| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315279 | A. BUILDING _____ B. WING _____ | 02/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **EMBASSY MANOR AT EDISON NURSING AND REHABILITATION** | **10 BRUNSWICK AVENUE EDISON, NJ 08817** |

| (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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| F 000 | INITIAL COMMENTS<br><br>Survey: 2/26/21<br><br>CENSUS: 178<br><br>SAMPLE: 35<br><br>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.<br><br>A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. | F 000 | | |
| F 604 SS=E | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and | F 604 | | 4/16/21 |

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

Electronically Signed | 03/17/2021

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| F 604 | Continued From page 1<br>any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) identify the use of Executive Order 26, 4.b. as a Executive Order 26, 4.b., b.) assess and implement the least restrictive measures prior to the use of a Executive Order 26, 4.b., and c.) obtain a consent with disclosure of risk versus benefits for the use of a Executive Order 26, 4.b. This deficient practice was identified for 2 of 2 residents (Residents #131 and #330) who were reviewed for the use of Executive Order 26, 4.b. and was evidenced by the following:<br><br>1. On 02/19/21 at 12:21 PM, the surveyor observed Resident #330 in his/her bed, wearing Executive Order 26, 4.b. on Executive Order 26, 4.b. The Executive Order 26, 4.b. were tied at the Executive Order 26, 4.b. to hold them in place on the resident's Executive Order 26, 4.b. but were not Executive Order 26, 4.b. The resident was able to move both arms freely.<br><br>The surveyor attempted to interview the resident, | F 604 | 1) Resident #330 Executive Order 26, 4.b. Resident #131 had the Executive Order 26, 4.b. discontinued secondary to Executive Order 26, 4.b.<br>2) The ADON will identify any other residents utilizing Executive Order 26, 4.b. These residents will be re-evaluated for continued use if appropriate or a change to a less restrictive devise if appropriate. All documentation will be completed to either support the change or the continued use of the Executive Order 26, 4.b. as Executive Order 26, 4.b.<br>3) The facility educator will re-educate all nursing staff on proper restraint documentation, including but not limited to evaluation, medical reason for use, care plan, consent, monitoring, releasing, and the utilization of the least restrictive device.<br>4) The DON/ADON will review all cases where Executive Order 26, 4.b. are ordered for a resident to assure appropriateness of use, and complete and accurate | |

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| F 604 | Continued From page 2<br>but the resident did not Executive Order 26, 4.b. Executive Order 26, 4.b. The surveyor observed a Executive Order 26, 4.b. ) in the resident's room which was not connected to the resident at this time.<br><br>On 02/23/21 at 10:18 AM, the surveyor observed the resident again lying in bed with his/her eyes closed. The surveyor noted that the Executive Order 26, 4.b. were secured on the resident's and were stained with a tan-brownish color substance.<br><br>On 02/24/21 at 9:52 AM, the surveyor observed the resident in bed with the head of bed elevated. The resident's eyes closed and the at the . The surveyor observed that the resident's Executive Order 26, 4.b. was in place and secured at the resident's . The surveyor was unable to observe the resident's because it was positioned underneath the resident's bed sheet.<br><br>On 02/25/21 at 9:26 AM, the surveyor entered Resident #330's room accompanied by the unit Licensed Practical Nurse (LPN#2). Upon interview, LPN#2 stated that the resident wore the Executive Order 26, 4.b. because he/she was when the nurses administered his/her medications and would pull at the LPN# 2 added that the was stained because the resident pulled at the<br><br>LPN#2 then removed the resident's Executive Order 26, 4.b. in the presence of the surveyor. The surveyor observed that the resident's skin was intact on Executive Order 26, 4.b. The resident's eyes remained closed when LPN #2 removed and | F 604 | documentation. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans. | |

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| F 604 | Continued From page 3<br>replaced the [redacted]<br><br>The surveyor reviewed the [redacted] for Resident #330.<br>According to the resident's [redacted] Sheet (An [redacted]), the resident was [redacted]<br><br>Review of the resident's [redacted] admission [redacted] an [redacted] tool used to facilitate the management of care, reflected that Resident #330 had [redacted] and that the resident's [redacted] for [redacted] making was [redacted]. The [redacted] further indicated in [redacted] that there were no [redacted] in use for the resident.<br><br>Review of the resident's [redacted] Physician Order Sheet (POS) reflected that the resident had diagnoses which included but were not limited to; [redacted]<br><br>Further review of the [redacted] POS reflected a physician's order dated [redacted] for [redacted] to prevent the resident from [redacted] and to check the resident's skin integrity every shift.<br><br>Review of the [redacted] medication list dated [redacted] and timed at [redacted] indicated that the [redacted] were discontinued for the resident [redacted] | F 604 | | |

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| F 604 | Continued From page 4 | F 604 | | |

Executive Order 26, 4.b.

Review of the resident's Executive Order 26, 4.b. Executive Order 26, 4.b. ) reflected that from Executive Order 26, 4.b. the nursing staff signed every shift on the 11:00 PM - 7:00 AM shift, 7:00 AM - 3:00 PM shift, and 3:00 PM - 11:00 PM shift that the resident was wearing the Executive Order 26, 4.b. to prevent the resident from Executive Order 26, 4.b.

Review of Executive Order 26, 4.b. dated Executive Order 26, 4.b. revealed documentation which indicated that Resident #330 was Executive Order 26, 4.b. had a Executive Order 26, 4.b. and Executive Order 26, 4.b. .

Review of the resident's Executive Order 26, 4.b. nursing assessment dated Executive Order 26, 4.b. and timed at Executive Order 26, 4.b. indicated that the resident had Executive Order 26, 4.b. - Executive Order 26, 4.b.

Review of the resident's Executive Order 26, 4.b. care plans dated Executive Order 26, 4.b. did not reflect a focus care area that addressed the fact that the resident had Executive Order 26, 4.b. and no care plan interventions written to address the use of the Executive Order 26, 4.b.

A complete review of the resident's Executive Order 26, 4.b. did not reflect that the resident had a Executive Order 26, 4.b. assessment or Executive Order 26, 4.b. signed by the resident's family member or guardian with an explanation of the risk versus benefits for the Executive Order 26, 4.b. . There was also no documented evidence of other least Executive Order 26, 4.b.

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| F 604 | Continued From page 5<br>forms of a [redacted] the facility tried prior to the implementation of the Executive Order 26, 4.b..<br><br>On 02/25/21 at 9:32 AM, the surveyor conducted an interview with LPN #2 who stated that she did not know Resident #330 was [redacted] The LPN #2 further stated that [redacted] needed an assessment by a Registered Nurse and a physician's order for the usage of the [redacted] LPN #2 stated that Resident #330 [redacted] Executive Order 26, 4.b. and was [redacted] when she administered medications to the resident.<br>LPN #2 further stated that she normally approached the resident slowly and calmly explained things to the resident before she performed any procedure to calm the resident down.<br><br>The surveyor reviewed the resident's chart in the presence of LPN #2 and could not find a care plan for the [redacted] or a consent form signed by a family member or guardian. There was also no assessment or documentation that regarding the [redacted] form of a [redacted] and Executive Order 26, 4.b. the facility tried for the resident prior to the implementation of the Executive Order 26, 4.b.. LPN #2 further stated that the [redacted] were placed on the resident because the resident [redacted]<br><br>On 02/25/21 at 9:57 AM, the surveyor interviewed the resident's Certified Nursing Assistant (CNA#5) who stated that the Resident #330 was [redacted]. CNA#5 stated that the resident was a [redacted] during care and that [redacted] normally | F 604 | | |

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| F 604 | Continued From page 6<br>slowed down, and spoke to the resident calmly before she performed the resident's care.<br><br>On 02/26/21 at 11:24 AM, the DON acknowledged that there was no restraint assessment performed upon the resident's Executive Order 26, 4.b. because at the time of Executive Order 26, 4.b. were not considered a Executive Order 26, 4. since they were used for Executive Order 26, 4.b. The DON further stated that the resident should have had an assessment and a care plan for the Executive Order 26, 4.b. Executive Order 26. The DON added that she did not think the resident's family was notified regarding the usage of the Executive Order 26, 4.b..<br><br>Review of the facility's Restraint Policy and Procedure dated 02/2021 indicated that the definition of a physical restraint was any manual method, physical or mechanical device, or piece of equipment that is attached or adjacent to the resident's body that cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body. The Restraint Policy and Procedure further identified hand mitts, lap trays, and seat belts as physical restraints. The Restraint Policy and Procedure further indicated; "The facility will implement alternatives to restraints prior to using the least restrictive option for the least amount of time and document on-going re-evaluation of the need for the restraint. Interventions will be designated to minimize or eliminate medical symptoms that prompt the usage of the restraint. An informed consent will be obtained from the resident/patient when clinically feasible; otherwise, informed consent will be obtained from the responsible party." | F 604 | | |

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| F 604 | Continued From page 7 | F 604 | | |

2. Review of the medical record showed that Resident # 131 was Executive Order 26, 4.b. [redacted]. The Quarterly Minimum Data Set (MDS ) an Executive Order 26, 4.b. dated 01/07/2021, revealed that Resident #131 was Executive Order 26, 4.b.

On 02/19/2021 at 12:45 PM, the surveyor observed Resident #131 seated in a chair in the room Executive Order 26, 4.b. utive Order 26, 4.b.. The Executive Order 26, 4.b. were not tied to the bed side rails or any other surface and the resident was able to move both arms freely.

On 02/19/2021 at 1:20 PM, the surveyor observed a Certified Nursing Assistant (CNA #4) in the room assisting the resident with lunch. The surveyor noted that Resident #131 was sitting quietly while eating and wore with the Executive Order 26, 4.b. Executive Order 26, 4.b.

At 1:25 PM, the surveyor interviewed CNA #4. CNA #4 stated that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b.. Upon further inquiry, CNA#4 informed the surveyor that Resident #131 wore the Executive Order 26, 4.b. to Executive Order 26 Executive Order 26, 4.b..

On 02/23/2021 at 8:39 AM, the surveyor observed Resident #131 again being fed lunch by staff and Executive Order 26, 4.b.

On 02/23/2021 at 12:45 PM, the surveyor observed Resident #131 again being fed by staff and wearing Executive Order 26, 4.b.

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| F 604 | Continued From page 8<br>On 02/23/2021 at 1:30 PM, the surveyor reviewed Resident #131's Executive Order 26, 4.b. and noted that Resident #131 was Executive Order 26, 4.b. . A Physician Order Sheet (POS) dated Executive Order 26 revealed an order for Executive Order 26, 4.b. Executive Order 26 to be used PRN ( as needed ) to Executive Order 26 Executive Order 26, 4.b. .<br><br>On 02/23/21 at 2:00 PM, the surveyor reviewed the POS with the nurse. The nurse informed the surveyor that Resident #131 had a Executive Order 26, 4.b. Executive Order 26, 4.b. which is a Executive Order 26, 4.b. Executive Order 26, 4.b. . The nurse added that the Executive Order 26, 4.b. were ordered to prevent Resident #131 from removing the Executive Ord Executive<br><br>Further review of the Executive Order 26, 4.b. revealed another physician order dated Executive Order 26, 4.b. timed Executive Order 26, 4.b , to discontinue the Executive Order 26, 4.b. Executive Order 26, 4.b.<br><br>There was no documentation in the Executive Order 26, 4.b. to justify the continued use of the Executive Order 26, 4.b. after the Executive Order 26, 4.b. was discontinued on Executive Order .<br><br>A review of Resident #131's Executive Ord Plan dated Executive Order 26, 4.b. and revised Executive Order 26, 4.b. identified the following problems:<br>Executive Order 26, 4.b.<br><br>The Interventions included: | F 604 | | |

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| F 604 | Continued From page 9<br>Executive Order 26, 4.b. - Executive Order 26, 4.b.<br>[redacted]<br><br>The facility staff did not remove the [redacted] and did not evaluate the need for continued use until after surveyor inquiry.<br><br>On 02/25/21 at 02:20 PM the team shared the above observations with the administrative staff. The Director of Nursing (DON) informed the survey team that she did not view [redacted] The DON further stated that the [redacted]<br><br>On 02/26/21 at 11:43 AM, the DON informed the surveyors that the [redacted] should have been [redacted] when the [redacted] was [redacted]. The DON further stated that staff were aware that all [redacted] should be released during lunch and supervised activities.<br><br>NJAC 8:39-27.19(d) | F 604 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, | F 756 | | 4/16/21 |

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| F 756 | Continued From page 10<br>and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to address in a timely manner the recommendations made by the Consultant Pharmacist (CP) during the Monthly Medication Review.<br>This deficient practice was identified for 1 of 6 residents reviewed for unnecessary medications (Residents #73) and was evidenced by the following:<br><br>The surveyor reviewed Resident #73's [redacted] | F 756 | 1) Resident #73 had the order for [redacted] clarified and rewritten as well as the order for [redacted] changed per the pharmacy consultant recommendation.<br>2) All current pharmacy consultant recommendations will be addressed for all facility residents.<br>3) The facility educator will re-educate the facility nurses on completing the nursing recommendations made by the pharmacy consultant within 1 week of | |

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| F 756 | Continued From page 11<br>Physician Order Sheet (POS) which revealed a physician Order (PO) dated [redacted] for [redacted]. The surveyor noted that there was no dosage amount documented for the [redacted]. The surveyor noted that both the [redacted] and [redacted] no dosage amount.<br><br>Review of Resident #73's [redacted] Medication Administration Record (MAR) had the same order as written on the POS and without dosage amount.<br>Further review of Resident #73's POS revealed a handwritten [redacted] PO dated [redacted] for [redacted] and no dosage amount.<br><br>Review of Resident #73's [redacted] that corresponded to the [redacted] PO for [redacted] no dosage amount.<br>A review of Resident #73's [redacted] revealed PO dated [redacted] for [redacted] but no dosage amount. The [redacted] POS also reflected the same order for [redacted] no dosage amount<br><br>Further review of the resident's [redacted] POS revealed PO dated [redacted] for [redacted] Further review of Resident #73's POS revealed a [redacted] PO dated [redacted].<br>Review of Resident #73's [redacted] revealed | F 756 | receiving the hard copy of the pharmacy consultant report. The facility educator will also reach out to all the attending physicians to alert them that they must complete the recommendations made to them by the pharmacy consultant within 1 week.<br>4) The Supervisor/Designee will perform monthly random audits to assure that the pharmacy report is being addressed within 1 week of report.Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans. | |

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| F 756 | Continued From page 12 | F 756 | | |

the corresponding orders for Executive Order 26, 4.b. to be administered Executive Order 26, 4.b. as needed for Executive Order 26, 4.b.

The surveyor then reviewed the Consultant Pharmacist's Report (CP Report) dated Executive Order 26, 4.b. which showed that the CP reviewed Resident #73's medication management and recommended that Resident #73's Executive Order 26, 4.b. Executive needed a dosage and frequency. The CP further documented that the recommended frequency for Executive Order 26, 4.b. Executive Order 26, 4.b.

The CP Report reflected a Executive Order 26, recommendation which indicated: "Regarding the comment made on Executive Order 26, 4.b. Regarding the comment made on Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b." The Pharmacy Consultant further documented in the report that his previous recommendations had been not addressed.

The surveyor observed that there were no handwritten notations on the Executive Order 26, 4.b. CP Report or a physician's signature to indicate that the CP's recommendations had been reviewed or addressed.

A review of the CP Report dated Executive Order 26, 4.b. showed that the CP made another recommendation regarding Resident #73's Executive Order 26, and explained the therapeutic criteria to order and administer the Executive Order 26, for maximum effectiveness. The surveyor noted no documented evidence to show that the Executive Order 26, 4.b.

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| F 756 | Continued From page 13<br>CP Report was addressed by the facility staff or the Physician.<br><br>A review of the CP Report dated [redacted], revealed that the CP recommended again that a dosage and frequency was needed for the [redacted] and explained the proper dosing and frequency for the medication which included:[redacted]<br><br>The CP Report also reflected a [redacted] recommendation regarding the resident's [redacted] and noted that [redacted] was not effective when dosed as a [redacted]<br><br>The surveyor noted no documented evidence to show that the [redacted] CP Report was addressed by facility staff or the physician.<br><br>A review of the CP Report dated [redacted] revealed that the CP made reference to the previous recommendations and repeated the same recommendations as documented on the CP report of [redacted].<br>The CP also documented that the Pharmacy recommendations were not addressed<br>The surveyor noted no documented evidence to show that the CP Report dated [redacted] was addressed by facility staff or the physician.<br><br>During an interview with the Director of Nursing (DON) on 02/26/21 at 1:15 PM, the surveyor requested a copy of Resident #73's [redacted] MAR but the DON stated that they were unable to locate the resident's [redacted] in the medical record. | F 756 | | |

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| F 756 | Continued From page 14<br><br>A review of Resident #73's Nursing Narrative Notes from [redacted] did not reveal documentation that the physician had been informed of the [redacted], and [redacted] CP recommendations.<br><br>A review of Resident #73's Physician's Progress Notes dated [redacted] revealed that Resident #73's attending physician examined the resident but did not document a review of the CP recommendations.<br><br>During an interview with LPN #1 on 02/25/21 at 01:23 PM, LPN #1 stated that it was the responsibility of all nurses to follow up and address CP recommendations. LPN #1 further stated that the facility process was for someone to flag the recommendations in the resident's chart and the floor nurse would follow up with the Physicians by calling to inform the physician of any CP recommendations. LPN #1 further stated the CP recommendations would remain flagged on the resident's chart until it had been addressed by the nurse.<br><br>The surveyor interviewed the DON on 02/25/21 at 02:34 PM and was told the CP recommendations were usually flagged in the residents' charts for nurses to follow up on. The DON further stated that the facility process was changed and that they now had a designated nurse to follow up with CP recommendations.<br><br>During a follow up interview with the DON on 02/26/21 at 11:34 AM, the DON stated that if the physician was not called regarding the CP recommendation, the document would remain | F 756 | | |

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| F 756 | Continued From page 15<br>flagged in the resident's chart for the physician to view on their next visit.<br><br>A review of the facility's "Drug Regimen Review" policy, with the effective date of February 2021, indicated that the CP must report irregularities to the physician, medical director, and the DON. The policy further indicated that the CP reports must be addressed prior to the next monthly medication regimen review. | F 756 | | |
| F 758 SS=D | NJAC 8:39-29.3(a)<br>Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically | F 758 | | 4/16/21 |

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| F 758 | Continued From page 16<br>contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, and review of other facility documents, it was determined that the facility failed to ensure that residents were free from unnecessary psychoactive medications. This deficient practice was identified for Resident #17, 1 of 2 resident reviewed for Executive Order 26, 4.b. medications and was evidenced by the following:<br><br>Review of Resident #17's Executive Order 26, 4.b. revealed that the resident was Executive Order 26, 4.b. [redacted] | F 758 | 1) The Executive Order 26, 4.b. re-reviewed resident#17 record and spoke with nursing staff and initiated a Executive Or for the standing order of Executive Order 2<br>2) A list will be obtained from the pharmacy of all residents on Executive Order 26, 4.b. medications to better evaluate the dates of last Executive Order 26, 4. Additionally, a revised Executive Order 26, 4.b. monitoring form will be initiated.<br>3) The facility educator will educate the nurses on the new Executive Order 26, 4.b. monitoring form. The Executive Order 26, 4.b. or his Nurse Practitioner will develop a system | |

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| F 758 | Continued From page 17<br>Executive Order 26, 4.b. The resident's Quarterly Executive Order 26, 4.b. an assessment tool dated Executive Order 26, 4.b., reflected that the resident was Executive Order 26, 4.b..<br><br>The surveyor observed the resident in bed with eyes closed during the initial unit tour on 02/19/2021 at 11:30 AM.<br><br>On 02/23/21 at 11:39 AM, the surveyor observed Resident #17 in bed with eyes closed. At this time the resident was receiving nutrition through a Executive Order 26, 4.b. which was Executive Order 26, 4.b. at the time of the surveyor observation.<br><br>The surveyor reviewed Resident #17's Executive Order 26, 4.b. Executive Order 26, 4.b. at 11:19 AM. The surveyor noted a Physician Order Sheet ( POS ) dated Executive Order 26, 4.b. Executive Order 26, 4.b., with a physician's order dated Executive Order 26, 4.b. for Executive Order 26, 4.b. The order indicated to administer the Executive Order 26, 4.b. Executive Order 26, 4.b.. The target behaviors for which the Executive Order 26, 4.b. was being administered were identified on the Monthly Executive Order 26, 4.b. Summary Executive Order 26, 4.b.) and included the Executive Order 26, 4.b. Executive Order 26, 4.b..<br><br>The surveyor reviewed the Consultant Pharmacist's Evaluation form from Executive Order 26, 4.b. Executive Order 26, 4.b. and noted that Resident #17 had not had a Executive Order 26, 4.b. for the Executive Order 26, 4.b. since the Executive Order 26, 4.b. Executive Order 26, 4.b.<br><br>The surveyor further reviewed the Monthly Executive Order 26, 4.b. Summary behavior from Executive Order 26, 4.b. Executive Order 26, 4.b. There was no documented evidence to show that Resident #17 exhibited any of the targeted behaviors. There was only Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. during | F 758 | for tracking Executive Order 26, 4.b. timelines and dates in order to be in compliance. Additionally, they will assure that behaviors match/warrant continued medication use.<br>4) The Supervisor/Designee will perform monthly random audits to assure that Executive Order 26, 4.b. are done per regulation. Audit will also include that there are documented behaviors to match the Executive Order 26, 4.b. notes. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans. | |

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| F 758 | Continued From page 18<br>an 11:00 PM to 7: 00 AM shift.<br><br>On 02/25//2021 at 01:05 PM, the surveyor had an interview with the Certified Nursing Assistant (CNA#4 ) who cared for the resident. CNA#4 stated that Resident #17 was Executive Order 26, 4.b. with care but would Executive Order 26, 4.b. Executive Order 26, 4.b.<br><br>The surveyor interviewed Resident #17's Registered Nurse (RN#2) on 02/26/2021 at 11:30. RN#2 stated that the resident received all his/her medications daily and was Executive Order 26, 4.b..<br><br>A review of the Executive Order 26, 4.b. Executive Order 26, 4.b. revealed that Executive Order 26, 4.b. because the Executive Order was Executive Order 26, 4.b.. There was no documentation to show that Resident #17 exhibited any Executive Order 26, 4.b. Executive Order 26, 4.b. . Review of the Executive Order also showed that in Executive Order 26, 4.b. Executive Order 26, 4.b. were Executive Order 26, 4.b. and staff documented that the resident did not Executive Order 26, 4.b.<br><br>A review of the Executive Order 26, 4.b. follow up evaluation dated Executive Order 26, 4.b., reflected the following documentation from the Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. The surveyor did not find any documentation of Executive Order 26, 4.b. in the Nursing Narrative Notes or in other sections of the resident's record. The facility did not provide information as to where the psychiatrist obtained his information. On Executive Order 26, 4.b. the Executive Order 26, 4.b. recommended to continue the Executive Order. He also documented that Resident #17 continued to have Executive Order 26, 4.b. during care. The | F 758 | | |

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| F 758 | Continued From page 19<br>Executive Order 26, 4.b. did not indicate where he obtained the information regarding the resident's Executive Order 26, 4.b.<br><br>On 02/26/2021, the facility provided a recommendation from the consultant pharmacist dated 12/01/2020, which indicated the following: "As per CMS guidelines, Executive Order when ordered for Executive Order 26, 4.b. should be reviewed quarterly for a Executive Order 26, 4.b. If a Executive Order 26, 4.b. is Executive Order 26, 4.b., remember to provide a short progress note."<br><br>On 02/25/2021 the surveyor interviewed the Director of Nursing (DON) regarding the Executive Order being administered in the absence of the identified target behaviors. The DON stated that the facility followed the Executive Order 26, 4.b. recommendations.<br><br>Review of the facility's "unnecessary Drugs-psychotropics" policy dated 2/2020 indicated that residents who used psychotropic medications would receive GDR and behavioral interventions unless contraindicated. The policy also indicated that the psychotropics would be routinely re-evaluated to check for need to continue. | F 758 | | |
| F 880 SS=F | NJAC:8-39-29.3 (a)<br>Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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. | F 880 | | 4/5/21 |

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| F 880 | Continued From page 20<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable | F 880 | | |

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| F 880 | Continued From page 21<br>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to don appropriate Personal Protective Equipment (PPE) while in the rooms of residents placed on transmission-based contact and droplet precautions residing on the units designated for Persons Under Investigation (PUI) and on the COVID-19 positive unit. This deficient practice was identified for 6 of 6 staff members observed on 2 of 2 PUI units and for 2 of 2 staff members a COVID-19 positive unit in the facility.<br><br>The deficient practice was evidenced as follows:<br><br>1. On 02/19/21 at 12:48 PM, the surveyor observed lunch meal service on the [redacted] unit, [redacted] wing which had been designated as a [redacted] area for new and readmissions. The | F 880 | 1)The facility staff were re-educated on the need to appropriately don PPE while on the PUI and COVID units.<br>2)All residents and employees have the potential to be affected by this deficient practice.<br>3) All facility staff will be re-educated at least quarterly by the facility educator and infection preventionist on following facility policy regarding donning appropriate PPE while on the PUI and COVID units.<br>4) The Infection Preventions Nurse/designee will do random audits on a weekly basis for 4 weeks; then monthly x 3 and quarterly x 2 until compliance attained and maintained.Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and | |

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| F 880 | Continued From page 22<br>surveyor observed a PUI room with signs on the door which indicated to stop. There was another sign on the door that indicated to follow Contact and Droplet precautions and to wear gown, gloves, masks, and eye protection before entering the room. The surveyor observed a metal bin hanging on the resident's door which contained gowns and gloves. The surveyor observed a staff member inside the room, standing next to a resident setting up the lunch tray. She was not observed to have direct contact with the resident. The surveyor observed that there was another resident in the room in the bed by the window. The surveyor noted that the staff member wore a respirator mask, a surgical mask over the respirator and a face shield. She was not wearing a gown or gloves. The staff member was identified as a Certified Nursing Assistant (CNA #1).<br><br>CNA #1 disposed of the surgical mask at the garbage can by the resident's door and used ABHR. CNA #1 exited and at that time, the surveyor interviewed CNA #1 who stated that the signage on the door meant that the resident was Executive Order 26, 4.b. [redacted] CNA#1 and the surveyor reviewed the signage together. CNA #1 acknowledged that she should have worn a gown and gloves before entering the room as indicated on the door signage. She stated that she was in a hurry and that she was aware that wearing the proper PPE was to prevent the spread of infection. CNA#1 continued delivering meal trays and wore PPE gown, gloves and a new surgical mask over the KN95 into the other PUI rooms. CNA #1 was not observed to leave the unit.<br><br>On 02/19/21 at 12:54 PM, the surveyor | F 880 | action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans.<br>5) PROBLEMS IDENTIFIED:<br>a) The facility failed to ensure staff wore proper PPE appropriately while in the facility to prevent the possible spread of COVID-19 as evidenced by:<br>" Housekeeping Director and housekeeper in training were observed entering the COVID positive unit without eye protection. Social Work Secretary was observed without a gown and gloves in a quarantine room. In addition, CNA #1,2 and 3 were observed walking into Quarantine rooms without gloves and a gown.<br><br>CONTRIBUTING FACTORS:<br>" These staff members did not recognize the severity of not wearing PPE appropriately to prevent the spread of COVID-19 even for a short period.<br>ROOT CAUSES:<br>" Housekeeping Director, housekeeper in training, Social Work Secretary, CNA #1,2 and 3 need further training on the severity of always wearing PPE appropriately.<br><br>CORRECTIVE ACTIONS:<br>" The Housekeeping Director, housekeeper in training, Social Work Secretary, CNA #1,2 and 3 were immediately in-serviced regarding appropriate PPE wearing at all times on 2/25/21 by the IP Nurse. An in-service for all staff was initiated on 2/25/2021 as well. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315279 | A. BUILDING _____ B. WING _____ | 02/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMBASSY MANOR AT EDISON NURSING AND REHABILITATION | 10 BRUNSWICK AVENUE EDISON, NJ 08817 |

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| F 880 | Continued From page 23<br>interviewed the Executive Order 2 floor Registered Nurse Supervisor (RNS) Executive Order 26, 4.b. . She stated that all staff should wear an N95 mask with a surgical mask over it, gown, face shield or goggles and gloves while in the rooms on the PUI unit, in order to prevent contamination or the spread of infection. The PUI rooms on Executive Order 26, 4.b. were on droplet and contact precautions. The RNS stated that staff should wear full PPE which would be an N95 mask with a surgical mask over it, gown, face shield or goggles and gloves in the transmission-based precaution rooms regardless of their reason for being in the room. The RNS further stated that the residents in the room were on precautions because they were Executive Ord Executive Order 26, 4.b. .<br><br>The facility had stated that the new and readmissions were all tested prior to admission, upon admission and weekly. The residents on Executive Order 26, 4.b. had all Executive Order 26, 4.b. to date and would be on PUI for 14 days of observation.<br><br>2. On 02/22/21 at 01:40 PM, the surveyor observed the Executive Order 26, 4.b. which was a PUI unit because the residents had been Executive Order 26, 4.b. staff member. On the Executive Order 26, 4.b. the surveyor observed a staff members inside a room and feeding a resident. The staff member was wearing a respirator mask with a surgical mask over it and a face shield but no PPE gown or gloves. The surveyor also noted a sign on the door which indicated to adhere to Contact and Droplet precautions and to wear gown, gloves, masks, and eye protection prior to entering the room. The surveyor observed a metal bin that contained gowns and gloves hanging on the resident's room | F 880 | " The IP Nurse and Department Heads took Video training on Infection Prevention & Control Program Module 1<br>" All staff were Video trained on the following 3 topics:<br>A) Module 6B- Principles of Transmission Based Precautions<br>B) CDC COVID-19 Prevention □ Keep COVId-19 Out!<br>C) CDC COVID-19 Prevention □ Use PPE Correctly for COVID-19<br><br>The Infection Prevention and Intervention Plan Was implemented<br><br>MONITORING/EVALUATIONS:<br>The IP Nurse/designee will do random audits on a weekly basis for 4 weeks; then monthly x 3 and quarterly x 2 until compliance attained and maintained. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans. | |

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| F 880 | Continued From page 24 | F 880 | | |

door. The surveyor noted three residents in the room with two of the residents visible and not wearing masks and the third resident was behind a curtain.

As the surveyor was standing by the entrance to the room, another staff member walked past the surveyor and made her way into the same transmission-based isolation room. The staff member was wearing a respirator type mask, a surgical mask over it, goggles and no isolation gown.

At that time, the surveyor interviewed the staff member. The staff member identified herself as the Social Worker Secretary (SWS). When questioned about PPE, the SWS acknowledged the signs on the resident's room door and stated that she had sanitized her hands prior to entering the room and that she was not touching the residents. Upon review of the signage again, the SWS acknowledged that she should have worn a gown and gloves before entering the room. The SWS stated she had been trained on PPE and the reason to wear PPE was to prevent the spread of infection.

The staff member who was feeding the resident was identified as CNA #2. CNA #2 also walked towards the door and the surveyor interviewed her. CNA #2 acknowledged the signage on the door and stated that she should have worn gown and gloves before going into the room. CNA #2 also stated that she had been in-serviced and that the PPE was needed to prevent the spread of infection.

CNA #2 immediately removed her surgical mask and disposed of it in the garbage can by the

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| | 315279 | A. BUILDING _____ B. WING _____ | 02/26/2021 |

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| EMBASSY MANOR AT EDISON NURSING AND REHABILITATION | 10 BRUNSWICK AVENUE EDISON, NJ 08817 |

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| F 880 | Continued From page 25<br>resident door. CNA #2 used ABHR, donned PPE gown, new surgical mask and gloves and entered the room to continue feeding the resident.<br><br>The SWS removed her surgical mask and disposed of it in the garbage can by the resident door, used ABHR, donned another surgical mask and left the unit.<br><br>During an interview on 02/22/21 at 01:48 PM, the Registered Nurse (RN #1) working on the [redacted] stated that all staff members should wear an N95 mask, a surgical mask cover, gown and gloves prior to going into the transmission-based precaution rooms, to prevent the infection from spreading.<br><br>3. On 02/23/21 at 08:04 AM, on the [redacted] the surveyor observed two residents in a [redacted] room. The surveyor observed a staff member wearing a respirator mask covered by a surgical mask and goggles as he walked into the room carrying a breakfast tray. The staff member walked past the first resident and went over to the second resident and placed the tray on the resident's bedside table. The surveyor did not observe any direct contact with the resident by the staff member. The staff member was not wearing an isolation PPE gown or gloves.<br><br>The surveyor noted a sign on the room door which indicated to adhere to Contact and Droplet precautions and to wear gown, gloves, masks, and eye protection to enter the room. The surveyor also observed a metal bin hanging on the door which contained PPE gowns and gloves. | F 880 | | |

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| **EMBASSY MANOR AT EDISON NURSING AND REHABILITATION** | **10 BRUNSWICK AVENUE EDISON, NJ 08817** |

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| F 880 | Continued From page 26<br>The surveyor interviewed the staff member who identified himself as certified nursing assistant (CNA #3). CNA #3 stated that he should have worn gown and gloves before entering the room. CNA #3 also stated that the purpose of wearing PPE was to protect staff and residents against infection. CNA #3 walked to the door, disposed of the surgical mask, used ABHR and exited the room. CNA #3 moved the food cart to the next Executive Order 26, 4.b. room, donned a PPE gown, gloves and new surgical mask, entered the room and another staff member handed him the food tray to deliver.<br><br>The facility had stated the Executive Order 26, 4.b. residents who had been Executive Order 26, 4.b. staff member had been Executive Order 26, 4.b. and were Executive Order 26, 4.b. The residents would continue to be monitored and tested.<br><br>None of the CNA's listed in the deficiency were noted to leave the unit.<br><br>During interview on 02/24/21 at 10:32 AM, the IP stated that staff should be wearing an N95 mask, surgical mask over it, and a face shield or goggles. The IP stated that PPE was required on the units whether staff were walking in the hallway or going into the residents' room. The IP stated that staff were supposed to don a gown and gloves prior to entering residents' room and confirmed that was the facility process for the Executive unit (Executive Order 26, 4.b.) and on Executive Order 26, 4.b. Executive Order 26 rooms. The IP further stated that the reason for wearing the PPE was because the residents on PUI units may have unknown exposure to COVID-19 and that the PPE was to prevent the spread of infection. | F 880 | | |

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| F 880 | Continued From page 27<br>During an interview on 02/26/21 at 11:44 AM, the DON stated that the SWS should have been in-serviced on PPE use but she was not sure if the SWS was in-serviced on donning and doffing of PPE. The DON stated that the CNAs were in-serviced on proper PPE use.<br><br>Review of the facility document titled: "Use of Goggles/Face shields, Storage No PPE going home" in-service dated 11/9/20, revealed that the SWS attended the in-service.<br><br>Review of the facility document titled: "Dual Member Checklist: Donning PPE for COVID 19" and "Dual Member Checklist: Doffing PPE for COVID 19" revealed that CNA #1 had shown competency in donning and doffing of PPE on 03/19/20.<br><br>Review of the facility document titled: "Dual Member Checklist: Donning PPE for COVID 19" and "Dual Member Checklist: Doffing PPE for COVID 19" revealed that CNA #2 had shown competency in donning and doffing of PPE on 04/02/20.<br><br>Review of the facility document titled: "Donning Personal Protective Equipment (PPE)" and "Doffing Personal Protective Equipment (PPE)" revealed that CNA #3 had shown competency in donning and doffing of PPE on 02/17/21.<br><br>Review of the facility's Post-Acute COVID-19 - Pandemic Preparedness Infection Control Policy and Procedure (Outbreak Response Plan) updated 02/11/2021 indicated in regard to Universal Source Control, " Eye protection (face shields, goggles, safety glasses) will be worn by staff when providing direct patient care or having | F 880 | | |

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| F 880 | Continued From page 28 | F 880 | | |

close (within 6 feet) contact with a patient or other individual. Team Members should wear eye protection and an N95 or higher respirator at all times while on the COVID-19 positive of Quarantine area with gown and gloves added when entering entering patient/resident rooms."

Review of the facility's Transmission Based Precautions Policy and Procedure revised 02/2021 indicated regarding Contact Precautions, "Gowns and gloves must be worn by all personnel upon entering the room. This is a proactive measure, as unexpected resident contact or contact with environmental surfaces or items in the resident's room cannot always be anticipated."

4. On 2/23/21 at 1:00 PM, the surveyor went to the Executive Order 26, 4.b. and observed the Housekeeping Director (HKD) and a housekeeping staff member in training as they walked through the hallway of the Executive Order 26, 4.b. unit wearing an N95 mask and a surgical mask over it. The surveyor did not observe the HKD or the housekeeping staff member in training wearing a face shield or goggles.

At that time, the surveyor interviewed the HKD and housekeeping staff member in training. Both confirmed that the unit Executive Order 26 ) was the Executive Order 26, 4.b. area and that the required PPE to be worn included an N95 mask, surgical mask over, face shield or goggles. The HKD further stated that he forgot to put on his eye protection, and that eye protection was required to be worn while in the Executive Order 26, 4.b. area.

On 2/24/21 at 10:34 AM, the surveyor interviewed

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| F 880 | Continued From page 29 | F 880 | | |

the Infection Preventionist (IP) who stated that all staff members working on the COVID-19 unit were required to wear an N95 mask with a surgical mask over it, including a face shield or goggles when on the unit.

On 2/26/21 at 11:47 AM, the Director of Nursing (DON) stated that the most recent facility policy and procedure on the COVID-19 unit is for every staff member to wear goggles or a face shield, N95 mask with a surgical mask over it while on the unit.

Review of the facility's "Post-Acute COVID-19 - Pandemic Preparedness Infection Control Policy and Procedure (Outbreak Response Plan)" updated on 02/11/2021, indicated that: "Eye protection (face shields, goggles, safety glasses) will be worn by staff when providing direct patient care or having close contact (within 6 feet) with a patient or other individual."

The policy further indicated that "team Members should wear eye protection and an N95 or higher respirator at all times while on the COVID-19 positive or Quarantine area with gown and gloves added when entering patient/resident rooms."

Review of the facility's Transmission Based Precautions Policy and Procedure revised on 02/2021, indicated that "Gowns and gloves must be worn by all personnel upon entering the room. This is a proactive measure, as unexpected resident contact or contact with environmental surfaces or items in the resident's room cannot always be anticipated."

Review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim

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| F 880 | Continued From page 30<br>Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 2/23/21, indicated that HCP (health care provider) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.<br><br>Review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Using Personal Protective Equipment (PPE), updated 8/19/20, included the following steps 1. Identify and gather the proper PPE; 2. Perform hand hygiene; 3. Put on isolation gown; 4. Put on N95; 5. Put on face shield or goggles; 6. Put on gloves; 7. HCP may now enter patient room.<br><br>Review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Responding to COVID-19 in Nursing Homes, updated 04/30/2020, included that a designated care area unit for resident's positive for COVID-19 should be established in the nursing facility. The CDC guidance further indicated to place signage at the entrance of the COVID-19 care unit that instructs HCP (healthcare personnel) that they must wear eye protection and an N95 respirator while on the unit.<br><br>NJAC 8:39-19.4(a); 27.1(a) | F 880 | | |

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 |
|---|---|---|
| 315279 Y1 | A. Building<br>B. Wing Y2 | 4/21/2021 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EMBASSY MANOR AT EDISON NURSING AND REHABILITATION | 10 BRUNSWICK AVENUE<br>EDISON, NJ 08817 |

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 F0604 | Correction | ID Prefix F0756 | Correction | ID Prefix F0758 | Correction |
| Reg. # 483.10(e)(1), 483.12(a)(2) | Completed | Reg. # 483.45(c)(1)(2)(4)(5) | Completed | Reg. # 483.45(c)(3)(e)(1)-(5) | Completed |
| LSC | 04/16/2021 | LSC | 04/16/2021 | LSC | 04/16/2021 |
| ID Prefix F0880 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 483.80(a)(1)(2)(4)(e)(f) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 04/05/2021 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| 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? |
|---|---|
| 2/26/2021 | ☐ YES ☐ NO |