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 _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 000	INITIAL COMMENTS STANDARD SURVEY: 3/10/2023 CENSUS: 210 SAMPLE: 35+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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		3/14/23

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

Electronically Signed | 03/30/2023

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) provide privacy and promote dignity during [redacted] care for 3 of 3 residents observed (Residents #180, #205 and #264) and b.) provide care and services in a dignified and respectful manner during dining in 1 of 4 dining rooms observed. This deficient practice was evidenced by the following: 1. During the initial tour of the [redacted] unit on 2/21/23 at 11:13 AM, the surveyor observed the facility's [redacted] and his assistant enter Resident #205's room. Resident #205 was awake and seated in their wheelchair. The [redacted] sat on the floor in front of the resident, put on gloves and removed the resident's [redacted] exposing the resident's [redacted] The [redacted] t opened a blue pad, "chux" (a disposable under pad) and placed it on the floor underneath the resident's [redacted] The door to the	F 550	F550 SS = E Residents Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) DATE: 3/14/23 1a. Resident #205, Resident #264, and Resident #180 were immediately assessed to make sure that their Dignity was intact and that their Rights were being upheld by the Social Worker. The [redacted] was immediately in-serviced by the Infection Preventionist and ADON regarding providing and promoting the proper Dignity during the care of each resident and was educated about closing the curtain and/or door to each of the resident□s rooms prior to the provision of care. 1b. C.N.A. #3 was immediately in-serviced	

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F 550	Continued From page 2 resident's room remained opened as the NJ EX Order. 264b1 performed NJ EX Order. 2 care to the resident which was visible to the surveyor in the hallway. The surveyor reviewed the medical records of Resident #205 which revealed the following: Resident #205 was admitted in NJ EX Order. 264b1 with diagnoses which included but were not limited to: NJ EX Order. 264b1 Review of Resident #205's Admission Minimum Data Set (MDS), an assessment tool, dated NJ EX Order. 26 revealed that the resident had a Brief Interview for Mental Status (BIMS) of 'NJ EX Order. 264b1 which indicated that the resident's cognition was NJ EX Order. 264b1. On 2/21/23 at 11:27 AM, the surveyor observed the NJ EX Order. 264b1 enter Resident #264's room. Resident #264 was awake and in bed. The NJ EX Order. 264b1 put gloves on and introduced himself to the resident as the NJ EX Order. 264b1. The NJ EX Order. 264b1 removed a blue pad from his bag and placed it under the resident's NJ EX Or on the bed. The door to the resident's room remained opened as the NJ EX Order. 264b1 stood at the end of the resident's bed and performed NJ EX Order. 26 care to the resident which was visible to the surveyor in the hallway. The surveyor reviewed the medical records of Resident #264 which revealed the following: Resident #264 was admitted in NJ EX Order. 264b1 with diagnoses which included but were not limited to: NJ EX Order. 264b1 and NJ EX Order. 264b1. Review of Resident #264's Quarterly MDS, dated	F 550	regarding Resident□s Rights and the Exercise of their Rights as related to a Homelike Environment when using a personal cell phone during direct care to a resident. The in service focused to ensure, maintain and protect a resident□s privacy during assistance with personal care and during treatment procedures. 2. All residents have the potential to be affected by these deficient practices. 3. All Nursing staff and Physicians were provided with an in-service education regarding Resident□s Rights and the Exercise of Rights as related to a Homelike Environment for the issues of the NJ EX Order. 264b1 not providing privacy during treatments and also for the improper usage of cellphones by the C.N.A during meal times. The NJ EX Order. 264b1 t was terminated from providing services to the facility. C.N.A. #3 was educated and disciplined, an □Employee Warning Notice□ was issued. 4. The NJ EX Order. 264b1 was terminated from providing services to the facility. The newly contracted service provider was interviewed regarding the efficacy of Privacy, Dignity, and Exercise of Resident Rights during the provision of services and was able to recite the proper methodology for both of these practices. Services will begin after NJ EX Order. 2 and the Social Worker/designee will train and in-service the NJ EX Order. 264b1 quarterly to	

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F 550	Continued From page 3 NJ EX Order. 264b1 revealed that Resident #264 had NJ EX Order. 264b1 - and NJ EX Order. 264b1 . On 2/21/23 at 11:31 AM, the surveyor observed the podiatrist enter Resident #180's room. Resident #180 was awake and seated in a wheelchair. The NJ EX Order. 264b1 sat on floor, put gloves on, unfolded a blue pad from his bag and put it down onto the floor under the resident's NJ EX Order. 264b1 door to the resident's room remained opened as the NJ EX Order. 264b1 performed NJ EX Order. 264b1 care to the resident which was visible to the surveyor in the hallway. The surveyor reviewed the medical records of Resident #180 which revealed the following: Resident #180 was admitted in NJ EX Order. 264b1 with diagnoses which included but were not limited to NJ EX Order. 264b1 , and NJ EX Order. 264b1 . Review of Resident #180's Quarterly MDS dated NJ EX Order. 264b1 , revealed that Resident #180 had BIMS of NJ EX Order. 264b1 " which indicated that the resident's NJ EX Order. 264b1 was NJ EX Order. 264b1 . During an interview with the surveyor on 2/21/23 at 11:36 AM, the NJ EX Order. 264b1 stated that he usually provided privacy during NJ EX Order. 264b1 care by pulling the curtain or sitting in front of the resident to block anyone from seeing, but acknowledged that he did not during those times. During an interview with the surveyor 3/2/23 at 9:40 AM, the Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that the residents should be provided privacy during care, exams, and procedures for dignity of the resident.	F 550	provide privacy during treatments and promote dignity in a homelike environment. All nursing staff and practitioners will be educated annually regarding Resident's Rights/the Exercise of Resident's Rights by the Social Worker/designee. Monthly audits will be conducted by the Social Worker/designee to ensure the provisions under Resident's Rights are being met and findings will be reported at the Quality Assurance Performance Improvement Meetings, quarterly for (1) year.	

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F 550	Continued From page 4 During an interview with the surveyor on 3/6/23 at 11:38 AM, the Director of Nursing (DON) stated the [redacted] should provide privacy during care. She stated that the Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) had previously spoke to the [redacted] about privacy. 2. On 2/22/23 at 1:21 PM, the surveyor entered the [redacted] dining room. There were 10 residents present. The surveyor observed a certified nurses aide (CNA) #3 collect two unsampled resident's lunch trays (one after the other) and placed them on the food cart while talking on her cell phone. CNA #3 did not interact with the residents while approaching them to remove their lunch trays. CNA #3 saw the surveyor and put her phone down. At that time, the surveyor interviewed CNA #3 who stated she was on her phone because her son's daycare had called, and she had answered the phone in case it was an emergency. During an interview with the surveyor on 3/2/23 at 10:01 AM, the LPNUM #1 stated that CNAs should not be on their phones in the dining room. If there was an emergency, they should leave the resident area and come back after. During an interview with the surveyor on 3/6/23 at 11:50 AM, the DON stated that staff should not be on their cell phone in front of the resident because it was the resident's home. She added that the staff had been previously in serviced not to use cell phones during care or in the dining room. Review of a facility policy titled, Quality of life, dignity dated February 1, 2021, revised January 3, 2023, included but was not limited to; "1.	F 550		

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F 550	Continued From page 5 Residents should be treated with dignity and respect at all times. 6. Resident's private space and property should be respected at all times. 10. Staff shall promote, maintain and protect resident privacy during assistance with personal care and during treatment procedures." Review of a facility policy titled, Cell Phone Usage (including texting, headsets, handsfree, IPADS, tablets, and any other electronic communication devices) dated February 1, 2021 and reviewed on January 26, 2023, included but was not limited to: "1. Employees are not permitted to use cell phones while on their individual work units. Incoming calls to employees should not be answered. If there is an emergency, the employee's family and friends should be instructed to call the main number to the facility." NJAC 8:39-4.1(a)(12)	F 550		
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 independence and does not pose a safety risk.	F 584		3/14/23

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F 584	Continued From page 6 (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: Based on observation, interviews, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that a resident's [NJ EX Order 26451] was maintained in a clean, sanitary, and homelike manner on 1 of 8 nursing units [NJ EX Order 26451] Unit). This deficient practice was evidenced by: During the initial tour of the facility on 02/21/21 at 11:08 AM, the surveyor observed Resident #108 seated in a wheelchair at the bedside beside his/her bed which was stripped. The [NJ EX Order 26451]	F 584	F584 SS = D Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) DATE: 3/14/23 1. The [NJ EX Order 26451] of Resident #108 was immediately removed and discarded by the Housekeeping Porter on 3/6/23 and a new [NJ EX Order 26451] was put in its place. All housekeepers, CNAs, RNs, LPNs, and	

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F 584	Continued From page 7 was NJ EX Order. 264b1 and NJ EX Order. 2, with NJ EX Order. 264b1 noted to the upper portion of the mattress. There was a NJ EX Order. 264b1 in the resident's room. The resident appeared well groomed and dressed and was not able to be interviewed due to his/her NJ EX Order. 264b1. The surveyor inspected the bathroom and trash cans in the room which did not contain any waste products that would have contributed to the NJ EX Or in the room. During an interview with the surveyor on 03/01/23 at 11:39 AM, Certified Nursing Assistant (CNA) #2 stated that Resident #108 sometimes NJ EX Order. 2 in time and was i NJ EX Order. 264b1 CNA #2 stated that the resident would remove the NJ EX Order. 26 off of the bed if they were NJ EX t and even attempted to place them in the soiled laundry. CNA #2 stated that housekeeping wiped the bed down prior to the CNA making the bed. During an interview with the surveyor on 03/02/23 at 12:49 PM, CNA #2 stated that she reported the condition of the resident's NJ EX Order. 264b1 and ensured that it was replaced with a new one as the old NJ EX Order. 264b1 was NJ EX Order. 264 despite being sanitized daily by housekeeping. During an interview with the surveyor on 03/06/23 at 11:41 AM, Registered Nurse Unit Manager (RNUM) #1 stated that the CNA or Housekeeping should have told the nurse or called housekeeping who would switch out the resident's NJ EX Order. 264b1 RNUM #1 stated that everything was done verbally by phone, but there was a book where staff could document concerns for maintenance to address. RNUM #1 reviewed the book in the presence of the surveyor and stated that she did not see that the soiled	F 584	UMs were then educated properly regarding procedures for identifying and reporting unsanitary NJ EX Order. 264b1 to the proper channel for replacement. 2. All residents have the potential to be affected by this deficient practice. 3. The Director of Maintenance provided in-services for the Proper Usage of Maintenance Log Books with all RN/LPN/CNAs/Housekeepers, he also discussed the Proper Reporting of NJ EX Order. 264b1 to HK Supervisor. The Housekeeping Supervisor went on to in-service all RN/LPN/CNAs/Housekeepers about Mattress Cleaning and Infection Control and reviewed the Bed and NJ EX Order. 264b1 Cleaning Procedure by having them complete a return demonstration for mattress cleaning. He reviewed the Bed Washing & Disinfection Procedure which has further instruction on reporting torn or badly NJ EX Order. 264b1. 4. Daily mattress checks will be completed by the C.N.A.□s during care and Housekeepers as well, for all residents and report the findings to the Director of Housekeeping. The Director of Maintenance will continue to purchase (5) NJ EX Order. 264b1 monthly for (1) year. Monthly Totals and findings will be reported and discussed by the Housekeeping Supervisor during the Quality Assurance Performance Improvement Meeting, quarterly for (1)	

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F 584	Continued From page 8 NJ EX Order. 264b1 was referenced for replacement. During an interview with the surveyor on 03/06/23 at 11:49 AM, Housekeeper #1 stated that she notified the Porter about the condition of Resident #108's NJ EX Order. 264b1 and requested that it be replaced. Housekeeper #1 stated that there was a brand new NJ EX Order. 264b1 in the resident's room now. During an interview with the surveyor on 03/06/23 at 12:17 PM, the Porter stated that he discarded Resident #108's soiled NJ EX Order. 264b1 in the garbage and replaced it with a new one. During an interview with the surveyor on 03/07/23 at 11:51 AM, the Infection Preventionist (IP) stated that Resident #108's NJ EX Order. 264b1 should have been discarded if it were NJ EX Order. 264b1 of NJ EX Order. 264b1. The IP stated that the Housekeeper should have been notified and the NJ EX Order. 264b1 should have been discarded. The IP stated, "the NJ EX Order. 264b1 was a NJ EX Order. 264b1. During an interview with the surveyor on 03/10/23 11:24 AM, the District Manager (DM) and the Administrator were present. The DM stated that she had documentation to demonstrate that Resident #108's NJ EX Order. 264b1 was inspected in January and February. The surveyor presented the DM and the Administrator with a photograph of the resident's NJ EX Order. 264b1 for review. DM confirmed that there was visible NJ EX Order. 264b1 and a NJ EX Order. 264b1 was noted on the bottom portion of the NJ EX Order. 264b1. The DM also stated that there was a visible NJ EX Order. 264b1 on the NJ EX Order. 264b1 which could retain NJ EX Order. 264b1. The Administrator stated that the NJ EX Order. 264b1 was NJ EX Order. 264b1 and the remainder of the NJ BkU EX Order. 264b1 at the facility were blue, so he was	F 584	year.	

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F 584	Continued From page 9 unable to determine the age of the [NJ EX Order 264b]. The Administrator stated that he was unable to provide the surveyor with documented evidence that a staff member had reported a concern with the condition of the [NJ EX Order 264b] prior to surveyor inquiry. The Administrator viewed the photo of the [NJ EX Order 264b] once more and stated, "That was a good call, that was a [NJ EX Order 264b1]." The Administrator was in agreement that the [NJ EX Order 264b] should have been replaced for sanitary reasons. Review of the facility policy titled, [NJ EX Order 264b] Care" (Reviewed 01/11/23) revealed the following: Policy: It is the policy of Embassy Manor to provide its residents with clean and comfortable [NJ EX Order 264b] experience. Procedure: 1. C.N.A. (Certified Nursing Assistant) will strip the bed of any/all soiled linen 2. Housekeeper will remove the [NJ EX Order 264b] from the bed and spray the frame down with a disinfectant. Housekeeper will allow for proper dwell time. 3. Spray the [NJ EX Order 264b] front and back with proper disinfectant. Housekeeper will allow for the proper dwell time. 4. Housekeeper will wipe the mattress down with a clean rag from front to back. 5. Then spray the [NJ EX Order 264b] again with the disinfectant and wipe again. 6. If there are any holes or worn indications please report to the Housekeeping Supervisor for replacement. NJAC 8:39-31.4	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		3/14/23

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F 656	Continued From page 10	F 656		

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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	315279	A. BUILDING _____ B. WING _____	03/10/2023

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

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F 656	Continued From page 11 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan to address a resident's NJ EX Order. 264b1 for 1 of 3 Residents (Resident #77) reviewed for NJ EX Order. 264b1 NJ EX Order. 26 This deficient practice was evidenced by the following: On 2/21/23 at 11:52 AM, Resident #77 was observed in wheelchair with their NJ EX Order. 264b1 The resident was NJ EX Order. 264b1 NJ EX Order. 264b1 A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ EX Order. 264 identified the resident as NJ EX Order. 264b1 and with NJ EX Order. 264b1 NJ EX Order. 264b1 . A review of the medical record indicated that Resident #77 was admitted to the facility with diagnoses which included, but not limited to: NJ EX Order. 264b1) NJ EX Order. 264b1 A review of Resident #77 care plan on NJ EX Order. 26 did not reflect this resident's NJ EX Order. 264b1	F 656	F656 SS = D Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) DATE: 3/14/23 1. Resident #77□s Care Plan was immediately reviewed and amended to reflect the resident□s NJ EX Order. 264b1 and was ensured that it was a comprehensive person-centered care plan to suit Resident #77□s medical needs identified in the initial nursing assessment. . 2. Every resident has the potential to be affected by these deficient practices. 3. The two policies and procedures titled, □Care Planning for Long Term Care□ and □Comprehensive Care Plan□ were reviewed and then all LPNs and RNs were in-serviced on both policies for (1) hour by the DON/ADON in the facilities NJ EX floor Conference Room, in a language they could understand. 4. All resident Care Plans will be audited quarterly by the DON/ADON/Unit Managers/MDS Coordinator and any discrepancies or omissions identified will be immediately addressed and the Care Plans will be corrected accordingly. Also, any discrepancies or concerns will be	

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F 656	Continued From page 12 During an interview with the surveyor on 3/2/23 at 11:51 AM, Licensed Practical Nurse (LPN) #1 confirmed that NJ EX Order: 264b1 should be identified on the care plan. During an interview with the surveyor on 3/2/23 at 12:09 PM, Registered Nurse Unit Manager (RNUM) #1 stated that NJ EX Order: 264b1 should be identified on the care plan, "especially on the baseline care plan." Upon reviewing the Resident's electronic medical record, RNUM#1 confirmed that there was no care plan for NJ EX Order: 264b1 During an interview with the surveyor on 3/8/23 at 1:05 PM, Assistant Director of Nursing (ADON) confirmed that Resident #77's NJ EX Order: 264b1 and interventions should have been identified on the care plan. A review of the facility's policy titled "Care Planning for Long Term Care", with a reviewed date of 1/26/23, revealed under Policy that, "The care plan is designed to ensure that residents receive appropriate care and treatment to address problems and needs on an ongoing basis. The goal of the care plan is to implement interventions that help achieve optimal outcomes, and to communicate and coordinate the support of resident needs and goals." A review of the facility policy titled "Comprehensive Care Plan", with a reviewed date of 1/26/23, revealed under Policy that, "The Comprehensive Care Plan includes the instructions needed to continue to provide effective and person-centered care that meets the professional standard of quality care. Each patient will have a person-centered	F 656	discussed at the Quality Assurance Performance Improvement Meeting quarterly for (1) year.	

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F 656	Continued From page 13 comprehensive care plan that is developed and implemented to meet all of their preferences, goals and addresses all clinical, physical, mental and psychosocial needs." NJAC 8:39-11.2(d)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		3/14/23

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F 657	Continued From page 14 Based on observation, interviews, and record review, it was determined that the facility failed to revise and update the care plan (CP) in a timely manner for residents who [redacted] This deficient practice was identified for 2 of 35 residents reviewed for comprehensive care plans, (Residents #130 and #264) and was evidenced by the following: 1. On 2/21/23 at 11:22 AM, Resident #130 was observed sleeping in bed. According to the Admission Record, Resident #130 was admitted to the facility in [redacted] with diagnoses which included but were not limited to; NJ EX Order. 264b1 Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated, [redacted] revealed that the resident had a Brief Interview for Mental Status (BIMS) of "[redacted]" which indicated that the resident had [redacted]. Additional review revealed that the resident had a diagnosis of [redacted] required NJ EX Order. 264b1 of one staff with transfers, and had [redacted] since the prior assessment. Review of an incident report (IR) dated, 1/11/23 at 8:25 AM, revealed that Resident #130 was observed lying on the floor next to their bed. [redacted] checks were initiated, the resident denied [redacted] and there were no visible injuries. The resident was seen by the Nurse Practitioner and orders were obtained for [redacted] work, and NJ EX Order. 264b1. Further review of the IR indicated an investigation was completed on [redacted]. The investigation summary did not indicate if the care plan was	F 657	F657 SS = D Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) DATE: 3/14/23 1(a). The Care Plan for Resident #130 was immediately reviewed and amended to reflect an intervention for the resident to attend ongoing group activity sessions with [redacted] speaking recreation staff on [redacted] in order to ensure that the comprehensive person-centered care plan suited Resident #130's medical needs identified in the initial nursing assessment. 1(b). The Care Plan for Resident #264 was immediately reviewed and amended to reflect an intervention of close monitoring by staff in the Day Room and for the resident to participate in activities that will minimize the potential for [redacted] while providing diversion and distraction on 3/9/23 in order to ensure that the comprehensive person-centered care plan suited Resident #264's medical needs identified in the initial nursing assessment. 2. Every resident has the potential to be affected by these deficient practices. 3. The policies and procedures titled, □Care Planning for Long Term Care□ and □[redacted]Prevention Guidelines□ were reviewed by the Administrator/DON/ADON and then all LPNs and RNs were in-serviced on both policies for (1) hour by the DON/ADON in the facilities [redacted] floor Conference Room, in a language they	

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F 657	Continued From page 15 revised or if an intervention was put into place after the [redacted]. Review of the resident's CP included a focus dated [redacted] which indicated that the resident was at risk for [redacted] due to NJ EX Order. 264b1 [redacted] and a history [redacted]. The goal was for the resident to be free from [redacted] for 90 days. The care plan included interventions dated, [redacted] to anticipate and meet the resident's needs, ensure the resident was wearing appropriate footwear, encourage the resident to participate in activities, the call light was within reach, follow facility fall protocol, safe environment, referral to rehab. Additional interventions for rehab referral for post fall screening were dated NJ EX Order. 264b1 and [redacted]. There was no documented evidence that Resident #130's care plan was revised or updated with an intervention for the [redacted] that occurred on [redacted]. 2. On 2/21/23 at 11:27 AM, Resident #264 was observed awake and in bed. According to the Admission Record, Resident #264 was admitted to the facility in [redacted] with diagnoses which included but were not limited to; NJ EX Order. 264b1 Review of the resident's Quarterly MDS dated [redacted] revealed that the resident had [redacted] and NJ EX Order. 264b1 [redacted], required NJ EX Order. 264b1 of one staff for bed mobility and transfers. Further review revealed that the resident did not have any [redacted] since the last	F 657	could understand. The Rehabilitation Director will continue to make Post Fall Rehabilitation Assessment Referral to determine if any resident would further require rehabilitative services like PT/OT/ST. 4. All resident falls will be audited daily by the DON/ADON/Unit Managers/Director of Rehabilitation/Director of Recreation to discuss and address falls interventions and update the care plans immediately to ensure that they are revised in a timely manner and in accordance with F657. The ADON/UMs will then audit all falls weekly to ensure completion of the incident reports and investigations and any discrepancies or concerns will be discussed at the Monthly Falls Committee Meeting and then again quarterly at the Quality Assurance Performance Improvement Meeting quarterly for (1) year.	

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assessment.

Review of an IR dated [redacted] at 5:30 AM, revealed the resident was observed sitting on the floor in their room with [redacted] from an [redacted] area to the resident's [redacted]. A [redacted] was applied, and the resident was transferred to the emergency room. A referral was made to rehab for a [redacted] evaluation upon return from the emergency room.

Review of the Progress notes dated [redacted] at 5:37 PM, revealed the family had requested a [redacted].

Review of the resident's [redacted] Treatment Administration Record (TAR) revealed, [redacted] check for function every shift with a start date of [redacted]

Review of Resident #264's CP revealed a focus dated [redacted] that the resident was at risk for [redacted] related [redacted]. The goal date [redacted] was that the resident would not sustain [redacted] injury through next review date. Interventions dated [redacted], included but were not limited to: anticipate and meet the resident's needs, call light within reach, ensure the resident is wearing appropriate footwear.

Additional review of the CP revealed that the intervention for a rehab referral was added to the CP on [redacted] days after the [redacted] and the [redacted] was added to the CP on [redacted] (over a month after the [redacted]

During an interview with the surveyor on 3/2/23 at 09:40 AM, the Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that the staff had a

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NJ EX meeting after every NJ EX to discuss interventions, and what could be done to prevent another NJ EX. She stated the CP would be updated by the Assistant Director of Nursing (ADON), unit managers, or nurses.

During a follow up interview with the surveyor on 3/3/23 at 11:49 AM, the surveyor reviewed Resident #130 and Resident #264's CP with the LPNUM #1. The LPNUM #1 stated there should be a CP intervention on Resident #264's NJ EX Order 12 NJ EX l care plan. She stated Resident #130 may have had the same interventions in place. She stated resident falls were discussed in morning meeting to see if there were new interventions for the CP. She stated the CP may not be updated during the meeting, but would updated when interventions were in place.

During an interview with the surveyor on 3/6/23 at 11:30 AM, the Director of Nursing (DON) stated that falls were discussed daily at morning meetings. Physical therapy would look at every NJ EX and would do a screen and evaluation. She stated that the ADON was responsible for review of every NJ EX investigation and update of interventions. She stated the ADON called staff to determine what happened and would put in the summary of the IR. The DON stated that every fall should have an intervention on the care plan.

During an interview with the surveyor on 3/7/23 at 11:03 AM, the ADON stated falls were thoroughly discussed in the morning meeting, and that the Rehab Director would be present. She further stated falls were discussed to determine the cause, and then the resident's care plans were updated. The ADON stated she reviewed NJ EX CP, and made sure the CP's were updated.

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F 657	Continued From page 18 The surveyor reviewed the IR and careplans for Resident #130 and Resident #264 with the ADON. The ADON confirmed she did not see the interventions on the printed copy of the CP. The ADON went on the computer to review the CPs and stated the interventions for #264's NJ EX on NJ EX Order 2 was a referral to rehab but she did not click "save" on the CP so it did not go on to the CP timely. The ADON continued to look on the computer for interventions for Resident #130's NJ EX Order 26403 and confirmed she did not see that the CP was updated. She stated,"interventions were NJ EX Order 2 on hold, reeducate immediately, kept in line of site, when in room increase supervision, and increased group activity". The ADON confirmed that those interventions were not on the CP or on the investigation summary and should have been. She stated the purpose of the investigation summary was to discuss what was done to prevent further NJ EXX. During a follow up interview with the surveyor on 3/8/23 at 11:02 AM, the ADON stated she was supposed to ensure that interventions were updated on the resident's CP timely. Review of the facility's NJ EX Or Prevention and NJ EX Ca NJ EX O Management Policy, dated February 1, 2021 with a revised date of February 1, 2022 revealed, The Interdisciplinary Team (IDT) would review on admission, and update the resident's fall prevention care plan at least quarterly, whenever a significant change occurs and after a NJ EXO occurrence.	F 657		

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F 657	Continued From page 19 Review of the facility's Care planning for Long Term Care Policy, dated February 1, 2021 with a reviewed date of January 26, 2023, revealed, Purpose: the care plan provides a systematic, comprehensive, and interdisciplinary method for the resident to identify treatment and care. Policy: The care plan is designed to ensure that residents receive appropriate care and treatment to address problems and needs on an ongoing basis. The goal of the care plan is to implement interventions that help achieve optimal outcomes, and to communicate and coordinate the support of resident needs and goals. NJAC 8:39-11.2(e)(1)	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to: a.) accurately transcribe a physician's order for NJ EX Order. 264b1 for 1 of 2 residents reviewed for NJ EX Order. 264b1 (Resident #23), b.) accurately transcribe a physician's order for NJ EX Order. 264b1 for 1 of 3 residents reviewed for NJ EX Order. 264b1 (Resident #77), c.) follow a physician's order for weekly NJ EX Order. 264b for 1 of 5 residents reviewed for NJ EX Order. 264b (Resident #183), d.) ensure NJ EX Order. 264b1 was accurately documented in the medical record for 1 of 3 residents reviewed for NJ EX Order. 264b1 (Resident	F 658	F658 SS=E Services Meet Professional Standards CFR(s): 483.21(b)(3)(i) Date: 3/14/23 1(a). Resident #23□s MD was immediately notified and a new NJ EX Order. 2 was given to clarify that the NJ EX Order. 264 should be given 3 NJ EX Order. 2 every NJ hours. The new order was then accurately transcribed to Resident #23□s	3/14/23

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F 658	Continued From page 20 #199), and e.) ensure NJ EX Order. 264b1 assessments 'NJ Ex Order checks" were completed for 2 of 4 residents reviewed for accidents (Residents #130 and #264). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/24/23 at 9:33 AM, the surveyor observed Resident #23 in bed as staff entered room to perform morning care.	F 658	Medication Administration Record to reflect the corrected physicians orders for the NJ EX Order. 264b1. 1(b). Resident #77□s MD was immediately notified and a new physicians order to note, □NJ EX Order. 264b1 with NJ EX Order. □ was accurately transcribed to reflect on Resident #77□s Treatment Administration Record. 1(c). Resident #183 was immediately placed onto monthly NJ EX Order. 26 monitoring. Resident #183□s NJ EX Order. 264b1 were reviewed for February 2023 and March 2023 for accuracy/stability and no significant loss was noted. Immediately an audit was completed on all other residents requiring weekly NJ EX Order 2 monitoring and any NJ EX Order N ledgering discrepancies observed were immediately addressed. 1(d). Residents #199□s NJ EX Order. 264b1 was immediately assessed for NJ EX Order. 264b1, which was noted and recorded in the Medication Administration Record. Resident #199 was monitored each shift for NJ EX Order. 264b1 and accurately documented in the medical record for resident #199 who was reviewed for NJ EX Order NJ EX Order. 264b1. 1(e). Residents #130 & #264 were immediately examined for any NJ EX OX Order. 264b1 deficits secondary to learning of the failure to ensure the initial NJ EX Order checks which were not completed at the interval of each shift for 72 hours. Both residents #130 & #264 were noted to be NJ EX Order. 264b1 with no NJ EX Order. 264b1 deficits and in NJ EX Order 2 condition. 2. Every resident has the potential to be	

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F 658	Continued From page 21 A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ EX Order. 264b1 identified Resident #23 as NJ EX Order. 264b1 on staff for all aspects of care. A review of the medical record indicated that Resident #23 was admitted to the facility with diagnosis which included, but not limited to: NJ EX Order. 264b1). A review of the Order Summary Report (OSR) revealed an order to NJ EX Order. 264b1 with NJ EX Order. mL of NJ EX Order. every NJ EX Order. hours. NJ EX Order. 264b1 NJ EX Order. with an additional NJ EX Order. every shift", with a start date of NJ EX Order. 264b1. The order was implemented with the specific administration times of NJ EX Order. 264b1. A review of the corresponding NJ EX Order. 264b1 Medication Administration Record (MAR) revealed the above order with a check mark and the administrating nurse's initials. During an interview with the surveyor on 03/06/23 at 10:45 AM, Licensed Practical Nurse (LPN) #2 confirmed that medication orders should not be combined into one order but "separate". During an interview with the surveyor on 03/06/23 at 10:50 AM, Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that "everyone" had the responsibility of reviewing orders for accuracy "when you give meds you review them". LPNUM #1 also confirmed that 24 hours chart checks were completed by the "night shift". Upon	F 658	affected by these deficient practices. 3(a)(b). The DON/ADON/designee re-educated all nurses on all shifts regarding proper documentation of Physicians Orders while entered them onto the EMAR. DON/ADON/designee re-educated 11-7 shift Nursing Supervisor and all nurses on the proper procedure for 24-hour chart checks so that any transcription errors will be identified and corrected. 11-7 Nursing Supervisor will conduct weekly random audits and will address any transcription errors with staff and correct them immediately. 3(c). The DON created a template in the EMAR to reflect all weekly weight orders be reflected onto the Medication Administration Record. The Registered Dietitian will audit all residents with weekly weight orders and report to nursing any discrepancies for immediate corrective action including NJ EX Order. refusals. 3(d). The DON/ADON educated all nursing staff on the proper monitoring of NJ EX Order. 264b1 for NJ EX Order. 264b1 each shift and how to document on the MAR accordingly. Any discrepancies will be reported to the physician. Unit Mangers will conduct weekly audits on all residents with NJ EX Order. 264b1 to review accuracy/findings of NJ EX Order. 264b1 documentation. The results of the audit will be addressed with staff and any documentation discrepancies will result in immediate corrective action. 3(e). Unit Mangers will audit all documentation for the proper NJ EX Order. 264b1 Assessments completed for residents	

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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
F 658	Continued From page 22 reviewing the MAR, LPNUM #1 confirmed that the orders should be separated, and the identified hours were not spaced correctly to correlate "every [redacted] hours". When asked what the dietitian's impression would be upon reviewing the MAR, LPNUM #1 stated, "she would be under the impression that the nurses were giving all the [redacted]." When asked why having two separate orders for the [redacted] would be important LPNUM #1 responded, "there is no way to determine if each [redacted] was given." During an interview with the surveyor on 3/6/23 at 11:30 AM, the Registered Dietitian (RD) reported that she used the nurse's documentation in the progress notes and the MAR for her nutritional assessment. When asked how she determined if the residents received their [redacted], the RD reported that she contacted the nurse and they confirm with the MAR. Upon reviewing Resident #23's MAR, the RD confirmed that she was under the impression that the resident was receiving [redacted]. The RD also stated that [redacted] are very specific, and this incorrect order was something that should have been brought to her attention. During an interview with the surveyor on 3/8/23 at 1:05 PM, the Assistant Director of Nursing (ADON) stated that the night shift was responsible for completing 24-hour chart checks and the unit manager was responsible for completing chart reviews. Upon reviewing Resident #23's MAR, the ADON confirmed that the orders should be separated. The ADON also confirmed it was not possible to determine if the resident had received the ordered [redacted] based on how it was transcribed on the MAR.	F 658	suffering multiple falls, those at risk for falls, due to confusion, gait/balance problems w/bed mobility, poor comprehension, those unaware of their safety needs, and those with [redacted] histories, and especially those with BIMS under [redacted]. Proper completion of the [redacted] Assessment will be completed, according to the Physician Orders as related to the nature of the residents condition and daily review of [redacted] Assessments will be completed by the Unit Manager. Weekly audits will be done by the ADON for accuracy and completeness. 4. Going forward all Physicians Orders will be reviewed monthly by the Pharmacy Consultant and a report will be sent to each Unit Manager, Assistant Director of Nursing, Director of Nursing, Medical Director, and Administrator monthly. Recommendations will be considered and implemented within 30 days of notice, and all findings/inconsistencies/reports will then be reviewed at the Quality Assurance Performance Improvement Meeting quarterly for (1) year.	

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2. On 2/21/23 at 11:52 AM, Resident #77 was observed in the wheelchair with NJ EX Order. 264b1 NJ EX Order. 264b1 The resident was NJ EX Order. 264b1 NJ EX Order. 264b1

A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ EX Order. 264b identified the resident as NJ EX Order. 264b1 and with NJ EX Order. 264b1

A review of the medical record indicated that Resident #77 was admitted to the facility with diagnosis which included, but not limited to: NJ EX Order. 264b1 .

A review of the Order Summary Report (OSR) revealed an order to separate digits at all times with gauze, with an order date of NJ EX Order. 264b

A review of the corresponding NJ EX Order. 264b and NJ EX Order. 264b1 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reflect this order.

On 2/24/23 at 9:54 AM, Resident #77 was observed without NJ EX Order. 2 between the NJ EX Order. 264b1 NJ EX Order. 264b1

On 2/28/23 at 10:25 AM, Resident #77 was observed without NJ EX Orde e between the NJ EX Order. 264b1

On 3/2/23 at 10:07 AM, Resident #77 was

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F 658	Continued From page 24 observed without [NJ EX Order: 26401] between the [NJ EX Order: 26401] [NJ EX Order: 26401]. On 3/6/23 at 11:44 AM, Resident #77 was observed without [NJ EX Order: 26401] between the [NJ EX Order: 26401] [NJ EX Order: 26401]. On 3/8/23 at 11:16 AM, Resident #77 was observed without [NJ EX Order: 26401] between the [NJ EX Order: 26401] [NJ EX Order: 26401] During an interview with the surveyor on 3/6/23 at 10:45 AM, Licensed Practical Nurse (LPN) #1 confirmed that she did not have any orders for Resident #77 regarding [NJ EX Order: 26401] During an interview with the surveyor on 3/2/23 at 12:09 PM, Registered Nurse Unit Manager (RNUM) #1 confirmed that the order was received to use [NJ EX Order: 26401] to separate [NJ EX Order: 26401]. When asked if this order could be located on the MAR or TAR, the RNUM#1 responded, "no". During an interview with the surveyor on 3/8/23 at 1:05 PM, the Assistant Director of Nursing (ADON) stated that the night shift was responsible for completing 24-hour chart checks and the unit manager was responsible for completing chart reviews. Upon reviewing Resident #77's MAR and TAR, the ADON reported that the orders were located on the OSR, "so it will never transcribe over". When asked if this order should have been clarified, the ADON responded, "yes, it should have". When asked if this order should have been transcribed to the MAR or TAR the ADON stated, "yes" . A review the facility Policy Titled "Physician Orders", with Reviewed Date of 2/1/2023,	F 658		

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revealed under Procedure that:
1.The discipline requesting the order will complete the appropriate request in its entirety in the electronic orders Portal and submit on behalf of the resident.
2.The nurse will notify the attending physician or physiatrist to ask for an order based on the disciplines request and then Confirm the orders in the Orders Pending Confirmation Tab. If the physician chooses not to give the order, the nurse must inform the discipline that requested the order.
4.Verbal telephone orders may only be received by licensed personnel (e.g RN, LPN, Physician, etc). Orders must be reduced to writing by the person receiving the order and recorded in the resident's medical electronic record. The entry must contain the instructions from the physician, date, time and the signatures and title of the person transcribing the information.
5.Upon receiving the telephone order, the nurse will transcribe the order in the electronic record, read the order back to the physician, sign with his/her name and document ordered by the physician's name, date, and time the order.

3.On 2/22/2023 at 10:40 AM, Resident #183 was observed in bed sleeping.

According to the Admission Record, Resident #183 was readmitted to the facility in [redacted] with diagnoses which included but were not limited to; [redacted] and [redacted].

Review of the Quarterly MDS dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) of "[redacted]", which

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indicated that the resident's [NJ EX Order. 264b1] was [NJ EX Order. 2] The MDS also revealed that the resident had a [NJ EX Order. 264b1] and weighed [NJ EX Or] pounds (lbs).

Review of Resident #183's care plan, created on [NJ EX Order. 264] revised [NJ EX Order. 26], included that the resident was at risk for NJ EX Order. 264b1 status related to [NJ EX Order. 264b1] and significant [NJ EX Order. 264b1]. An intervention created on [NJ EX Order. 264] and revised on [NJ EX Order. 26], included to monitor weights monthly and that the resident had a history of NJ EX Order. 264b1 despite encouragement and education.

Review of the Registered Dietician's (RD) progress notes (PN) dated [NJ EX Order. 264b] included, to initiate NJ EX Order. 264b1 for four weeks to "monitor."

Review of a physician's order dated [NJ EX Order. 264b] with a start date of [NJ EX Order. 264b], revealed NJ EX Order. 264b1 for [NJ EX Or] weeks, one time a day, every [NJ EX Order. 264b] for monitoring.

Review of the Resident's November and December MAR did not reflect the 1[NJ EX Order. 264] order for [NJ EX Order. 2] weights.

Review of Resident #183's weight summary report revealed a weight of [NJ EX Order.] lbs documented on [NJ EX Order. 26]. There were no [NJ EX Order. 2] weights documented as ordered for NJ EX Order. 264b1 [NJ EX Order. 26], and [NJ EX Order. 264b]

During an interview with the surveyor on 3/2/23 at 9:50 AM, the LPNUM #1 stated the RD would recommend [NJ EX Order. 2] weights, and would put an order in the computer. She stated the Certified Nurses Aides (CNAs) would obtain the weight,

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document the weight on paper and the RD would enter the weight in the computer.

During an interview with the surveyor on 3/2/23 at 10:43 AM, the RD stated she would put in the order for [redacted] weights and provided a list to the CNAs and the unit managers. In the presence of the surveyors, the RD reviewed Resident #183's weights and progress notes. She stated that the resident's [redacted] and the resident's weights were [redacted] She confirmed that she did not see the [redacted] ordered [redacted] weights documented and would follow up.

During an interview with the surveyor on 3/3/23 at 10:59 AM the Director of Nursing (DON), in the presence of the RD, stated that there was a documentation error when the RD put the order for [redacted] weights in the computer. The RD selected "no documentation required" which was why the order was on the physician order sheet (POS) only and not on the MAR where the nurses would see the order. The DON and RD confirmed there was no documentation of [redacted] based on the order. The DON stated that there should have been documentation if resident [redacted] to be weighed, but the order was only on the POS, it was an error, and the RD "clicked the wrong thing."

Review of the facility's policy titled, "Physicians Orders", revised on [redacted], reviewed on [redacted], included that it was the "policy of Embassy Manor to receive requests/recommendations through electronic medical record, orders portal from dietary departments for patient/resident physician orders. Procedure: the discipline requesting the order will complete the appropriate request in it's entirety in

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the electronic Orders Portal and submit on behalf of the resident ...A 24 hour check will be conducted so any transcription errors will be picked up, clarified and then corrected. Upon receiving the telephone order, the nurse will transcribe the order on the electronic record ...It is the responsibility of the discipline requesting the order to assure that the order they have requested has been obtained in a timely manner."

Review of a facility policy titled, NJ EX Order. 264b1 t NJ EX Or" revised January 3, 2023, included "Policy: In order to ensure an ongoing and accurate record of a resident's weight as part of the medical record ...Procedure: 2. A monthly weight shall be obtained by the assigned certified nurses aide, under the supervision of the licensed nurse or RD. The certified nurses aide shall record the weight on the units monthly tracking sheet. The dietician shall then transcribe the weight on the electronic medical record. 3. A resident may be reweighed for various reasons, i.e significant changes in weight. This shall be recorded in the same manner as procedure #2."

4. On 2/28/23 at 10:35 AM, Resident #199 was observed sleeping in bed. The resident's NJ EX Orde was NJ EX Order. 264b1 .

According to the Admission Record, Resident #199 was admitted to the facility in NJ EX Order. 264b1 NJ EX Orde with diagnosis which included but were not limited to: NJ EX Order. 264b1 .

Review of the resident's Admission MDS dated NJ EX Order. 264b1 , revealed that the resident had NJ EX Orde and NJ EX Order. 264b1 , and had an NJ EX Order. 264b1

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Review of the resident's care plan dated [redacted] revealed that the resident had an [redacted] related to NJ EX Order. 264b1 due to NJ EX Order. 264b1). Interventions included to monitor and document NJ EX Order. 264b1 per facility policy.

Review of the resident's Order Summary report included an order dated [redacted] to monitor [redacted] every shift for NJ EX Order. 264b1

Review of the resident's NJ EX Order. 264b1 Medication Administration Record (MAR) included the aforementioned order. Additional review of the MAR revealed that "[redacted]" was coded as the output for the shift on the following dates and times: [redacted] night shift, [redacted] day and evening shift, [redacted] evening and night shift, [redacted] evening and night shift, [redacted] evening shift, [redacted] night shift, and [redacted] night shift.

During an interview with the surveyor on 2/28/23 at 10:44 AM, Licensed Practical Nurse (LPN) #4 stated that the nurses entered the resident's [redacted] every shift in the Treatment Administration Record (TAR), and Resident #199 had [redacted] every shift.

During an interview with the surveyor on 3/7/23 at 12:17 PM, Registered Nurse (RN) #2 stated nurses monitored and assessed NJ EX Order. 264b1, and the [redacted] in the [redacted]. The CNAs emptied the urine from the [redacted] and notified the nurses of the resident's output. The nurses then documented the [redacted] on the MAR. If there was [redacted] output, the nurse would notify the physician and obtain an order.

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During an interview with the surveyor on 3/7/23 at 01:03 PM, LPNUM #1 stated nurses observed the resident's NJ EX Order. 264b1 to make sure it was patent, NJ EX Order. 264 and there was a certain amount of NJ EX Orde each shift. She stated the CNA's emptied the urine and report the NJ EX Order. to the nurse who would document the output on the MAR. The surveyor reviewed Resident #199's NJ EX Order. 264b1 MAR with LPNUM #1. LPNUM #1 stated, that "no one" should have a NJE " documented, and that she would ask the nurse if the NJ EX Ord was already NJ EX Order. 26 prior to the documentation on the MAR or if the NJ EX Order. 264b1 was NJ EX Order. 264 .

During an interview with the surveyor on 3/8/23 at 10:41 AM, the DON stated that nurses should monitor NJ EX Order. 264b1 and document the NJ EX Order. every shift. She stated the CNAs emptied the NJ EX Order. 264b1 , measured the NJ EX Order. and notified the nurse who would document on the MAR. The DON stated Resident #199 always had NJ EX Order. 264b1 and was disappointed that the nurses did not document correctly. The DON stated LPNUM #1 was contacting the nurses for clarification.

During an interview with the surveyor on 3/9/23 at 11:30 AM, LPN #5 stated Resident #199 always had NJ EX Order. 264b1 the days she worked, but she inadvertently clicked NJ EX on the MAR. She stated it was a "human error" and if there was no NJ EX Order. 2 she would have called the physician.

Review of an employee statement form written by LPN #6, dated 3/8/23, revealed that LPN#6 was the assigned nurse for Resident #199 on NJ EX Order. 2 and that the resident's NJ EX Order. 264b1 was NJ EX Order. 2 and NJ EX Order. 26401 LPN #6 wrote that the resident had an NJ EX Order. 26401 milliliters at the end of the

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shift, and LPN #6 mistakenly entered [redacted].

Review of a facility's policy titled, "Intake and output", effective February 1, 2021, with a reviewed date of January 26, 2023, included but was not limited to; "Policy: Accurate intake and output shall be documented, when indicated by a resident's medical condition ...Measure and record the amount of [redacted]. If the resident has a [redacted] or other [redacted] device, empty at the end of each shift and record the amount."

5. a. On 2/21/23 at 11:22 AM, Resident #130 was observed sleeping in bed.

According to the Admission Record, Resident #130 was admitted to the facility in [redacted] with diagnoses which included but were not limited to: [redacted] ia.

Review of the Quarterly MDS, an assessment tool, dated [redacted], revealed that the resident had a BIMS of "[redacted]" which indicated that the resident had [redacted]. Additional review revealed that the resident had a diagnosis of [redacted] of one staff with transfers, and had [redacted] since the prior assessment.

Review of the resident's CP included a focus dated [redacted], that the resident was at risk for falls due to [redacted] problems, [redacted], [redacted], [redacted] of [redacted] needs and a history [redacted]

Review of an incident report (IR) dated [redacted] at 4:00 PM, revealed that Resident #130 was

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observed lying on the floor on their right side, and the resident had a [redacted] on their [redacted]. A [redacted] was applied, vital signs were checked, [redacted] checks were initiated. The resident was assisted back to bed.

Review of an IR dated, [redacted] at 8:25 AM, revealed that Resident #130 was observed lying on the floor next to their bed. The resident was unable to provide a description of the [redacted] checks were initiated, the resident denied [redacted] and there were no visible injuries.

Review the [redacted] Flow Sheet indicated the following: "Note: This checklist should be completed at the following intervals for follow up for all [redacted] or [redacted] in which [redacted] is struck, initial assessment followed by every [redacted] minutes x [redacted], every [redacted] minutes x [redacted], every hour x [redacted], once per shift for [redacted] hour[s]."

Review of Resident #130's [redacted] assessment flow sheet's dated [redacted] and [redacted] revealed [redacted] assessments were completed for the first four hours after each [redacted] however there was no documented [redacted] assessments on the flow sheet for the interval of once per shift for [redacted] hours.

b. On 2/21/2023 at 11:27 AM, Resident #264 was observed awake and in bed.

According to the Admission Record, Resident #264 was admitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted].

Review of the resident's Quarterly MDS dated [redacted], revealed that the resident had [redacted] and

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

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F 658		F 658		

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NJ EX Order. 264b1, required NJ EX Order. 264b1 of one staff for bed mobility and transfers. Further review revealed that the resident did not have any since the last assessment.

Review of Resident #264's CP revealed a focus dated that the resident was at risk for related to NJ EX Order. 264b1.

Review of an IR dated at 2:15 PM, revealed that the resident was observed sitting on the floor in front of their wheelchair in the dining room. The resident was unable to provide a description of the checks were initiated and there were no injuries. The resident was assisted back to the wheelchair.

Review of an IR dated at 10:43 PM, revealed that the resident was observed sitting on the floor by the side of the wheelchair in the activity room. The resident was unable to provide a description of the checks were initiated and there were no injuries. The resident was assisted to their wheelchair and to their bed.

Review of Resident #264's Assessment Flowsheet dated revealed that assessments were completed from 2:15 PM though 8:15 PM. There was no further assessments documented on the flow sheet for the interval of once per shift hours.

During an interview with the surveyor on 3/2/23 at 10:12 AM, LPNUM #1 stated assessment should be in the resident's chart. The surveyor reviewed Resident #130's and Resident #264's flow sheets with LPNUM #1. The LPNUM #1 was unable to provide additional

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F 658	Continued From page 34 information. During an interview with the surveyor on 3/7/23 at 11:03 AM, the ADON stated [redacted] checks would be completed for NJ EX Order. 264b1 and would be completed to identify any deficits. LPNUM #1 would be responsible to ensure completion. The surveyor reviewed Resident #130 and Resident #264's IRs and NJ EX Order. 264b1 assessments with the ADON. The ADON confirmed the assessments were incomplete. Review of a facility policy titled, [redacted] prevention and [redacted] management", revised February 1, 2021 included, if an NJ EX Order. 264b1 occurs or there is a suspected head injury, or if ordered by a physician, a [redacted] evaluation status [redacted] will be completed. Documentation for [redacted] evaluation starts with the time of the [redacted] The [redacted] form must be completed. [redacted] evaluation will be completed by a nurse only and documented as follows: Initial neurological evaluation includes: Vital signs, [redacted] NJ EX Order. 264b1, [redacted], [redacted], [redacted] and [redacted] function. NJAC 8:39-11.2(b), 27.1(a)	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,	F 695		3/14/23

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F 695	Continued From page 35 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure a resident who was dependent on supplemental [redacted] received supplemental [redacted] in accordance with physician orders for 1 of 2 residents reviewed for [redacted] care (Resident #66). This deficient practice was evidenced by: During the initial tour of the building on 02/21/23 at 12:36 PM, the surveyor observed a stop sign posted outside of Resident #66's room which cautioned that an [redacted] was required to enter the resident's room. From the doorway, the surveyor observed Resident #66 lying in bed asleep with the head of bed elevated. The resident had a [redacted] and was noted to have a [redacted]. According to the Admission Record (an admission summary) Resident #66 was readmitted to the facility in [redacted] with diagnoses which included but were not limited to: [redacted]	F 695	F695 SS = D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) DATE: 3/14/23 1.Resident #66 was immediately assessed by the DON/ADON to ensure that [redacted] was being provided. [redacted] and vital signs were noted to be stable at that time and Resident #66 was in no acute [redacted] distress. The contracted [redacted] supply company was then immediately requested to see Resident #66 and assess [redacted] supplementation needs. The recommendation was received by the DON/ADON/UM and the attending physician was then notified of such recommendation and [redacted] orders were updated to specify: [redacted] via [redacted] as needed when [redacted] less than [redacted] 2.Every Resident has the potential to be affected by these deficient practices. 3. All other residents receiving [redacted] supplementation were reviewed by the ADON/DON to ensure the accuracy of physician orders for [redacted] supplementation. The policies and procedures titled, [redacted]	

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F 695	Continued From page 36 Review of Resident #66's Annual Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1 revealed that the resident was NJ EX Order. 264b1, had a NJ EX Order. 264b1 and NJ EX Order. 264b1. Further review of the MDS revealed that the resident was totally dependent with the assistance of NJ EX Order. persons for both bed mobility and transfers and was totally dependent with assistance of of one person for NJ EX Order. assistance. Further review of the MDS revealed that the resident received NJ EX Order. 264b1 via a NJ EX Order. 264b1 (e.g. NJ EX Order. 264b1). The MDS specified that the resident received special treatments which included NJ EX Order. 26 therapy, NJ EX Order. 264b1 and NJ EX Order. 264b1 care. Review of Resident #66's Care Plan (CP) revealed an entry initiated on NJ EX Order. 264b1 which detailed that the resident had a NJ EX Order. 264b1 related to NJ EX Order. 264b1. Further review of the CP revealed an intervention that was also initiated on NJ EX Order. 264b1 for NJ EX Order. 264 settings of NJ EX Order. via NJ EX Order. 264b1, NJ EX Order. 264b1 as necessary and NJ EX Order. care every shift. Review of Resident #66's Order Summary Report revealed an entry dated NJ EX Order. 264b1 for NJ EX Order. 264b1 at NJ EX Order. 264b1 continuously every shift for NJ EX Order. 264b1. On 02/23/23 at 9:36 AM, the surveyor observed Resident #66 lying in bed awake with the head of bed elevated. The resident had a NJ EX Order. 264 NJ EX Order. 264b1 r (medical device that delivers continuous, NJ EX Order. 264b1) that was set to deliver NJ EX Order. 264b1. The resident was able to NJ EX Order. 264b1, NJ EX Order. 264b1 when spoken	F 695	Administration□, □Physicians Orders□, □50 PSI Air Compressor□, and □Care of the NJ EX Order. 264b1 □ were immediately reviewed by the Administrator/DON/ADON. The policy for □Care of the NJ EX Order. 264b1 □ was updated to include verbiage that states all patients with NJ EX Order. 264b1 will be further consulted and managed in collaboration with the oxygen supply company to assess and provide supplemental care for NJ EX Order. 264b1 residents. All LPNs and RNs were in-serviced on all (4) policies for (1) hour by the DON/ADON in the facilities 1st floor Conference Room, in a language they could understand. Materials were provided and attendance was taken. 4. Going forward all residents with oxygen supplementation will be reviewed daily by the LPN/RN/Unit Manager/Nursing Supervisor and confirmed for accuracy against physician orders. Weekly audits will be completed by the UM/designee and any discrepancies, changes, or recommendations will be considered and implemented immediately. All findings, inconsistencies, and reports will then be reviewed monthly and presented at the Quality Assurance Performance Improvement Meeting quarterly for (1) year.	

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to and voiced no concerns.

On 02/24/23 at 10:13 AM, the surveyor observed Resident #66 lying in bed asleep with the head of bed elevated. The NJ EX Order. 264b1 was set at NJ EX Order. 264b1.

On 02/28/23 at 11:21 AM, Resident #66 was observed lying in bed with the head of bed elevated and the resident's NJ EX Order. 264b1 was set at NJ EX Order. 264b1.

On 03/01/23 at 12:30 PM, Resident #66 was observed lying in bed asleep with the head of bed elevated and the resident's NJ EX Order. 264b1 was set at NJ EX Order. 264b1.

During an interview with the surveyor on 03/03/23 at 10:55 AM, Licensed Practical Nurse (LPN) #4 stated that Resident #66 was ordered continuous NJ EX Order. 26 at NJ EX Order. 264b1 delivered via the NJ EX Order. 264b1. LPN #4 looked at the NJ EX Order. 264b1 NJ EX Order. 2 and agreed that the NJ EX Order. 264b1r was set to NJ EX Order. 264b1 instead of NJ EX Order. 264b1 of NJ EX Order. 26 as ordered. LPN #4 then attempted to turn the dial to increase the NJ EX Order. 264b1g from NJ EX Order. 264b1 but was unable to do so. LPN #4 stated that she would obtain a NJ EX Or NJ EX Order. 264b1

During an interview with the surveyor on 03/03/23 at 1:29 PM, the Director of Nursing (DON) stated that there was an order for Resident #66 to have NJ EX Order. 26 at NJ EX Order. 264b1 and nursing was responsible to check the rate and ensure accuracy.

During an interview with the surveyor on 03/06/23 at 11:15 AM, Registered Nurse Unit Manager (RNUM) #1 stated that NJ EX Order. 26 orders were based

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on physician orders and nurses were required to round and ensure that the settings were maintained. RNUM #1 stated that she thought that Resident #66's NJ EX Order. 264b1 order was changed to NJ EX Order. 264b1 after the weekend supervisor phoned the primary physician.

On 03/06/23 at 12:09 PM, the surveyor observed Resident #66 lying in bed asleep with the head of bed elevated. The surveyor observed that the NJ EX Order. 264b1 was placed in the corner of the room and was not in use. The resident had an NJ EX or (device used to deliver NJ EX Order. 264b1 on the night stand to the left of the resident that was set at NJ EX Order. 264b1 and there was no NJ EX Order. 264b1 beside the resident to deliver NJ EX Order. 26 as described by RNUM #1.

During an interview with the surveyor on 03/06/23 at 12:14 PM, LPN #4 stated that they had to change Resident #66's NJ EX Order. 264b1 r, so she changed it. LPN #4 stated that the resident's current NJ EX Order. 26 order was for NJ EX Order. 264 with NJ EX NJ EX Order. 264b1. When the surveyor asked LPN #4 to demonstrate how the NJ EX Order. 264 was delivered to the resident if the NJ EX Order. 264b1 was not utilized she was unable to answer the question and instead stated, "A technician set it up for us."

During an interview with the surveyor on 03/06/23 at 12:48 PM, RNUM #1 accompanied the surveyor into Resident #66's room to view and clarify the resident's NJ EX Order. 264b1 equipment against the current physician's order for NJ EX Order. 264 of NJ EX Order. 264b1 NJ EX Order. 264b1 with NJ EX Order. 264b1. The RNUM #1 viewed the equipment and stated, "I do not know why they set it up like that." RNUM #1 stated that she was unable to tell

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if the resident received NJ EX Order. 264b1 as ordered. RNUM #1 stated that she would find out and report back to the surveyor.

During an interview with the surveyor on 03/07/23 at 12:39 PM, RNUM #1 stated that when she saw Resident #66's order for NJ EX Order. 264b1 which did not match the NJ EX Order. 264b1 equipment that was NJ EX Order in the room she spoke with LPN #4 who informed her that a NJ EX Order. 264b1 supply company technician came in and set it up that way. RNUM #1 stated that she informed LPN #4 that the resident had not received NJ EX Order. 264b1 because the NJ EX Order. 264b1 was in the corner of the room. RNUM #1 stated that the Assistant Director of Nursing (ADON) had the respiratory supply technician come back out to the facility last night NJ EX Order. 264. RNUM #1 explained that when the respiratory supply technician came to the facility initially, they did not bring the NJ EX Order. 264 NJ EX Order. 264b1 that was required to connect NJ EX Order. 26 ng from the NJ EX Order. 264b1 to the NJ EX Order. 264b1 and they did not have the attachment either.

RNUM #1 further stated the NJ EX Order. 264b1 supply technician should have spoke with the nursing staff and confirmed the NJ EX Order. 264 order prior to delivery and set up. RNUM #1 stated that a new NJ EX Order. 264b1 was ordered because the NJ EX Order. 26 level would rise and fall on its own and needed to be fixed. RNUM #1 stated, "It was important that the resident received the right amount of NJ EX Order. 264 because it helped you to breathe and without it, you could stop breathing."

On 03/07/23 at 1:03 PM, Resident #66 was observed lying in bed awake with the head of bed elevated. The concentrator was set to deliver NJ EX O of NJ EX Order. 264 and the NJ EX Order. NJ EX Or was set to

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NJ EX Order. 264b1n as described by RNUM #1 in accordance with the physician's order that was written on NJ EX Order. 264b1

During an interview with the surveyor on 03/08/23 at 11:16 AM, RN #1 stated that when he cared for Resident #66 over the weekend he was told in report that the resident had new equipment, a NJ EX Order. 264b1 which NJ EX Order. 264b1 to the resident and had replaced the NJ EX Order. 264b1. RN #1 stated that he was unsure why the resident's equipment was changed. He stated that you could check the dial on the NJ EX Order. 264b1 to determine if the settings were correct.

During an interview with the surveyor on 03/08/23 at 11:16 AM, ADON stated that the NJ EX Order. 264b1 supply company came to the facility on NJ EX Order. 264b1 to train the nursing staff regarding NJ EX Order care as nursing was primarily responsible for NJ EX Order care. The ADON stated that the plan was to wean Resident #66 from the NJ EX Order. 26 for now and later from the NJ EX Order.

During a phone interview with the surveyor in the presence of the survey team on 03/08/23 at 1:27 PM, the NJ EX Order. 264b1 Therapist (NJ EX 2, who was employed by the NJ EX Order. 264b1 supply company, stated that she was asked to come out to the facility on NJ EX Order. 264b1 to perform a whole assessment to assess patient care, what they needed and to take an inventory of supplies. The NJ EX stated that she did not see a problem with Resident #66's NJ EX Order. 264b1 and made a recommendation to maintain the resident on NJ EX 2 NJ EX Order. 264b1 with NJ EX Order. 264b1. The NJ EX 2 explained that she was not part of the NJ EX Order. 264b1r delivery. She stated that the NJ EX Order. 264b1 was air to NJ EX Order. 264b1, it was

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F 695	Continued From page 41 called an air NJ EX Order. 264b1 by definition. The NJ EX O stated that the NJ EX Order. 264b1 was required in order to delivery NJ EX Order. 264 . The RT stated that no concerns were noted as the resident was NJ EX Order. 2 cooperative and was in no distress. During an interview with the surveyor on 03/10/23 at 10:19 AM, the DON stated that LPN #4 was not fully educated on the use of Resident #66's NJ EX Order. 264b1 r prior to surveyor inquiry and required additional in-service training. Review of the facility policy titled, NJ EX Order. 264b1 Administration" (02/01/21) revealed the following: Policy: It is the policy of this facility to provide comfort to residents by administering NJ EX Order. 26 when insufficient NJ EX Order. 26 is being carried by the blood to the tissues. Procedure: Check physician's order for liter flow and method of administration...A reserve NJ EX Order. 26 NJ EX Order. 264b1 should be available to provide continuity of care... For PRN NJ EX Order. 26 order the nurse will provide the NJ EX Order. 264 NJ EX Order. 264b1 or tank when needed.. NJ EX Order. 264b NJ EX Order. 264b1 : Set the flow meter to the rate ordered by the physician. Properly affix mask or cannula to NJ EX Order. 264b1 . Unused NJ EX Order. 264b1 will be kept in Central Supply... NJAC 8:39-11.2(b);27.1(a)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		3/14/23

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F 698	Continued From page 42 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their NJ EX Order. 264 schedule for 1 of 2 residents (Resident #71) reviewed for NJ EX Order. 264. This deficient practice was evidenced by the following: During the initial tour of the facility on 02/21/23 at 11:22 AM, the Licensed Practical Nurse (LPN) #3 informed the surveyor that Resident #71 had begun NJ EX Order. 264 (the process of removal NJ EX Order. 264b1 from the NJ EX Order in people whose NJ EX Order. 264b can no longer perform these NJ EX Order. 264b1 ly) approximately one month ago and was presently out of the facility for NJ EX Order. 264 treatment. According to the Admission Record (an admission summary), Resident #71 was admitted to the facility in NJ EX Order. 264b1 with diagnoses which included but were not limited to: NJ EX Order. 264b1 [redacted]. Review of Resident #71's Admission Minimum	F 698	F698 SS=E Dialysis CFR(s): 483.25(l) Date: 3/14/23 1. Resident #71□s MD was immediately notified and corrected physician orders were obtained to adjust the medication times of the NJ EX Order. 264b1 medications for this NJ EX Order. 264 patient. All other necessary medications were then also immediately adjusted to accommodate Resident #71□s NJ EX Order. 264b1, and NJ EX Order. 264b1 schedule in the same fashion. 2. All residents have the potential to be affected by these deficient practices. 3. All other NJ EX Order. 264 patients Medication Administration Records were analyzed by the ADON/DON to ensure appropriateness of medication scheduling. Then all nursing staff were in serviced to ensure that all NJ EX Order. 's resident□s medication times are adjusted to accommodate their NJ EX Order. 264 schedules in accordance with the Policy and Procedure titled, □ NJ EX Order. 264 □ Care of the Patient Receiving□. 4. Monthly audits will be initiated by ADON/DON/designee to ensure that all NJ EX Order. 264 patient□s medication	

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F 698	Continued From page 43 Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident's cognition was NJ EX Order. 264b1. Further review of the MDS revealed that Resident #71 received [redacted] treatments while a resident at the facility. Review of the Order Summary Report revealed a physician's order dated [redacted] for [redacted] times per week on NJ EX Order. 264b1, and [redacted]s at 10:25 AM, transport at 9:25 AM. Review of a Consultant Pharmacist (CP) Evaluation contained within Resident #71's paper chart revealed an entry dated [redacted], in which the CP recommended that the facility adjust the resident's medications for [redacted] Review of Resident #71's Medication Administration Record (MAR) dated NJ EX Order. 264b1 3 revealed the following: 1. [redacted] Capsule 1[redacted]mg. Give 1 (one) capsule by mouth one time a day for [redacted] (NJ EX Order. 264b1 for [redacted]) month with a start date of [redacted] and D/C (discontinue) date of [redacted]. The medication was plotted on the MAR for administration at 9:00 AM, and all doses were charted as administered. 2. [redacted] Oral Tablet 1 (one) gm [redacted] mg [redacted] (NJ EX Order. 264b1) Give 1 (one) capsule by mouth [redacted] times a day for [redacted]. Start date [redacted] and D/C date [redacted]. The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). On NJ EX Order. 264b1 at 1300 the medication was charted as "OO" which indicated that the	F 698	administration times work to accommodate their [redacted] schedules weekly for (4) weeks, and then monthly thereafter. All results will be presented at the Quality Assurance Performance Improvement Meeting quarterly for (1) year.	

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	315279	A. BUILDING _____ B. WING _____	03/10/2023

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

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F 698	Continued From page 44 resident was "Out on Pass." On [redacted] at 1300, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. 3. [redacted] Tablet [redacted] mg ([redacted]) Give [redacted] tablets by mouth four times a day for [redacted] management [redacted]) grams [redacted]/day from all sources. Start date [redacted] and D/C date [redacted]. The medication was plotted on the MAR for administration at 0900 (9 AM), 1200 (12 PM), 1700 (5 PM) and 2100 (9 PM). On [redacted] at 1200 the medication was charted as "OO" which indicated that the resident was "Out on Pass." On [redacted] at 1200, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. 4. [redacted] ([redacted]) Solution [redacted] every [redacted]) hours for [redacted]. The start date of the medication was on [redacted] and the D/C Date was on [redacted]. The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM). On [redacted] at 1400, the medication was charted as "OO" which indicated that the resident was "Out on Pass." On [redacted] at 1400, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. 5. [redacted] Tablet [redacted] mg Give 1 (one) tablet by mouth every [redacted]) hours for [redacted]). Hold [redacted]	F 698		

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F 698	Continued From page 45 NJ EX Order. 264b1) less than NJ EX Order Start date NJ EX Order. 264b1 and D/C date NJ EX Order. 264b1 The medication was plotted on the MAR for administration at 0400 (4 AM), 1200 (12 PM) and 2000 (8 PM). On NJ EX Order. 264b1 at 1200, the medication was charted as "OO" which indicated that the resident was "Out on Pass." On NJ EX Order. 264b1 NJ EX Order. 264b1 at 1200, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. Review of Resident #71's Medication Administration Record (MAR) dated NJ EX Order revealed the following: 1. NJ EX Order. 264b1 Capsule 100 mg. Give NJ EX Order. 26 capsule by mouth NJ EX Order times a day for NJ EX Order. 264b1 for NJ EX Order. 264b1 until NJ EX Order. 264b1 at 07:43. Start date of NJ EX Order. 264b1 and D/C date of NJ EX Order. 264b1 The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). On NJ EX Order. 264b1, NJ EX Order. 264b1, NJ EX Order. 264b1 NJ and NJ EX Order. 264b1 NJ EX Order. 264b1 at 1300, the medication was charted as "OO" which indicated that the resident was "Out on Pass." 2. NJ EX Order. 26 Oral Tablet 1 NJ EX Order gm 2 NJ EX mg NJ EX Or (NJ EX Order. 264b NJ EX Orde Give NJ EX Order. 26 capsule by mouth NJ EX Order times a day for NJ EX Order. 264b. Start date NJ EX Order. 264b1 and D/C date NJ EX Order. 264b1 The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). On T NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1	F 698		

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F 698	Continued From page 46	F 698		

NJ EX Order. 264b1 at 1300, the medication was charted as "OO" which indicated that the resident was "Out on Pass."

3. NJ EX Order. 264b1 Oral Tablet NJ EX Order. 264b1) gm NJ EX Order. 264b1 mg NJ EX Order. 264b1 (NJ EX Order. 264b1) Give NJ EX Order. 264b1 (one) capsule by mouth NJ EX Order. 264b1 times a day for NJ EX Order. 264b1 . Start date was NJ EX Order. 264b1 and the D/C date was NJ EX Order. 264b1 The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM), and 1700 (5 PM).

On NJ EX Order. 264b1 at 1300, the medication was charted as "OO" which indicated that the resident was "Out on Pass."

4. NJ EX Order. 264b1 Solution NJ EX Order. 264b1 every NJ EX Order. 264b1 (eight) hours for NJ EX Order. 264b1 . Start date of the medication was on NJ EX Order. 264b1 and the D/C Date was on NJ EX Order. 264b1 .

The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM).

On NJ EX Order. 264b1 and NJ EX Order. 264b1 at 1400, the medication was charted as "OO" which indicated that the resident was "Out on Pass."

5. NJ EX Order. 264b1 every NJ EX Order. 264b1 NJ EX Order. 264b1 hours for NJ EX Order. 264b1 . The start date of the medication was on NJ EX Order. 264b1 and the D/C date was NJ EX Order. 264b1

The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM).

On NJ EX Order. 264b1 at 1400, the medication was charted as "OO" which indicated that the resident was "Out on Pass."

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F 698	Continued From page 47 6. NJ EX Order. 264b1 Tablet NJ EX Order. 264b1 mg Give NJ EX Order. 264b1 tablet by mouth every NJ EX Order. 264b1 hours for NJ EX Order. 264b1. Hold NJ EX Order. 264b1 less than NJ EX Order. 264b1 Start date NJ EX Order. 264b1 and D/C date NJ EX Order. 264b1. The medication was plotted on the MAR for administration at 0400 (4 AM), 1200 (12 PM) and 2000 (8 PM). On NJ EX Order. 264b1 and NJ EX Order. 264b1 at 1200, the medication was charted as "OO" which indicated the resident was "Out on Pass." 7. NJ EX Order. 264b1 NJ EX Order. 264b1 in NJ EX Order. 264b1 times a day for NJ EX Order. 264b1 (NJ EX Order. 264b1) for NJ EX Order. 264b1) days. Start date NJ EX Order. 264b1 The medication was plotted on the MAR for administration at 0900 (9 AM), 1200 (12 PM), 1700 (5 PM) and 2100 (9 PM). On NJ EX Order. 264b1 and NJ EX Order. 264b1 at 1200, the medication was charted as "OO" which indicated that the resident was "Out on Pass." 8. NJ EX Order. 264b1 Tablet NJ EX Order. 264b1 mg (NJ EX Order. 264b1) Give NJ EX Order. 264b1 tablets by mouth four times a day for NJ EX Order. 264b1 management NJ EX Order. 264b1) grams NJ EX Order. 264b1 /day from all sources. Start date NJ EX Order. 264b1 NJ EX Order. 264b1 and D/C date NJ EX Order. 264b1 The medication was plotted on the MAR for administration at 0900 (9 AM), 1200 (12 PM), 1700 (5 PM) and 2100 (9 PM). On NJ EX Order. 264b1, NJ EX Order. 264b1, NJ EX Order. 264b1, NJ EX Order. 264b1, NJ EX Order. 264b1, and NJ EX Order. 264b1 NJ EX Order. 264b1 at 1200, the medication was charted as "OO" which indicated that the resident was "Out on Pass."	F 698		

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F 698	Continued From page 48	F 698		

Review of Resident #71's Medication Administration Record (MAR) dated NJ EX Order. 264b1 revealed the following:
1. NJ EX Order. 264b1 mg. Give NJ EX Order. 26 capsule by mouth NJ EX Order times a day for NJ EX Order. 264b1 for 1 NJ EX Order. 264b1 until NJ EX Order. 264b1 at 07:43. Start date of NJ EX Order. 264b1 and D/C date of NJ EX Order. 264b1.
The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM).
On NJ EX Order. 264b1 at 1300, the medication was charted as "OO" which indicated the resident was "Out on Pass."
2. NJ EX Order. 264b1 Tablet NJ EX Order. 26 gm NJ EX mg NJ EX Or (NJ EX Order. 264b1 Give NJ EX Order. 26) capsule by mouth NJ EX Order times a day for NJ EX Order. 264. The start date was NJ EX Order. 264b1 and the D/C date was NJ EXEX Order. 26.
The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM), and 1700 (5 PM).
On NJ EX Order. 264b1 at 1300, the medication was charted as "OO" which indicated the resident was "Out on Pass."
3. NJ EX Order. 264b1 Solution NJ EX Order NJ EX Order. 264b1 ml NJ EX Order. 264b1 every NJ NJ EX Order. 2 hours for NJ EX Order. 264b1. Start date of the medication was on NJ EX Order. 264b1 and the D/C date was NJ EX Order. 264b1
The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM).
On NJ EX Order. 264b1 at 1400, the medication was charted as "OO" which indicated that the resident was "Out on Pass."

Review of Resident #71's Order Summary Report

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F 698	Continued From page 49	F 698		

provided by the Administrator on NJ EX Order. 264b1, which contained active orders as of NJ EX Order. 264b1, revealed the following Pharmacy Orders:

1. NJ EX Order. 264b1 Capsule NJ EX O mg Give NJ EX Order. 26 capsule by mouth one time a day for NJ EX Order. 264b1. For NJ EX Order. 264b1.
2. NJ EX Order. 26 Oral Tablet NJ EX Order 2) gm NJ EX Or mg (NJ EX O NJ EX Order. 264b1) Give NJ EX Order.) tablet by mouth NJ EX Order times a day for NJ EX Order. 26
3. NJ EX Order. 264b1) Solution NJ EX Order NJ EX Order. 264b1 every NJ EX Order. 2 hours for NJ EX Order. 264b1.
4. NJ EX Order. 264b1 Tablet NJ EX O mg Give NJ EX Order.) tablet by mouth every NJ EX Order. 26) hours for NJ EX Or (NJ EX Order. 264b1. Hold NJ EX Order. 264b1 5 Monitor NJ EX O per policy.
5. NJ EX Order. 264b1 Oral Tablet NJ EX Order. 26 mg NJ EX Order. 264b1) Give NJ E tablets by mouth NJ EX O times a day for NJ EX Or management.

Review of Resident #71's Care Plan revealed that the resident was ordered NJ EX Order. 264b1 therapy NJ EX Order. 264b1 NJ EX Order. 264b1 in NJ EX Order. 264b1 r times a day for NJ EX Order. 264b1NJ EX O for NJ EX Order. 26 days on NJ EX Order. 264b1 Interventions included administer medications as ordered.

During an interview with the surveyor on 03/02/23 at 1:01 PM, LPN #3 stated that Resident #71's medications were adjusted to correlate with the resident's NJ EX Order. 26 schedule on NJ EX Order. 264b1 NJ EX Order. 264b1 as the resident was scheduled for transport at 9:25 AM and received dialysis treatment at 10:25 AM. LPN #3 further stated that the physician discontinued the resident's scheduled dose of NJ EX Order. 264b1 (medication used to treat NJ EX Order. 264b1)

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F 698	Continued From page 50 last week as the resident was out of the facility to dialysis when the medication was scheduled. LPN #3 further stated that the resident's [redacted] medications were administered at [redacted]. During an interview with the surveyor on 03/06/23 at 10:58 AM, Registered Nurse Unit Manager (RNUM) #1 stated that the CP reviewed the resident's medications on a monthly basis and provided the Director of Nursing (DON) with the recommendations. RNUM #1 further stated that the DON then distributed the CP's recommendations to the unit managers. RNUM #1 stated that, "A recommendation to adjust medications for dialysis indicated that the orders needed to be changed right away." RNUM #1 stated that oral medications scheduled for 9:00 AM were administered to Resident #71 at 8:00 AM before the resident left for [redacted]. RNUM #1 stated that she spoke with the resident's primary physician during rounds regarding the resident's medication scheduling. RNUM #1 further stated that the DON had the documentation that directly related to the interventions that were implemented to the resident's medications in response to the CP recommendations. On 03/07/23 at 8:44 AM, the Administrator provided the surveyor with Resident #71's "Consultant Pharmacist's Monthly Report" which was dated [redacted] and revealed the following entry: "A review of the Medication Administration Record indicated medication doses are being held due to the resident '[redacted]'." The times of administration should be modified to accommodate the needs of the resident. Please obtain a physicians order for changes in administration times. Review: [redacted]	F 698		

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F 698	Continued From page 51 (medication that can NJ EX Order. 264b1 in the NJ EX Order. 264b1 who are on d NJ EX Order. 264b1), NJ EX Order. 264b1 medication), NJ EX Order. 264b1 used to NJ EX Order. 264b1), NJ EX Order. 264b1 NJ EX Order. 264b1 Further review of the Consultant Pharmacist's Monthly Report revealed a handwritten entry next to the recommendations which specified, "NJ EX Order. 264b1 NJ EX Order. 264b1 days." During an interview with the surveyor on 03/07/23 at 11:01 AM, the CP stated that she visited the facility monthly and made recommendations based off review of the resident's Medication Administration Record (MAR). The CP stated that once the unit review was complete the office sent the report to the DON and Administrator to distribute to the unit managers. The CP stated that she reviewed the medical record on her next scheduled monthly visit to ensure the recommendations were addressed. The CP stated that she made recommendations for Resident #71 "to ensure that the doses were given as ordered, rather than to reflect that they were going to be NJ EX Order. 264b1 out of the resident." During an interview with the surveyor on 03/08/23 at 11:25 AM, RNUM #1 stated that she first learned of the issue with Resident #71 who had not received his/her medications on NJ EX Order. 26 days from the CP in NJ EX Order. 264b1 During an interview with the surveyor on 03/09/23 at 11:33 AM, the DON stated that any resident who was on NJ EX Order. 264b1 had to have their medications changed to match the NJ EX Order. 264b1 days and times. The DON stated that if a medication was scheduled when the resident was out of the	F 698		

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F 698	Continued From page 52 facility to [NJ EX Order 264] then the nurse had to call the doctor to obtain an order to change the time of administration to accommodate the resident's [NJ EX Order 264] schedule. The DON stated that all nurses were trained to ensure that if a medication was missed, then they were required to call the doctor who would provide orders and instructions on how to proceed. The DON stated that the facility did not wait for the CP to review the resident's orders before they reviewed medications that were required to be administered on scheduled [NJ EX Order 264] days. The DON stated the unit manager should have reviewed the medications when she initiated and prepared the resident's [NJ EX Order 264] communication binder to ensure that the binder was complete and contained all related [NJ EX Order 264] information. The DON stated that the nurses had a one-hour window of time to administer medications and if the medication was not administered within that time frame, then the nurse was required to notify the doctor. The DON further stated, "If a medication was not administered, then you have to handle it immediately and ensure that the medications were given at alternate times when the residents are in the facility." Review of the facility policy titled, "[NJ EX Order 264]-Care of the Patient Receiving" (Reviewed 05/11/22) revealed the following: ...Re-arrange medication and treatment times as needed to accommodate resident/patient being out of the building. NJAC 8:39-27.1(a)	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		3/14/23

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F 812	Continued From page 53 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 2/21/23 at 9:43 AM, the surveyor, in the presence of the Dietary Director (DD), observed the following during the kitchen tour: 1. In the food preparation area, Dietary Aide #1 and Dietary Aide #2 were observed wearing baseball caps with their hair at the back of the head exposed and were not wearing hairnets. The DD acknowledged the dietary aides should have been wearing hairnets. 2. In the food preparation area, Dietary Aide #2	F 812	F812 SS = E Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) DATE: 3/14/23 1. Dietary Aide #1 and #2 were immediately instructed to wear the proper hair nets and in-serviced. 2. Dietary Aide #2 was immediately instructed to wear the proper facial hair restraint and in-serviced. 3. The 8lb. container of macaroni salad found in the walk-in refrigerator was immediately discarded. 4. The half-cut head of cabbage was immediately discarded.	

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F 812	Continued From page 54 was observed wearing a surgical mask above his chin area and his facial hair was exposed. The DD stated Dietary Aide #2 should have facial hair covered and provided a facial hair restraint to the dietary aide. 3. On a shelf in the walk-in refrigerator, the surveyor observed an 8-lb container of macaroni salad, which had a manufacturer's label that had a best used by date of 01/03/23. The DD confirmed the date and stated the food item would be disposed. 4. On a shelf in the walk-in refrigerator, in a box containing cabbage, a half-cut head of cabbage wrapped in plastic, was observed undated and had an area that was grey in color to the cut side of the cabbage. The DD inspected the cabbage and stated it should be thrown away. On 2/22/23 at 10:25 AM, the Administrator provided the surveyor with the policy for expired foods and dietary personnel standards. The Administrator stated the macaroni salad was not being used as their menu had previously changed, and that the macaroni salad had not been thrown out at the time. The surveyor asked the Administrator how often and who was responsible for checking the refrigerated food items. The Administrator stated it was indicated in the policies provided. On 3/7/23 at 11:00 AM, the surveyor interviewed the DD about refrigerator storage being checked for expired items. The DD stated that himself or an assigned dietary staff would check for expired food items. The DD further stated they used a FIFO [First In, First Out] policy for food items stored.	F 812	The entire dietary department was in-serviced on the Policy & Procedure for, □Personnel Standards□, as it was related to wearing hairnets and beard guards. The staff was also in-serviced on the Policy & Procedure for, □Food Service□, and □Expired Food□ as it related to identifying and eliminating expired foods, the proper labeling/dating of perishable food items, and also First In/First Out (FIFO) Methodology. 2. All residents have the potential to be affected by these deficient practices. 3. The Regional Food Services Director/designee held in-services to address the entire food services department on the following issues: Hairnets/Beard Guard Usage, Proper Dating and Labeling, Checking for Expiration Dates, Eliminating Expired Foods, and Proper Storage in food areas/FIFO. 4. The Food Services Director/designee will conduct daily inspections of the ongoing food safety outcomes, environmental inspections, and will manage an □Active Item Expiration Sheet□ checklist which will reviewed and updated weekly. Any expired findings will be disposed of immediately. The Food Services Director will continue to make daily rounds in the kitchen to oversee the entire operation of the day to day food procurement and assurance of proper hair guards. The Food Services Director will	

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F 812	Continued From page 55 On 3/9/23 at 1:15 PM, the surveyor informed the Administrator, and the Director of Nursing of the above concerns. The surveyor reviewed the facility's policy titled, "Personnel Standards" with an effective date of February 2021. Under Procedure, it read "All staff members will have their hair off the shoulders, confined in a hairnet or cap, and facial hair properly restrained." The surveyor reviewed the facility's policy titled, "Food Service" with an effective date of 2/1/2021. The policy read "Maintain a clean, safe, and sanitary storage for all items". Under Procedures, it read "F-I-F-O (First In First Out) rule will be followed at all times" and "Put a date, label as necessary, all foods stored in walk-in refrigerators and freezers that are out of its original packaging from the time it was opened.". The surveyor reviewed the facility's policy titled, "Expired Foods" with a revised date of 7/1/2022. The policy indicated "The Dietary aide/designee will ensure proper dating for all food upon delivery" and "All expired food will be discarded immediately". The policy did not further address checking food item expiration dates.	F 812	also conduct weekly food safety and environmental inspections and report those findings monthly to the Administrator and then to the Quality Assurance Performance Improvement Committee quarterly for (1) year.	
F 880 SS=E	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		3/14/23

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F 880	Continued From page 56	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

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

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

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F 880	Continued From page 57 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) perform hand hygiene before and after [redacted] care for 3 of 3 residents (Residents #180, #205 and #264). This deficient practice was evidenced by the following: 1.During the initial tour of the 2A unit on 2/21/23 at 11:13 AM, the surveyor observed the facility's [redacted] and his assistant enter Resident #205's room. Resident #205 was awake and seated in their wheelchair. The [redacted] t sat on the floor in front of the resident, put on gloves and removed the resident's [redacted] exposing the resident's [redacted]	F 880	F880 SS=E Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) DATE: 3/14/23 1.The facility immediately checked to ensure that all infection prevention and control programs were in place for Resident #205, Resident #264, and Resident #180. The [redacted] was immediately in-serviced by the Infection Preventionist regarding proper hand hygiene with return demonstration which needs to be provided before and after the	

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F 880	Continued From page 58 NJ EX Ord. The NJ NJ EX Order. 264b opened a blue pad, "chux" (a disposable under pad) and placed it on the floor underneath the resident's NJ EX Orde. The door to the resident's room remained opened as the podiatrist performed NJ EX Orde il care to the resident which was visible to the surveyor in the hallway. After the NJ EX Order. 264b1 completed the resident's toenail care, the NJ EX Order. 264b t folded the blue pad, stood up off the floor, removed his gloves and left the resident's room. There was no hand hygiene observed. The surveyor reviewed the medical records of Resident #205 which revealed the following: Resident #205 was admitted in NJ EX Order. 264 with diagnoses which included but were not limited to; NJ EX Order. 264b1 Review of Resident #205's Admission Minimum Data Set (MDS), an assessment tool, dated NJ EX Order. 26 revealed that the resident had a brief interview for mental status (BIMS) of NJ EX which indicated that the resident's NJ EX Order. 264b3 was NJ EX Order. 264b1. On 02/21/23 at 11:27 AM, the surveyor observed the NJ EX Order. 264b1 enter Resident #264's room. Resident #264 was awake and in bed. The NJ EX Order. 264b1 put gloves on and introduced himself to the resident as the NJ EX Order. 264b1. The NJ EX Order. 264b1 removed a blue pad from his bag and placed it under the resident's NJ EX Orde on the bed. The door to the resident's room remained opened as the NJ EX Order. 264b1 performed NJ EX Order. 26 care to the resident which was visible to the surveyor in the hallway. After the NJ EX Order. 264b1 completed the resident's NJ EX Order. 26 care, the NJ EX Order. 264b1 folded the blue pad	F 880	care of each resident, including Resident #205, #264 and #180. The NJ EX Order. 264b1 was also educated regarding individualized usage of the disposable blue □chux□ pads between each resident for infection control purposes. 2.All residents have the potential to be affected by these deficient practices. 3. First, management reviewed the Infection Prevention & Control Policy and Procedure for its annual review as per CFR 483.80(f). Then, the ADON/ICPO provided in-services for Hand Washing and Infection Control Policy and Procedures with return demonstrations for all employees. Directed Plan of Correction, DPOC, In-Service Trainings were provided to all appropriate staff, staff competencies were validated by the Director of Nursing/Medical Director/Infection Preventionist. All in-services were held by the Infection Preventionist and the DON/ADON for up to (4) hours in the facility□s 1st floor conference room. Materials were presented in a language that could be understood by all staff on a television screen. Modules included: Nursing Home Infection Preventionist Training Course Module 1- Infection and Prevention & Control Program, Module 4-Infection Surveillance, Module 7-Hand Hygiene, Module 6A- Principles of Standard Precautions, and CDC COVID-19 Prevention Messages for Front Line Long-TermCare Staff: Keep COVID-19 Out! & Clean Hands. All new	

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F 880	Continued From page 59 and placed it back into his bag, removed his gloves and left the resident's room. There was no hand hygiene observed. The surveyor reviewed the medical records of Resident #264 which revealed the following: Resident #264 was admitted in [redacted] with diagnoses which included but were not limited to, NJ EX Order. 264b1 and NJ EX Order. 264b1. Review of Resident #264's Quarterly MDS, dated [redacted] revealed that Resident #264 had [redacted]- and NJ EX Order. 264b1. On 02/21/23 at 11:31 AM, the surveyor observed the [redacted] enter Resident #180's room. Resident #180 was awake and seated in a wheelchair. The [redacted] touched resident's hand to greet the resident and explained to the resident that he would look at their [redacted] The [redacted] sat on floor, put gloves on, unfolded a blue pad from his bag and put it down onto the floor under the resident's f[redacted] The door to the resident's room remained opened as the [redacted] performed [redacted] care to the resident which was visible to the surveyor in the hallway. After the [redacted] completed the resident's toenail care, the [redacted] folded the blue pad, discarded it, removed his gloves and left the resident's room. There was no hand hygiene observed. The surveyor reviewed the medical records of Resident #180 which revealed the following: Resident #180 was admitted in [redacted] with diagnoses which included but were not limited to NJ EX Order. 264b1, and [redacted]	F 880	hires will be in-serviced upon their orientation for these same policies and procedures. A Root Cause Analysis was conducted by the facility with assistance the Infection Preventionist, the Quality Assurance and Performance Improvement committee, the Administrator, the DON, and the Medical Director. The Root Cause was identified as the facilities [redacted] The governing body theorized that a systemic change needed to be made and the [redacted] was terminated from providing services to the facility. 4. The Podiatrist was terminated from providing services to the facility. The newly contracted service provider was interviewed regarding the efficacy of Infection Prevention and Control during the provision of services and was able to recite the proper methodology for these practices. Services will begin after 4/1/23 and the Infection Preventionist/designee will train and in-service the new [redacted] quarterly with return demonstration to ensure that these practices are being maintained. Monthly audits will be conducted by the IPCO and will report findings at the Quality Assurance Performance Improvement Meetings, quarterly for (1) year.	

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F 880	Continued From page 60 Review of Resident #180's Quarterly MDS dated, [redacted], revealed that Resident #180 had a BIMS of "[redacted]" which indicated that the resident's [redacted] was [redacted] During an interview with the surveyor on 2/21/23 at 11:36 AM, the [redacted] stated he kept hand sanitizer in his bag and would do hand hygiene after care. The [redacted] acknowledged that he did not perform hand hygiene in between the three residents. During an interview with the surveyor 3/2/23 at 9:40 AM, Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that hand hygiene should be performed before and after resident care for infection control. During an interview with the surveyor on 03/06/23 at 11:38 AM the Director of Nursing (DON) stated the [redacted] should perform hand hygiene because of infection control. She stated that the Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) had previously spoke to the [redacted] about hand hygiene. During an interview with the surveyor on 03/08/23 at 01:19 PM, the IP stated that she and the ADON had previously went over hand hygiene, use of the blue pad (chux), with the [redacted] She stated between each resident the [redacted] should perform hand hygiene for infection control because he touched [redacted], and the blue pad (chux) should be individualized for infection control. Review of a facility policy titled, Handwashing and hand hygiene purposes, dated 2/2021, revised on 2/2022, included but was not limited to;" It is the	F 880		

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F 880	Continued From page 61 policy of Embassy Manor that hand washing and hand hygiene will be performed in accordance with the Center of Disease Control (CDC) Guidelines. Definitions: Hand hygiene cleansing the hands with facility-approved alcohol- based antimicrobial hand cleanser. Procedure: Hand washing and hand hygiene indications. 1. The use of gloves does not eliminate the use of hand hygiene. 2. Indications for hand washing and hand hygiene include, but are not limited to the following: After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes blood or body fluid secretions or excretions...Before and after performing invasive procedures...After removing gloves. Handwashing Method: Scrub the hands for at least 20 seconds." NJAC 8:39-19.4(a)	F 880		

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S 000	Initial Comments 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: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a. maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 14 of 14 day shifts reviewed. This deficient practice was evidenced by the following: 1.Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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	S 560	S560 8:39-5.1 Mandatory Access to Care P.L. 2020 c 112 N.J.S.A. 30:13-18 (The Act) DATE: 3/14/23 1.Regarding the facility's failure to provide minimum staffing on 2/5/23 to 2/18/23, the Nursing Supervisor asked 11-7 staff previously scheduled to work to continue working the next shift. The Nursing Supervisor called contracted staffing agencies to provide additional staffing to the facility. The Unit Managers, Staffing Coordinator, Nursing Supervisor, and ADON also immediately attempted to call	3/14/23

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift; One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 2/5/2023 and 2/12/2023 revealed the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/05/23 has 20 CNAs for 210 residents on the day shift, required 26 CNAs. -02/06/23 had 20 CNAs for 208 residents on the day shift, required 26 CNAs. -02/07/23 had 20 CNAs for 208 residents on the day shift, required 26 CNAs. -02/08/23 had 24 CNAs for 208 residents on the day shift, required 26 CNAs. -02/09/23 had 20 CNAs for 208 residents on the day shift, required 26 CNAs. -02/10/23 had 20 CNAs for 208 residents on the day shift, required 26 CNAs. -02/11/23 had 21 CNAs for 206 residents on the day shift, required 26 CNAs.	S 560	unscheduled 7-3pm CNAs to replace the callouts and also tried notifying 3-11pm CNAs to come early and work 7-3pm and offered them a pick-up shift differential bonus. The Nursing Supervisor, Unit Managers, Staffing Coordinator/ADON also then notified the unit clerks and floor nurses to inform them of the callouts on 2/5/23 through 2/18/23. On 3/10/23, management called a stat meeting with all CNAs, Unit Clerks, LPNs, RNs, UMs, Nursing Supervisors, Staffing Coordinator, HR, Payroll, ADON, DON, to discuss all implications for S560. 2. All residents have the potential to be affected by these deficient practices. 3. Management reviewed the facility's policies for 'Proper Call Out Procedure', and 'Employee Warning Notice'. The ADON/DON/Administrator in-serviced all CNAs, LPNs, RNs, and Supervisors on both company policies on 3/10/23. The in-service contained the specific information related to the procedure for calling out and submitting personal time off requests with advanced notice. They also discussed the repercussions of not following those procedures and the progressive disciplinary action notification system and how it relates to patient care outcomes. Next, they discussed all of the regulated staffing ratios as related to S560. Management reviewed each census by unit and calculated the patient acuities, and appropriated adequate staff according	

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S 560	Continued From page 2 -02/12/23 had 16 CNAs for 206 residents on the day shift, required 26 CNAs. -02/13/23 had 20 CNAs for 206 residents on the day shift, required 26 CNAs. -02/14/23 had 23 CNAs for 206 residents on the day shift, required 26 CNAs. -02/15/23 had 21 CNAs for 209 residents on the day shift, required 26 CNAs. -02/16/23 had 20 CNAs for 209 residents on the day shift, required 26 CNAs. -02/17/23 had 20 CNAs for 209 residents on the day shift, required 26 CNAs. -02/18/23 had 22 CNAs for 211 residents on the day shift, required 26 CNAs. During an interview with the surveyor on 3/6/23 at 10:09 AM, the Staffing Coordinator stated she was familiar with minimum staffing ratio requirements. During an interview with the surveyor on 03/09/23 at 11:39 AM, the Administrator stated he was aware of the minimum staffing ratio requirements and there had been staffing challenges since the COVID-19 pandemic and with staff callouts.	S 560	to the C.N.A. ratios. The ADON/DON/Administrator discussed the procedures for usage of the Master Schedule and its daily interaction with the staff and Supervisors, the daily confirmation and exchange of the PTO Calendar, the PTO Request Off Form/Switch of Shift Form, the Overtime Request Form, and the completion of the Nurse Staffing Report which will be reviewed by the ADON/DON/designee daily. Lastly, they discussed the staffing coordinator's role to complete daily rounds and confirm each unit's staff attendance and to report it to the ADON/DON. All CNAs were re-educated about their job description including but not limited to floating to different units when shortages are noted. The in-services were given verbally by the ADON/DON/Administrator in the facility's 1st floor conference room for (1) hour in a language the entire staff could understand, materials were provided as well. New hires will be in-serviced upon their orientation on these same policies and procedures. 4. The Administrator/DON/ADON/UMs/Staffing Coordinator/Director of Human Resources will identify daily callouts that are listed on the Daily Census Sheet and will discuss any/all shortages in staffing 5x/week during Clinical Meeting to ensure that a root cause has been identified. A recruitment firm was put in place to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061205	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHAE	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) COMPLETE DATE
S 560	Continued From page 3	S 560	provide us with new applicants on a weekly basis, to hire and on-board new nursing staff to ensure that the care of the residents is being met. Contracted staffing agencies will continue to provide nursing staff as needed. The ADON/DON will review the Master Schedule weekly, and weekly Labor Meetings will be held by the Director of Human Resources/Staffing Coordinator/Administrator. The Staffing Coordinator/Director of Human Resources/designee will monitor these findings daily, 5x/week, track improvement monthly for 3 months, and then present these findings in the Quality Assurance Performance Improvement Meetings quarterly for 1 year or until progress is constantly achieved.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061205 Y1	A. Building B. Wing Y2	5/5/2023 Y3

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

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 03/14/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/10/2023	☐ 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
315279 Y1	A. Building B. Wing Y2	5/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY MANOR AT EDISON NURSING AND REHABILITATION	10 BRUNSWICK AVENUE 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 F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0656	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	03/14/2023	LSC	03/14/2023	LSC	03/14/2023
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	03/14/2023	LSC	03/14/2023	LSC	03/14/2023
ID Prefix F0698	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/14/2023	LSC	03/14/2023	LSC	03/14/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061205 Y1	A. Building B. Wing Y2	5/5/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/14/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO