IP who stated that the Ex Order 26. 4B1 should not be on the floor or in bed with the resident. The ADON/IP stated that the Ex Order 26. 4B1 should be placed on a table, and the tubing and mask should be stored in a bag when not in use to prevent contamination. On 3/4/22 at 10:12 AM, the LNHA in the presence of the DON, ADON/IP, Corporate Nurse, and survey team acknowledge that the Ex Order 26. 4B1 , and mask should not be placed on the floor. A review of the facility's "Oxygen Administration" policy dated updated 12/2021 included it is the policy and procedure of Stratford Manor to provide oxygen to residents in compliance with their physician order as followed out by the resident's care provider...Tubing and other accessories will be changed weekly and dated. A review of the facility's "Respiratory Tubing" policy dated updated 11/2021, included... respiratory tubing will be properly dated, maintained, and stored to prevent infection...when not in use, store respiratory tubing in an oxygen bag that is labeled with the date the tubing was changed. NJAC 8:39-11.2(b); 19.4(a); 27.1(a)	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		4/14/22

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F 755	Continued From page 17 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure medications were administered to a resident in accordance with professional standards of practice and b.) a controlled	F 755	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION	

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F 755	Continued From page 18 *Ex Order 26. 4B1* [redacted], was accurately accounted for in accordance with professional standards of practice. This deficient practice was identified for 2 of 24 residents (Resident #51 and Resident #163) reviewed for medication management and the evidence was as follows: 1. On 2/23/22 at 11:02 AM, the surveyor observed Resident #51 alone, lying in bed awake with their tray table directly over the bed. The surveyor observed on top of the tray table, a disposable medication cup that contained five medication pills and an additional medication cup that contained *Ex Order 26. 4B1* of an orange/brownish colored liquid. The surveyor interviewed the resident who stated that he/she still had their morning medications in front of them because the nurse left their morning medications with them, but the nurse did not give them all their medications. The resident stated that he/she was waiting for the nurse to return to their room to inform them they were missing medications. On 2/23/22 at 11:07 AM, the surveyor observed the Registered Nurse (RN) in the hallway outside the resident's room. The surveyor asked the RN to come into Resident #51's room. At this time, the RN noticed the medications and asked the resident why he/she had not taken their medications. The resident responded that he/she was missing medications. The RN proceeded to remove the medications from the tray table and proceeded into the hallway to the medication cart with the surveyor. At this time, the RN identified the five medication pills as *Ex Order 26. 4B1* [redacted] The RN	F 755	The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. F 755 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ NP was notified in regard to the deficient practice with Resident #51 and gave a one-time order to give the medication at that time. Nurses in reference to this deficient practice for resident # 51 were educated on proper medication administration. ¿ Nurse involved was educated on proper administration of narcotics and signatures of the declining sheet for resident #163. ¿ Nurses were educated on the importance of administering medications according to standards of practice. 2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents have the potential to be affected by this deficient practice. ¿ Weekly rounding by ADON, UM, or	

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F 755	Continued From page 19 identified the liquid cup to be *Ex Order 26. 4B1* [redacted]. The RN stated that she was training Licensed Practical Nurse (LPN #1) this morning who administered the resident their medications. The RN reviewed the Medication Administration Record (MAR) and stated that LPN #1 signed for the administration of the above medications at 8:19 AM. The RN identified that the LPN only administered one *Ex Order 26. 4B1* tablet instead of two and one *Ex Order 26. 4* tablet instead of three. The RN stated that medications should never have been left bedside, and the nurse was expected to sign the MAR after they witnessed the resident swallow the medications. The RN stated that Resident #51 was alert and oriented to person, place, and time and knew what medications they were supposed to receive. The RN stated that the resident had a roommate who was confused, but they could not ambulate or self-propel in a wheelchair and were dependent on staff for all activities of daily living. The RN disposed of the medication at this time and informed the surveyor that she was going to follow-up with the Assistant Director of Nursing (ADON). On 2/23/22 at 11:20 AM, the surveyor interviewed LPN #1 who stated that she was a new nurse and was shadowing LPN #2 today. She stated that she had dispensed medications today for one resident who she could not recall that resident's name, but she did not administer the medications to the resident. LPN #1 stated that she had dispensed the medication with LPN #2 today and denied touching any of the RN's residents' medications today. LPN #1 confirmed that medications should not be left bedside with the resident.	F 755	designee for one month and monthly for three months and quarterly thereafter to ensure medications are administered according to standard of practice. . 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ DON and ADON will audit all Narcotic administration processes including MAR review and declining sheets for accuracy daily for a week and weekly for three months and quarterly thereafter. ¿ ADON or designee will in-service all nurses on proper medication administration procedure to the nursing department quarterly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The DON or designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	

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F 755	Continued From page 20 On 2/23/22 at 11:30 AM, the surveyor re-interviewed Resident #51 who stated that LPN #1 had administered the medications to him/her today and did not dispense all his/her [redacted].	F 755		
	On 2/23/22 at 12:34 PM, the surveyor re-interviewed the RN who stated that she spoke with the resident's Nurse Practitioner (NP) who gave a one time order for all the missed medications except the [redacted] which needed to be administered with meals since it was a [redacted]. The RN stated that the resident would receive the [redacted] with lunch.			
	The surveyor reviewed the medical record for Resident #51.			
	A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted].			
	A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a [redacted] score of a [redacted] out of 15, which indicated a [redacted].			
	A review of the active Order Summary Report reflected the following physician orders (PO):			
	A PO dated [redacted] for [redacted] to administer [redacted] two times a day for supplement. A PO dated [redacted] for [redacted]			

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(mg) tablet; give one tablet by mouth one time a day every Monday, Wednesday, and Friday for Ex Order 26. 4B1.
A PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 capsule; give one capsule by mouth one time a day for Ex Order 26. 4B1.
A PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 tablet; give two tablets by mouth three times a day every Monday, Wednesday, Friday, and Sunday for Ex Order [redacted]. Give with meals.
A PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 capsule; give one capsule by mouth one time a day every Wednesday for supplement.
A PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 tablet; give three tablets by mouth one time per day for Ex Order 26. 4B1.

A review of the corresponding Ex Order 26. 4B1 MAR, reflected that the above medications were signed as administered for the morning dose on Ex Order 26. 4B1.

On 3/1/22 at 9:12 AM, the surveyor interviewed the ADON who stated that all newly hired nurses shadowed other nurses during orientation and were observed completing medication pass at least two or three times before completing orientation. The ADON stated that newly hired nurses were not allowed to be left alone in a resident's room without their preceptor, and the medication administration needed to be monitored. The ADON confirmed that the nurse had to observe the resident swallow the medication prior to exiting the room, and then the nurse signed that the medications were administered in the MAR.

On 3/1/22 at 10:44 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of

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F 755	Continued From page 22 the Director of Nursing (DON), ADON, Corporate Nurse, and the survey team, acknowledged that medications should not be left by the nurse with the resident. A review of the facility's "Medication Administration" policy dated updated 10/2021, included that ...10. the nurse will stay with same resident until all medication is prepared and taken; and 11. the nurse will then document per regulation. The nurse will initial on the MAR for the scheduled time of medication administration... 2. On 2/23/22 at 11:28 AM, the surveyor in the presence of LPN #3 inspected the Northwest medication cart. During the reconciliation of controlled medications with the LPN caring for Resident #163, the surveyor observed that the [redacted] liquid bottle contained approximately [redacted]. A review of the corresponding Individual Patient Controlled Substance Administration Record (declining inventory sheet) reflected the last time the [redacted] was signed as administered was on [redacted] at 9:00 PM, with a remaining balance documented as [redacted]. On 2/23/22 at approximately 11:40 AM, the surveyor interviewed LPN #3 regarding the discrepancy with the [redacted] declining inventory sheet which indicated there was [redacted] remaining in the bottle, while the actual bottle contained [redacted]. LPN #3 was unable to speak to this. At this time, LPN #3 had the ADON and	F 755		

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an additional surveyor (Surveyor #2) joined them at the medication cart. Surveyor #2 verified the volume remaining was approximately Ex Order 26. 4B1 and asked LPN #3 how much Ex Order 26. 4B1 was remaining in the bottle. LPN #3 responded that "we were told here that we cannot guess with the amount of medication," and it should be measured to determine how much medication was left on the bottle. LPN #3 also stated that she administered Ex Order 26. 4B1 at 9:00 AM to the resident and she forgot to sign it on the declining inventory sheet. The LPN confirmed that she should have signed the declining inventory sheet immediately upon administering the medication at 9:00 AM, and "it's my fault."

At this time, the ADON read the measurement of the liquid remaining in the medication bottle and stated, "approximately there were Ex Order 26. 4B1 remaining in the bottle." The ADON further stated that in order to verify the exact amount remaining, it would need to be measured, and she would be right back with the Registered Nurse/Unit Manager (RN/UM) to measure the actual amount left.

On 2/23/22 at 11:57 AM, the RN/UM in the presence of LPN #3, ADON, and the surveyors measured the Ex Order 26. 4B1 and confirmed the amount remaining in the bottle was Ex Order 26. 4B1.

A further review of the declining inventory sheet revealed in addition to the omission of the Ex Order 26. 4B1 9:00 AM dose, on Ex Order 26. 4B1 the balance remaining and the administered time were both blank.

On 3/3/22 at 10:49 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that

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she checked the narcotics and the corresponding declining inventory sheets and always checked the liquid medications because there was generally a higher incidence of errors. The CP acknowledged the declining inventory sheet should match the volume remaining in the bottle. The CP further stated the nurse should sign the declining inventory as she administered the medication and if there was an issue that someone forget to sign, it should be found at change of shift, when the nurses double checked the counts and signed the "change of shift log." The CP concluded there should be no discrepancies between the documented declining inventory sheet remaining volume and the actual volume remaining in the bottle.

On 3/4/22 at 10:13 AM, the LNHA in the presence of the DON, ADON, and the survey team, acknowledged the discrepancies in the documentation of the Ex Order 26. 4B1 and stated that those errors accounted for the differences in the Ex Order 26. 4B1 volume. The DON further acknowledged that one dose on Ex Order 26. 4B1 and one dose on Ex Order 26. 4B1 was not documented but was administered which was in addition to the Ex Order 26. 4B1 9:00 AM, dose that was also not accounted for.

A review of the facility's "Controlled Drug Storage and Administration Policy" dated updated 5/2021 included that... controlled medication dose should be prepared based on the order in the Medication Administration Record; declining inventory sheet [Individual Patient Controlled Substance Administration Record] should be signed as dose is prepared and reconciled with quantity on hand; immediately after administration, Medication Administration Record should be signed.

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F 755	Continued From page 25 Refer F760	F 755		
F 756 SS=D	NJAC 8:39-27.1(a); 29.7(c) 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 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	F 756		4/14/22

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F 756	Continued From page 26 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 observation, interview, and record review, it was determined that the facility failed to ensure the Consultant Pharmacist identified that a medication used to control [redacted] was administered in accordance with manufacturer's specifications. This deficient practice was identified for 1 of 3 resident (Resident #27) reviewed for [redacted] and was evidenced by the following: Reference: VIMPAT Highlights of Prescribing Information: "VIMPAT tablets should be swallowed whole with liquid. Do not divide VIMPAT tablets." On 3/7/22 at 10:32 AM, the surveyor observed Resident #27 in bed with [redacted] being administered via a [redacted]. The resident was unable to be interviewed. The surveyor reviewed the medical record for Resident #27. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted],	F 756	Stratford manor Rehabilitation and Care Center PLAN OF CORRECTION The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. F 756 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ Doctor of resident #27 and Pharmacy consultant were notified upon finding. ¿ Resident #27 [redacted] tablet order was changed to [redacted] liquid. ¿ Nurses were educated on giving medications according to manufacturer recommendations. 2. How you will identify other residents having the potential to be affected by the same deficient practice:	

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F 756	Continued From page 27 Ex Order 26. 4B1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS) an assessment tool dated Ex Order 26. 4B1, reflected a Ex Order 26. 4B1 [redacted] score to be unable to determine. The resident had Ex Order 26. 4B1 [redacted]. A review of the active Order Summary Report reflected the following physician's orders (PO): A PO dated Ex Order 26. 4B1, may administer crushed medications as Ex Order 26. 4B1 [redacted] if not contradicted by manufacturer. A PO dated Ex Order 26. 4B1, for Ex Order 26. 4B1 [redacted] tablet; give one tablet via Ex Ord [redacted] every twelve hours for Ex Order 26. 4B1. A review of the Consultant Pharmacist Evaluation from admission until present, did not include to not crush Ex Order 26. 4B1. On 3/8/22 at 9:33 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident received small amounts of food and liquids orally, but their main nutrition was provided by the Ex Order 26. 4B1 via the Ex Ord [redacted]. The LPN stated that the resident received all their medications through their Ex Ord [redacted] either in liquid form or a crushed tablet. When asked how she determined if a medication could not be crushed, the LPN responded that it was not written on the	F 756	¿ All residents have the potential to be affected by not administering medication in accordance with recommendations and manufacturer orders. ¿ All medications will be administered according to the manufacturer recommendations. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ Pharmacy consultant will conduct a monthly audit of all residents' medication to ensure residents are receiving their medications according to their recommendations and cautionaries. ¿ New admission orders will be reviewed by the consultant pharmacist per policy to ensure accuracy and cautionaries are implemented. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The DON or designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	

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F 756	Continued From page 28 Medication Administration Record (MAR) so if she was unsure about a medication, the LPN could look the medication up on the Internet. When asked if [redacted] can be crushed, the LPN responded that the [redacted] had always been crushed at the facility. On 3/8/22 at 10:17 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that monthly she reviewed all residents' medications to ensure that the medications ordered were appropriate, they were in the appropriate form for the resident, and no irregularities. The CP stated that medication cautionaries were written on the bingo card (blister packet which contains the medication) and if the cautionary advised against crushing a medication, the nurse would need to clarify the order with the Physician. When asked if [redacted] tablets could be crushed, the CP stated that she was unsure and would need to research that. The CP confirmed that [redacted] was available in liquid source and that liquid medications were the preferred medication form for [redacted]. At this time, the surveyor provided the CP with a copy of the resident's [redacted] bingo card with the displayed cautionary "Swallow Whole. Do Not Chew Or Crush." The CP acknowledged the cautionary and stated that she was unsure where the Provider Pharmacy received their cautionaries from. The surveyor then provided the CP with a copy of the resident's Consultant Pharmacist Evaluation from admission until present and asked the CP if she had addressed the [redacted] tablet could not be crushed. The CP acknowledged that the [redacted] tablet not being crushed was not on the sheet. The CP stated that she would get back to the surveyor with any	F 756		

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F 756	Continued From page 29 additional information. On 3/8/22 at 11:31 AM, the CP in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Corporate Nurse, and survey team, confirmed that the manufacturer did not recommend Ex Order 26. 4B1 being crushed. A review of the facility's "Title: Consultant Pharmacist during regular monthly visits" policy dated updated 1/2022, include...the Consultant Pharmacist shall identify, document and report actual and potential irregularities for review and action to the Director of Nursing and/or Designee, Administrator, Medical Director and physicians (where appropriate). The physicians recommendations will be communicated to the Director of Nursing and/or Designee for distribution and action by the attending physician via email, fax (or both)... NJAC 8:39-	F 756		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and other pertinent facility documentation, it was determined that the facility failed to ensure: a.) 2 of 3 *Ex Order 26. 4B1* Ex Order 26. 4B1 ordered upon discharge from the were appropriately discussed with the	F 760	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION _____ _____ _____	4/14/22

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F 760	Continued From page 30 Physician for re-order, reconciled, received from the Provider Pharmacy, and administered in accordance with *Ex Order 26. 4B1* instructions for a resident with recent *Ex Order 26. 4B1* (Resident #163), and b.) an *Ex Order 26. 4B1* was available and administered as ordered for a second resident with a history of *Ex Order 26. 4B1* (Resident #27). This deficient practice was identified for 2 of 3 residents reviewed for *Ex Order 26. 4B1* management (Resident #27 and #163). Resident #163, who had a *Ex Order 26. 4B1* , was admitted to the facility on *Ex Order 26. 4B1* with active diagnoses which included *Ex Order 26. 4B1* as recent as *Ex Order 26. 4B1* in the *Ex Order 26. 4B1* . The resident had a physician's order (PO) for an *Ex Order 26. 4B1* and controlled drug *Ex Order 26. 4B1* to be given twice a day since admission. The medication was not administered for ten days from *Ex Order 26. 4B1* at the 9:00 AM dose. Further, the *Ex Order 26. 4B1* instructions indicated to continue on another *Ex Order 26. 4B1* but the resident was never started on the medication at the facility. There was no documented evidence as to why the *Ex Order 26. 4B1* was not re-ordered from admission to the facility on *Ex Order 26. 4B1* when the resident was subsequently *Ex Order 26. 4B1* , and there were no labs drawn to determine *Ex Order 26. 4B1* . Interviews with the Director of Nursing (DON) who reconciled the resident's admission orders, indicated that she could not speak to why the *Ex Order 26. 4B1* was not re-ordered. The resident was not	F 760	The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. F 760 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ Resident #163 no longer resides in the facility. Doctor was notified about delayed *Ex Order 26. 4B1* administration and missing *Ex Order 26. 4B1* from residents orders. ¿ Doctor for Resident #27 was notified immediately. Resident #27 has been receiving *Ex Order 26. 4B1* since the findings per physician orders. Documentation of *Ex Order 26. 4B1* monitoring and *Ex Order 26. 4B1* were implemented. ¿ Nurses were in-serviced on proper procedure to ensure medications and scripts are in the facility and the significance of medication errors. 2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents on seizure medications have a potential to be affected by not receiving seizure medications in a timely fashion. ¿ A facility audit was conducted to identify all residents with a seizure	

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F 760	Continued From page 31 seen by the Attending Physician or a Nurse Practitioner until Ex Order 26. 4B1. Resident #163 was never monitored for Ex Order 26. 4B1 while the medications were omitted, an alternate *Ex Order 26. 4B1* or other intervention was never discussed with the Physician or implemented while Ex Order 26. 4B1 was not available and while Ex Order 26. 4B1 was not being given to prevent rebound *Ex Order 26. 4B1*. A second resident, Resident #27, who had *Ex Order 26. 4B1* had a physician's order dated Ex Order 26. 4B1 for the *Ex Order 26. 4B1* and controlled drug, Ex Order 26. 4B1, twice a day for Ex Order 26. 4B1. The Ex Order 26. 4B1 was neither available nor administered from Ex Order 26. 4B1 at 9:00 PM until Ex Order 26. 4B1 at 9:00 AM and again from Ex Order 26. 4B1 at 9:00 PM until Ex Order 26. 4B1 at 9:00 AM. There was no documented evidence that the physician was made aware that the medication was unavailable. Interviews and review of records revealed that some nurses were falsely documenting for the administration of the medication when it was not available, never sent from the pharmacy and it was not kept in a back-up supply of medications. There was no documented evidence of *Ex Order 26. 4B1*, monitoring of side effects for omitted dosage, or an alternate *Ex Order 26. 4B1* or other intervention discussed with the Physician as a means to prevent rebound Ex Order 26. 4B1. The facility's failure to ensure all residents who had physician orders for *Ex Order 26. 4B1* were administered the doses as ordered or otherwise received the necessary follow-up and communication with the Physician, and the failure to implement ongoing monitoring for those residents for rebound Ex Order 26. 4B1 while Ex Order 26. 4B1 doses of those medications over periods of time	F 760	diagnosis and seizure medications All residents with seizure diagnosis were given monitoring orders and precautions put in place. All seizure medications for these residents were reconciled as well. DON, ADON, and other designees will perform daily audits for two weeks and then weekly for three months and will report quarterly on all residents with seizure medications to ensure medication is available to be administered. Nurses were re-educated on identifying medications that are running low and how and when to reorder the medications. Nurses were also educated on the process of informing physicians of medications needing prescriptions and following through until the medications are in the facility. Seizure medications were added to the back up and is available on demand. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ New admission medication list will be audited daily by DON, ADON, or Designee for 2 weeks and weekly for three months and quarterly thereafter. Chart checks will be audited weekly for three months and monthly up to six months and quarterly thereafter to reconcile any new seizure medication orders. All residents with a seizure diagnosis will have precautions and monitoring put in place. ¿ DON or ADON or Designee will audit MAR and declination sheets of controlled seizure medications to ensure residents are free of errors daily for two weeks then	

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F 760	Continued From page 32 were being omitted, posed a serious and immediate threat for adverse effects, including various [redacted] types which is likely to result in serious harm, impairment, or even death. This resulted in an Immediate Jeopardy (IJ) situation that began on 1/31/22. The facility Administration was notified of the IJ on 3/4/22 at 2:44 PM. The facility submitted an acceptable written Removal Plan (RP) on 3/4/22 at 5:25 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 3/7/22. The non-compliance remained on 3/6/22 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The evidence was as follows: A review of the Manufacturer specifications for the anti-seizure medication and controlled drug VIMPAT included, Highlights of Prescribing Information: WARNINGS AND PRECAUTIONS... "VIMPAT should be gradually withdrawn to minimize the potential of increased seizure frequency."... "5.5 Withdrawal of Antiepileptic Drugs (AEDs) As with all AEDs, VIMPAT should be withdrawn gradually (over a minimum of 1 week) to minimize the potential of increased seizure frequency in patients with seizure disorders." A review of the Manufacturer specifications for the anti-seizure medication, Keppra included, "Antiepileptic drugs, including KEPPRA, should be withdrawn gradually to minimize the potential of increased seizure frequency."	F 760	monthly then quarterly thereafter. ¿ DON and ADON educated all nurses on the importance of contacting the Doctor for Narcotic scripts and to contact the Medical director in a scenario where the Physician can not be reached after 2 hours. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ DON will bring New admission audits to a Quality assurance meeting monthly for three months and quarterly thereafter to review the results and progress made from the audits. ¿ The DON or designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	

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F 760	Continued From page 33 1. On 2/23/22 at 10:59 AM, the surveyor observed Resident #163 with his/her eyes closed in bed, appearing to be asleep. The surveyor observed that the bed was positioned low, floor mats were on both sides of the bed, and the resident was [redacted] NJ Exec. Order 26:4.b.1 . The next day on 2/24/22 at 9:56 AM, the surveyor observed the resident with their eyes closed in a bed positioned low with floor mats on either side on the bed. The surveyor observed that the resident was [redacted] NJ Exec. Order 26:4.b.1 but it was placed on a nightstand next to the bed. The surveyor observed that the resident had a bandage applied to the right side of the [redacted] Ex Order 26. 4B1 . On 2/25/22 at 11:43 AM, the surveyor observed the resident with his/her eyes closed in bed appearing to be asleep. The bed was in the low position with floor mats on either side of the bed. The surveyor observed that the resident was [redacted] and there was still bandage to the right side of the [redacted] Ex Order 26. 4B1 . The surveyor reviewed the medical record for Resident #163. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility on [redacted] following a [redacted] Ex Order 26. 4B1 . Diagnoses included [redacted] Ex Order 26. 4B1 .	F 760		

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F 760	Continued From page 34 The surveyor reviewed the Ex Order 26. 4B1 records for Resident #163 prior to the resident's admission to the facility which revealed the following: A review of the Neurosurgery Health and Physical Noted dated Ex Order 26. 4B1 included that the [resident] has a past history of *Ex Order 26. 4B1* on Ex Order 26. 4B1 and was sent to the *Ex Order 26. 4B1* . The [resident] had a right *Ex Order 26. 4B1* from a previous fall and had a computed *Ex Order 26. 4B1* which revealed an enlargement of the Ex Order 26. 4B1; the *Ex Order 26. 4B1* was consulted for possible intervention. A review of a Nursing Note dated Ex Order 26. 4B1 at 5:49 AM, reflected that the [resident] was found sitting on the floor in the room with a *Ex Order 26. 4B1* to the right side of the Ex Order 26 and Ex Order 26. 4 on the floor. The [resident] could not recall what happened, and a *Ex Order 26. 4B1* were ordered. A review of a Nursing Note dated Ex Order 26. 4B1 at 1:50 PM, reflected that the [resident] had *Ex Order 26. 4B1* at the bedside. A review of a Nursing Note dated Ex Order 26. 4B1 at 8:15 AM reflected that at 6:21 AM, the [resident] started NJ Exec. Order 26:4.b.1 was rechecked, and vital signs were taken. At 6:45 AM, laboratory tests were drawn, and the physician ordered Ex Order 26. 4B1 ; the first bag was hung [via the *Ex Order 26. 4B1*]. A review of a Nursing Note dated 1/22/22 at 10:00	F 760		

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F 760	Continued From page 35 PM reflected that the resident had [redacted] and [redacted] every two hours. A review of a Nursing Note dated [redacted] at 8:05 AM, reflected that the resident had video [redacted] monitoring in progress with no observed [redacted] activity during the shift. A review of the [redacted] medications included the following [redacted]: 1. [redacted] by [redacted] two times a day. Maximum daily dose [redacted]. 2. [redacted] tablet; give [redacted] by [redacted] two times a day. 3. [redacted] oral liquid; give [redacted] by [redacted] two times a day. The surveyor continued to review the facility's medical record for Resident #163 upon admission to the facility on [redacted]. A review of the Progress Notes reflected an Admission Progress Note dated [redacted] at 7:37 PM, which included that the resident was newly admitted to the facility from the [redacted] with slurred speech and [redacted] with an admission diagnosis of [redacted]	F 760		

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Ex Order 26. 4B1 [redacted]. The resident was admitted for Ex Order 26. 4B1 [redacted] with Ex Order 26. 4B1 to [his/her] Ex Order 26. 4B1 [redacted] and NJ Exec. Order 26:4.b.1 out of bed.

A review of the admission Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1 [redacted], reflected a Ex Order 26. 4B1 [redacted] score could not be determined, so staff conducted a cognitive assessment for the resident which determined that the resident had a Ex Order 26. 4B1 [redacted]

A review of the resident's individualized comprehensive Care Plan reflected a focus area initiated on Ex Order 26. 4B1 [redacted] that the resident was at the facility for a short term stay with a goal to discharge to the community upon completion of Ex Order 26. 4B1 [redacted]. A further review reflected a focus area for Ex Order 26. 4B1 initiated on Ex Order 26. 4B1 [redacted] due to a history of Ex Order 26. 4B1 [redacted], which was evacuated status post Ex Order 26. 4B1 [redacted]. The goal was to remain free of injuries related to Ex Order 26. 4B1 during the facility stay. Interventions included to "give medications as ordered, and monitor/document for effectiveness and side effects; nurse will obtain and monitor laboratory/diagnostic work as ordered; and Ex Order 26. 4B1 [redacted]: do not leave alone during Ex Order 26. 4B1 [redacted], protect from injury if out of bed help to the floor to prevent injury, remove or loosen tight clothing, don't attempt to restrain during a Ex Order 26. 4B1 as this could make NJ Exec. Order 26:4.b.1 more severe, protect from onlookers, draw curtain, etc." (etcetera; and the rest).

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F 760	Continued From page 37 A review of the current physician Order Summary Report reflected the following physician's order (PO) for Ex Order 26. 4B1 : 1. A PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 ; give Ex Order 26. 4B1 via Ex Ord two times a day related to Ex Order 26. 4B1 . 2. A PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 ; give Ex Order 26. 4B1 via Ex Ord two times a day related to traumatic Ex Order 26. 4B1 . The Order Summary Report did not include a PO for the Ex Order 26. 4B1 tablets in accordance with the Ex Order 26. 4B1 discharge medication list. A review of the Medication Administration Record (MAR) for Ex Order 26. 4B1 reflected the following for order for the Ex Order 26. 4B1 : A PO dated Ex Order 26. 4B1 and discontinued Ex Order 26. 4B1 at 2:28 PM, for Ex Order 26. 4B1 ; give Ex Order 26. 4B1 via Ex Ord two times a day. The nurses signed that the resident allegedly received the Ex Order 26. 4B1 on Ex Order 26. 4B1 at 9:00 PM and Ex Order 26. 4B1 at 9:00 AM. A review of the corresponding MAR for PO dated Ex Order 26. 4B1 reflected that from Ex Order 26. 4B1 at 9:00 PM through the Ex Order 26. 4B1 at 9:00 PM dose, the nurses signed a code "Ex ", which indicated the medication was not given and "other/see Nurse Notes." The same MAR reflected that the resident allegedly received the next doses of Ex Order 26. 4B1 beginning on Ex Order 26. 4B1 at 9:00 AM. A review of the corresponding electronic Progress Notes (PN) for the above dates reflected the following Nurse Notes (NN): For the Ex Order 26. 4B1 at 9:00 PM - NN at 9:07 PM that Pharmacy call, awaiting prescription delivery and Physician #1 made aware. For the Ex Order 26. 4B1 at 9:00 AM - NN at 3:06 PM that needs a prescription.	F 760		

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F 760	Continued From page 38 For the [Ex Order 26. 4B1] at 9:00 PM - NN at 10:29 PM awaiting delivery. For the [Ex Order 26. 4B1] at 9:00 AM - NN at 11:44 AM called Physician #1's office for a prescription. For the [Ex Order 26. 4B1] at 9:00 PM - NN at 10:47 PM with no additional information. For the [Ex Order 26. 4B1] at 9:00 AM - NN at 1:57 PM with no additional information. For the [Ex Order 26. 4B1] at 9:00 PM - NN at 10:56 PM, that medication ordered will administer upon delivery. For the [Ex Order 26. 4B1] at 9:00 AM - NN at 1:49 PM that medication not administered, and Pharmacy called. For the [Ex Order 26. 4B1] at 9:00 PM - NN at 11:05 PM awaiting a prescription. For the [Ex Order 26. 4B1] at 9:00 AM - no NN or additional information. For the [Ex Order 26. 4B1] at 9:00 PM - NN at 9:35 PM awaiting a prescription. For the [Ex Order 26. 4B1] at 9:00 AM - NN at 7:24 PM, no additional information. For the [Ex Order 26. 4B1] at 9:00 PM - NN at 10:13 PM, no additional information For the [Ex Order 26. 4B1] at 9:00 AM - NN at 12:01 PM that Physician #1 needs to send a prescription. An additional NN at 2:50 PM that Physician #1 was called due to needing a prescription and awaiting a callback. The NN further indicated that helmet must be worn at all times. For the [Ex Order 26. 4B1] at 9:00 PM - NN at 10:58 PM for awaiting delivery. There was no documentation that the resident was being monitored for *Ex Order 26. 4B1* or monitored for side effects of missing dosages of *Ex Order 26. 4B1* or that the Medical Director was notified in an effort to promptly communicate with a physician, when Physician #1 was not available.	F 760		

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F 760	Continued From page 39 A review of the Individual Patient Controlled Substance Administration Record (a declining inventory record used for the accountability of controlled drugs) reflected that Ex Order 26. 4B1 was filled on Ex Order 26. 4B1 and received by the facility on Ex Order 26. 4B1. The sheet reflected the first documented dose was on Ex Order 26. 4B1 (not on Ex Order 26. 4B1 at 9 AM as the MAR was allegedly signed). The time was not recorded when the Ex Order 26. 4B1 was administered on Ex Order 26. 4B1 and there was no balance remaining documented. The declining inventory record revealed there was only one dose removed from inventory on Ex Order 26. 4B1 and not two doses in accordance with the physician's order, but the MAR for Ex Order 26. 4B1 was signed to reflect the resident received two doses on Ex Order 26. 4B1, one at 9 AM and the second at 9 PM and again on Ex Order 26. 4B1 at 9 AM and 9 PM. The Individual Patient Controlled Substance Administration Record further reflected that the next dose that was signed out was on Ex Order 26. 4B1 for Ex Order 26. 4B1. The space to record the time of removal was left blank, and the balance remaining was also left blank. The third time the medication was removed from inventory was Ex Order 26. 4B1 at 9:00 AM for Ex Order 26. 4B1 for a remaining balance of Ex Order 26. 4B1. (This revealed that even when the facility had the medication available for the resident on Ex Order 26. 4B1, the resident only received one dose on Ex Order 26. 4B1, instead of the two doses daily as ordered). On 3/3/22 at 12:09 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), DON, Assistant Director of Nursing (ADON), and Corporate Nurse and requested for additional information regarding the blanks on the Individual Patient Controlled Substance Administration Record for the Ex Order 26. 4B1 delivered on	F 760		

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Ex Order 26. 4B1.

On 3/4/22 at 10:12 AM, the LNHA stated in the presence of the DON, ADON, Corporate Nurse, and the survey team, that the facility completed an audit upon surveyor inquiry of the Individual Patient Controlled Substance Administration Record for the Ex Order 26. 4B1 received on Ex Order 26. 4B1, which revealed that the dose signed out on Ex Order 26. 4B1 with no recorded time and the Ex Order 26. 4B1 dose removed with the no recorded time were both signed by the evening nurses who gave the 9:00 PM doses. The LNHA stated that the nurses allegedly administered the Ex Order 26. 4B1 at 9:00 AM and Ex Order 26. 4B1 at 9:00 AM, but they forgot to document it on the Controlled Substance Administration Record. (There was no explanation as to why the remaining balance would indicate Ex Order 26. 4B1 total on Ex Order 26. 4B1 at 9 AM, which reflected only Ex Order 26. 4B1 was removed, instead if the resident received those doses then it should have have reflected Ex Order 26. 4B1 total was removed with a balance of Ex Order 26. 4B1 remaining as of Ex Order 26. 4B1 at 9 AM).

On 3/4/22 at 11:22 PM, the surveyor reviewed with the LNHA and the DON the Progress Notes written from Ex Order 26. 4B1 regarding the Ex Order 26. 4B1 and the conflicting documentation of waiting for the Pharmacy to deliver the medication and waiting on the prescription. The LNHA responded that he thought "poor verbiage by the nurse was waiting for a prescription and not delivery."

At this time, the surveyor reviewed the Ex Order 26. 4B1 MAR for Ex Order 26. 4B1 with the LNHA and DON, which reflected that the nurses signed that the resident allegedly received Ex Order 26. 4B1 on Ex Order 26. 4B1 at 9:00 PM, Ex Order 26. 4B1 at 9:00 AM, Ex Order 26. 4B1 at 9:00 AM

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and 9:00 PM (which did not correspond with any declining inventory logs and the availability of the medication from the Pharmacy Provider). The DON stated that the resident did not receive those doses because the facility did not have the [redacted] until [redacted] at 4:30 AM. The DON also confirmed that the facility did not have Vimpat in their emergency back-up supply of controlled medications. The LNHA stated that the [redacted] was included in the resident's admission PO, and the facility was unable to reach Physician #1 to obtain a prescription for the [redacted]. When asked what the nurse should do in a situation where they cannot contact the physician, the LNHA stated that they should try to contact another Physician, including the Medical Director. When asked if any adverse reactions could occur from not receiving the [redacted], the DON responded that it was an *Ex Order 26. 4B1* that was being administered to the resident for a *Ex Order 26. 4B1*. The DON confirmed that a person could have a [redacted] without observed physical activity or if staff were not present but stated that the resident had no observed *Ex Order 26. 4B1*. When asked if the resident was placed on one-to-one supervision during this time, the DON responded no and acknowledged that the resident could have had an unobserved [redacted], and delaying treatment or suddenly stopping an *Ex Order 26. 4B1* could trigger an adverse reaction or rebound [redacted].

On 3/4/22 at 12:48 PM, the surveyor interviewed the resident's Registered Nurse (RN #1), who stated that the process for residents with [redacted] was to make sure side rails were padded, the head of the bed was elevated for safety, and make sure they have their *Ex Order 26. 4B1* as

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F 760	Continued From page 42 prescribed. RN #1 stated that residents who did not receive their [redacted] could relapse and have a rebound [redacted], and a resident could have a [redacted] without anyone knowing. RN #1 stated that there was no specific monitoring for residents with [redacted], such as monitoring/checks at a certain time. RN #1 stated that Resident #163 was never observed out of bed or by the Nurse's Station that the resident always remained in bed. RN #1 stated that if you could not get in touch with the physician for a prescription, she would have to let the Supervisor know, and she confirmed that there were times she could not get in touch with the physician and told the Supervisor. On 3/4/22 at 12:50 PM, the surveyor attempted to call Physician #1 via telephone with no response and a voice message system that indicated that the call was missed or "do not want to speak with you." On 3/4/22 at 12:55 PM, the surveyor confirmed Physician #1's phone number as dialed with the DON. The DON stated that since she had been at the facility, she had yet to meet Physician #1. The surveyor asked who transcribed and reconciled the resident's admission physician's orders, and the DON responded that she did. On 3/4/22 at 12:57 PM, the surveyor team reviewed the resident's discharge PO from the hospital with the DON. The DON stated that the check next to the medication indicated that the physician wanted to continue with the medication and that she verified that the medication was in the computer. The surveyor showed the DON the checkmark next to the [redacted] order, and the DON confirmed that the [redacted] was ordered	F 760		

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based on her documentation. At this time, the surveyor showed the DON the Ex Order 26. 4B1 MAR and asked her to find where the Ex Order 26. 4B1 was transcribed for nurses to know it needed to be administered. The DON confirmed that the Ex Order 26. 4B1 was not appearing on the MAR nor was it administered, and she would need to look into why. When asked if she would document if a Physician would not want to continue on a specific medication for the Ex Order 26. 4B1 medication list such as Ex Order 26. 4B1 or other Ex Order 26. 4B1 drug, the DON stated "no." When asked if she entered an order for the medication directly into the electronic medical record at the time when reviewing the medication with the physician, the DON stated "no."

The surveyor continued to review the resident's medical record.

A review of the Physician's Progress Notes revealed that the Nurse Practitioner saw the resident for the first time on Ex Order 26. 4B1 (7 days after the Ex Order 26. 4B1 had been delivered on Ex Order 26. 4B1) and there was no documentation regarding the omitted doses of Ex Order 26. 4B1 or why Ex Order 26. 4B1 was not reordered. The Nurse Practitioner also saw the resident on Ex Order 26. 4B1 and she again did not address the omitted doses of the Ex Order 26. 4B1 or the plan regarding monitoring the resident's Ex Order 26. 4B1 activity including obtaining Ex Order 26. 4B1 labs if doses were omitted. There was no documentation that the resident was seen by Physician #1 or their Nurse Practitioner within the forty-eight hours of admission.

A review of the resident's Admitting Evaluation History which was completed on Ex Order 26. 4B1 and signed (illegibly) where indicated "Signature of

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F 760	Continued From page 44 Physician," which reflected that the resident was admitted post status Ex Order 26. 4B1 post fall with a history of Ex Order 26. 4B1. A review of the PN reflected a NN dated Ex Order 26. 4B1 at 8:09 PM, that the resident was noted with Ex Order 26. 4B1, coughing and congested, noted with difficulty breathing. Upon Ex Order 26. 4B1, wheezing was noted to left Ex Order 26. 4B1. The physician was made aware and ordered to be transferred to the Ex Order 26. 4B1 for evaluation. A NN dated Ex Order 26. 4B1 at 3:32 AM reflected that the resident was admitted to the Ex Order 26. 4B1 with the diagnoses of Ex Order 26. 4B1. There was no documentation of Ex Order 26. 4B1 or increased Ex Order 26. 4B1 specifically during the time in which there were omitted doses of Ex Order 26. 4B1, and there was no documentation as to why Ex Order 26. 4B1 was not ordered and no evidence that Ex Order 26. 4B1 laboratory tests were ordered for the resident's Ex Order 26. 4B1 levels. On 3/4/22 at 1:15 PM, the surveyor attempted to interview the Nurse Practitioner via telephone but there was no response. The surveyor left a message to call back. On 3/4/22 at 1:16 PM, the surveyor attempted to interview the facility's Provider Pharmacy Representative (PPR) via telephone with no response. The surveyor was unable to leave a message because the mailbox was full.	F 760		

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F 760	Continued From page 45 On 3/4/22 at 1:19 PM, the surveyor attempted to interview the Medical Director via telephone with no response. The surveyor left a message to call back. On 3/4/22 at 1:25 PM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone, who confirmed that the manufacturer recommended that Ex Order 26. 4B1 was weaned off and not abruptly stopped. The CP acknowledged that there are various Ex Order 26. 4B1 types that may not be visible to another person. The facility's failure to ensure all residents who had physician orders for *Ex Order 26. 4B1* were administered the doses as ordered or otherwise received the necessary follow-up and communication with the Physician, and the failure to implement ongoing monitoring for those residents for rebound Ex Order 26. 4B1 while Ex Order 26. 4B1 doses of those medications over periods of time were being omitted, posed a serious and immediate threat for adverse effects, including various Ex Order 26. 4B1 types which is likely to result in serious harm, impairment, or even death. This resulted in an Immediate Jeopardy situation. The IJ was identified on 3/4/22, and the LNHA, DON, ADON, and Regional Administrator were notified of the IJ at 2:44 PM. An acceptable written Removal Plan was accepted on 3/5/22 which included identifying all residents with *Ex Order 26. 4B1* ; audit of charts for residents with *Ex Order 26. 4B1* to ensure accuracy of medication reconciliation, availability of Ex Order 26. 4B1 [redacted], omitted doses, and timeliness of administration; staff in-serviced on Ex Order 26. 4B1 [redacted]; monitoring for *Ex Order 26. 4B1*; and	F 760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 46 reconciling of Ex Order 26. 4B1 medications. On 3/7/22 at 9:15 AM, the surveyor interviewed Resident #163's Representative (RR) via telephone, who confirmed that the resident was still in the Ex Order 26. 4B1. The RR stated that the resident had Ex Order 26. 4B1 for the past three years and has been on two to three Ex Order 26. 4B1 for the past few years. The RR could not recall which Ex Order 26. 4B1 the resident had been taking. The RR stated that he/she visited the resident while at the facility, and the resident was always in their room in bed during those visits. On 3/7/22 at 2:48 PM, the surveyor interviewed the Provider Pharmacy Representative (PPR) via telephone, who stated that the facility received medication deliveries twice a day with a delivery that leaves the Pharmacy at noon and midnight. The PPR stated that if the facility ordered new medications, the cutoff time was 10:00 AM for noon deliveries, and all refill medication was delivered at midnight. The facility could also order a STAT or emergency order that the facility paid an additional fee for but received the medication within four hours. The PPR stated that the prescription was entered into the facility's [electronic medical system] for controlled medications. The prescription was faxed to the Pharmacy; the physician could send an electronic prescription directly to the Pharmacy; or the physician can call a three-day supply directly into the Pharmacy. The PPR stated that medications were generally not delayed from the Pharmacy unless the facility missed the order cutoff time or the order needed to be clarified. At this time, the surveyor requested a timeline regarding Resident #163's Ex Order 26. 4B1 for Ex Order 26. 4B1	F 760		

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F 760	Continued From page 47 Ex Order 26. [redacted].	F 760		

On 3/7/22 at 4:49 PM, the PPR emailed the surveyor the following timeline regarding Resident #163's Ex Order 26. 4B1: The resident was admitted to the facility on Ex Order 26. 4B1, and the facility did not fax the order from the [electronic medical system] the day the [resident] was admitted. All Ex Order 26. 4B1 [redacted] must be printed out from [electronic medical system] and faxed to the Pharmacy. Customer Service received a phone call from the facility on Ex Order 26. 4B1. Please see attachment. (*nurse will follow-up with physician for prescription)
On Ex Order 26. 4B1, physician wrote the wrong strength; instead of Ex Order 26. 4B1 wrote Ex Order 26. 4B1 on Ex Order 26. 4B1.
On Ex Order 26. 4B1, Pharmacy sent clarification to the physician and the facility.
On Ex Order 26. 4B1, Pharmacy sent blank Ex Order 26. 4B1 to Physician's office.
On Ex Order 26. 4B1, Pharmacy paged the physician and left a voice message.
On Ex Order 26. 4B1, Pharmacy reached out to the physician's office and faxed Ex Order 26. 4B1.
On Ex Order 26. 4B1, the physician corrected Ex Order 26. 4B1 to read Ex Order 26. 4B1 and was faxed to Pharmacy.
On Ex Order 26. 4B1, medication was sent to the facility on Midnight delivery.

On 3/8/22 at 9:56 AM, the surveyor interviewed the Medical Director via telephone, who stated that his role was to ensure compliance was met and attended quarterly meetings. The Medical Director stated that he was at the facility almost daily and was available 24-hours a day for any issues. The Medical Director stated that he did not involve himself with other physician's residents and does not like to "interfere" with other Physicians. The Medical Director stated if

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F 760	Continued From page 48 the physician was not returning their calls to the facility, he would expect to be notified. The Medical Director stated that for a prescription for a controlled substance, he preferred that the resident's physician wrote their own prescription. The Medical Director stated that if the facility was trying to contact the physician for several days with no response, he would then write a prescription for the resident for a few days. When asked how many days were acceptable for the resident to wait for their medications, the Medical Director stated that there is no answer. The surveyor reviewed the resident's Ex Order 26. 4B1 records from their staying beginning on Ex Order 26. 4B1. A review of the physician's orders revealed on Ex Order 26. 4B1 at 10:00 AM, Ex Order 26. 4B1 liquid two times a day was ordered. A review of a Neurology Consultation Final Report dated Ex Order 26. 4B1 included that at the present time, Ex Order 26. 4B1 evaluation is limited; I would suggest having a Ex Order 26. 4B1 of the head to evaluate for any Ex Order 26. 4B1 ; I would suggest having routine Ex Order 26 ...[he/she] has a history of Ex Order 26. 4B1, treated with Ex Order 26. 4B1; I would suggest having blood work for Ex Order 26. 4B1 level...further management will be determined on above-mentioned test results. A review of a Video Ex Order 26. 4B1 Report included on date of study dated Ex Order 26. 4B1 from 7:00 AM to Ex Order 26. 4B1 7:00 AM, that Ex Order 26. 4B1. The above findings are c/w [consistent with] Ex Order 26. 4B1 status with Ex Order 26. 4B1	F 760		

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F 760	Continued From page 49	F 760		

Ex Order 26. 4B1
Further adjustment of *Ex Order 26. 4B1* is recommended.

During the sample expansion of reviewing residents receiving *Ex Order 26. 4B1* on *Ex Order 26. 4B1*, the survey team identified a second resident (Resident #27) who did not receive their *Ex Order 26. 4B1* for a prolonged period of time because it was not available. The findings were as follows:

2. On 3/7/22 at 10:32 AM, the surveyor observed Resident #27 in bed with *Ex Order 26. 4B1* being administered via a *Ex Order 26. 4B1*. The resident was unable to be interviewed.

The surveyor reviewed the medical record for Resident #27.

A review of the Admission Record reflected that the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included other *Ex Order 26. 4B1*

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A review of the most recent quarterly MDS dated *Ex Order 26. 4B1* reflected a *Ex Order 26. 4* score was unable to be determined. The resident had *Ex Order 26. 4B1*

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F 760	Continued From page 50	F 760		

Ex Order 26. 4B1 .

A review of the individualized person-centered Care Plan included a focused area initiated Ex Order 26. 4B1 for Ex Order 26. 4B1. Interventions included to give Ex Order 26. 4B1 as ordered by doctor, monitor/document for effectiveness and side effects; identify the presence/absence of Ex Order 26. 4B1 upon admission; nursing staff to modify room environment to enhance safety; keeping bedat its lowest position, padded side rails, and frequent monitoring; and Ex Order 26. 4B1 : padded Ex Order 26. 4B1 rails for safety; do not leave alone during a Ex Order 26. 4B1; protect from injury if out of bed help to the floor to prevent injury, remove or loosen tight clothing, don't attempt to restrain during a Ex Order 26. 4B1 as this could make convulsions more severe, protect from onlookers, draw curtain, etc.

A review of the active Order Summary Report reflected the following physician's orders (PO):
A PO dated Ex Order 26. 4B1, for Ex Order 26. 4B1 tablet; give one tablet via Ex Ord every twelve hours for Ex Order 26. 4B1.
A PO dated Ex Order 26. 4B1 to maintain Ex Order 26. 4B1 at all times every shift.

A review of the Individual Patient Controlled Substance Administration Record for Ex Order 26. 4B1 tablet indicated that on Ex Order 26. 4B1, 28 tablets were delivered to the facility. The first dose was removed from inventory on Ex Order 26. 4B1 at an illegible time, and the last dose was taken from inventory on Ex Order 26. 4B1 at 10:34 AM.

A review of another Individual Patient Controlled Substance Administration Record for Ex Order 26. 4B1

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F 760	Continued From page 51 [redacted] tablet indicated on [redacted], four (4) tablets were delivered to the facility. The first dose from this stock was removed from inventory on [redacted] at 9:55 AM, and the last dose was signed as removed on on [redacted] at 10:00 PM. A review of a third Individual Patient Controlled Substance Administration Record for [redacted] tablets, indicated on [redacted], 30 tablets were delivered to the facility. The first dose was removed from active inventory on [redacted] at 9:00 AM, and the last dose was removed from active inventory on [redacted] at an illegible time. There were no Individual Patient Control Substance Administration Records for [redacted] to reflect [redacted] was available or removed from an active inventory stock for the period of time from [redacted] at 9:00 PM through [redacted] at 9:00 PM, [redacted] at 9:00 AM, and [redacted] at 9:00 PM. A review of the corresponding *Ex Order 26. 4B1* MAR reflected that the nurse signed that the medication was administered on [redacted] for the 9:00 PM dose of *Ex Order 26. 4B1* but the declining inventory record did not correspond that a dose was available to administer. A review of the corresponding *Ex Order 26. 4B1* MAR reflected the following: On [redacted] at 9:00 AM and 9:00 PM; [redacted] at 9:00 AM; [redacted] at 9:00 AM; [redacted] at 9:00 PM; [redacted] at 9:00 AM and 9:00 PM; and [redacted] at 9:00 AM, *Ex Order 26. 4B1* was signed by the nurse as administered, but the declining inventory sheets for the [redacted] did not reflect that it was available to administer.	F 760		

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F 760	Continued From page 52 On [redacted] at 9:00 PM; [redacted] at 9:00 AM and 9:00 PM; [redacted] at 9:00 PM; [redacted] at 9:00 AM and 9:00 PM; [redacted] at 9:00 AM; and [redacted] at 9:00 PM, the nurse signed the code "[redacted]" which indicated "other/see Nurse Notes." A review of the corresponding electronic Progress Notes (PN) for the above dates reflected the following Nurse Notes (NN): For the [redacted] at 9:00 PM - no additional information. For the [redacted] at 9:00 AM - NN at 9:44 AM indicating awaiting prescription. For the [redacted] at 9:00 PM - NN at 11:00 PM indicating awaiting delivery. For the [redacted] at 9:00 PM - NN at 11:39 PM indicating awaiting delivery. For the [redacted] at 9:00 AM - NN at 4:09 PM indicating will administer upon delivery. For the [redacted] at 9:00 PM - NN at 9:11 PM indicating medication on order. For the [redacted] at 9:00 AM - no additional information. For the [redacted] at 9:00 PM - NN dated created date [redacted] at 4:46 PM effective date [redacted] at 11:43 PM, that Pharmacy was called for medication delivery and medication will be delivered within the next delivery. The physician was called and made aware. No *Ex Order 26. 4B1* was observed. During this period, there was no documented evidence that the resident had additional [redacted] monitoring, monitoring for side effects of omitted dosage, the physician was made aware, and the Resident's Representative was made aware of the missing medication.	F 760		

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F 760	Continued From page 53	F 760		

A further review of the Ex Order 26. 4B1 MAR reflected on Ex Order 26. 4B1 at 9:00 AM and 9:00 PM, the nurse, indicated a code for "Ex" (hold/see Nurse Notes) for the Ex Order 26. 4B1 tablet administration.

A review of the corresponding PN reflected the following NN:
For the Ex Order 26. 4B1 at 9:00 AM - NN at 12:09 PM included no additional information.
For the Ex Order 26. 4B1 at 9:00 PM - NN at 11:46 PM included no additional information.

During this period, there was no documented evidence that the resident had additional Ex Order 26. 4B1 , monitoring for side effects of missed dosage, the physician was made aware, and the Resident's Representative was made aware of the missing medication.

A review of the Ex Order 26. 4B1 Treatment Administration Record (TAR) reflected that on Ex Order 26. 4B1 during the day shift (7:00 AM to 3:00 PM), the nurse did not sign that Ex Order 26. 4B1 were maintained at all times during that shift.

On 3/7/22 at 10:57 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1), who stated that she was recently in-serviced by the facility on Ex Order 26. 4B1 which were to verify bed in the lowest position and Ex Order 26. 4B1 rails were in the up position. The LPN stated that nurses documented this on the TAR.

On 3/7/22 at 10:38 AM, the surveyor interviewed LPN #2, who stated that she was Agency staff, and this was her second day at the facility. The LPN stated that she was in-serviced on Ex Order 26. 4B1 which were to make sure the resident

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F 760	Continued From page 54 was positioned on their side, padded side rails were in the up position at all times, floor mats on the side of the bed, bed in the lowest position, and if the resident was having a [redacted] to ensure they were in a safe position. On 3/7/22 at 11:20 AM, the surveyor interviewed the DON, who defined the [redacted] the nurses were signing for to be the bed in the lowest position and side rails in the up position when in bed. On 3/7/22 at 2:07 PM, the surveyor interviewed the LNHA and DON regarding the resident's Individual Patient Controlled Substance Administration Record for [redacted] and the MAR from [redacted] at 9:00 PM through [redacted] at 9:00 PM. The LNHA responded that the facility also identified the discrepancies for the resident's [redacted] during their audit for the IJ RP. When asked what the conclusion from the audit, the LNHA and DON both acknowledged that they personally did not participate in the resident's audit, but that the Corporate Nurse conducted Resident #27's audit. On 3/7/22 at 2:18 PM, the surveyor interviewed the Corporate Nurse in the presence of the LNHA and DON, who stated that her audit entailed looking at the resident's [redacted], specifically [redacted], adding [redacted] precautions, updating the Care Plan, reviewing the MAR for the past three months for omissions and noted any omissions. The Corporate Nurse stated that she observed discrepancies for Resident #27, including missing documentation in the NN, but she still needed to contact all the nurses involved. At this time, the surveyor requested an investigation for the resident's	F 760		

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F 760	Continued From page 55 Ex Order 26. 4B1 from Ex Order 26. 4B1 at 9:00 PM through Ex Order 26. 4B1 at 9:00 PM. On 3/7/22 at 2:48 PM, the surveyor interviewed the Provider Pharmacy Representative (PPR) via telephone, who stated that the facility received medication deliveries twice a day with a delivery that leaves the Pharmacy at noon and midnight. The PPR stated that if the facility ordered new medications, the cutoff time was 10:00 AM for noon deliveries, and all refill medication was delivered at midnight. The facility could also order a STAT or emergency order that the facility paid an additional fee for but received the medication within four hours. The PPR stated that for controlled medications, the prescription was entered into the facility's [electronic medical system], and the prescription was faxed to the Pharmacy; the physician could send an electronic prescription directly to the Pharmacy; or the physician can call a three-day supply directly into the Pharmacy. The PPR stated that medications were generally not delayed from the Pharmacy unless the facility missed the order cutoff time or the order needed to be clarified. At this time, the surveyor requested a timeline regarding Resident #27's Ex Order 26. 4B1 from Ex Order 26. 4B1 [redacted] until the present time. On 3/8/22 at 9:04 AM, the DON, in the presence of the LNHA, ADON, and the survey team, stated that for Ex Order 26. 4B1 for the 9:00 PM doses, RN #2 signed that medication was administered prior to checking the inventory. RN #2 confirmed that there was no Ex Order 26. 4B1, so they called the Pharmacy and forgot to document that the medication was not administered, and the Pharmacy was called. The DON stated that LPN	F 760		

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F 760	Continued From page 56 #3 stated that in error she signed that the [redacted] was administered on *Ex Order 26. 4B1* [redacted] at 9:00 AM that it was administered and forgot to document that the medication was not administered. The DON stated that LPN #4 confirmed that the [redacted] on [redacted] at 9:00 PM was clicked as administered in error, that the medication was not available and not given. The DON confirmed that the resident had not received [redacted] from [redacted] at 9:00 PM until the [redacted] at 9:00 AM; the Pharmacy provided four tablets which were administered to the resident on [redacted] at the 9:00 AM and 9:00 PM doses, and no [redacted] was administered from [redacted] at 9:00 AM until the [redacted] at 9:00 AM dose. On 3/8/22 at 9:33 AM, the surveyor interviewed LPN #3 via telephone, who stated that the resident received *Ex Order 26. 4B1* . The LPN #3 stated that there was a period in [redacted] that she could not recall the exact dates that the resident had no [redacted], and she accidentally signed that she had administered the medication in error. LPN #3 stated that if missing a medication, the nurse was supposed to call the Pharmacy to see if there was a refill available; if the Pharmacy needed a prescription, the nurse informed the Unit Manager, who contacted the physician. LPN #3 stated that she called the Pharmacy to inform them to send [redacted], but she forgot to document it. The LPN stated that the resident's Physician #2 did not have a Nurse Practitioner, and Physician #2 did not fax prescriptions, so the nurse had to wait for the physician to come to the facility for the prescription. LPN #3 stated that Physician #2 came once a week to the facility and would not stop at the facility just to bring a prescription no matter how many times you called him, so you	F 760		

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F 760	Continued From page 57 had to wait for the prescription. On 3/8/22 at 9:56 AM, the surveyor interviewed the Medical Director via telephone, who stated that his role was to ensure compliance was met and attended quarterly meetings. The Medical Director stated that he was at the facility almost daily as well as was available 24-hours a day for any issues. The Medical Director stated that he did not involve himself with other physician's residents and does not like to "interfere" with other Physicians. The Medical Director stated if the physician was not contacting the facility, he would expect to be notified. The Medical Director stated that for a prescription for a controlled substance, he preferred that the resident's physician wrote their own prescription. The Medical Director stated that if the facility was trying to contact the physician for several days with no response, he would then write a prescription for the resident for a few days. When asked how many days were acceptable for the resident to wait for their medications, the Medical Director stated that there is no answer. On 3/8/22 at 11:11 AM, the PPR emailed the surveyor the following timeline regarding Resident #27's [redacted]: On [redacted] at 10:03 PM, the Pharmacy received a refill request for [redacted]; the medication went out on the noon delivery on [redacted]. On [redacted] at 4:09 PM, the Pharmacy received a refill request for [redacted]; the resident only had a quantity of 4 tablets remaining for a two-day supply that went out on the midnight delivery on [redacted] and was received by the facility on [redacted]. On [redacted] at 1:18 PM, the Pharmacy received a prescription for [redacted]; medication went out on the midnight delivery on [redacted] and was	F 760		

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F 760	Continued From page 58 received by the facility on Ex Order 26. 4B1. On Ex Order 26. 4B1 at 3:03 PM, the Pharmacy received a phone call from nurse [name redacted] requesting a refill on Ex Order 26. 4B1; medication went out with the midnight delivery on Ex Order 26. 4B1 and was received by the facility on Ex Order 26. 4B1. The PPR had no documentation provided that the facility contacted them from *Ex Order 26. 4B1* and no documentation from the two-day supply received on *Ex Order 26. 4B1*. On 3/8/22 at 11:32 AM, the survey team informed the LNHA, Regional Administrator, DON, ADON, and Corporate DON regarding the Resident #27's omitted Ex Order 26. 4B1, and the failure to notify the Physician for an alternate intervention until it became available, and increase the monitoring for *Ex Order 26. 4B1* to ensure there were no rebound Ex Order 26. 4B1. The acknowledged that the nurses falsely documented in the MAR for several dates for the Administration of Ex Order 26. 4B1 and that this resident would be the second resident included in the Immediate Jeopardy. On 3/7/22 and continued on 3/8/22, the survey team verified the implementation of the facility's Removal Plan through observation, interview and review of the resident medical records. A review of the facility's "Physician Services" policy dated updated 6/2021 included that...the physician will: a. evaluate residents within 48 hours of admission to the facility; b. review the resident's total care program, including medications and treatments at each visit; c. write, sign and date progress notes at each visit; and d. sign and date all orders.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE WEST ORANGE, NJ 07052**

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F 760	Continued From page 59 A review of the facility's "Medication Transcription" policy dated updated 5/2021 included that ...all medication orders will be entered by nursing personnel into the patient's written POS [Physician's Order Sheet] in the chart and into MAR via the orders tab on [electronic medical system]. A copy of the prescriber's order will be electronically transmitted promptly to the pharmacy... all updates will be checked against the prescriber's orders (electronic and/or written). A review of the facility's "Controlled Drug Storage and Administration Policy" dated updated 5/2021 included that... controlled medication dose should be prepared based on the order in the Medication Administration Record; declining inventory sheet [Individual Patient Controlled Substance Administration Record] should be signed as the dose is prepared and reconciled with quantity on hand; immediately after administration, Medication Administration Record should be signed. A review of the facility's "Medical Director Roles and Responsibilities" dated 9/2021 included that... ensures coverage for medical emergencies...coordinates physician and Nurse Practitioner/Physician Assistant services...reviews practitioners quality of care and quality of documentation...reviews performance of consultants... NJAC 8:39-11.2(a)(c); 23.2(b); 27.1(a); 29.2(d)	F 760		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060714	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND C	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection control program had no other responsibilities as mandated by the State of New Jersey. This deficient practice was identified, and the findings were as followed: Reference: New Jersey Executive Directive 20-026 "Directive for the Resumption of Services in all Long-Term Care Facilities" dated 1/6/21, directs the following: "iv: Facilities with no	S 560	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION _____ _____ _____ The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory	4/14/22

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

Electronically Signed | 03/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060714	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND C	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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S 560	Continued From page 1 Ventilator Beds a. Facilities with 100 beds or more beds or on-site hemodialysis services must: 1.) Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to hiring no later than August 10, 2021." (*extended to February 1, 2022) On 2/23/22, the surveyor conducted entrance conference with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Assistant Director of Nursing (ADON). The surveyor asked who was responsible for the facility's infection control and prevention program, and the LNHA stated that the ADON was also the facility's Infection Preventionist (IP). The LNHA acknowledged that he was aware that the facility was required to have a designated full-time IP with no additional roles and that the facility needed to hire either a new ADON or a new IP. At this time, the ADON confirmed that she was the IP and had the required specialized training in infection control and continued education. On 3/1/22 at 9:00 AM, the surveyor interviewed the ADON who stated that her role as the ADON included to provide clinical support as far as admissions, physician's orders, ensuring Care Plans are completed, liaison with Physician and clinical aspects. The ADON stated that her role as the IP was to provide staff education and inservicing, auditing, antibiotic stewardship, and COVID-19 infection control and prevention. On 3/4/22 at 10:35 AM, the LNHA in the presence of the DON, ADON, Corporate Nurse, and survey team, acknowledged that the facility needed to	S 560	standard. S 560 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ Ads were placed in search for an Infection Preventionist and a recruiter contacted in search for an IP. 2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ Facility will place an ad out for an IP nurse and will reach out to a recruiter for assistance. Ads will be reviewed and candidates will be reached out to and interviewed if eligible weekly. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ Ads and resumes received will be monitored weekly by the administrator or designee until the position is filled. A weekly call by administrator or designee to a recruiter will be put in place to monitor	

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STRATFORD MANOR REHABILITATION AND C	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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S 560	Continued From page 2 hire a full-time ADON or IP in order for the facility to have a full-time one position IP. A review of the facility's "Position Title: Assistant Director of Nursing Services" included that the responsibilities were to: assists and participates in the development, organization and implementation of philosophy, objectives, policies, and procedures and standards of nursing care in accordance with the goals of Stratford Manor Care & Rehabilitation Center; Confers with the DON in assessing quality of nursing care being delivered and recognizes the need for improving or changing nursing practices; Assists with the development, direction, participation, and evaluation of the orientation program for nursing personnel; responsible for orientation of new nursing employees in the absence of the Director of staff Development; Makes daily rounds to evaluate resident care, the progress of individual employees, monitors nursing practices and assists personnel with nursing and educational needs... Assists with daily scheduling to ensure adequate and safe staffing necessary to deliver nursing services; keeps within predetermined par level staffing ratios; Acts as on-call nursing clinical resource person, as scheduled... Compiles end-of-month reports to be submitted to the DON...Acts as a liaison for residents, families, visitors and staff to resolve concerns and issues, always with the goal of resident satisfaction... A review of the facility's "Infection Preventionist" dated revised July 2016, included that the primary purpose of this position is to plan, organize, develop, coordinate, and direct our infection control program and its activities in accordance with current federal, state, and local standards, guidelines, and regulations that govern such	S 560	progress of our hiring process. ¿ Administrator or designee will bring findings to a quarterly Quality assurance meeting. Date of Compliance: 4/14/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 programs, and as may be directed by the Administrator and the Infection Prevention and Control Committee to ensure that an effective infection prevention and control program is maintained at all times... NJAC 8:39 5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315066 Y1	A. Building B. Wing Y2	5/4/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658	Correction	ID Prefix F0695	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	04/14/2022	LSC	04/14/2022	LSC	04/14/2022
ID Prefix F0756	Correction	ID Prefix F0760	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(2)	Completed	Reg. #	Completed
LSC	04/14/2022	LSC	04/14/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/8/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060714 Y1	A. Building B. Wing Y2	5/4/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/14/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/8/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING **01** B. WING _____	**03/08/2022**

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STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE** **WEST ORANGE, NJ 07052**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/01/22 and 03/02/22 and Stratford Manor Rehabilitation and Care Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Stratford Manor Rehabilitation and Care Center is a single (1) story, Type V Protected building that was built in January 1964. The facility is divided into 8 smoke zones.	K 000		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment.	K 341		4/14/22

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

Electronically Signed | 03/31/2022

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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K 341	Continued From page 1 Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide notification by audible and visible signals for 1 of 1 outside enclosed courtyard in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 3/1/22 starting at 9:45 AM, the surveyor with the facility's Regional Maintenance Director (RMD) and Director of Maintenance (DOM), conducted a tour of the facility. During the tour on 3/1/22 at 11:08 AM, an inspection of the outside fenced-in resident courtyard area was performed. The surveyor observed no evidence of an audio and visual (horn and strobe) alarm connected to the building's fire alarm and detection system to notify residents in the event of a fire alarm going on. At this time, the surveyor asked the RMD if the facility had a horn and strobe alarm out here to notify residents of a fire alarm going on. The RMD informed the surveyor that the facility had a new audio and visual alarm, but it was not hooked up.	K 341	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION _____ _____ _____ The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. K 341 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ A strobe light was installed in the closed patio area. 2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents have the potential to be affected by this deficient practice.	

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K 341	Continued From page 2 The findings were verified and confirmed by the RMD and DOM during the observations. The Licensed Nursing Home Administrator was informed of the findings during the Life Safety Code survey exit conference on 3/2/22 at 12:10 PM. Fire Safety Hazard. NJAC 8:39-31.2(a)	K 341	3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ A strobe light was installed in the closed patio. ¿ Fire Alarm Company will test the strobe light to ensure operability semiannually . 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Administrator or designee will review any findings of these tests and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351		4/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 3 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility provided documentation, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. This deficient practice was identified in 1 of 1 observed Resident Shower Area and was evidence by the following: Reference #1: N.J.A.C. 5:23 -Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2. During the entrance conference on 3/1/22 at 9:22 AM, the surveyor requested the Licensed Nursing Home Administrator (LANA) and Director of Maintenance (DOM) provide a copy of the facility	K 351	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION _____ _____ _____ The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. K 351 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ A sprinkler company was consulted to ensure compliance with NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1 (1) immediately. An additional sprinkler head was added to the affected area.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE** **WEST ORANGE, NJ 07052**

(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
K 351	Continued From page 4 lay-out which identified the various rooms and smoke compartments in the facility. Starting on 3/1/22 at 9:45 AM, the surveyor in the presence of the facility Regional Maintenance Director (RMD) and DOM conducted a building tour. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1. At 10:22 AM, an inspection of the Resident Shower Room next to Resident Room #20 was conducted. During the inspection, the surveyor observed no fire sprinkler coverage inside the 6' deep by 4' (six feet by four feet) wide shower stall area. The sprinkler in the room would not reach around a wall to cover the shower stall. A review of the facility provided lay-out identified that there were seven (7) resident sleeping rooms in that smoke compartment. The facility RMD and DOM confirmed the finding at the time of observation. The Licensed Nursing Home Administrator was informed of the findings during the Life Safety Code survey exit conference on 3/2/22 at 12:10 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	2. How you will identify other residents having the potential to be affected by the same deficient practice: ¿ All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ Sprinkler company was contacted to add a new sprinkler head to the affected area and an additional sprinkler head was installed. ¿ Administrator or designee will audit the building quarterly to ensure that this deficient practice will not recur. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Administrator or designee will review any findings of this audit and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/29/2022	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		4/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING **01** B. WING _____	**03/08/2022**

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K 355	Continued From page 5 inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation, it was determined that the facility failed to a.) perform and document on the tag attached to the fire extinguisher a monthly visual examination for 1 of 14 fire extinguishers and b.) maintain 2 of 14 portable fire extinguishers in proper working condition, as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. The evidence was as follows: Reference: NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguisher. Starting on 3/1/22 at 9:45 AM, the surveyor in the presence of the facility Regional Maintenance Director (RMD) and Director of Maintenance (DOM), conducted a tour of the facility. Along the tour, the surveyor inspected 14 portable fire extinguishers and observed the following: 1. At 10:33 AM, one class "K-Wet" chemical extinguisher located in the kitchen had the pressure indicating needle in the "RED" discharge zone on the gauge. The surveyor also observed on the tag attached to the extinguisher, that the	K 355	Stratford Manor Rehabilitation and Care Center PLAN OF CORRECTION _____ _____ _____ The facility is submitting this Plan of Correction in compliance with the law. Nothing in this Plan of Correction constitutes or shall be construed as an admission that the facility has failed to comply with any statutory or regulatory standard. K 355 1. What corrective actions(s) will be accomplished for those residents affected by the deficient practice ¿ All mentioned fire extinguishers were replaced. ¿ The Maintenance Director was in-serviced regarding proper fire extinguisher inspections and maintenance in accordance with NFPA 10 , Standard for Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10. 2. How you will identify other residents having the potential to be affected by the same deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 6 monthly visual examination was documented for 3/1/22. 2. At 10:39 AM, one ABC type fire extinguisher located in the Maintenance Office was last annually inspected April 2021, with no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for September 2021, October 2021, November 2021, December 2021, January 2022 and February 2022. At this time, the surveyor questioned the DOM if this was a spare fire extinguisher? The DOM responded, yes. 3. At 11:05 AM, an inspection inside the Explorers Room identified one ABC type fire extinguisher discharge handle was broken. This would not allow the fire extinguisher to function properly in the event of a fire. The facility RMD and DOM confirmed the finding at the time of observation. The Licensed Nursing Home Administrator was informed of the findings during the Life Safety Code survey exit conference on 3/2/22 at 12:10 PM. Fire Safety Hazard. NFPA 10 NJAC 8:39 -31.1 (c); 31.2 (e).	K 355	¿ All residents have the potential to be affected by this deficient practice. ¿ Rounds were done by the administrator and Maintenance Director to identify any issues. ¿ All fire extinguishers that do not meet regulatory standards will be replaced. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: ¿ Fire extinguishers will be audited monthly by the Maintenance Director including the spare fire extinguisher and signed for. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Administrator or designee will review any findings of these tests and present them quarterly with the QAPI committee to determine the frequency of future audits. Date of Compliance: 4/14/2022	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315066 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/4/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 04/14/2022	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 04/29/2022	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 04/14/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/8/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO