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	315187	A. BUILDING _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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E 000	Initial Comments Survey: 12/20/23 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		
F 000	INITIAL COMMENTS Complaint #: NJ00158413, NJ00159043, NJ00159091, NJ00157069, NJ00156915, NJ00155925, NJ00156539, NJ00159631 Survey Date: 12/20/2023 Census: 223 Sample: 56 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		1/15/24

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

Electronically Signed | 01/15/2024

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint NJ #:159091	F 580	1.Resident #431 experienced no negative	

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F 580	Continued From page 2 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to notify the resident's representative of a change in condition for 1 of 35 residents (Resident #431) reviewed. This deficient practice was evidence by the following: According to the Admission Record, Resident #431 was admitted to the facility with diagnoses which included, NJ EX Order. 264b1 [redacted] A review of the individualized Care Plan (CP) created [redacted], reflected a focus area: the resident's family had established an advanced directive (to appoint a person other than yourself to make health care decisions for you) with an intervention to inform resident/representative of any changes in status or care needs. A review of the Progress Note (PN) reflected the following: - [redacted] at 15:18 [3:18 PM], "rapid covid test NJ EX Order. 264b1 [redacted] - good at detecting the [redacted] collected sent to lab." [redacted] at 18:47 [6:47 PM], spoke to [redacted], they had been upset that they weren't notified the resident had [redacted]. [redacted] at 20:20 (8:20 PM), "refused in house [redacted] for routine check." Further review of the progress notes, dated [redacted] through [redacted] did not include	F 580	effects from the deficient practice. 2.All residents noted to have a change of condition are at risk of being affected by the deficient practice. An audit was completed of residents identified to have had a change of condition in the past 30 days to ensure that their responsible party had been notified of the change and interventions put into place. 3. The Change in condition notification policy was reviewed and updated. Licensed Nurses and Supervisors were re-educated on the timely notification of all changes in condition to resident's responsible parties. Those notifications are to be documented in the medical record by the licensed nurse. 4. The DON or designee will conduct an audit of the Nursing Shift report daily for 30 days and weekly for an additional 30 days to identify those residents having a change in condition and will verify that the responsible party notification has been documented in the medical record. The results of these audits will be reported to the QAPI committee for 2 months.	

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notification to the resident's representative that Resident #431 tested NJ EX Order. 264b1 and refused the in-house NJ EX Order. 2 routine check.

A review of the Resident/Visitor/Grievance/Complaint form dated NJ EX Order. 264b1, indicated that the resident's NJ EX Order. 264b1 stated NJ EX O was not informed of the NJ EX Order. 264b1 result. A further review included for staff to make follow up calls until they spoke to family.

During an interview with the surveyor on 12/18/23 at 10:04 AM, the Registered Nurse/Infection Preventionist (RN/IP) stated the nurse managers were responsible for notifying the families of any changes. The RN/IP further stated that once they families were notified it was documented in the electronic medical record (EMR) and the CP was updated. The RN/IP stated that the nurses could also notify the family representative of any changes and that the family should be notified of any changes that occurred.

During an interview with the surveyor on 12/18/23 at 10:11 AM, the Licensed Practical Nurse (LPN) stated that the nurses were responsible for notifying the family and the doctor of any changes. She stated that it was important to notify them because the responsible party needed to be informed of any changes that occurred with the resident. The LPN stated that any time they talked to the family it should be documented in the nursing notes in the EMR.

During an interview with the surveyor on 12/19/23 at 10:17 AM, the Director of Nursing (DON) stated the process for notification to families was for the resident's representative should be notified for any change of condition. She

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explained if there were significant changes such as a fall, then the family would be notified and updated so they knew what was happening with the resident. The DON stated that if a resident tested NJ EX Order. 264b1, the family "would definitely be notified." The DON stated that at the height of covid they had designated staff to call the families. When asked if Resident #431's family was notified she stated she believed they were called because during that time the Unit Managers (UM) and the Social Workers (SW) notified the families. The DON further stated that once the family was notified then normally it would be documented in the EMR that they were notified. She stated that Resident #431's family was very involved and believed that the UM notified the family of any changes and that it would have been documented.

During an interview with the surveyor on 12/19/23 at 10:44 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the UMs were responsible for notifying the families of any changes and that it should have been documented in the EMR. The LPN/UM then stated that there were times when the families did not answer the phone, but they would still document in a PN that they left a message or there was no answer. She explained if there were any changes then the families were notified, but if there were no changes then they did not have to. The surveyor asked if there were issues such as with the resident's teeth would the family be notified? The LPN/UM stated that the families should be notified because it was a change in condition. She then stated that the families were involved with the care and should know what was going on, so they would not be surprised if anything happened such as the resident being

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F 580	Continued From page 5 sent out to the hospital. On 12/20/23 at 10:12 AM, the DON in the presence of the Vice President of Clinicals, the License Nursing Home Administrator (LNHA), and the survey team acknowledged that the resident's representative should have been notified of any changes. A review of the facility's Change in Condition Notification policy, reviewed 07/2023, included, "3. The responsible party/family member will be notified of changes in condition unless directed otherwise in the resident's chart." A review of the facility's Nursing Documentation/Nurse's Note policy, reviewed 07/2023, included, "4. Ongoing nurses notes should include, at a minimum: changes in status or behavior, family/physician notifications." NJAC 8:39-13.1(c)	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		1/29/24

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F 584	Continued From page 6 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00159091 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment by: a) ensuring that resident's clothing was laundered and returned in a timely manner and b) ensuring that repairs were made to damaged walls and moldings in a timely manner. This deficient practice was observed for 1 of 2 residents (Resident #69) observed for	F 584	1. All clothing belonging to resident #69 was immediately returned and reimbursed for missing items. Broken molding removed from behind resident #64 bed. The hole in front of Resident #95 bed was repaired. Announced at resident council that any resident missing clothing to notify the social services director. Audit all rooms for broken moldings or holes in the walls. 2. All residents are at risk to be affected	

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F 584	Continued From page 7 personal property and for 1 of 4 nursing units (Second Floor/East). This deficient practice was evidenced by the following: a. On 12/12/23 at 12:32 AM, during the initial tour of the facility the surveyor observed Resident #69 seated on the side of the bed. The resident stated that his/her clothing was missing and he/she was only able to be changed into clean clothing once in the past three days. The resident stated that the laundry was sent down to be laundered and never returned. The resident stated that he/she reported the issue to the Certified Nursing Assistant (CNA #1) and the CNA agreed to look into the matter further. Review of Resident #69's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ EX Order. 264b1 [redacted] NJ EX Order. 264b Review of Resident #69's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that the resident was NJ EX Order. 264b1. Further review of the assessment indicated that the resident had no documented behaviors and was dependent for NJ EX Order. 264b1 and personal hygiene.	F 584	by the deficient practice. 3. Director of Environmental Services and Laundry staff were in-serviced regarding returning personal belongings in a timely fashion as per facility policy. Maintenance director was in-serviced about requirements for resident rooms to be free of disrepair as per facility policy. 4. Director of Environmental Services / Designee will audit 4 residents' personal laundry weekly for 4 weeks then Monthly for 3 Months. Maintenance director / Designee will audit 4 resident rooms weekly for 4 weeks then Monthly for 3 Months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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Review of Resident #69's Progress Notes within the electronic health record (EHR) failed to contain any documentation that pertained to the resident's allegation of missing clothing.

On 12/13/23 at 2:09 PM, the surveyor observed Resident #69 seated at the bedside. The resident was well groomed and dressed. When interviewed, the resident stated that CNA #1 had resolved the issue with the laundry and the resident had a clean change of clothing available today. The resident stated that he/she had no idea how many articles of clothing they had.

On 12/13/23 at 2:28 PM, the surveyor interviewed CNA #1 who stated that he worked at the facility for nine months. CNA #1 stated, "There was a change in department heads and clothes were not delivered here at all." CNA #1 stated that he went down to the laundry room and picked up the resident's clothing himself. CNA #1 stated that he dropped the resident's bag of soiled laundry in the laundry chute and it was delivered within four days. CNA #1 stated that Resident #69 should have nine or ten outfits and now had none except for the pants that the resident wore now. CNA #1 stated that when he went down to the laundry he helped himself and found the resident's clothing. CNA #1 stated that the issue had been reported to the Unit Manager over and over and addressed in the morning meeting.

On 12/13/23 at 3:25 PM, the surveyor presented to the Licensed Nursing Home Administrator (LNHA) and requested to see the laundry room. LNHA called for the Laundry and Housekeeping Director and stated that she had been in the position for one month. LNHA stated that the

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linens were outsourced to be laundered. The LNHA stated that another employee was previously responsible for the personal laundry and the resident's loved her. He further explained that the employee, "butted heads with the new Director and demoted demoted herself from full-time to part-time." LNHA maintained that the issue was resolved.

On 12/13/23 at 3:29 PM, the surveyor interviewed the Director of Environmental Services (DES) who stated that she began working at the facility one month ago. The DES stated, "the employee who did the resident's personal laundry previously refused to tell us her system and downgraded herself to part-time." DES further stated that we were backed up with the laundry for three weeks and were getting caught up."

At that time, the DES escorted the surveyor to the basement laundry area. The surveyor observed two laundry attendants folding clothing. DES spoke to the attendants in Spanish and confirmed that there was no clothing available for Resident #69. The surveyor took photos of a large bin filled with bagged cleaned clothing and a smaller bin filled with bagged clean clothing. The DES then took the surveyor to the area where the laundry chute was. The door to the room was closed, when opened, the surveyor observed many bags of soiled linens piled high from the floor to the level of the laundry chute. The DES stated that she had just opened the chute before the surveyor arrived. DES stated that personal clothing was bagged in mesh bags and was labeled with the resident's name and done separately. The DES stated that there were two functioning washing machines and two dryers. She stated that wash was done on the 7-3 and

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3-11 shifts. The DES stated that if Resident #69's clothing was missing, they were missing before she started. DES stated that Unit Managers were responsible to inform her of missing personal laundry. DES stated that no aide came down today to look for clothing and if they did, they came down while my staff was out delivering laundry.

On 12/18/23 at 10:43 AM, the surveyor interviewed CNA #1 who stated that he went to the laundry last Thursday and saw the resident's clothing on a rack and got four to five outfits himself. CNA #1 stated that Resident #69 had since worn all but one outfit. CNA #1 stated that he did not believe that Resident #69 wore an outfit for more than one day, unless it was on Monday when he was off. CNA #1 stated when he returned to work he changed the resident's clothing. CNA #1 stated that a lot of people on this side of the hallway have not received their clothing and the problem was not isolated to the resident. CNA #1 stated that the DES told him not to use the laundry chute because the laundry staff would pick up the laundry themselves. CNA #1 opened the resident's closet and showed me a pair of pants that had a different resident's name and room number written on the label. He stated, "They are someone else's." CNA #2 stated I will go down to the laundry myself and get the resident's clothes. He stated that there was one sweater, and six shirts in the resident's closet. CNA #1 removed the pants from the resident's closet that belonged to someone else.

On 12/18/23 at 10:57 AM, the surveyor interviewed the Second Floor Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that resident's soiled laundry had to be placed in a bin

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in their room. LPN/UM stated that the laundry was bagged and placed in the laundry chute and then it was washed and delivered back to the resident's room. LPN/UM stated that until just recently, after surveyor inquiry, there were no complaints of missing items. LPN/UM stated that if there were any other current complaints of missing laundry she was not aware. LPN/UM stated that if she was notified of missing clothing she would call the laundry and tell them that they had to find it. LPN/UM stated, "CNA #1 should have told me".

On 12/18/23 at 1:40 PM, the surveyor phoned the former Laundry Supervisor who reportedly down graded herself to Laundry Attendant (LA). She stated that she worked at the facility for one year. LA stated,"The residents were ranting and raving since she stopped doing their personal laundry and she heard that residents were not getting any laundry back." LA explained that she was removed from doing any personal laundry because she was part-time. LA explained that sometimes when agency staff worked they sent clothing down the chute in plastic bags instead of mesh bags. LA stated when she did the resident's personal laundry, there was not a time when a person did not have laundry.

On 12/18/23 at 2:35 PM, the surveyor interviewed the Social Worker who stated that she was not informed of any residents who had missing clothing. The Director of Social Services (DSS) was present at that time and stated that an unsampled resident from Unit 2 recently informed her of missing clothing and we reimbursed the resident for four shirts. DSS stated that there was no record of missing clothing for Resident #69, but if the family were unable to find the clothing in

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the laundry, the resident would be reimbursed.

On 12/29/23 at 10:01 AM, the surveyor interviewed the Director of Nursing (DON) who stated she would call the DES to see where Resident #69's clothing was so the resident received the clothing in a timely manner. DON stated that she could go to the basement and look for them. DON stated that resident's on [redacted] side liked to dress up. DON stated that she would address the issue with both the LNHA and the DES. DON further stated, "Our laundry should be done in a timely manner."

On 12/19/23 at 12:45 PM, the DES stated that eleven pieces of Resident #69's clothing were returned yesterday and ten pieces of the resident's clothing was returned today. DES stated that the clothing was placed in the laundry chute and were sent down in bags that were not labeled. DES stated that the clothing was labeled with the resident's name.

On 12/19/23 at 2:13 PM, LNHA stated that he was not aware until yesterday how much clothing was missing. He stated that last week he reimbursed for missing clothing. LNHA stated that when the former Laundry Supervisor was here it was great.

On 12/20/23 at 10:47 AM, the surveyor observed Resident #69 lying in bed awake. The resident stated that he/she was told that their clothing had been returned. The surveyor inspected the resident's closet with resident permission and noted that the closet was now full and the clothes were hung on hangers and additional clothing was bagged in plastic.

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b. On 12/12/23 at 11:32 AM, during the initial tour of the facility the surveyor observed that the wooden molding strip (moldings, material such as wood used for decorative purposes) behind Resident #64's bed was broken and jagged. The molding strip had a night stand placed in front of it. The resident was not in the room at the time of the observation.

On 12/12/23 at 12:05 PM,the surveyor observed a large hole in the lower portion of the wall in front of Resident # 95's bed that was positioned to the right of the bathroom door frame. The resident was asleep at the time and was unable to be interviewed.

On 12/13/23 at 2:35 PM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated that Resident #95's room mate repeatedly made holes in the wall with his/her wheelchair. CNA #1 stated that it was an ongoing issue.

On 12/13/23 at 3:00 PM, the surveyor interviewed Resident #64 who stated that the broken moldings behind his/her bed had been like that since the resident was admitted to the facility.

Review of Resident #64's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ EX Order: 264b1

[redacted]

Review of Resident #64's Admission Minimum Data Set (MDS), an assessment tool dated

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NJ EX Order. 264b1, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ EX out of NJ EX which indicated that the resident was NJ EX Order. 264b1.

On 12/18/23 at 10:49 Am, the surveyor interviewed CNA #1 who stated that the broken moldings behind Resident #64's bed had been like that for awhile and maintenance was aware. CNA #1 stated that he was not assigned to the resident and had not placed a request for repair. CNA #1 stated that if he were assigned to the resident he would have called down to the maintenance department or went down there himself to inform them of the need for repair.

On 12/18/23 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the NJ EX Order. 264b1 Floor NJ EX Order. 264b1 Units, who stated that she put a request into the system for maintenance to repair the moldings in Resident #64's room and the hole in the wall in Resident #95's room. LPN/UM stated that the resident's room mate had a motorized wheelchair and kept bumping into the wall which caused it to break. The surveyor was provided with maintenance request log and noted that on 10/23/23, the LPN/UM placed the following request on behalf of Resident #95, "Hole in wall, air conditioner issue" The response was dated 10/30/23 as completed. On 11/14/23, LPN/UM informed the maintenance department on behalf of Resident #64, "Walls need to get fixed and painted consult." The response was dated 11/14/23 and revealed, "Fixed left brake." Which did not pertain to the repair request.

On 12/19/23 at 9:58 AM, the surveyor interviewed the Director of Nursing (DON) who stated that

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staff needed to report things that required repair in the resident's environment. The DON stated that the facility used a 24 hour on call maintenance system and were able to communicate with maintenance electronically.

On 12/19/23 at 10:35 AM, the surveyor requested that the Maintenance Director (MD) accompany the surveyor to the [redacted] floor to observe both Resident #64 and Resident #95's room. MD accompanied the surveyor into Resident #64's room and stated that the request to repair the moldings behind the resident's bed were not placed in the electronic system to his knowledge. MD stated that the broken molding was removed and spackled (a compound used to fill cracks in plaster and produce a smooth surface) today after surveyor inquiry. The surveyor and MD then went to Resident #95's room and viewed the hole in the wall. MD stated, "We can definitely repair the hole and replace the sheet rock."

On 12/19/23 at 12/20/23, the Licensed Nursing Home Administrator (LNHA) stated that he was aware of the repairs that were needed in both Resident #64 and Resident #95's room. LNHA further stated that the moldings in Resident #64's room were removed and needed to be replaced.

Review of an untitled facility policy reviewed/revised 12/23, revealed the following:

Policy: To assure that infection control measures are maintained during routine laundering of patient clothing and to prevent misplaced or lost articles.
To provide patients with personal laundry services and to assure the proper handling and laundering of patient clothing.

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Procedure:
...Patient's personal laundry will be laundered by the facility per the resident, legal representative and/or other family member's choice.
Should the resident and/or legal representative choose to have his/her laundry done elsewhere:
All soiled laundry must be kept in a laundry basket, Picked up at least weekly, preferably twice a week, Sufficient clothing must be maintained on the premises to keep the patient clean and dry at all times...
Inquiries concerning laundry or services should be referred to Social Services or designee.
The policy failed to detail the frequency at which the facility washed and returned the resident's clothing.

Review of an untitled policy reviewed 12/23, revealed the following:

To establish a system that assures, when possible, a patient's lost or misplaced clothing and personal articles are returned.
The facility shall implement a policy to assure that a lost and found program is established to safeguard and return patient's personal property.

Procedure:
All lost articles found on the premises must be turned over to the Social Services Director or designee within twenty-four (24) hours.
...Articles of clothing that are turned in to the Social Director or designee will be maintained in the laundry area for ease of identification by patients and/or family members.
...Patient or family complaints of missing items must be reported to Social Services Director or designee.

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F 584	Continued From page 17 ...Reimbursement for a lost clothing article is in accordance with facility protocol; requests should be forwarded to the administrator. NJAC 8:39-27.1(a), 4.1 (a)	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 4 of 29 residents reviewed (Residents #23, #428, #132 and #19). This deficient practice was evidenced by the following: 1. The surveyor reviewed the Admission Record for Resident #23 which reflected that the resident was admitted with diagnoses that included NJ EX Order. 264b1 The surveyor reviewed the Weights and Vitals Summary which reflected a weight of [redacted] pounds on [redacted] which was corrected on [redacted] to reflect a weight of [redacted] pounds. The surveyor reviewed Resident #23's Admission MDS, an assessment tool utilized to facilitate the management of care, dated [redacted] and reflected a weight of [redacted] pounds. When interviewed on 12/14/23 at 1:36 PM, the part-time Dietician in the presence of the	F 641	1. Resident's # 23, 428, 132 and 19 experienced no negative effects due to the incorrect MDS coding. The MDSs for those residents were modified and resubmitted to CMS. 2. All residents have the potential to have their MDS miscoded. An audit of the MDSs of all residents who [redacted] have had [redacted] or have a [redacted] was completed. In addition, an audit of all residents was completed to ensure that the correct weight has been coded. 3. The policy RAI Process-MDS Completion was reviewed and updated. The MDS coordinators were re-educated on accurate completion of the MDS. 4. The MDS coordinator will audit 5 MDSs per week for 4 weeks and 3 MDS per week for an additional 4 weeks to ensure that they accurately reflect the resident's status. The results of these audits will be reported to the QAPI committee for 2 months.	1/15/24

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Corporate Dietician stated that Resident #23 was seen by the full-time Dietician when the resident was admitted to the facility. The part-time Dietician stated when she saw the resident, she believed the weight of [redacted] pounds was incorrect as she knew the resident from previous admissions. Resident #23 at that time weighed [redacted] pounds. The dietician acknowledged that the weight documented on the Admission MDS dated [redacted], was coded incorrectly.

When interviewed on 12/18/23 at 1:34 PM, the MDS coordinator acknowledge that Resident #23's weight was incorrect on the Admission MDS dated [redacted]

2. The surveyor observed Resident #19 returning to their room. When interviewed, the resident informed the surveyor that they were returning from eating and a [redacted] break and [redacted] three times a day.

The surveyor reviewed the Admission Record for Resident #19 which reflected that the resident was admitted with diagnoses that included but was not limited to NJ EX Order. 264b1 [redacted].

The surveyor reviewed Resident #19's care plan which included care focus area created on [redacted], and indicated the resident had NJ EX Order. 264b1 [redacted]. Further review of the care plan revealed a care focus area created on [redacted], which indicated the resident liked to [redacted].

Further review of the Resident #19's medical record revealed a [redacted] Contract addendum

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2020" NJ EX Order. 264b agreement signed and dated by the resident on NJ EX Order. 264, and a progress note dated NJ EX Order. 264 at 1:53 PM, that indicated the resident "attended every NJ EX Order. 2 break."

Review of a NJ EX Order. 264b assessment dated NJ EX Order. 264b1 NJ EX Order. 264b1, indicated Resident #19's use of

The surveyor reviewed Resident #19's annual MDS dated NJ EX Order. 264b which indicated under section "N - Health Conditions" "no" for NJ EX Order. 264b use.

On 12/20/23 at 9:32 AM, the surveyor interviewed the MDS coordinator who acknowledged that the MDS was coded incorrectly for NJ EX Order. 264b2 use for this resident.

3. The surveyor reviewed the admission record for Resident #428 which reflected that the resident was admitted from acute care with diagnoses that included but were not limited to NJ EX Order. 264b1 .

A review of Resident #428's progress notes indicated that on NJ EX Order. 2 "While rounding observed resident laying on the floor in front of his/her wheelchair." Further review of the progress notes revealed that on NJ EX Order. 264b1 "Resident received in bed this am. Shortly after resident noted on the floor sitting with his/her back against the bed."

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F 641	Continued From page 20 A review of Resident #428's discharge MDS, dated [redacted], revealed section [redacted] was coded "0" indicating that the resident had no[redacted] since the previous MDS on [redacted]. When interviewed on 12/18/23 at 1:20 PM, the MDS Coordinator acknowledged the MDS was inaccurate at this time and stated that she needed to modify the discharge MDS to include two [redacted] without injury. 4. The surveyor reviewed Resident #132's the admission record which indicated that the resident was admitted in [redacted] from acute care with diagnoses that included but not limited to: NJ EX Order. 264b1 [redacted]. A review of Resident #132's MDS dated [redacted], indicated the resident had a NJ EX Order. 264b1 function. Review of the same MDS, indicated section [redacted] was coded "0" indicating [redacted]. When interviewed on 12/18/23 at 1:22 PM, the MDS Coordinator stated that section [redacted] should be coded as [redacted] (indicating that the resident had an [redacted]) and would be modified. A review of the policy "RAI Process-MDS Completion", revised 10/2023, "4. The MDSs will be filled out accurately, after proper collection of data, in a timely manner according to the RAI manual standards ...	F 641		

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F 641	Continued From page 21 N.J.A.C. 8:39-11.1	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to consistently follow appropriate professional standards of practice for: a) medication administration and b) accurately completing the NJ EX Order: 264b1 Monthly Summary for 1 of 5 residents (Resident # 84) reviewed for unnecessary medications, NJ EX Order: 264b1 medications, and medication regime review for 1 of 3 nurses on 1 of 2 nursing units NJ EX Order: 264 reviewed for the medication administration observation. 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 case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 658	1.Residents #95 and 84 were not negatively affected by the deficient practices. The nurse who administered the medication to resident #95 received one on one education on the day of the occurrence. 2. All residents who receive medication, including p NJ EX Order: 264b1 medication, and have pharmacy consultant recommendations are at risk of being affected by the deficient practice. An audit was completed of all NJ EX Order: 264b1 summaries to ensure that all current NJ EX Order: 264b1 medications were addressed. An audit of the most recent pharmacy consultant reports was conducted to ensure all recommendations were addressed timely. 3. The Medication Regime Review policy, Psychotropic Medication policy and Medication Administration policy were reviewed and updated. Licensed Nurses were re-educated on the proper steps in Medication Administration, including	1/15/24

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F 658	Continued From page 22 physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the following: a. On 12/18/23 at 8:03 AM, the surveyor observed Licensed Practical Nurse (LPN #1) as she prepared medications to be administered to Resident #95 which included NJ EX Order. 264b1 (drug used to NJ EX Order. 264b1 EX Order. 264b1 mg (milligrams) NJ EX Order. 264b1 tablets as needed for NJ EX Order. 264b1 NJ EX Order. 264b1 drug used to treat NJ EX Order. 264b1 mg NJ EX Order. 264b1 tablet) NJ EX Order. 264b1 mg, and NJ EX Order. 264b1 (used to treat NJ EX Order. 264b1 and NJ EX Order. 264b1 mg. LPN #1 then proceeded to enter the room of Resident #95, and handed the resident a plastic cup filled with the previously mentioned medications and walked out of the room before she observed the resident take the medications. LPN #1 returned to the medication cart and documented the medications as administered after. Review of Resident #95's Admission Record (an admission summary) revealed that the resident	F 658	remaining with the resident until all medication is taken. The Unit Mangers were re-educated on timely addressing the Pharmacy consultant recommendations and thorough completion of the monthly NJ EX Order. 264b1 summaries to include all current NJ EX Order. 264b1 medications. 4. The DON or designee will audit the Pharmacy recommendations of 10 residents per month for 2 months to ensure all recommendations have been followed up on. The DON or designee will audit the NJ EX Order. 264b1 summaries of 5 residents per month for 2 months to ensure all current NJ EX Order. 264b1 medications have been addressed. Medication administration observations will be done on 3 licensed nurses per month by the DON or Pharmacy consultant to ensure all protocols of medication administration are being followed. The results of these audits and medication administration administrations will be reported to the QAPI committee for 2 months.	

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was admitted to the facility with diagnosis which included but were not limited to: NJ EX Order. 264b1).

Review of Resident #95's Annual Minimum Data Set (MDS), an assessment tool dated , revealed that the resident had a Brief Interview for Mental Status (BIMS) score of which reflected that the resident was fully .

Review of Resident #95's Order Summary Report for revealed that Resident #95 was ordered the following medications: Tablet mg Give tablets by mouth every hours as needed for (and for NJ EX Order. 264b1 and above..., Oral Tablet mg Give table by mouth times a day for mg total and Oral Tablet mg) Give e tablet time a day for targeting

On 12/18/23 at 9:02 AM, in an interview with LPN #1 she stated, "I am supposed to make sure that the resident took their medications". LPN #1 further stated, "It was just a habit."

On 12/18/23 at 11:05 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the Floor Unit who stated that nursing was required to remain with the resident during medication administration until they ensured that the resident swallowed the medication, in order to be one hundred percent sure the resident had taken the medications.

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F 658	Continued From page 24 On 12/19/23 at 9:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that nursing was required to ensure when medications were administered to a resident that the resident swallowed the medications. DON stated that if the nurse did not directly observe the resident take blood pressure medications for example, and the resident did not take it, there may be consequences that resulted for the resident. DON stated, "You must stay with the resident and ensure that all of the medications were taken." b. On 12/12/23 at 12:01 PM, during the initial tour of the facility, the surveyor observed Resident #84 sitting in a wheelchair at the nurses' station. The resident smiled and waved but the surveyor was unable to interview the resident at that time. According to the Admission Record, Resident #84 was admitted to the facility with the diagnoses which included, NJ EX Order. 264b1 [redacted] A review of the annual Minimum Data Sheet (MDS), an assessment tool, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had NJ EX Order. 264b1 [redacted]. A further review of the MDS in [redacted] revealed: Medications, included the resident was taking NJ EX Order. 264b1 and [redacted] medications.	F 658		

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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
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A review of the Order Summary Report (OSR) for NJ EX Order. 264b1 reflected the resident had a physician order for [redacted] tablet [redacted] milligrams (mg) for [redacted]

A review of the Consultant Pharmacist's Medication Regime Review (MRR) revealed the following:

[redacted] Please do the monthly quantitative behavioral summary.

NJ EX Order. 264b1 was not included in the monthly [redacted] summary from [redacted]. Please review and correct [redacted] summary.

NJ EX Order. 264b1 was not included in the monthly psych summary from [redacted]. Please review and correct [redacted] summary.

A review of the NJ EX Order. 264b1 Monthly Summary revealed for NJ EX Order. 264b1 and NJ EX Order. 264b1 signed [redacted], the NJ EX Order. 264b1 medications sections was left blank.

A review of the [redacted] Progress note dated [redacted] at 16:54 [4:54 PM] indicated the resident was taking [redacted] for [redacted].

During an interview with the surveyor on 12/19/23 at 10:26 AM, the Director of Nursing (DON) stated that the Unit Manager (UM) was responsible for completing the monthly NJ EX Order. 264b1) summary. The DON stated the UM on the [redacted] floor just started on [redacted] and was just getting adjusted. The DON stated that the Assistant Director of Nursing (ADON)

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was covering as UM on the [NJ EX Order 2] floor, but she was also longer here at the facility. The surveyor asked what was the [NJ EX Order 26401] Monthly Summary? The DON stated that the monthly [NJ EX Order 2] summary was a look back at the resident behaviors over the month, so it could be discussed with the [NJ EX Order 26401] to determine if the medications needed to be adjusted. She stated it was important to accurately complete the monthly [NJ EX Order] summary because it gave a full picture of the resident. She further stated that it should have included all [NJ EX Order 2] meds and was completed monthly due to any changes. The DON reviewed the monthly [NJ EX Order 26401] summary in the electronic medical record (EMR) and acknowledged that [NJ EX Order] was not listed. The surveyor asked was there a supervisor on the [NJ EX Order] floor that could have completed the [NJ EX Order 26401] Monthly Summary? The DON confirmed that the previous UM was there during that time and acknowledged it could have been completed accurately and that it should have been.

During an interview with the surveyor on 12/19/23 at 10:39 AM, Licensed Practical Nurse/Unit Manager (LPN/UM) for the [NJ EX Order 2] floor stated that the UM was responsible for completing the monthly [NJ EX Order 2] summary. The LPN/UM stated that it included the [NJ EX Order] meds, the last time the resident was seen by the consultant, if a gradual dose reduction (GDR) was done, and then they wrote in the comments any behavior issues, problems, if the interventions were effective, if there were any side effects, and if the physician needed to be notified. She further stated that all [NJ EX Order] medications should be reflected on the monthly [NJ EX Order] summary and how many behaviors occurred that month. The LPN/UM stated that the UM was responsible for ensuring

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any notes reflected from the pharmacy consultant should be reflected on the following month.

During an interview with the surveyor on 12/19/23 at 10:51 AM, the Registered Nurse/Unit Manager (RN/UM) for the [NJ EX Order] floor stated that the UM was responsible for the monthly [NJ EX Order 2] summary. She stated as the UM she was responsible to ensure the care plans were up to date, the target behaviors, any GDRs (gradual dose reductions), the medications and all NJ EX Order. 264b1 were captured on the monthly [NJ EX Order. 1] summary. She further stated as a UM she was responsible for ensuring that the pharmacy consultant recommendations were followed through each month. The RN/UM stated that it was important to assure that the [NJ EX Order. 264b1] Monthly Summary was accurately completed and that they followed up on the pharmacy consultant recommendations for the resident's safety and that they were getting the care needed.

On 12/20/23 at 10:14 AM, the DON in the presence of the Vice President of Clinicals, the License Nursing Home Administrator (LNHA), and the survey team stated she in-serviced the unit managers on ensuring that the monthly [NJ EX Order] summary was done. She further stated that the monthly [NJ EX Order] summary should have been completed and reviewed to ensure they were accurate.

A review of the facility [NJ EX Order. 264b1] Medication Use reviewed 07/2023, included, "8. Nursing will complete a monthly [NJ EX Order. 264b1] summary describing resident progress or deterioration, including a summary of [NJ EX Order. 264b1] medications being used and their subsequent effects to the resident/patient. Include the last visit with the

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F 658	Continued From page 28 NJ EX Order. 264b1 and any plans for reduction and/or continuation of medications." A review of the facility Medication Regime Review policy, reviewed 07/2023, included, "7. Upon completion of the MRR, the facility designee and or physician, will respond to the recommendations in a timely manner. A review of the facility Medication Administration policy, reviewed 07/2023, revealed the following: ...Administer oral medications with a full glass of water unless otherwise ordered. Remain with the resident until all medication is taken... N.J.A.C. 8:39-27.1 (a) (c) (3i)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation it was determined the facility failed to ensure that physician orders were obtained to change a resident's NJ EX Order. 264b1 [redacted]). This deficient practice	F 695	1. Resident #433 was not negatively affected by the deficient practice. An order was immediately entered into the resident's medical record to have the NJ EX Order. 264b1 changed daily. 2. All residents with a NJ EX Order. 264b1 have the potential to be affected by the deficient	1/22/24

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F 695	Continued From page 29 was identified in 1 of 1 resident reviewed for NJ EX Order. 264b1 care (Resident #433) and was evidenced by the following: On 12/12/23 at 01:06 PM, during the initial tour of the facility the resident was observed sitting at the bedside. The resident had a NJ EX Order. 264b1 and was being provided with a NJ EX Order. 264b1 to a NJ EX Order. 264b1. During the observation the resident was with the therapist and discussed evaluations and the possibility of diet advancement following the evaluation. Review of the Admission Record revealed that Resident #433 was admitted to the facility with medical diagnoses which included but were not limited to NJ EX Order. 264b1. The admission Minimum Data Set (MDS), an assessment tool was in progress. On 12/14/23 at 09:24 AM, the surveyor observed Resident #433 in a wheelchair being pushed by family exiting the physical therapy room. The resident's NJ EX Order. 264b1) was in place with NJ EX Order. 264b1 to a NJ EX Order. 264b1 on the back of the resident's chair. The resident had a clean white behind the NJ EX Order. 264b1 and . On 12/14/23 at 10:01 AM, the surveyor reviewed the physician orders for Resident #433 which showed the following orders: NJ EX Order. 264b1 every night shift every for monitoring, NJ EX Order. 264b1 every night shift every for monitoring, and	F 695	practice. All other residents with NJ EX Order. 264b1 were audited to ensure that they had orders to change their NJ EX Order. 264b1 daily. 3. The policy NJ EX Order. 264b1 Care was reviewed and revised. Nurses were re-educated on NJ EX Order. 264b1 care and ensuring all necessary orders to provide that care are entered into the medical record. 4. The DON or designee will audit the orders of residents with NJ EX Order. 264b1 per week for 2 months to ensure all necessary orders for NJ EX Order. 264b1 care have been entered. The results of these audits will be reported to the QAPI committee for 2 months.	

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Care every shift, Check NJ EX Order. 264b1 every shift for monitoring. They were active orders dated 1[redacted]. Further review indicated the resident had a NJ EX Order. 264b1 with a disposable NJ EX Order. 264b1 (meaning the NJ EX Order. 264b1 was required to be changed as ordered by the physician and to be completed by the nursing staff caring for the resident).

On 12/14/23 at 10:27 AM, the surveyor observed Resident #433 in the room. The resident was in a wheelchair with NJ EX Order. 264b1 at the prescribed dosage. All NJ EX Order. 264b1 had dates on them.

On 12/18/23 at 10:15 AM, Resident #433 was observed in the therapy room. NJ EX Order. 264b1 was in place to NJ EX Order. 264b1 was provided to the resident who was participated in therapy.

On 12/19/23 at 09:54 AM, the surveyor interviewed the unit charge nurse for the day regarding [redacted] care as the resident was not available. She stated that [redacted] care included cleaning the [redacted] and inspecting the NJ EX Order. 264b1 the [redacted] and changing the [redacted] She stated that the resident had NJ EX Order. 264b1 and did not require NJ EX Order. 264b1 The surveyor asked how frequently the NJ EX Order. 264b1 was changed and she responded, "I think it's changed once per day, but I have to look at the policy." The surveyor asked if the changing of the NJ EX Order. 264b1 should be on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) and the nurse said, "All [redacted] care should be on the TAR". The surveyor asked if the resident had NJ EX Order. 264b1 in the room and the nurse said, "They should be in there". The surveyor entered room with the nurse and there

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was a box of NJ EX Order: 264b1 on the night stand.

On 12/19/23 at 0950 AM, the charge nurse approached the surveyor and stated, "I reviewed the policy, the NJ EX Order: 264b1 should be changed every shift, I will make sure it is added on the TAR".

On 12/19/23 at 10:47 AM, the surveyor reviewed the Minimum Data Set (MDS), an assessment tool, list in the Electronic Medical record (EMR) which showed that the five-day MDS was in progress as resident was a new admission. Review of the care plan included a NJ EX Order: 264b1 and NJ EX Order focus, and the interventions included NJ EX Order care every shift.

On 12/19/23 at 11:32 AM, the surveyor interviewed the Director of Nursing (DON) regarding caring for a resident with a NJ EX Order: 264b1 The surveyor asked the DON to define NJ EX Order: 264b1 The DON stated, "NJ EX Order: 264b1 is to make sure to suction the NJ EX Order clean the area, make sure it's not clogged". The surveyor asked how often NJ EX Order: 264b1 care was performed and she responded, " It's done once daily but if a resident has a lot of NJ EX Order: 264b1 they will NJ EX Order: 264 extra". The surveyor then asked about the changing of the NJ EX Order: 264b1. The DON told the surveyor, "It gets changed when it was soiled and clogged and we change it as needed". The surveyor asked the DON if changing the NJ EX Order was on the MAR or TAR and she stated, "I believe it's on the MAR". The surveyor made the DON aware it was not on the MAR, TAR, or physician orders at that time. The surveyor then asked the DON if the staff should be signing a MAR or TAR when they changed the NJ EX Order NJ EX Order: 264 and she stated, "Yes".

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F 695	Continued From page 32 On 12/21/23 at 11:35 AM, the surveyor reviewed the policy titled, NJ EX Order. 264b1 Care", a policy with a reviewed date of 07/2023. The policy was to provide guidance in the preventive measures for controlling common infections for residents with a NJ EX Order. 264b1 y as part of the overall infection control program. Under the procedure section of the policy, it indicated that the staff would change the NJ EX Order. 264b1 as indicated, and as per facility policy.	F 695		
F 697 SS=D	NJAC 8:39-25.4 (c) (4) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure a NJ EX Ord management regimen was followed in accordance with physician orders. This deficient practice was identified in 2 of 3 residents reviewed for NJ EX Ord (Resident #99 and #132). This deficient practice was evidenced by the following: 1. On 12/12/23 at 10:15 AM, during the initial tour of the facility Resident #99 was observed in the bed. The resident told the surveyor that he/she	F 697	1. Resident # 99 was sent to the hospital during the survey. Upon return she had a new NJ EX Ord assessment and NJ EX Ord management orders. The physician for resident #132 was contacted and a new order was received for NJ EX Order. 264b1 2. All residents with NJ EX Ord are at risk to be affected by this deficient practice. An audit was conducted to identify any other resident with scores of NJ EX Order. 264b1 without appropriate orders. 3. The NJ EX Ord management policy was reviewed and updated. Licensed nurses	1/29/24

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F 697	Continued From page 33 was at the facility for rehabilitation and had come to the facility from the hospital. The surveyor reviewed Resident #99's Admission Record (an admission summary) which showed that Resident #99 was admitted to the facility with diagnoses which included but were not limited to infection of NJ EX Order. 264b1 . Review of the Admission Minimum Data Set (MDS), an admission summary, dated NJ EX Order. 264b1 indicated the resident had a Brief Interview of Mental Status (BIMS) score of NJ EX Order. 264b1 which indicated the resident was NJ EX Order. 264b1 NJ EX Order. Review of NJ EX Order. 264b1 titled Health Conditions, revealed that the resident had a NJ EX Ord assessment completed. It showed that the resident was on a NJ EX Ord regimen, had NJ EX Or "frequently", had NJ EX Ord that interrupted NJ EX Ord "frequently", and had NJ EX Ord that had interfered on day-to-day activities "frequently". NJ EX Ord intensity for the five days prior to the assessment was a seven, meaning it was NJ EX Order. 264b1 on the one to ten scale. On 12/13/23 at 11:04 AM, the surveyor reviewed Resident #99's physician orders which showed an order for NJ EX Order. 264b1 / NJ EX O mg tablets (NJ EX Order. 264b1), one tablet every NJ EX hours as needed for NJ EX Order. 264b1 NJ EX Order. 264b1 on the one to NJ EX O numeric NJ EX O scale). The surveyor then reviewed the Medication Administration Record (MAR) which showed that the resident received NJ EX Order. 264b1 on 12/2/23 for a NJ EX Or level of NJ EX Order at 4:47 PM, on 12/8/23 for a NJ EX n level of NJ EX Orde at 2:30 AM, on 12/9/23 for a NJ EX Or level of NJ EX Order. 2 at 1:59 PM, on 12/10/23 for a NJ EX Or level of NJ EX Order. 2 at	F 697	were re-educated on the NJ EX Orde management policy with a focus on obtaining appropriate physician orders for different levels of pain. 4. The DON or designee will audit the NJ EX Or medication records of 3 residents per week for 60 days to ensure that they have appropriate orders to manage their NJ EX Or as indicated by their documented NJ EX Or scales. The results of these audits will be reported to the QAPI committee for 2 months.	

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11:50 AM and again for a [redacted] level of [redacted] at 7:42 PM, and on 12/11/23 for [redacted] level of eight at 4:38 AM and a [redacted] level [redacted] at 6:04 PM. [redacted] of [redacted] to [redacted] on the numeric [redacted] scale indicated [redacted]

On 12/14/23 at 10:38 AM, the surveyor observed Resident #99 in their room in bed. The surveyor asked the resident what type of [redacted] he/she had, and the resident stated, "My [redacted]". The surveyor asked the resident how he/she would describe the [redacted], and the resident stated, [redacted] at times". The resident continued to tell the surveyor that the [redacted] medication only helped, "Sometimes".

On 12/18/23 at 09:43 AM, the surveyor went to see Resident #99 and was told by the staff he/she was admitted to the hospital.

On 12/18/23 at 09:47, the surveyor reviewed the residents MAR which showed that on [redacted] the resident received [redacted] (ordered for [redacted] with [redacted] levels ([redacted]).

On 12/18/23 at 12:32 PM, the surveyor interviewed the [redacted] unit nurse who cared for Resident #99 regarding [redacted] The LPN told the surveyor that they used a scale of [redacted], a numeric scale. The surveyor asked the LPN to explain the numeric [redacted] scale and the LPN stated, [redacted] and [redacted]". The surveyor asked the LPN what she would have to do if a resident said they have [redacted] but only had medication for [redacted] The LPN responded, "I would have to call the doctor because the [redacted] is out of the [redacted]

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range, and they would need something else".

On 12/19/23 at 11:29 AM, the surveyor interviewed the Director of Nursing (DON) regarding [redacted] scales for the oriented residents. The DON stated they used a numeric scale, one t NJ EX Order. 264b1 The surveyor asked the DON what if a resident's [redacted] was a [redacted] meaning [redacted] and the resident only had NJ EX Order. 264b1 medication ordered. The DON responded, "I would call the doctor to get something for [redacted]". The surveyor asked why that would be important and the DON stated, "the resident would be asking for more [redacted] medicine very soon because we are not treating the resident's [redacted] correctly".

On 12/21/23 at 10:30 AM, the surveyor reviewed the facility policy titled, [redacted] Management" with a reviewed date of 07/2023. The policy stated that the facility must ensure that [redacted] management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident goals and preferences. Under the section titled, "Treatment", number one revealed that if the residents [redacted] is not controlled by the current treatment regimen, the practitioner should be notified.

NJAC-8:39-27.1 (a)

2. On 12/12/23 at 10:56 AM, during the initial tour of facility the surveyor observed Resident #132 lying in bed. The resident stated that all was well except for [redacted] and the resident lifted his/her shirt to show a NJ EX Order. 264b1

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NJ EX Order. 264b1).

The surveyor reviewed Resident #132's Admission Record (an admission summary) which showed that the resident was admitted to the facility with diagnoses that included but not limited to: NJ EX Order. 264b1

A review of the MDS dated 9/28/23 revealed that Resident #132 had a Brief Interview of Mental Status (BIMS) score of NJ EX Order. 264b1, which meant the resident had NJ EX Order. 264b1. Review of NJ EX Order. 264b1 titled Health Conditions revealed the resident had a NJ EX Or assessment completed. It indicated that the resident was on a NJ EX Or regimen, had NJ EX Or "almost constantly",,,, had NJ EX Or that interrupted sleep and limited day to day activities. NJ EX Order. intensity for the NJ EX Or days prior to the assessment was a NJ EX Order. meaning it was NJ EX Order. on the scale of NJ EX Order. 264b1.

The surveyor reviewed Resident #132 physician orders which included, but were not limited to NJ EX Order. Tablet NJ EX Or MG (NJ EX Order. 264b1, a NJ EX Order. 264b1), Give NJ tablet by mouth every NJ hours as needed for NJ EX Order. 264b1 and NJ EX Order. 264b1 Tablet NJ EX Or MG, Give NJ tablet by mouth every NJ hours as needed for NJ EX Order. 264b1 NJ EX Order. (NJ EX Or. There were no orders found for medication for NJ EX Order. 264b1 of NJ EX Or.

A review of the MAR for NJ EX Order. 264b1 showed Resident #132 received the NJ EX Order. 264b1 mg for NJ EX Or of NJ EX Order. on 12/4/23 at 6:10 AM and for NJ EX Or of NJ EX Order. on 12/12/23 at 4:19 AM.

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F 697	Continued From page 37 On 12/18/23 at 11:27 AM, the surveyor interviewed licensed practical nurse (LPN), who stated that if Resident #132 complained of a [NJ EX Or] level above [NJ EX O], she would call the physician to discuss this. On 12/18/23 at 12:42 PM, the surveyor interviewed the DON who stated that if the resident complained of [NJ EX Order: 264b1], the nurse should call MD and ask for different medication appropriate for the [NJ EX Or] level. She acknowledged that there was no order for [NJ EX Or] level [NJ EX Order: 264b1]. She also stated that medication ordered for [NJ EX Order: 2] [NJ EX Order: 264] level should not be given for a [NJ EX Order: 264b1] of [NJ EX Order] or [NJ EX Or] without speaking to the physician. A review of policy [NJ EX Date] Management" revised 7/2023, indicated "treatment: 1. If the resident's pain is not controlled by the current treatment regimen the practitioner should be notified." NJAC 8:39-27.1(a)	F 697		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		1/29/24

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F 755	Continued From page 38 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 pertinent record review, it was determined that the facility failed to ensure: a) accountability of the Narcotic Shift Count logs were completed in accordance with facility policy and accurately accounted for and documented the administration of controlled medications and b) medications were administered in accordance with the medication's cautionary statement and manufacturer specifications. This deficient practice was identified on 5 of 5 medication carts observed on 4 of 4 nursing units and for 2 of 3 nurses who administered medications to 2 of 6 residents (Resident #95 and Resident #179) observed during the medication observation pass. This deficient practice was evidenced by the following:	F 755	1. Residents # 95,179,160,105,156,60,170,147,2,56,5,21 were not negatively affected by the deficient practices. LPN # 1,2,3,4 received one on one re-education immediately. 2. All residents receiving medication are at risk to be affected by the deficient practices. An audit was completed of all shift to shift narcotic logs, narcotic decline sheets and medication administration records to ensure proper documentation was completed. 3. The policies for Medication Administration and Schedule II controlled substance policy were reviewed and updated. Licensed nurses were re-educated on both of these policies with	

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F 755	Continued From page 39 1. On 12/14/23 at 9:58 AM, the surveyor, in the presence of Licensed Practical Nurse #1 (LPN #1), reviewed the controlled substance logs for the NJ EX Orde floor NJ EX Orde side medication cart. The surveyor observed the following: Resident #160 was administered NJ EX Order. 264b1 NJ EX Order. 264b1 medication) NJ milligram (mg) at 9:00 AM and the LPN stated she did not sign it out in the "Individual Patient Controlled Substance Administration Record" (declining inventory log). Resident #105 was administered NJ EX Order. 264b1 medication) NJ EX Order. mg at 9:17 AM and was not signed out on the declining inventory log. At this time, LPN #1 acknowledged that these medications should have been signed out immediately once dispensed and stated, "I forgot to sign it out." LPN #1 was able to show that the medication was given and signed in the residents' electronic medication administration record (MAR). On 12/14/23 at 10:50 AM, the surveyor, in the presence of LPN #2, reviewed the controlled substance logs for the NJ EX Order -floor NJ EX Orde side medication cart. The surveyor observed the following: The "Record of Narcotic NJ EX Order. 264b1 Abuse Drug Count" (shift change log) was pre-signed by LPN #2 for 1 NJ Ex Order. 264b 3:00 PM "nurse - outgoing." At this time, LPN #2 acknowledged that this log should not have been pre-signed, and this was to be signed at the time of the narcotic count with the incoming and outgoing nurses at shift change. Resident #156's MAR indicated the resident was administered NJ EX Order. 264b1 medication) NJ EX mg tablet at 9:09 AM and was not signed out in the	F 755	a focus on proper documentation and accounting of narcotic medications, as well as following pharmacy cautionaries when administering all medications. 4. The DON or designee will audit the narcotic documentation (shift to shift count logs) on 3 med carts weekly for 60 days to ensure that there are no blanks or pre-signing. She will also do 3 random med pass observations per week for 60 days to ensure narcotic medications are being signed for as per policy at the time of administration on both the medication record as well as the narcotic decline sheet, and that medications are being administered as per the cautionary or manufacturer guidance. The results of these audits will be reported to the QAPI committee for 2 months.	

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declining inventory log.

The declining inventory log for Resident #60 was pre-signed for a 2:00 PM administration of [redacted] (a medication used to treat [redacted] [redacted] mg indicating there should have been [redacted] tablets remaining , but the medication card contained [redacted] tablets, which indicated one was not given yet. At this time LPN #2 acknowledged that this was pre-signed and the medication was not yet administered.

On 12/14/23 at 11:32 AM, the surveyor, in the presence of LPN #3, reviewed the controlled substance logs for the [redacted]-floor [redacted] side medication cart. The surveyor observed the following:
The shift change log outgoing nurse signature was blank for 12/13/23 3:00 PM.
At this time, LPN #3 acknowledged that there should have been no missing signatures.

On 12/14/23 at 12:40 PM, the surveyor, in the presence of LPN #4, reviewed the controlled substance logs for the [redacted]-floor [redacted] side medication cart two. The surveyor observed the following:
Resident #170's prescription cards (BINGO cards, in blister packs) containing [redacted] mg tablets contained [redacted] tablets, but the declining inventory log indicated [redacted] tablets should have been present. At this point, LPN #4 stated she administered the medication to the resident, but did not sign it out in the declining inventory log or in the resident's MAR. After surveyor's observation, LPN #4 signed the MAR for this dose at 1:07 PM.

Resident #147's [redacted]

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NJ EX Order medication) NJ EX Order mg BINGO card contained NJ EX Order tablets, while the declining inventory log indicated NJ EX should have been present. LPN #4 was able to show the surveyor that this dose was signed in the MAR and informed the surveyor the 2:00 PM dose was also accidentally signed out in the MAR as well.

At this time, LPN #4 informed the surveyor that the remaining narcotic BINGO cards for the logbook were stored in a second east medication cart.

On 12/14/23 at 1:15 PM, the surveyor and LPN #4 continued the review of the NJ EX Order -floor NJ EX Or narcotics count and logs in medication cart two. The following was observed:
Resident #2's declining inventory log for NJ EX Order. 264b1 (a medication used to treat NJ EX Order. 26 mg tablet was missing a nursing signature for the 12/14/23 9:00 AM dose.
Resident #2 had NJ EX Order. 264b1 mg tablet signed in the MAR as administered 12/14/23 at 11:41 AM and was not signed out in the declining inventory log.
Resident #56 had NJ EX Order. 264b1 mg tablet signed in the MAR as administered NJ EX Order. 264b1 at 11:42 AM and was not signed out in the declining inventory log.
Resident #5's MAR indicated the resident was administered one dose of NJ EX Order. 264b1 medication) oral NJ mg tablet on 12/14/23 at 8:10 AM which was not signed out on the declining inventory log, a dose signed on the declining inventory log on NJ EX Order. 264b1 at 6:00 AM and not signed as administered in the MAR.
Resident #21's p NJ EX Order. 264b1 (medication used to treat NJ EX Order. 264b1 mg BINGO cards contained NJ EX capsules; the declining inventory log indicated

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NJ EX capsules were documented as received from the pharmacy by the nursing staff with NJ EX capsules remaining on hand.
At this time the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated that this was a clerical error in documenting how many capsules were received. The LPN/UM provided a packing slip indicating the facility received NJ EX capsules for Resident #21.

On 12/14/23 at 2:03 PM, the surveyor, in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), interviewed the Director of Nursing (DON). The DON acknowledged that narcotics were to be signed out at the time of dispensing on the declining inventory logs, and there should be no pre-signing or missing signatures on narcotic count logs. The DON further stated that upon receiving of narcotics from the pharmacy, the nursing supervisor and a nurse should confirm the count and document it accurately. The DON provided no answer as to how the incorrect count was documented if two staff members were required to confirm the count together. The DON acknowledged that the incorrect count should have been caught during shift change narcotic reconciliation.

2. On 12/18/23 at 8:03 AM, the surveyor observed Licensed Practical Nurse (LPN#1) prepare three oral medications for Resident #95 which included NJ EX Order. 264b1 Oral Tablet NJ EX mg (milligrams) give one NJ EX tablet, by mouth two times a day for NJ EX Order. 264b1 NJ EX Order. 264b1 mg Total. Start date NJ EX Order. 264b1 ..LPN #1 reviewed the label that was on

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the bingo card (blister pack) in the presence of the surveyor and failed to acknowledge a pharmacy cautionary statement that specified, "Take after a meal..." prior to administration. When asked if the resident had eaten yet? LPN #1 stated that breakfast was not served yet. LPN #1 failed to offer the resident any food at the time of the observation.

On 12/18/23 at at 8:17 AM, the surveyor observed Licensed Practical Nurse (LPN #2) prepare four oral medications for Resident #179 which included NJ EX Order. 264b1 oral tablet NJ EX Order mg Give NJ EX O tablet by mouth NJ EX O times a day for NJ EX Order. 264b1, a disease in which body's NJ EX Order. 264b1 . LPN #2 reviewed the label that was on the bingo card in the presence of the surveyor and failed to acknowledge a pharmacy cautionary statement that specified, "Take with food..." prior to administration. LPN #2 stated, "I give it with a little pudding" and proceeded to put one teaspoonful of pudding in the NJ EX O milliliter (ml) plastic medication cup with the oral medications. The surveyor observed a food cart in the hallway and noted that the meal trays had not yet been distributed to the residents. LPN #2 failed to offer the resident any food at the time of the observation.

On 12/18/23 at 8:52 PM, when interviewed LPN #2 stated that Resident #179 was going directly to the dining room to eat breakfast after he/she received their medications. LPN #2 further stated, "That is why I gave the the medications with pudding."

On 12/18/23 at 9:02 AM, the surveyor interviewed LPN #1 who stated, "She did not normally wait

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until a resident had eaten before she administered their medications." LPN #1 further stated that she did not observe the cautionary statement that specified, "Take medication with food or immediately after a meal." LPN #1 stated, "She should have waited until the tray arrived to administer the medication to avoid stomach upset or dizziness."

On 12/18/23 at 11:05 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the [redacted] Floor 2 East/West Unit who stated, "If the medication label cautioned to administer a medication with food the nurse should ensure that the resident had a meal tray prior to medication administration." LPN/UM stated that one spoonful of pudding was not enough food and was not sufficient enough to give with medications.

On 12/19/23 at 8:33 AM, the surveyor interviewed the Consultant Pharmacist (CP) via speaker phone with permission. The CP stated that we always told the nurses to give [redacted] with a meal when we do in-services (education) due to the side effects of [redacted] if the medication was absorbed in the body too quickly. CP stated that a spoonful of pudding was not a meal, and was not enough. CP stated that nursing usually knew when the trays were expected to be delivered to the nursing unit. CP stated, "I know that nursing anticipated trays, but they do not always know when that will happen." CP stated, "The pharmacy put a lot of cautionary labels on the medications, but I am not fond of that because the writing was very small." CP stated that when she did classes with nursing, she spoke to the classes of medications that needed to be administered with food. CP stated,

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"The professional should know."

On 12/19/23 at 9:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that nursing should make sure that they followed protocol during medication administration. The DON stated that the nurses should look at those residents with NJ EX Order: 264b1 first and ensured that they had breakfast so that medications were given with meals. She stated that nursing should read the precautionary instructions for residents who were on specialized medications to ensure that medications were administered at the right time. The DON stated that Metoprolol should not be administered until the meal was in front of the resident. She stated that it was not appropriate to give NJ EX Order: 264b1 with a spoonful of pudding because it must be given with food, even if the resident was going to the dining room after. The DON stated that she would ensure that NJ EX Order: 264b1 was instead administered with a meal.

The surveyor reviewed the facility policy, "Hand Hygiene" (Revived 07/23) which failed to provide documentation that pertained to adherence to the cautionary statements during medication administration.

Review of the facility's "Schedule II Controlled Substance Medication" policy with effective date 2023 included but was not limited to:
"a declining inventory sheet will be provided with each dispensed prescription for controlled dangerous medications. The form will contain the following information: patient name, medication name, medication strength, dosage form, name of prescribing physician, amount dispensed, prescription number and date dispensed. When the licensed staff member/nurse receives a CDS

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F 755	Continued From page 46 medication from the pharmacy, he/she will verify the contents with the label and will note the date received and quantity on the declining inventory form. When a CDS medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials. An inventory count of all CDS medications stored on each nursing unit shall be performed at each change of each shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form." NJAC 8:39-29.7(c);29.2(d)	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		1/29/24

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F 761	Continued From page 47 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) properly store medications and properly label opened multidose medications. This deficient practice was observed in 4 of 4 medication carts and 1 of 2 medication storage rooms reviewed for medication storage and labeling and was evidenced by the following: On 12/14/23 at 9:58 AM, the surveyor, in the presence of the Licensed Practical Nurse #1 (LPN #1) reviewed the fifth floor's east side medication cart. The surveyor observed one opened [redacted] milliliter (ml) bottle of NJ EX Order. 264b1 and one opened [redacted] ml bottle of NJ EX Order. 264b1 stored in the space as opened containers of over the counter (otc) medications. One opened undated and not labeled [redacted] ml bottle of NJ EX Order. 264b1 solution (prescription used to treat g, NJ EX Order. 264b1 in the) and [redacted] ml opened bottle of NJ EX Order. 264b1 solution (prescription used to treat were both stored alongside and (injectable medication for One opened and undated NJ EX Order. 264b1 (medication used to treat NJ EX Order. 264b1 and one opened and undated foil pouch of	F 761	1. There were no residents affected by the deficient practice. At the time of the inspection all loose pills were properly disposed of , any expired medication was removed from the med room, any unlabeled or undated medication was removed from the medication carts, all medications were organized by route of administration. 2. All resident receiving medication are at risk to be affected by the deficient practice. 3. The Medication storage policy was reviewed and updated. Nurses were re-educated on the policy and proper labeling, dating, sorting and medication disposal. 4. The DON or designee will audit two medication rooms and two medication carts per week for 60 days to ensure all medications are within proper date, labeled, not expired and not loose in the cart. The results of these audits will be reported to the QAPI committee for 2 months.	

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NJ EX Order 2 NJ EX Order. 264b1 milligrams (mg)/3 ml (medication used to treat NJ EX Order. 264b1 and 13 loose pills of various shapes, colors, and sizes.

At this point the surveyor interviewed LPN #1. When asked about the undated and unlabeled NJ EX Order. 264b1 solution, the LPN stated she could not identify which resident it belonged to or when it was opened. LPN #1 further stated that these undated medications should have been labeled with the date opened as well as resident's name to whom it belonged. LPN #1 acknowledged that there should have been no loose pills in the cart, and medications should have been separated according to the method of their administration (eye drops, oral medication, injectables, liquids, inhalers). She then collected and disposed of the identified loose pills in the drug buster (solvent used to dissolve medication) bottle.

On 12/14/23 at 10:50 AM, the surveyor, in the presence of LPN #2 reviewed the NJ EX Order -floor NJ EX Order side's medication cart. The surveyor observed a total of 85 loose pills of various shapes, colors, and sizes which included two pills located in the locked controlled substance box within the cart.

At this point LPN #2 acknowledged that there should have been no loose pills in the medication cart, collected them and disposed of them in the medication drug buster bottle.

On 12/14/23 at 11:32 AM, the surveyor, in the presence of LPN #3 reviewed the NJ EX Or -floor NJ EX Order medication cart. The surveyor observed a total of 78 loose pills of various shapes, colors, and sizes.

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At this point LPN #3 acknowledged that there should have been no loose pills in the medication cart, collected them and disposed of them in the medication drug buster bottle.

On 12/14/23 at 12:06 PM, the surveyor, in the presence of LPN #4 reviewed the [redacted]-floor's medication storage room. The surveyor observed one expired bottle of [redacted] tablets of [redacted] (a medication used to [redacted] mg which was dated by the manufacturer with expiration date [redacted].

On 12/14/23 at 12:40 PM, the surveyor, in the presence of LPN #5 reviewed the [redacted]-floor [redacted] side's medication cart. The surveyor observed a total of 23 loose pills of various shapes, colors, and sizes.

At this point LPN #5 acknowledged that there should have been no loose pills in the medication cart, collected them and disposed of them in the medication drug buster bottle.

On 12/14/23 at 2:03 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), who stated that a contracted pharmacy consultant comes on a monthly basis to check medication storage and carts and was present in the facility "last week."

Review of the facility's "Medication Storage" policy with effective date 2023 included but was not limited to: "medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the residents and is in accordance with NJ Department of Health Guidelines ... medications for external use will be

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F 761	Continued From page 50 stored separately from medications for internal use. Ophthalmic, otic and nasal products will be stored separately from other medications for internal use. Medications will be stored in an orderly and organized manner in a clean area ... medications will be stored in the original, labeled containers received from the pharmacy. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy." N.J.A.C. 8:39-29.4	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint #NJ00156539 and NJ00156915 Based on observation, interviews, and review of pertinent facility documentation it was determined that the facility failed to serve hot foods at an acceptable temperature for the residents. This deficient practice was identified in the kitchen tray line during the plating of the lunch meal service for the [redacted] floor [redacted] side.	F 804	1. No residents were negatively affected by the deficient practice. The Spaghetti was immediately reheated to proper temperature. 2. All residents are at risk to be affected by the deficient practice. 3. Food Service Director and Cooks were in-serviced on what the proper temperature should be as per facility policy.	1/29/24

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F 804	Continued From page 51 The deficient practice was evidenced by the following: On 12/19/23 at 12:22 PM, the surveyor met with the Food Services Director (FSD) to obtain food temperatures on the kitchen tray line. The FSD obtained a thermometer and stated that it was the thermometer that was used to check the lunch meal. The FSD and surveyor approached the cook area where steam was observed coming from the steam table. The FSD tested the temperature of spaghetti which read 85 degrees Fahrenheit (F). The FSD instructed the cook to mix up the pasta and the FSD rechecked the temperature which read 85 degrees F. The FSD checked the temperature of a meatball which read 127 degrees F and checked the temperature of a hot dog which read 118 degrees F. When asked what the temperature for the spaghetti and the meatball should have been, the FSD stated 135 degrees F and above, and when asked what the temperature for the hot dog should have been, the FSD stated 140 degrees F and above. On 12/19/23 at 12:35 PM the surveyor met with the Vice President of Dining Services (VPDS) who was made aware of the food temperatures at the steam table. At that time, in the presence of the VPDS and FSD, the Food Temperatures log was reviewed and the VPDS stated that the recorded temperatures for the lunch meal service were done at 11:25 AM. Per the log, the recorded lunch meal temperatures read: meat 180 F, potato/rice 177 F, gravy 186 F, vegetables 0 F, pureed meat 189 F, pureed vegetable 187 F, mashed potato	F 804	4. Food Service Director / Designee will test the temperature of 3 trays prior to leaving the kitchen for 3 meals a week for 4 weeks then monthly for 3 months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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F 804	Continued From page 52 177 F, ground meat 180 F, coffee 187 F, milk 40 F, juice 39 F. During an interview at that time, the VPDS stated, "the temperature at the steam table should have been 140 degrees F and above but usually on the steam table it was 160 degrees and above." A review of the facility's policy, "Food Temperatures," revised 10/2023, revealed: Procedure: Acceptable serving temperatures are: Meat, entrees >140 degrees but preferably 160-175 degrees. Potatoes, pasta >140 degrees but preferably 160-175 degrees.	F 804		
F 812 SS=E	NJAC 8:39-17.4(a)2 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		1/29/24

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F 812	Continued From page 53 This REQUIREMENT is not met as evidenced by: Complaint #NJ00156539 Based on observations, interviews and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) failed to maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 12/12/23 from 10:19 AM-11:47 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the following: 1. A dietary aide (DA#1) was sorting silverware and placing them into clear plastic bags that contained a napkin. He stated that he was bagging clean silverware for the meal trays. The DA was wearing a hairnet on his head with hair exposed behind each ear. DA#1 had long chin hair and was not wearing a beard guard. During an interview at that time, DA#1 acknowledged that no hair should have been exposed and that he was not wearing a beard guard. He stated that hair nets were to have been worn in the kitchen and that no hair should have been visible outside of the hairnet. DA#1 stated that it was important to wear hair coverings correctly, so hair did not get into the food.	F 812	1. Dietary Aide #1 and #2 were immediately in-serviced on requirements to wear hair coverings correctly. All food without a use By, Pull, Received and or Expiration date were immediately discarded. All unsealed food was immediately discarded. All dented cans were immediately moved to the dented cans section. The red sanitizer bucket was immediately removed and refilled with proper amount of sanitizing solution. All cutting boards with imperfections were immediately removed from the kitchen and discarded. The Slicer was immediately cleaned and recovered. Emergency order placed to replenish 3-day backup supply. 2. All residents are at risk to be affected by the deficient practice. 3. All Dietary staff were in-serviced on the facility policy titled “Personal Hygiene.” All Dietary staff were in-serviced on the facility policy titled “Food Storage.” All Dietary staff were in-serviced on the facility policy titled “Dented Can Policy.” All Dietary staff were in-serviced on the facility policy titled “Sanitation Policy.” All Dietary staff were in-serviced on the facility policy titled “Food Equipment”.	

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F 812	Continued From page 54 2. A dietary aide (DA#2) was placing applesauce into plastic cups on a large tray. DA#2 stated that she was prepping applesauce cups. DA#2 was observed wearing a hairnet on her head with shoulder length hair exposed behind each ear. She acknowledged that her hairnet was not fully covering her hair and stated that it was important to wear a hairnet correctly so that no hair fell into the food. During an interview at that time, the FSD stated that the policy on hairnets in the kitchen was that all staff were to cover their hair when in the kitchen, and acknowledged they were not wearing the hairnets correctly. 3. On a rolling metal rack in the walk-in refrigerator there were three full trays of cooked ribs that were partially covered with clear plastic wrap with the ribs visible and exposed to air on each tray. There was one full size deep pan that contained four 10 pound (lb) sealed bags of defrosted chicken that were resting in cloudy pink liquid. One of the bags of chicken had a sticker marked pull date 12/10/23 use by 12/15/23, and there was no pull date or use by stickers on the other three bags of chicken. There was one half size roaster pan that contained two 10 lb sealed bags of diced beef cubes with one bag that had a sticker marked pull date 12/11/23 use by 12/15/23, and there was no pull date or use by sticker on the other bag of diced beef cubes. There was another half size roaster pan that contained two 10 lb sealed bags of diced beef cubes with one bag that had a sticker marked pull date 12/11/23 use by 12/15/23, and there was no pull date or use by sticker on the other bag of diced beef cubes.	F 812	All Dietary staff were in-serviced on the facility policy titled “Emergency Food Supply.” 4. Food Service Director / Designee will: A) Audit staff weekly X4 weeks, then monthly X3 months to ensure compliance with Personal Hygiene. B) Audit dry goods storage weekly X4 weeks, then monthly X3 months to ensure proper storage is adhered. C) Audit dented cans weekly X4 weeks, then monthly X3 months to ensure dented cans are stored in proper locations. D) Audit sanitizer bucket weekly X4 weeks, then monthly X3 months to ensure proper sanitizing solution amounts are being used. E) Audit cutting boards weekly X4 weeks, then monthly X3 months to ensure proper equipment is being used. F) Audit the slicer weekly X4 weeks, then monthly X3 months to ensure the slicer is in clean and sanitary condition. G) Audit Emergency backup supply weekly X4 weeks, then monthly X3 months to ensure proper backup supply is adequate. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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During an interview at that time, the FSD acknowledged that the ribs were not covered correctly with clear plastic wrap and that the chicken and the beef cubes were not marked. He stated that food could only be defrosted for five days and that it was important to mark the food items with pull dates and use by dates so that everyone knew the life of the food as it could have been spoiled past the date.

4. On the same rolling metal rack, there was one defrosted 8 lb sealed package of cooked roast beef marked with a manufacturer's stamp use or freeze by 11/29/23. The roast beef was soft to touch with liquid observed contained in the packaging. The FSD acknowledged there was no pull date and was unable to state when it was received or pulled. He further stated that the roast beef should have had a use by and received date and that it was important to label and date all food items to ensure the products were not expired. The FSD told a DA to discard the roast beef.

5. On a metal shelf in the walk-in freezer, there was one half pan partially covered with clear plastic wrap that contained sliced pieces of white meat that had two uncovered areas, with the meat visible and exposed to air. There were several pieces of chunks of ice on the plastic wrap and on the meat. There was a sticker on the plastic that was marked prep 12/5/23, use by 12/7/23, and a second sticker marked open 12/6/23, use by 6/3/24. The FSD identified the meat as sliced pork and acknowledged the pork was not covered correctly and stated it was freezer burnt. The FSD further stated that it should have been completely covered to prevent freezer burn and so that taste was maintained.

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There was one half pan of pasta that was partially covered with clear plastic wrap, that the FSD identified as stuffed shells. There were several pieces of chunks of ice on the plastic wrap and on the shells. There was a sticker on the plastic that was marked open 10/29/23, use by 4/26/24. The FSD acknowledged the ice and stated that they were garbage and threw away the shells and the pork. Resting on the bottom shelf of a metal rack there was one sealed 10 lb frozen log of ground beef with a manufacturer's stamp marked best before or freeze by 11/10/23. There was no received date marked on the ground beef. When the surveyor inquired as to whether the meat was still good, the FSD stated yes but stated he did not know when it was received or frozen. The FSD acknowledged that the ground beef should have had a received date on it and told the DA to discard it.

6. On the bread rack there was one half loaf of rye bread in an unsealed bag that was open to air. There was one 12 pack of English muffins that had no received or expiration date. The FSD acknowledged that the rye bread should not have been stored unsealed and that he did not know when the English muffins came in. The FSD removed the bread from the rack.

7. On the can rack in the dry storage room, there were two dented 106 ounce (oz) cans of fruit mix and one dented 7 lb 5 oz can of jellied cranberry sauce. The FSD acknowledged the dents and stated that the dented cans should have been in the dented can section. He further stated that it was important that dented canned foods were not used because they could have contained bacteria.

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8. On the bottom shelf of a metal table at the cook's area there was a green bucket that contained soapy liquid which the FSD identified as the cleaning bucket. There was a red bucket that contained clear liquid that the FSD identified as sanitizer. The FSD stated that after the cook used the metal table that it would have been washed and then wiped with the sanitizer. The FSD tested the sanitizer liquid with a Hydrion test strip which resulted in an orange color and read zero. The FSD stated that it should have been between 200 and 400 parts per million (ppm.) The FSD removed the red bucket, refilled it, and retested it. It then read 200 ppm.

9. On a rack in the dry storage area, there was: one green cutting board with scrapes and gouges; two large green cutting boards with black smudges and gouges; and one blue cutting board with scrapes, gouges, and large amounts of white debris that the FSD scraped off with his fingernail. The FSD acknowledged that the cutting boards should not have scrapes, gouges, and smudges and stated that it was important not to use them because dirt could have gotten stuck on them and transferred to the food. The FSD removed the cutting boards from the area and stated they would be replaced.

10. The slicer was covered with a clear plastic bag which the FSD stated meant the machine was clean. The FSD removed the bag and there was a small amount of clear liquid noted on the base and a large amount of stuck on brown debris noted on the underside of the rocker tray. The FSD acknowledged the debris and stated that it should not have been there. The FSD further stated that it was important to keep equipment clean to prevent bacterial

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contamination.

11. In the emergency food closet, there were two 108 oz cans of ravioli, six 108 oz cans of chili con carne, one case of applesauce, two cases of pureed chicken broth, one case of three bean salad, three cases of diced fruit, two cases of fruit mix, one case of dry milk.

During an interview at that time, the FSD acknowledged the food items and stated that there should have been enough food for a three-day supply for all the residents. The FSD stated there were [redacted] residents in house and that he did not think there was enough food in the emergency storage. He stated there was more in the paper room.

12. In the paper room, for emergency food storage, there were three cases of nectar thickened orange juice and one case of mashed potatoes. The FSD stated that it was his responsibility to keep track of the emergency food and that it was checked every month and stated, "but sometimes if they need something they will take it from here and not tell me."

On 12/12/23 at 01:36 PM, the surveyor met with the FSD and again toured the emergency food storage. The surveyor requested to have the Licensed Nursing Home Administrator (LNHA) join the tour.

On 12/12/23 at 01:44 PM, the surveyor escorted the LNHA to the kitchen to tour the emergency food and water. In the presence of the FSD, the surveyor told the LNHA of the emergency food observations and asked if this was all the food that should be here. The FSD stated no, that it

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was not an adequate emergency supply for all the residents and that he had to restock. The LNHA stated, "It seems like there should be more." When the surveyor inquired if there was enough emergency water, both the FSD and LNHA stated no. The FSD stated that there should have been one gallon per day for three days for each resident. The LNHA stated that he was not sure of the policy and that it was important to have enough emergency food and water because you "never know what can happen."

On 12/13/23 at 11:58 AM, in the presence of the FSD, the surveyor toured the kitchen and observed DA#1 at a prep table scooping cinnamon apples. DA#1 was wearing a hairnet on his head and was not wearing a beard guard on his long chin hair. DA#1 stated he was scooping apples for dessert, acknowledged he was not wearing a beard guard, and stated that he should have been wearing a beard guard. DA#1 left the area.

During an interview at that time, the FSD stated that it was the FSD and assistant FSD's responsibility to ensure the staff were wearing appropriate hair coverings but stated, "They don't listen." The FSD further stated it was important to wear hairnets and beard guards in the kitchen so hair would not get into the food.

On 12/19/23 at 12:35 PM, the surveyor interviewed the Vice President of Dining Services (VPDS) who was made aware of the emergency food observation from 12/12/23 with photographs provided. When the surveyor inquired as to whether that was enough emergency food, the VPDS stated, "No, for 3 days, no that is not enough." and that the facility should have had "a

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lot" of emergency food. The VPDS further stated, "we need at least three day's emergency supplies."

On 12/19/23 at 02:05 PM, the Administration team was made aware of all the kitchen concerns.

A review of the facility document, "Inventory Checklist-Emergency Food Supply," dated 12/14/23, revealed a list of emergency foods on hand. The document also revealed, *FSD/Supervisor will do an inventory every month and was signed by the FSD.

On 12/20/23 at 11:15 AM, the surveyor requested from the Vice President of Dining Services (VPDS) the last three months of inventory checklist for the emergency food supply. He stated that the FSD was unavailable and would provide the document.

On 12/20/23 at 11:17 AM, the surveyor requested from the FSD the last three months of inventory checklist for the emergency food supply. The FSD stated, "I don't think we have that." No further documentation provided.

A review of the facility's policy, "Personal Hygiene," reviewed 10/1/2023, revealed Procedure: 3. Head covering worn: if hair is long and not covered properly with a cap, a hairnet must be worn, Beards or any body hair that may be exposed (i.e., arms) must be covered.

A review of the facility's policy, "Sanitation Policy," reviewed 10/1/2023, revealed Policy and Procedure [sic] 4. Green containers contain water and soap solution; the red container contains

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 812	Continued From page 61 sanitizing solution. The sanitizing solution should have a PPM between 200-400. A review of the facility's undated policy, "Dented Can Policy," revealed 1. Dented cans which were received damaged or dented, will be placed on a designated area strictly for dented cans ... A review of the facility's policy, "Emergency Food Supply," reviewed 10/1/2023, revealed Policy: The dietary department will maintain a three day inventory of water and staple food products that require minimal preparation. A review of the facility's policy, "Food Storage," reviewed 10/1/2023, revealed Procedure: All products shall be dated upon receipt or when they are prepared. Use Date shall be marked on all food containers according to the timetable in the Dry, Refrigerated and Freezer Storage Chart ...Leftovers shall be dated according to the Leftovers policy. Raw meat: 4. Fresh meats shall be cooked or frozen within three to four days of purchase depending on the type of meat. 5. All cooked meat shall be used within 3-4 days of cooking. Frozen Meat/Poultry and Foods: Storage: Foods to be frozen shall be stored in airtight containers or wrapped in heavy-duty aluminum foil or special laminated papers. Label and date all food items. Canned Fruits: Dented or bulging cans shall be placed on Damaged Goods Shelf ... NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		2/7/24

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 63 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to maintain proper infection control practices during the Medication Administration Observation. This deficient practice was identified on 1 of 4 nursing units (1 CH Order 2940 Floor 1 EA Order 2940) and for 2 of 3 nurses observed during the medication pass. This deficient practice was evidenced by the following: On 12/18/23 at 8:03 AM, the surveyor observed	F 880	1. Residents #95,31,179,28,192 were not negatively affected by the deficient practice. LPN #1 and 2 were immediately re-educated on hand hygiene. Residents #28,31,95,179,192 all had the potential to be but were not negatively affected by the deficient practice. 2. All residents are at risk for the development and transmission of communicable diseases and infections due to the deficient practice. 3. The policies Hand hygiene, and Medication Administration were reviewed	

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F 880	Continued From page 64 Licensed Practical Nurse (LPN #1) who was assigned to the [redacted] Medication Cart as she prepared medications and administered them to Resident #95. When finished, LPN #1 failed to perform hand hygiene before she returned to the medication cart and charted the medications as administered. At 8:09 AM, LPN #1 obtained the automated blood pressure machine and entered the room of Resident #31. LPN #1 was observed placing the [redacted] on the resident's [redacted] and obtained a reading. LPN #1 removed the blood pressure cuff from the resident and failed to clean the blood pressure cuff or perform hand hygiene when finished. At 8:10 AM, LPN #1 returned to the medication cart, obtained the keys to the medication cart from her pocket and opened the medication cart. LPN #1 then proceeded to prepare medications for Resident #31, which the resident refused. LPN #1 returned to the medication cart with the resident's medications, opened the bottom drawer of the cart and obtained a canister of drug solvent (used to dissolve medications) and placed the medications in the solvent and returned the canister of solvent to the bottom drawer of the medication cart. On 12/18/23 at 9:02 AM in a later interview with LPN #1, she stated that she should have performed hand hygiene between residents and cleaned the NJ EX Order. 264b1 after use to prevent cross-contamination. On 12/18/23 at 8:14 AM, the surveyor observed LPN #2 who was assigned to the [redacted] Medication Cart. The surveyor observed LPN #2	F 880	and updated. Licensed Nurses were re-educated on these policies with focus on hand hygiene during medication administration. The policy Cleaning and Disinfection of reusable equipment was reviewed and updated. Licensed nurses were re-educated n the proper disinfection of re-usable equipment, including [redacted] NJ EX Order. 264b1 4. The Infection Preventionist or designee will conduct 5 random audits of nurses during medication pass per week for 30 days and 3 per week for an additional 30 days to ensure that hand hygiene is being performed as per policy. The Infection Preventionist or designee will audit 3 residents per week for 60 days while getting their vital signs taken to ensure that proper disinfection of the [redacted] NJ EX Order. 264b1 afterwards is completed as per policy. The audits will be reported to the QAPI committee for two months. The results of these audits will be reported to the QAPI committee for 2 months.	

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F 880	Continued From page 65	F 880		

as she placed a NJ EX Order. 264b1 on Resident #179's NJ EX Order. 264b1 and a NJ EX Order. 264b1 (measures the percentage of NJ EX Order. 264b1 NJ EX Order on the resident's NJ EX Order. 264b1 and obtained a reading. When finished, LPN #2 removed the NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order and proceeded to clean them with disinfectant wipes without first donning (putting on) gloves. LPN #2 failed to perform hand hygiene when she finished cleaning the equipment before she proceeded to access the computer to view the resident's scheduled medications. At 8:25 AM, LPN #2 then proceeded to wash her hands for 21 seconds in the presence of the surveyor after she medicated the resident.

At 8:26 AM, the surveyor observed LPN #2 as she placed a NJ EX Order. 264b1 on Resident #28's NJ EX Order. 264b1 and NJ EX Order. 264b1 on the resident's NJ EX Order. 264b1 and obtained a reading. When finished, LPN #2 removed the NJ EX Order and NJ EX Order. 264b1 and proceeded to clean them with disinfectant wipes without first donning gloves. LPN #2 failed to perform hand hygiene when she finished cleaning the equipment before she proceeded to access the computer to view the resident's scheduled medications.

At 8:38 AM, LPN #2 performed hand hygiene with alcohol based hand rub (ABHR) after she returned to the medication cart. LPN #2 then proceeded to prepare Resident #192's medications. LPN #2 noted that the resident's NJ EX Order. 264b1 Patch (topical agent used to NJ EX Order. 26 NJ EX Order was not available in the medication cart. LPN #2 administered all oral medications to the resident and signed them out in the computer as administered. When finished, LPN #2 went to the

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medication room and opened the locked door with a key that was in her pocket to look for the NJ EX Order. 264b1 Patch. LPN #2 opened and closed the medication refrigerator door while in the medication room. LPN #2 obtained NJ EX Order. 264b1 NJ EX Patches from stock medications and proceeded to return to the medication cart after. LPN #2 then opened the NJ EX Order. 264b1 packaging and wrote her initials, date and time on the back of the patch. LPN #2 then donned gloves without first performing hand hygiene, entered the resident's room, pulled up the resident's shirt and adjusted the resident's pants and applied the patch to the resident's NJ EX Order. 264b1 as ordered. When finished, LPN #2 doffed her gloves and washed her hands for 22 seconds before she signed out the medication as administered.

At 8:52 AM, in a later interview with LPN #2, she stated that she did not think to wash her hands before she donned her gloves and administered the NJ EX Order. 264b1 Patch to Resident #192 as she did not think that it was necessary to wash her hands before she donned gloves. LPN #2 further stated, "It was not necessary."

On 12/18/23 at 11:05 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the NJ EX Order. 264 Floor NJ EX Order. 2 Unit who stated that nursing was required to wash their hands prior to medication preparation and administration because failure to do so was an infection control issue. LPN/UM stated that nursing should also wash their hands between residents to prevent contamination. LPN/UM stated that if the NJ EX Order. 264b1 and NJ EX Order. [redacted] were not cleaned after use it could result in cross-contamination. LPN/UM stated that she would wear gloves when the NJ EX Order. [redacted]

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NJ EX Order. 264b1 and NJ EX Order. 264b1 were cleaned and perform hand hygiene after as the resident may have something that was contagious. LPN/UM further stated that nursing should wash their hands and donn gloves prior to NJ EX Order. 264b1 Patch application to protect both the nurse and the resident from sickness.

On 12/19/23 at 9:18 AM, the surveyor interviewed the Infection Preventionist Registered Nurse (IP/RN) who stated, "Hand hygiene was the most important thing during the medication pass because it was the number one tool to prevent infection."
He stated that hand washing should be done after medication administration and vital signs NJ EX Order. 264b1 and NJ EX Order. 264b1) were obtained because there was a possibility to transmit something to the next resident. IP/RN stated that gloves should be worn when the blood pressure machine was cleaned because the dirt that may be on the hands reduced the effectiveness of the cleaning agents. IP/RN stated that if the equipment were cleaned without gloves and hand hygiene not performed prior to medication administration both the computer equipment and medications may be cross-contaminated. IP/RN stated that hand hygiene was basic and glove use was not to be substituted in lieu of hand washing which was the "golden rule".

On 12/19/23 at 9:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that nursing should wash their hands before they accessed the computer to review the resident's medications and obtained all necessary items before seeing the resident. The DON stated that nursing was required to make sure that

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F 880	Continued From page 68	F 880		

equipment was disinfected and hand hygiene was completed to prevent cross-contamination to another resident. She stated that you must wear gloves and perform hand hygiene after when the blood pressure machine was cleaned because it was a standard of practice and failure to do so could result in cross-contamination. The DON stated that nursing was required to perform hand hygiene prior to donning gloves and after doffing (removing) gloves during medication administration.

Review of the facility policy, "Hand Hygiene" (Reviewed 07/23) revealed the following:

...In this facility, hand hygiene is performed by using either alcohol-based hand rub (ABHR) or washing hands with soap and water.
Purpose: Hand hygiene is a simple and effective method for preventing the spread of pathogens, such as bacteria and viruses, which cause infections. Pathogens can contaminate the hands of a staff member during direct contact with residents or contact with contaminated equipment and environmental surfaces within close proximity of a resident. Failure to clean contaminated hands can result in the spread of these pathogens to residents, staff (including the person whose hands were contaminated), and environmental surfaces.
To Protect our residents, visitors and staff, our facility promotes hand hygiene practices during all care activities when working in all locations within the facility.
...Hand washing with a non-antimicrobial soap and water or with anti-microbial soap and water is indicated for the following:
Before having contact with patients
...After contact with a patient's intact skin (e.g.,

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F 880	Continued From page 69 when taking a pulse or blood pressure, and lifting a patient) ...After contact with inanimate objects (including medical equipment in the immediate vicinity of the patient) After removing gloves... Review of the facility policy, "Medication Administration" (Reviewed 07/23) revealed the following: Procedure: Wash hands...Perform necessary assessments prior to administering specific medications. Example: pulse, blood pressure... ...Wash hands, Proceed to the next resident/patient as indicated. NJAC 8:39-19.4 (a)	F 880		

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S 000	Initial Comments Complaint # NJ00156915, NJ00157069,NJ155925,NJ00159043,NJ0015963 1,and NJ00156539 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #s: NJ00156915, NJ00157069,NJ155925,NJ00159043,NJ0015963 1, and NJ00156539 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to: a) train the two (2) appointed designated staff members and the facility staff within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency	S 560	1. Additional staff member signed up for LGBTIA+ training by certified provider. Staffing coordinator was immediately re in-serviced on staffing ratio requirements. 2. All residents are at risk to be affected by the deficient practice. 3. Human resources director was in-serviced on the need to have 2 staff members with training by a certified provider. New staffing agency contracted to help provide staff, Shift bonuses offered to pick up extra shifts.	1/29/24

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

Electronically Signed | 01/15/24

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S 560	Continued From page 1 Virus [a virus that attacks cells that help the body fight infection] positive) program and b) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:	S 560	4. Administrator / Designee will review the staff members with certification once a week for 4 weeks then monthly for 3 months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed. Staffing coordinator / Designee will review the staffing ratio once a week for 4 weeks then monthly for 3 months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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S 560	Continued From page 2 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual	S 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060408	A. BUILDING: _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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S 560	Continued From page 4 directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including an employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.	S 560		

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 5 The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. A. On 12/12/23 at 10:56 AM, during the entrance conference both the Licensed Nursing Home	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060408	A. BUILDING: _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 6 Administrator (LNHA) and Director of Nursing (DON) stated that they had both completed their LGBTQI+ Training and agreed to furnish the surveyor with their certificates of completion and evidence of staff training competencies. On 12/13/23 at 4:00 PM, the LNHA provided the surveyor with his Certificate of Completion dated 09/30/22, to confirm that he had successfully completed the LGBTQI+ Resident's Rights: Designated Representative Training. The LNHA also provided copies of staff in-service records titled, "LGBTQI and HIV+ Residents Have Rights" staff education that was provided to the facility staff by the DON under her previous title of Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 11/17/22 and 12/04/22. The DON who was present at that time, stated that she successfully completed the training but was unable to find her certificate. The LNHA stated that he had attempted to reach out to the New Jersey Hospital Association in order to obtain validation of the DON's successful course completion and awaited a response. On 12/18/23 at 10:38 AM, The DON stated that she contacted the LGBTQI+ website administrator and was informed that there was no record of her online course completion. The DON confirmed that she was unable to provide documented evidence of course completion to establish that the facility designated two employees, including an employee representing management at the facility and one employee representing direct care staff at the facility, and received in-person training and provided staff training within six months after the effective date of the LGBTQI+ Law.	S 560		

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 7 B .Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 01/23/2022 to 02/05/2022, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -01/23/22 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -01/24/22 had 22 CNAs for 187 residents on the day shift, required at least 23 CNAs. -01/29/22 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs.	S 560		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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S 560	Continued From page 8 -01/30/22 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. 2. For the week of Complaint staffing from 06/19/2022 to 06/25/2022, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -06/19/22 had 23 CNAs for 197 residents on the day shift, required at least 25 CNAs. -06/20/22 had 23 CNAs for 197 residents on the day shift, required at least 25 CNAs. -06/22/22 had 22 CNAs for 197 residents on the day shift, required at least 25 CNAs. 3. For the 2 weeks of Complaint staffing from 07/31/2022 to 08/13/2022, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -07/31/22 had 20 CNAs for 200 residents on the day shift, required at least 25 CNAs. -08/01/22 had 23 CNAs for 200 residents on the day shift, required at least 25 CNAs. -08/03/22 had 22 CNAs for 199 residents on the day shift, required at least 25 CNAs. -08/06/22 had 24 CNAs for 199 residents on the day shift, required at least 25 CNAs. -08/09/22 had 23 CNAs for 199 residents on the day shift, required at least 25 CNAs. -08/10/22 had 23 CNAs for 199 residents on the day shift, required at least 25 CNAs. -08/12/22 had 22 CNAs for 202 residents on the day shift, required at least 25 CNAs. 4. For the 3 weeks of Complaint staffing from 10/09/2022 to 10/29/2022, the facility was	S 560		

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 9	S 560		

deficient in CNA staffing for residents on 15 of 21 day shifts as follows:

-10/09/22 had 23 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-10/10/22 had 22 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-10/11/22 had 23 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-10/12/22 had 22 CNAs for 194 residents on the day shift, required at least 25 CNAs.
-10/15/22 had 20 CNAs for 197 residents on the day shift, required at least 25 CNAs.

-10/16/22 had 24 CNAs for 197 residents on the day shift, required at least 25 CNAs.
-10/17/22 had 21 CNAs for 197 residents on the day shift, required at least 25 CNAs.
-10/22/22 had 24 CNAs for 200 residents on the day shift, required at least 25 CNAs.

-10/23/22 had 20 CNAs for 200 residents on the day shift, required at least 25 CNAs.
-10/24/22 had 21 CNAs for 200 residents on the day shift, required at least 25 CNAs.
-10/25/22 had 26 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-10/26/22 had 26 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-10/27/22 had 25 CNAs for 222 residents on the day shift, required at least 28 CNAs.
-10/28/22 had 26 CNAs for 225 residents on the day shift, required at least 28 CNAs.
-10/29/22 had 24 CNAs for 224 residents on the day shift, required at least 28 CNAs.

5. For the 2 weeks of staffing prior to survey from 11/26/2023 to 12/09/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts and deficient in total staff for residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 10 on 1 of 14 overnight shifts as follows: -11/26/23 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs. -11/27/23 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. -11/30/23 had 27 CNAs for 226 residents on the day shift, required at least 28 CNAs. -12/01/23 had 26 CNAs for 226 residents on the day shift, required at least 28 CNAs. -12/02/23 had 24 CNAs for 225 residents on the day shift, required at least 28 CNAs. -12/03/23 had 23 CNAs for 225 residents on the day shift, required at least 28 CNAs. -12/04/23 had 25 CNAs for 224 residents on the day shift, required at least 28 CNAs. -12/05/23 had 25 CNAs for 223 residents on the day shift, required at least 28 CNAs. -12/06/23 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. -12/07/23 had 27 CNAs for 223 residents on the day shift, required at least 28 CNAs. -12/08/23 had 26 CNAs for 222 residents on the day shift, required at least 28 CNAs. -12/08/23 had 14 total staff for 222 residents on the overnight shift, required at least 16 total staff. -12/09/23 had 25 CNAs for 222 residents on the day shift, required at least 28 CNAs. On 12/20/23 at 9:55 AM, the surveyor interviewed the Staffing Coordinator (SC). The surveyor asked the SC if she was familiar with the regulations regarding staffing, and she replied, yes and she was able to state the required ratios. The SC stated she did the staffing schedules daily and if there were struggles, she informed administration. The SC further stated that the facility followed the ratios until there were call outs.	S 560		

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 11 On 12/09/23 at 11:48 AM, the surveyor reviewed the Nursing Services and Sufficient Staff policy last reviewed on 7-2023. The policy reflected that the facility would supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance New Jersey State guidelines with regards to staffing ratios for all licensed nurses and Certified Nurse Assistants. NJAC 8:39-5.1(a)	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. 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 provide two evening activity programs per week. This deficient practice was identified in 2 of 3 months reviewed, October 2023 and November 2023 and was evidenced by the following: On 12/18/23 at 10:15 AM, the surveyor held a Resident Council meeting with four residents, Resident # 28, #55, #130, and #134. The surveyor asked about activities and four of the four residents in attendance told the surveyor they were pleased with the activities, but the facility did not offer any evening activities for the	S 720	1. Activities were immediately initiated. 2. All residents are at risk to be affected by the deficient practice. 3. Activities director in-serviced on requirements to have at 2 evening activities per week. 4. Activities director / Designee will review evening activities once a week for 4 weeks then monthly for 3 months. Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	1/29/24

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 720	Continued From page 12 residents. On 12/19/23 at 09:15 AM, the surveyor reviewed the Activities calendar for the months of October, November, and December of 2023. Review of the three months revealed that all activities stopped after the 3:00 PM activity. On 12/19/23 at 10:13 AM, the surveyor interviewed the Acting Director of Activities (AAD) who stated the facility did have evening activities until, "The activities aide was out sick". The surveyor asked why the evening activities were not on the activities calendar and she told the surveyor it was her first time doing the calendar in December and she forgot to add the evening activities. The AAD stated, "I made flyers, and they got posted in elevators and on units". The AAD provided the surveyor with the flyers for the December evening activities for review. The AAD stated the evening activities in December started at 6:00 PM and included board games, cards, and trivia depending on the crowd who attended. The surveyor then asked about the evening activities for the months of October and November and the AAD replied, "I wasn't the Acting Director for October and November". On 12/21/23 at 12:07 PM, the surveyor reviewed the policy titled, "Activities", with a reviewed date of 07/2023. Which revealed under the procedure section, number three, that the facility would offer one evening activity per week, depending on population needs.	S 720		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060408		4/15/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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 01/29/2024	ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 01/29/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060408		4/15/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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 01/29/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
12/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315187 Y1	A. Building B. Wing Y2	4/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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 F0580	Correction	ID Prefix F0584	Correction	ID Prefix F0641	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed
LSC	01/15/2024	LSC	01/29/2024	LSC	01/15/2024
ID Prefix F0658	Correction	ID Prefix F0695	Correction	ID Prefix F0697	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(k)	Completed
LSC	01/15/2024	LSC	01/22/2024	LSC	01/29/2024
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0804	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	01/29/2024	LSC	01/29/2024	LSC	01/29/2024
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/29/2024	LSC	02/07/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/20/2023	☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315187	A. Building B. Wing	4/15/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ECHELON CARE & REHAB	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

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 F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 01/15/2024	ID Prefix F0804 Reg. # 483.60(d)(1)(2) LSC	Correction Completed 01/29/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/29/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
12/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO