STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 08/03/22 CENSUS: 134 SAMPLE SIZE: 27 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		9/13/22

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

Electronically Signed | 08/29/2022

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

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F 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and other pertinent facility documentation it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) for 1 of 1 residents reviewed (Resident #101) for reportable incidents. This deficient practice was evidenced by the following: According to the Admission Record, Resident #101 was admitted with diagnoses which included, but were not limited to, [redacted] Review of the Minimum Data Set (MDS), an assessment tool, dated [redacted], Resident #101 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that Resident #101 had NJ EX Order. 264b1 . The MDS documentation also indicated that Resident #101 required [redacted] assistance for Activities of Daily Living (ADLS). Review of Resident #101's Care Plan (CP) revealed a Focus: [redacted] therapy, risk for injury [redacted] and/or [redacted] to use of NJ EX Order. 264b1 to [redacted].	F 609	A current [redacted] assessment for resident #101 showed no [redacted] integrity issues noted. Safety has been maintained, the resident sits comfortably in a wheelchair and there have been no further [redacted] incidents noted. Any resident sustaining an injury of unknown origin has the potential to be affected by the deficient practice. The Administrator and Director of Nursing pulled incident reports from August 1st, 2022 to current. The investigations were reviewed to ensure proper reporting to the DOH. All incidents with injuries of unknown origin had been reported as required. The facility nursing leadership team, including the DON/ADON/RN Supervisors, have been inserviced on notification and reporting requirements outlined in 483.12(c)(1). The Administrator/DON receives real time automated notifications on all incidents. The Administrator/designee will ensure that injuries of unknown origin are reported to the DOH within the required	

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F 609	Continued From page 2 Effective 3/24/2021, Interventions: Assess for signs of NJ EX Order. 264b1), effective Skin assessments as per protocol. Report NJ EX Order. 264b1 effective . Focus: skin integrity: bruising effective Focus: climbing ...attempts to get out of NJ EX Order. 264b1) chair by over the when in it. Also, when sitting in the wheelchair, around the of the chair., effective Review of a Integrity Incident report dated revealed Description: "while doing AM care on Resident #101 the aide and I found a his/her and ." Review of the Event Analysis completed by the Assistant Director of Nursing (ADON) dated , revealed Investigation: ..."it was reported by the CNA who took care of the resident on that she did not see any bruising on the resident's and the resident was in the with over the chair constantly trying to climb out of it .....constantly being reminded and encouraged to put his/her back on the chair....Due to advanced and wanting to get up and go, he/she is constantly being reminded and encouraged to put back on the chair." Review of the Nursing Progress note dated at 08:58 AM revealed: "At 1:15am I assisted the Aide to help change Resident #101 in bed. While changing the resident we noticed a on his/her and Supervisor notified." On 07/22/22 at 11:33 AM, the surveyor interviewed the ADON in the presence of the	F 609	timeframes. On a monthly basis, for three months, the Administrator will audit the incident reports and notifications to ensure the DOH was notified timely for any injuries of unknown origin. The results of these audits will be presented to the QAPI Committee which will meet on a monthly basis. After 3 months the QAPI Committee will make recommendations on the need for continued audits.	

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Director of Nursing (DON). The ADON stated that the process for an injury of unknown origin [redacted] include taking statements from all staff who had provided care of a resident during the last 72 hours to determine a timeline as to when the incident occurred and to identify a cause. She further stated it would be reported to the nurse, the supervisor would be notified, an incident report would be completed, an investigation would be started immediately, and it would be reported to the NJDOH within 24 hours. The ADON stated "It was reportable if we don't know what happen."

During an interview with the survey team on 07/22/22 at 12:26 PM, the Social Worker (SW), stated that that an injury of unknown origin [redacted] be reported to the supervisor. The supervisor would contact the abuse officers: herself, the DON and the Administrator. The abuse officers would discuss the incident, make sure the investigation was completed and would report the incident to NJDOH within 24 hours. The SW reviewed the incident report for Resident #101, she stated "she did not know anything about the incident. I would think that I would have been made aware, I should have been consulted. I would think as an abuse officer I should be involved." The SW then stated that all injuries of unknown origin should be reported to the NJDOH and then a determination would be made after the investigation was completed.

During an interview with the surveyor on 7/27/22 at 11:03 AM, the Administrator stated that an injury of unknow origin would be reported to the supervisor and an incident report would be completed. A new [redacted] required a lookback of 72 hours of all staff members for a potential

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explanation, interview the resident, the roommate, and all staff that cared for the resident for the last 72 hours. He stated it would be initially treated as abuse until abuse could be ruled out. The Administrator was given the [redacted] incident report packet by the surveyor to review. The Administrator was not at the facility at the time of the incident. After reviewing the [redacted] incident report packet, he stated "it seems like there were not statements from staff 72 hours prior to the incident to corroborate the statement of climbing out of the chair."

During an interview with the surveyor on 07/27/22 at 10:22 AM, the Registered Nurse Educator (RDE) stated that there would be a 72 hour look back for a newly identified [redacted], the nurse would do a s[redacted] packet, an incident report would be done, the supervisor would be notified immediately, and an investigation which included statements from all staff taking care of the resident for 72 hours prior to the discovery of the bruise to try to determine the cause. She further stated that the reason you would go back 72 hours was because sometimes [redacted] do not always show up immediately and to make sure there isn't a pattern. The RDE stated it would be reported to the NJDOH if the resident could not tell you how it happened.

A review of the facility's policy, "Abuse Prevention" effective 07/2022 revealed Procedure: 4. All staff will be given information on how to identify and report incidents of abuse, or suspected abuse. A. Staff will be trained on how to identify events, such as suspicious [redacted] adverse occurrences involving un-witnessd falls and injuries of unknow origins. Certain patterns and trends may be suspicious of abuse, such as:

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F 609	Continued From page 5 similar or repeat occurrences on the same shift, involving multiple resident/patients in the same assignment block and occurring after certain family members, friends or other resident/patient visits. 7. Reporting and Response, The following is to be conducted immediately: c. [redacted] must report mistreatment, neglect, abuse, injuries of unknown source ...to the State Survey & Certification (S&C) agency. [redacted] must also report the results of their investigation of these violations to the state S&C agency; f. The Administrator and/or designee, HMQC representative and/or Risk Management will conduct an event review all occurrences to determine root causes and what changes are needs, if any, to policies and procedures to prevent further occurrences. NJAC 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 610		9/13/22

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F 610	Continued From page 6 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and pertinent facility documents, it was determined that the facility failed to thoroughly investigate an Injury of Unknown origin for 1 of 2 residents (Resident #101) reviewed for injury of unknown origin. This deficient practice was evidenced by the following: According to the Admission Record, Resident #101 was admitted to the facility with diagnoses including but not limited to: NJ EX Order: 264b1. Review of the Minimum Data Set (MDS), an assessment tool NJ EX Order: 264b1, Resident #101 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating that Resident #101 had NJ EX Order: 264b1. The MDS documentation also indicated that Resident #101 required extensive staff assistance for Activities of Daily Living (ADLS). Review of Resident #101's Care Plan (CP) revealed Focus: Anticoagulant therapy, risk for injury [redacted] and/or [redacted] due to use of anticoagulant secondary to [redacted] use. Effective [redacted] Interventions: Assess for signs of NJ EX Order: 264b1 [redacted], effective [redacted]. Skin assessments as per protocol. Report [redacted] and NJ EX Order: 264b1, effective [redacted]. Focus: skin integrity: bruising effective [redacted]. Focus: climbing ...attempts to get out of wheel and [redacted] (specialized [redacted]) by [redacted] over the [redacted] when in it. Also, when sitting in the wheelchair, [redacted] around the [redacted] of the chair., effective [redacted].	F 610	The Director of Nursing and Assistant Director of Nursing reviewed Resident #101's current [redacted] condition and no skin integrity issues noted. Safety has been maintained, the resident sits comfortably in a wheelchair and there have been no further bruising incidents noted. Any resident involved in an injury of unknown origin has the potential to be affected by the deficient practice. The Administrator and Director of Nursing reviewed incident reports from August 1st, 2022 to current. The investigations were reviewed to ensure they were thorough and complete and the summary and conclusions were updated as needed. The Administrator in-serviced the facility leadership team, including the DON/ADON/RN Supervisors/Social Workers, on the policies and procedures related to Incident and Accident Investigation outlined in 483.12. The Administrator/DON will be notified immediately by the nursing supervisor with any injuries of unknown origin. Additionally, the Administrator/DON receives automated real time reports via email notifying them of any incident or accidents when the incident report is completed. All incident reports will be reviewed daily, in clinical meeting, and the Administrator/DON will ensure any injuries of unknown origin are thoroughly investigated and followed up within the required timeframes.	

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F 610	Continued From page 7 Review of the [redacted] Integrity Incident report dated [redacted], revealed Description: "while doing AM care on Resident #101 the aide and I found a [redacted] on his/her [redacted] and [redacted] Review of Employee statements revealed the following: Licensed Practical Nurse (LPN) #1 that took care of the resident on 04/14/22 "while doing am care on resident, a [redacted] was found on [redacted] and [redacted] Certified Nursing Assistant (CNA) #1 that took care of the resident the evening of [redacted] and the morning of [redacted] "Resident was put to bed by nurse and CNA at 1:15 am. When I came back from the break room the nurse informed me that the resident have a NJ EX Order. 264b1. There was nothing there on [redacted]" CNA# 2 that took care of the resident on the day shift of [redacted], "While rendering care on the resident I did not notice any [redacted] Review of the Event Analysis completed by the Assistant Director of Nursing (ADON) dated [redacted], revealed Investigation: ..."it was reported by the CNA who took care of the resident on [redacted] that she did not see any [redacted] the resident's [redacted] and the resident was in the NJ EX Order. 264b1 over the chair constantly trying to climb out of it .....constantly being reminded and encouraged to put his/her [redacted] back on the chair....Due to advanced [redacted] and wanting to get up and go, he/she is constantly being reminded and encouraged to put [redacted] back on the chair." Review of the Nursing Progress note dated [redacted] at 08:58 AM revealed: "At 01:15 am I	F 610	On a monthly basis, for three months, the Administrator will audit the incident reports to ensure injuries of unknown origin were thoroughly investigated and reported as required. The result of these audits will be reviewed monthly for 3 months by the Quality Assurance Team who will make recommendations on the need for continued audits going forward.	

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assisted the Aide to help change Resident #101 in bed. While changing the resident we noticed a [redacted] on his/her [redacted] and [redacted]. Supervisor notified." Further review of the nursing progress notes for the month [redacted], did not reveal any notes of the resident's behavior of [redacted] over the chair and/or trying to climb out of it.

During an interview with the surveyor in the presence of the Director of Nursing (DON) on [redacted] at 11:33 AM, the ADON stated that the process for an injury of unknown origin would be to take statements from all staff taking care of a resident for the last 72 hours to determine a timeline as to when the incident occurred and identify a cause. She further stated it would be reported to the nurse, the supervisor would be notified, an incident report would be done, an investigation would be started immediately, and it would be reported to the state within 24 hours. When asked why there were only three (3) staff member statements, the ADON stated "she was able to determine when the [redacted] occurred from what the daytime CNA stated about the resident constantly trying to climb out of the chair, it was determined it was inflicted by the chair."

During an interview with the survey team on 07/22/22 at 12:26 PM, the Social Worker (SW) stated that the process for an injury of unknown origin would be reported to the supervisor. The supervisor would contact the abuse officers: herself, the DON and the Administrator. The abuse officers would discuss the incident, make sure the investigation was completed and would report the incident to the New Jersey Department of Health (NJDOH) within 24 hours. She further stated that statements should be taken from the patient, if they were alert, and if they were not

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alert, you would speak with the family, take staff statements, anybody that had been around the resident for the last 72 hours, including the roommate and other residents to determine if anyone may have witnessed it. The SW reviewed the incident report for Resident #101, she stated "she did not know anything about the incident. I would think that I would have been made aware, I should have been consulted. I would think as an abuse officer I should be involved." The SW then stated that all injuries of unknown origin should be reported to the NJDOH and then a determination would be made after the investigation was completed.

During an interview with the surveyor on 07/27/22 at 10:03 AM, CNA#3 stated that the process if you identify a new bruise was to inform the nurse and the supervisor right away and a statement would be written about when and how you discovered the bruise.

During an interview with the surveyor on 07/27/22 at 10:25 AM, LPN #2 stated that the process if you identify a new bruise was to assess it, a skin incident report package would be started, the manager would go back three days and gets statements to see if anyone knew how the incident happened. She stated that the bruise would be entered into the computer reporting system and an event # would be generated that would be written on the skin incident report. LPN#2 stated that a skin assessment would be done to document were the bruise was located. She further stated that if residents exhibit any kind of behaviors, a new or a current behavior, a behavior progress note should be done.

During an interview with the surveyor on 07/27/22

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at 10:40 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the process if a new bruise was discovered was the nurse would be notified, an incident report was begun, statements would be taken from everybody who was there, primarily the CNA and the nurse caring for the resident. She stated that incident reports were discussed in the morning huddle meetings to discuss interventions to add to the care plan to keep it from happening again. She stated if abuse was suspected, the care giver would be removed immediately, and an investigation would be completed.

During an interview with the surveyor on 07/27/22 at 11:03 AM, the Administrator stated that an injury of unknown origin would be reported to supervisor and an incident report completed. A new bruise required a lookback of 72 hours of all staff members for a potential explanation, interview the resident, the roommate, and all staff that cared for the resident for the last 72 hours. He stated it would be initially treated as abuse until abuse could be ruled out. The Administrator was given the [redacted] incident report packet by the surveyor to review. The Administrator was not at the facility at the time of the incident. After reviewing the skin incident report packet, he stated "it seems like there are not statements from staff 72 hours prior to the incident to corroborate the statement of climbing out of the chair."

During an interview with the surveyor on 07/27/22 at 11:18 AM, the DON stated, "we gave you everything we have for the investigation". He further stated that the ADON completed the investigation because she knew the resident well and at the time of incident she was working on

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the unit. The DON was unable to answer why the ADON did not do a statement for the investigation. He stated the purpose of doing a 72 hour look back was to identify a causative factor, timeframe, and identify people that knew what happened.

During an interview with the surveyor on 07/27/22 at 10:22 AM, the Registered Nurse Educator (RNE) stated that there would be a 72 hour look back for a newly identified bruise, the nurse would do a [redacted] packet, an incident report would be done, the supervisor would be notified immediately, and an investigation which included statements from all staff taking care of the resident for 72 hours prior to the discovery of the bruise to try to determine the cause. She further stated that the reason you would go back 72 hours was because sometimes [redacted] do not always show up immediately and to make sure there wasn't a pattern. The RDE stated it would be reported to the NJDOH if the resident could not tell you how it happened.

During the pre-exit meeting with the survey team on 08/03/22 10:01 AM, the administrator stated that the investigation "is what it is, the statements were not done".

A review of the facility's policy, "Abuse Prevention" effective 07/2022 revealed Procedure: 4. All staff will be given information on how to identify and report incidents of abuse, or suspected abuse. A. Staff will be trained on how to identify events, such as suspicious bruising, adverse occurrences involving un-witnessed falls and injuries of unknown origins. Certain patterns and trends may be suspicious of abuse, such as: similar or repeat occurrences on the same shift,

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COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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F 610	Continued From page 12 involving multiple resident/patients in the same assignment block and occurring after certain family members, friends or other resident/patient visits. 7. Reporting and Response, The following is to be conducted immediately: c. [redacted] must report mistreatment, neglect, abuse, injuries of unknown source ...to the State Survey & Certification (S&C) agency. [redacted] must also report the results of their investigation of these violations to the state S&C agency; f. The Administrator and/or designee, HMQC representative and/or Risk Management will conduct an event review all occurrences to determine root causes and what changes are needs, if any, to policies and procedures to prevent further occurrences. NJAC 8:39 4.1 (a)	F 610		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		9/13/22

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F 625	Continued From page 13 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for 3 of 3 residents (Resident #68, #81 and #436) reviewed for hospitalizations. This deficient practice was evidence by the following: 1. On 07/26/22 at 10:26 AM, the surveyor reviewed Resident #68's medical record, which revealed that the resident was transferred to the hospital on [redacted] The surveyor did not observe evidence of written notification of the facility's bed hold policy prior to or upon transfer to the hospital to the resident or the resident's representative. A review of the [redacted] nurse's Progress Note (PN) indicated that the resident was transferred to the hospital on [redacted] due to [redacted] in the b[redacted]) and was admitted to the hospital with	F 625	The current residents referenced on the 2567 (Statement of Deficiencies) were provided with written notification of the facilities bed hold policy. All residents recently discharged or out on pass have the potential to be affected by the deficient practice. Any resident/responsible party recently discharged or out on pass have been contacted by the Admission Department and have been provided written notification of the facilities bed hold policy. The Admission Department has been in-serviced by the Administrator on proper notification of Residents/Representatives related to Bed Hold notifications. All residents with planned discharges or therapeutic leaves will be notified of the facilities bed hold policy in writing, in advance of the discharge. Any emergent transfers will be contacted as soon as possible with verbal notification of the bed hold policy, which will be followed up in writing within 3 days. The Administrator will audit the resident discharges monthly for the next 3 months	

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F 625	Continued From page 14 NJ EX Order. 264b1 . A further review of the PN revealed "a copy of Notice of Emergency Transfer provided to the PT {resident} and was faxed to NJ LTC (long-term care) Ombudsman." The PN did not reflect a post discharge note was completed to verify the bed hold policy and procedure. On 07/29/22 at 09:25 AM, the Director of Nursing (DON) stated he was "not sure" of the bed hold policy and that the admission department handles it. The DON concluded he knew the bed hold policy was given as a part of the admission agreement. On 07/29/22 at 09:27 AM, The Admission Director (AD) stated the facility does not send out a written notification and that it was only signed during admission. The AD stated Medicaid has a 10-day bed hold policy and that a resident will still get their bed unless they need to quarantine. She further stated if the resident exceeded the 10-days she would call and speak with the resident or resident's representative. The AD emphasized that residents "always" went back to their rooms "as this is their home." The AD acknowledged she was not aware of following up with a bed hold notification to the resident or resident's representative prior to or upon transfer to a hospital after the initial signed admission agreement. On 07/29/22 at 09:52 AM, the AD provided the facility's notification of bed hold policy and showed the surveyor a highlighted Step 2 which revealed: "Upon the discharge of a Medicaid resident, the social worker will verbally notify the resident where applicable and follow-up with a letter to the representative notifying of such. A	F 625	to ensure bed hold notifications were provided as required. The results of these audits will be presented to the QA Committee monthly for 3 months and they will make recommendations for further audits as needed.	

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copy of any notification is kept tint he {in the} Social Services office."

The surveyor reviewed the bed hold policy Resident #68 signed and dated 8/7/18.

A review of the Notice of Emergency Transfer was completed [redacted] which indicated, "A copy of this notice must be provided to the resident/ resident representative, as well as to the Office of the Ombudsman ...."

2.) The resident face sheet reflected that Resident # 81 was admitted to the facility with the diagnoses that included and was not limited to; [redacted] The significant change Minimum Data Set (MDS) an assessment tool dated [redacted], indicated that Resident #81 required [redacted] with all aspect of activities of daily living (ADLs) and had [redacted]

On 07/19/22 at 11:03 AM, the surveyor reviewed Resident #81's clinical record and MDS and assessment tool which revealed that the resident was discharged from the facility on the following dates [redacted]

There was no documentation in the resident's clinical record regarding notification of family or representative regarding notification of bed hold policy prior to discharge from the facility.

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On 07/29/22 at 08:39 AM, the surveyor interviewed the Director of Social Services (DSS) who stated that the AD notified families and discusses the bed hold policy with the residents, family, and representative during the admissions process. The DSS stated that there was a discrepancy in the policy for bed holds and that the Social Worker (SW) did not have any involvement with notification of the family or representative of resident bed holds on discharge.

On 07/29/22 at 08:47 AM, the AD stated that she goes over the admission agreement and the bed hold policy with families and residents that were alert and oriented during the admission process into the facility. She stated that when Medicaid residents were transferred to the hospital, they get a 10-day bed hold and that it was explained to them on admission. She stated that Long-Term Care residents or Medicaid residents or representatives were not given a second verbal notification or letter when the resident were transferred/ discharged to the hospital. The AD reviewed the policy titled, "Bed Holds" with the surveyor and stated that the SW did not have any involvement with the bed holds and that she was not aware that the policy indicated that the resident or the family had to be provided with written notification regarding bed holds.

3. On 07/21/22 at 10:14 AM, the surveyor reviewed Resident #436's medical record, which revealed that the resident was transferred to the hospital on [redacted]. Further review revealed that Resident #436 returned to the facility on [redacted] The surveyor did not observe evidence of written notification of the facility's bed hold policy prior to or upon the transfer to the hospital to the resident or the resident's representative.

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F 625	Continued From page 17 On 07/21/22 at 12:05 PM, during surveyor interview, the AD stated that the facility did not mail out any notification about the bed hold prior to any hospitalization and that they would call the family. She then stated that the bed hold policy is provided in the admission agreement. On 07/21/22 at 01:03 PM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) to provide the surveyor documented evidence of the written notification of the bed hold policy prior to the transfer to the hospital. On 07/21/22 at 01:30 PM, the LNHA provided the surveyor with a document titled, "Attachment C HMH Residential Care, Inc. Bedhold Policy" which Resident #436 signed and was dated [redacted]. The LNHA did not provide any documented evidence of written notification of the bed hold policy prior to Resident #436's hospitalization on [redacted] On 07/26/22 at 12:13 PM, during surveyor interview, the DON stated that the facility did not send out written notification to the family regarding bed hold policy when transferred to the hospital. He added that the facility provided the bed hold policy on admission. On 08/2/22 at 01:29 PM, during surveyor interview in the presence of the survey team, the LNHA stated that the facility had not been providing written notification of the bed hold policy prior to hospitalization. He added that the bed hold policy had been provided on [initial] admission [to the facility]. On 08/3/22 at 09:54 AM, the LNHA	F 625		

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F 625	Continued From page 18 acknowledged in the presence of the DON, Vice President (VP) of Nursing, Assistant LNHA and survey team that the facility did not complete the resident's bed hold policy notification prior to or upon transfer to the hospital. A further review of the facility's Notification of Bed Hold dated effective 8/2021 reflected ...."A discharged resident's bed will be held per Medicaid guidelines and the facility's admission policies and procedures.....Step 1. Residents receiving Medicaid benefit are entitles to a bed hold of 10 days if discharged to a general or psychiatric hospital.....Step 4. If the resident is unable to return before the end of the 10 day period, the resident or representative can pay the daily private rate to hold the same bed until medically stable.....Step 5. The social worker or designee will follow-up with the resident or representative on a post discharge to verify bed hold policy and procedure. N.J.A.C. 8:39-5.1 (a)	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		9/13/22

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F 656	Continued From page 19 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and review of pertinent facility documentation, it was determined that the facility failed to develop a resident-centered care plan with objectives and time frames to meet the needs of a resident who had an [redacted] pound (lb) [redacted]. This deficient practice was identified for 1 of 28 residents (Resident #114) reviewed for	F 656	The [redacted] orders for resident #114 were revised and the care plan was updated with NJ EX Order. 264D1 objectives and time frames. The physician, family and hospice have been notified of the revisions. Any resident with a recent significant [redacted] change has the potential to be	

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F 656	Continued From page 20 Care Plans (CP). This deficient practice was evidenced by the following: During tour on 07/20/22, the surveyor observed Resident #114 lying in bed and was not responding to the surveyor. The surveyor observed a NJ EX Order. 264b1 with no being at that time. A review of the medical records revealed that Resident #114 h,ad been recently admitted to the facility with diagnoses which included but were not limited to,NJ EX Order. 264b1 A review of the most recent Significant Change Minimum Data Set (MDS-an assessment tool) dated revealed under that Resident #114 was totally dependent on staff for Activities of Daily Living. revealed that the resident lbs, required a t and obtained or more of calories and NJ EX Order. 264b1 (cc) of intake A review of the Physician's Orders included the following: an order dated to Infuse NJ EX Order. 264b1 milliliter (ml) at until a NJ EX Order. 264b1 An order dated for NJ EX Order. 264b1 07/01/22 to the resident every month on 1st Wednesday. A review of the facility provided, "Clinical Monitoring Detail Report", dated through , revealed a t on of lbs, and on , one week later, of	F 656	affected. The Registered Dieticians reviewed resident from orward and confirmed the care plans for any significant weight changes were updated with measurable objectives and timeframes. On a weekly basis, during our meeting, admission/weekly/monthly will be reviewed. The Registered Dietician will check the care plans of residents with a significant change to ensure there is a measurable ht objective and time frame. Additionally each re-admission for the prior week will be reviewed to ensure there is a nutrition progress note. On a monthly basis the Administrator/designee will complete an audit of the prior months' weight meetings to ensure significant weight changes are reflected in the plans of care. The results of these audits will be presented to the Quality Assurance Committee for 3 months, The Committee will make recommendations on the need for continued audits.	

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F 656	Continued From page 21 [redacted] lbs. This calculated to an [redacted] The surveyor was unable to locate any nutrition admission assessment completed by the Registered Dietitian (RD), or any progress notes regarding the assessment of the [redacted] or documentation that the physician or [redacted] agency had been notified of the [redacted]. The surveyor reviewed a hospice note dated [redacted] After the surveyor brought the concern to the facility, which revealed Resident #114 had a [redacted] of + [redacted] lbs, hospice was going to contact the guardian and the facility RD stated that the resident's [redacted] would be changed. On 08/03/22 at 10:10 AM, the facility provided an on-going and Active Care Plan. The CP included but was not limited to a focus area of NJ EX Order. 264b1 and that Resident #114 was at risk for NJ EX Order. 264b1 related to [redacted] effective [redacted]. This focus area included that the [redacted] team and facility team will collaborate.. regarding nutrition support. The facility provided Care Plan had not been updated to reflect the NJ EX Order. 264b1 on [redacted], or the assessment from hospice on [redacted], which resulted in the change of the [redacted]. There were no measurable goals or interventions to address the unplanned significant [redacted] reflected on the CP. This concern was discussed with the facility on [redacted]. On [redacted], the Director of Nursing (DON) stated that Resident #114's CP had not been updated to reflect the significant unplanned [redacted] lb [redacted]. The DON acknowledged that if there was an identified [redacted] change, the CP	F 656		

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should be updated.

A review of the facility provided, "Job Description Dietitian" revised 08/31/21, included Job Functions: 2. .. Assure that nutrition assessments, reassessments and care plans are completed to meet each patient's identified needs.

A review of the facility provided, "Job Description RN (Registered Nurse)" revised May 2019, included but was not limited to Job Functions: 6. Identify and report all real or potential problems regarding the development or administration of patient care.

A review of the facility provided, "Job Description Unit Manager RN" not dated, included but was not limited to Job Functions: 4. Works with Interdisciplinary Team to ensure quality services are provided.

A review of the facility provided, "Care Plan" policy last approved 07/22, included but was not limited to Purpose: To develop .. a care plan for each resident that includes the interventions needed to provide effective and person-center care of the resident.. The Care Plan will be consistent with the resident rights that include measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified... Procedure: B. Comprehensive Care Plan: 2.c. reviewed and revised by Interdisciplinary team after each assessment, including both the comprehensive, significant change, quarterly, and annual review assessment.

NJAC 8:39-11.2 (i), 27.1(a)

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to follow professional standards of practice by ensuring that staff did not utilize personal equipment, a personal blood pressure (BP) monitor, for resident care. This deficient practice was identified for 1 of 2 Licensed Practical Nurses (LPN) observed during medication administration, and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	A root cause analysis was conducted and the underlying cause of the deficient practice was a lack of education provided to agency nurses on the process of obtaining replacement medical equipment. The BP cuff provided by the nurse was removed from the resident care area. The nurse was provided with a replacement BP cuff issued by the facility. The nurse was in-serviced on logging defective or malfunctioning equipment and how to obtain a replacement cuff immediately through the supervisor. All residents have the potential to be affected by the deficient practice. All units were checked to ensure needed blood pressure monitoring equipment was available and an adequate inventory was noted. All Med carts were checked to ensure personal blood pressure monitoring equipment was not used. None were found. All nursing staff were in-serviced on using facility issued equipment and how to log defective or malfunctioning equipment and obtain replacement equipment from the nursing supervisor immediately. The nursing supervisor office has a backup supply of equipment which is checked on a daily basis by the day shift nursing	9/13/22

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F 658	Continued From page 24 responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 07/21/22 at 7:33 AM, the surveyor began the medication administration observation on the [redacted] unit. At 8:23 AM, the LPN informed the surveyor that she was going to use her own personal wrist BP cuff because the BP machine was not working. The LPN stated she had reported the malfunctioning BP machine to the supervisor a few days ago. The LPN utilized her personal BP cuff and obtained a BP reading with the BP wrist cuff on an unsampled resident. On 07/21/22 at 9:24 AM, the surveyor requested to speak to the supervisor on [redacted] Wing, and was informed the Unit Manager was not working today. During an interview with the surveyor on 07/21/22 at 9:30 AM, the Registered Nurse Staff Educator (RN/SE) stated staff should use a vital sign tower to obtain a BP reading, and if that machine was not working, the facility had back-up manual arm and wrist cuff BP cuffs. The RN/SE showed the surveyor the extra manual arm BP cuffs on A wing. The RN/SE showed the surveyor the green Velcro wrist BP cuffs in the nursing office that were available. The RN/SE stated that the facility had back-up BP cuffs and the staff should not be using their own.	F 658	supervisor. The Nursing Educator/designee will audit 2 agency staff for standard of practice for use of personal medical equipment weekly for one month. The DON/designee will review the results of the agency and equipment audits for one month and present the findings to the monthly Quality Assurance Committee. The QA Committee will make recommendations on the frequency and necessity of future audits.	

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F 658	Continued From page 25 During an interview with the surveyor on 07/21/22 at 9:36 AM, the RN/SE and the surveyor went to [redacted]. The RN SE informed the LPN that she should not be using her personal BP wrist cuff and stated that the LPN would be provided with a vitals tower that was available. The RN/SE stated the staff should not use their own personal equipment because of germs. She further stated the staff should use what the facility issued and had available. On 07/21/22 at 9:39 AM, during an interview with the surveyor, the RN SE stated staff are informed not to use their own equipment. She stated the LPN was an agency nurse and would be instructed by her the RN/SE during orientation that the facility provides equipment. The RN/SE further stated there were plenty of vitals towers and BP cuff backups to use. On 07/21/22 at 9:49 AM, during an interview with the surveyor, the Director of Nursing (DON) stated nurses have vital towers, and wrist BP cuffs to use. The DON stated the facility had other machine towers and manual BP cuffs for back-up. He further stated staff should not be using their personal BP cuffs. During a follow up interview at 12:00 PM, the DON stated it was not a best practice for staff to use their own BP cuff because the BP cuff should be calibrated. On 07/22/22 at 12:22 PM, during an interview with the surveyor, the Maintenance Director stated if any new equipment comes into the facility that the maintenance department would assemble and test it. He stated the maintenance department would go over the equipment to	F 658		

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F 658	Continued From page 26 ensure that the assembly wires and hardware were tight "like our safety inspection to ensure the equipment is working correctly". On 08/02/22 at 12:42 PM, the surveyor informed the facility of the above concern. On 08/03/22 at 10:03 AM, the Licensed Nursing Home Administrator (LNHA) stated the facility had a process for broken equipment and acknowledged that staff should not use their own personal equipment because the facility also had back up equipment. NJAC 8:39-27.1(a)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and clinical record reviews, and review of pertinent facility documentation, it was determined that the facility failed to: a.) provide personal care for 1 of 27 residents reviewed for activities of daily living (ADLs), Resident # 18, and b.) provide a resident (Resident #85) 1 of 27, with the care needed to meet the resident assessed needs. This deficient practice was evidenced by the following: a) On 07/19/22 at 11:47 AM, the surveyor toured the [redacted] Wing of the facility and observed Resident #18 lying in bed. The resident's [redacted] was partly closed and some [redacted] were	F 677	A root cause analysis was conducted by the team and the underlying cause identified was lack of a consistent unit manager to communicate and supervise required ADL care. Resident #18's [redacted] were [redacted] and [redacted] and the plan of care was revised. The Certified Nursing aide assigned to the resident was immediately inserviced on appropriate ADL care and the residents updated plan of care. Resident #85 was toileted by the CNA. All nursing staff were in-serviced on timely toileting of dependent residents and /residents requiring assistance with	9/13/22

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F 677	Continued From page 27 exposed with a NJ EX Order 264b1 The fingers of the resident's were observed into the NJ EX Order 264b1. When the resident was asked if he/she could open their, he/she opened and the were observed to be with a NJ EX Order 264b1 approximately Another observation on 07/20/22 at 9:25 AM, revealed Resident #18 lying in bed. The were observed to be with a noted the On 07/20/22 at 11:09 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for Resident #18. The CNA stated that Resident #18 was NJ EX Order 264b1 upon staff for care. She stated that Resident #18 had a and could not take anything. She also stated that Resident #18 was admitted with a and the CNA told the surveyor that Resident #18 had not been Out of Bed (OOB) because of the and also the facility was short of staff. On 07/20/22 at 11:45 AM, the surveyor returned to the resident's room and observed the CNA in the room. The CNA told the surveyor that she was going to perform AM [morning] care. On 07/20/22 at 1:05 PM, the surveyor returned to the room and observed the resident in bed. The surveyor observed Resident #18's were not or and the was still present the On 07/21/22 at 10:04 AM, the surveyor interviewed the Licensed Practical Nurse/Unit	F 677	toileting. All residents dependent for ADL care and toileting have the potential to be affected by this deficient practice. All residents dependent for ADL care were checked for and by the nursing managers. No care issues identified. All residents dependent for toileting assistance were checked to ensure their needs were met. No further toileting issues identified. All nursing staff were educated on ADL care and toileting for dependent residents. Daily ADL care includes nail care as needed. Education on ADL care for dependent residents will be added to the orientation of new nursing staff. Inservice on documentation of ADL care under grooming will be provided to all CNAs by the Nursing Educator/designee. All nursing staff will be educated on the new process of documentation regarding ADL care. Mandatory education will be provided for all staff regarding toileting assistance and the expectation to address resident toileting needs immediately. Reinforced to all staff the “NO PASS ZONE” which means everyone should be responsible to respond to residents request for assistance. The Unit Manager/designee will audit 5 ADL dependent residents daily. An audit tool will be utilized to complete the audit. The Audit will be submitted to the Director of Nursing/ Administrator. The Unit Manager/designee will interview 5 residents requiring toileting assistance to ensure toileting is being provided in a timely manner.	

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F 677	Continued From page 28 Manager (LPN/UM) #1 regarding Resident #18's care needs. LPN/UM #1 confirmed that Resident # 18 was dependent upon staff for all ADLs. When asked if Resident #18 could get OOB, LPN/UM #1 replied, "They [referring to the staff] should ask the resident if he/she wants to get OOB. LPN/UM #1 could not comment on the CNA's statement that the "resident had not been OOB because he/she had a [redacted] to the [redacted] area and also the facility was short of staff". LPN/UM #1 added that Resident #18 had a [redacted] in place prior and could not get OOB however, the [redacted] was discontinued on [redacted] and the resident should get OOB. There was no documentation in the medical record regarding when Resident #18 was last transferred out of bed. There was no documentation of episodes of rejection of care. On 07/21/22 at 10:40 AM, when the surveyor visited Resident #18, he/she told the surveyor he/she would like to get OOB. On 07/22/22 at 9:00 AM, the surveyor returned to the room and observed Resident #18 in bed. The resident's [redacted] had not been [redacted] or [redacted]. On 07/22/2022 at 9:30 AM, the surveyor with the assistance of LPN/UM #1, was able to further assess the condition of Resident #18's [redacted]. The [redacted] were observed by both to be [redacted] with some [redacted] present [redacted] the [redacted]. On 07/22/22 at 12:24 PM, the surveyor inquired about how the facility supervised resident care.	F 677	The ADL audits will be reviewed by the DON who will spot check 10% of the residents per week. The DON/designee will present the findings to the QA committee monthly for 3 months. The committee will review and make recommendations for further audits.	

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F 677	Continued From page 29 LPN/UM #1 revealed that she made the CNA assignments and would usually do rounds. She further stated the primary nurses were to do walking rounds with the on-coming/out-going nurse. She added that dependent residents must be dressed, fed, kept dry, clean, shaven, and have nail care completed, and the staff "must" assess residents on a daily basis and address their needs. On 07/22/22 at 12:30 PM, during an interview with LPN/UM #2 regarding the care delivery revealed that all were responsible to ensure that the care was being delivered as necessitated by the resident's condition. She stated that the ADL care entailed bathing, shaving, and nail care. She further added that the nurses were to check on residents during walking rounds with the on-coming shift and during their shift. When the surveyor showed LPN/UM #2 Resident #18's [redacted] condition after care had been delivered for the last 4 days, she stated, "That was unacceptable" and "I will in-service the staff". On 07/22/22 at 11:59 AM, during an interview with the surveyor, another CNA assigned to the B Wing stated all CNAs documented the care provided on the computer in the hallway. The CNA accompanied the surveyor in the hallway, logged on the computer and showed the surveyor how the care area could be accessed. The surveyor noted that the same CNA provided care to Resident #18 for the last 4 days and omitted to provide [redacted]. The documentation entered in the computer did not include [redacted]. The documentation only revealed that Resident #18 received care, was totally dependent on staff. The exact care provided was unknown.	F 677		

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F 677	Continued From page 30 On 07/22/22 at 12:30 PM, the surveyor reviewed Resident #18's medical record. The admission Face Sheet revealed that Resident #18 was admitted to the facility with diagnoses which included but were not limited to [redacted].	F 677		

The Quarterly Minimum Data Set (MDS) an assessment tool dated [redacted] coded Resident #18 as scoring a [redacted] out of a possible [redacted] on the Brief Interview for Mental Status (BIMS) which indicated that Resident #18 had [redacted] of the MDS which referred to Activities of Daily Living, indicated that Resident #18 was [redacted] upon staff for [redacted] Section E008 which addressed rejection of care was coded with a [redacted] value which indicated that Resident #18 did not reject/refuse care.

An entry in the electronic progress notes dated 06/30/22 timed 10:19 AM, revealed Occupational Therapy Screen (OT) documented the following: Resident remains [redacted] for all aspects of [redacted] bedside. Resident remains [redacted], therefore [redacted] [not applicable]. Resident remains a [redacted] for OOB [out of bed [redacted]] chair. Resident may [redacted] chair for maximum [redacted] with a [redacted] due to [redacted]

A Quarterly entry from the Speech and Language Pathologist (SLP) dated [redacted] at 9:50 AM, indicated the following: BIMS: [redacted] Resident is [redacted] on staff for [redacted]

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F 677	Continued From page 31 [redacted]. Minimal verbalizations. Remains [redacted] with [redacted]. No functional change in [redacted] or [redacted] status. No ST [speech therapy] warranted at this time. Another entry in the Progress Notes dated [redacted], documented, that Resident #18 was [redacted] but [redacted]. He/she can make [redacted] by saying [redacted] which is not always appropriate to questions. The comprehensive care plan dated [redacted] documented Resident #18 had a focus for ADLs function-impaired with [redacted] recent [redacted] [redacted] with [redacted]. The goal: Resident #18 will maintain current ADLs and self-care functional status. Staff will meet all Resident #18's needs related to ADLs status. Will remain clean, well groomed, and free of body odor. The Certified Nursing Assistant electronic Task was reviewed. The documentation revealed that hygienic care was completed, there was no specific entry for [redacted]. An interview was conducted 07/22/22 at 11:30 AM with CNA #1 who cared for Resident #18 over the last 4 days. CNA #1 acknowledged Resident #18 was [redacted] upon staff for care. CNA #1 stated that she provided care to Resident #18 this morning and she could not recall if the [redacted]	F 677		

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F 677	Continued From page 32 needed to be trimmed/cleaned. On 07/26/22 at 10:42 AM, a second interview with the CNA who cared for Resident #18 mostly on a daily basis, confirmed that Resident #18 was [redacted] t upon staff for care. When asked to elaborate on the care provided, she added that AM care entailed, washing, mouth care, dressed, changed brief, and communicate with the nurse if the [redacted] needed to be [redacted]. She informed the surveyor that she would transfer the resident to the [redacted] -chair now. She was not aware that the resident could get OOB. She also added she would provide [redacted] as part of ADLs. The CNA informed the surveyor that she [redacted] and [redacted] Resident #18's [redacted]. On 07/27/22 at 8:45 AM, the surveyor observed Resident #18 in bed eyes, his/her eyes were opened, feet were elevated, and the resident denied [redacted]. The surveyor observed a splint on the resident's [redacted] and [redacted] and the resident was [redacted]. The above concerns were discussed with the Director of Nursing (DON) on 07/26/22. On 07/27/22 at 11:33 AM, the DON provided a policy titled, ".. Nursing and rehabilitation.. Quality of Life. The policy last revised 07/22, outlined the following: "The facility will ensure that the care and services provided are person-centered, and honor and support each resident/patient's preferences, choices and beliefs. The facility will create an environment that humanizes and promotes each resident/patient's overall quality of life. Under Activity of Daily Living	F 677		

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the following were noted: If necessary the facility will provide the following care and services: hygiene (including, but not limited to bathing, oral hygiene, nail care, hair care, dressing, grooming, etc.), mobility, elimination, dining, and communication for resident/ patients exhibiting need.

Team members will refer to the Activities of Daily Living Critical Element (CE) Pathway as well as the most recent comprehensive, person-centered care plan, the physician orders and ADLs documentation from previous shifts to determine if facility practices are in place to identify, evaluate, and intervene to maintain, improve or prevent an avoidable decline in ADLs.

The surveyor reviewed the Progress notes from the date the [redacted] was discontinued on [redacted] to date and could not find documentation regarding Resident #18 being OOB.

The facility could not provide documentation to verify when [redacted] was last provided to Resident #18. There was no documentation that Resident #18 had been OOB since the [redacted] was discontinued on [redacted]. The surveyor observed Resident #18 OOB in the [redacted] chair in the room on [redacted] At that time, the surveyor interviewed Resident #18, who stated to the surveyor he/she felt good and liked to be out of the bed.

b) A review of Resident #85's medical record revealed the resident was admitted to the facility with diagnoses which included, but were not limited to, [redacted]

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NJ EX Order. 264b1.

The Quarterly MDS dated [redacted], revealed that Resident #85 was totally dependent upon staff for ADLs. Resident #85 was coded as required [redacted] person physical assist for bed mobility and toileting. Resident #85 scored 99 on the BIMS which was indicative of NJ EX Order. 264b1 [redacted].

On 07/27/22 at 9:00 AM, the surveyor observed Resident #85 seated at a table in the dayroom adjacent to the nursing station. The surveyor entered the room and sat at the next table.

Resident #85 was sitting at the table [redacted] and kept saying [redacted]. The surveyor looked at the clock from the nursing station and noted it was 9:40 AM. A staff member who later identified herself as the Unit Secretary (US) could heard the resident from the nursing station. She approached the resident [redacted] and inquired about why he/she was m[redacted]. Resident #85 told her clearly, [redacted]. The US left the dayroom and inform the LPN/UM #2 that Resident #85 requested to use the [redacted] The US returned and sat in the dayroom. Resident #85 kept [redacted] and repeating [redacted], NJ EX Order. 264b1.

On 07/27/22 at 10:15 AM, a staff member from the Activity Department entered the day room, provided 2 residents with a magazine and left the room. The television was on. The staff left the room and did not engage in any conversation with the Resident #85.

Resident #85 became louder and the surveyor asked the US if she informed someone that

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Resident #85 requested to use the bathroom. The US replied, " yes" I told the LPN/UM #2 that Resident #85 was [redacted] and requested to use the [redacted]. The US stated that the LPN/UM #2 was looking for the CNA assigned to Resident #85. Resident #85 was assisted to the [redacted] at 10:30 AM, after the LPN/UM #2 went to the break room and informed the CNA that Resident #85 needed to use the [redacted]

On 07/27/22 at 10:20 AM the surveyor interviewed the US regarding the protocol to assist any resident with toileting needs. The US stated, "Only CNA or nurses could assist residents to the [redacted] The US added, she had reported to the LPN /UM #2 that Resident #85 requested to use the [redacted] and that LPN/UM #2 stated she was going to find a CNA to take him/her. The US stated she had told the UM Resident #85 was [redacted] and she had to go the [redacted]. The US stated she believed the CNA assigned to Resident #85 was caring for another resident.

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On 07/27/22 at 10:26 AM the surveyor interviewed the LPN/UM #1 regarding the protocol to assist any resident in the [redacted]. She indicated that any nurse or CNA could assist a resident to the [redacted]. She added,"I was not aware of the above resident request to [redacted]". LPN/UM #1 stated the protocol would be to get up, identified the resident and see if you could assist the resident to the [redacted]. She stated that should would assist a lot of residents and that she could assist any resident to the [redacted]. She further added that a restorative aid could assist the resident to the [redacted] also.

On 07/27/22 at 11:15 AM, the surveyor

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interviewed the CNA who cared for Resident #85. She revealed that Resident #85 was [redacted] on staff for care, was [redacted], did [redacted] very well, and was aware of his/her [redacted] needs. She added the resident could not toilet self. She added she transferred Resident #85 to the chair at 8:30 AM, was placed on the toilet and [redacted] but did not have a [redacted]. She added she was in the break room for her break and the LPN/UM came to the break room and informed her that Resident #85 needed to use the [redacted]. She assisted Resident #85 to the bathroom at 10:30 AM after being informed by LPN/UM #2. Resident #85 had a [redacted] and was not soiled. The CNA stated usually if she was on break the other CNA working on the same side would assist residents to the [redacted]. The CNA added that Resident #85 could [redacted] when addressed in his/her [redacted]. She further stated that she informed the US that she was going on break.

On 07/27/22 at 11:26 AM, the surveyor interviewed the LPN/UM #2. She confirmed that the US informed her that Resident #85 needed to go to the [redacted] She stated that she could not remember the exact time but it was before 10:00 AM. She added she went to find the nurse but could not locate the nurse. She thought the resident needed her aid because she Resident #85 stated [redacted] now. LPN/UM #2 further stated she went to get the CNA assigned to Resident #85 and had walked in the hallway to locate the CNA assigned to Resident #85. She stated she walked in the hallway, looked in every room and could not locate her [CNA]. LPN/UM #2 stated she walked in the other hallway and could not find any CNA to assist Resident #85 to the

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bathroom. LPN/UM #2 stated she did not know Resident #85's [NJ EX Order 2540]. LPN/UM #2 stated she walked to the break room and observed the CNA standing in the break room talking to someone so she pulled the CNA aside and informed her that Resident #85 was [NJ EX Order 2540] and needed to go to the [NJ EX Order 2540]. The CNA left the break room and went to assist Resident #85 to the [NJ EX Order 2540]. LPN/UM #2 stated she did not know the exact time the resident was assisted to the [NJ EX Order 2540]

The surveyor then asked LPN/UM #2 about the facility protocol to meet any resident's needs. She stated, "The protocol will be if you know the resident you can assist someone to the [NJ EX Order 2540]". She confirmed that she did not inform LPN/UM #1 that Resident #85 needed to use the [NJ EX Order 2540]. She added that there was no one around.

LPN/UM #2 further added that she could have looked up Resident #85's information on the computer and assist him/her to the bathroom. She further stated that she was not familiar about how to use a [NJ EX Order 2540] and during her nursing training, she never used a mechanical lift. LPN/UM #2 stated she did not have any idea on how to use a [NJ EX Order 2540] and the facility training did not cover [NJ EX Order 2540].

On 08/01/22 at 9:16 AM, during a second interview with LPN/UM #1 regarding Resident #85 issues with being assisted in the [NJ EX Order 2540] in a timely manner, she confirmed that LPN/UM #2 could have look in the computer, verified the transfer method and assist Resident #85. LPN/UM #1 stated "That was unacceptable".

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F 677	Continued From page 38 On 08/02/22 at 10:30 AM, the surveyor aided by the CNA and LPN/UM #1, performed a [redacted] assessment on Resident #85 and observed no NJ EX Order 264b1 noted on [redacted]. The above concerns was discussed with the facility on [redacted] at 2:15 PM. On 08/03/22 at 9:36 AM, the facility administrative staff presented their findings. The Licensed Nursing Home Administrator stated, "We [facility] were embarrassed. This is not how we [facility] care for our residents. I do not allowed that behavior to happen in my building. In-services education was provided". NJAC 8:39-27.2 (h)	F 677		
F 679 SS=F	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to: a.) provide a meaningful and individualized activity programs to enhance the	F 679	The Administrator met with the Resident Council and solicited their input and approval of the August activity calendar. The calendar included trips, evening activities and other special food events	9/13/22

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F 679	Continued From page 39 life of NJ EX Order. 264b1 residents (Resident #18 and Resident #101), and b.) ensure activities, social events and schedules were developed in conjunction with resident interests and needs. This deficient practice occurred for 3 of 3 residents reviewed for activities (Resident #18, Resident #101, and Resident #239), on 3 of 4 resident care units (Unit [redacted] and for 6 of 6 residents who attended a resident council meeting. The deficient practice was evidenced by the following: Refer to 680F On 07/26/22 at 10:30 AM, the surveyor conducted a resident meeting with six alert and oriented residents. Resident (R1) stated that the facility has not had a Director of Recreation for about six months, and it had affected the residents. R #1 stated that the residents had felt that they were not getting enough activities, and there were no activities during the weekend. R #1 stated "we just sit here". R #1 stated there was not much offered during the week, and "once a week we might do a craft". R1 stated that there were no outside trips since the pandemic began (approximately a two-year time span). R #1 stated the resident council was concerned and wanted to know what the facility was providing to ensure the confused residents received activities since the alert and oriented residents were not being provided with resident activities. R#1 stated the facility did not offer any activities in the evening. Six of Six residents in attendance agreed with R #1's statements. Another resident, (R #2) stated that he/she could not remember the nursing staff member's name, however, stated that he/she had been told by nursing staff to find things keep him/herself busy, and that was what	F 679	per their request. The new August activity calendar was posted during the survey and contained times/locations for activities. An activities assessment was completed on Resident #18 and Resident #239 and a radio and daily newspaper access are being provided on an ongoing basis. Resident #101 has been re-assessed by the activity staff and will be encouraged and assisted to attend activities in the Main Activity Room, specifically musical activities or movies. Activity rooms are open and we are following CMS guidance for group activities and dining. We hired/transferred 3 additional FT activities staff and staggered the program times to provide additional coverage for evenings and weekends. All residents have the potential to be affected by the deficient practice. A new Recreation Director is in place. The Recreation Director will audit the resident files to ensure every resident has an updated Activity Assessment with individual preferences. The resident preferences will be reviewed and updated quarterly. The Recreation Staff have been in-serviced on Recreation Assessments and how to access care plans (which have always been available). The upcoming Activity Calendar will be reviewed and approved by the Resident Council prior to posting and will include Activities focused on severely cognitively impaired individuals. Resident participation and visitation will be tracked weekly and reviewed to ensure each resident has their individual needs met.	

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F 679	Continued From page 40 R #2 had tried to do. a. On 07/24/22, the surveyor reviewed Resident #18's electronic medical record (EMR). Resident #18's diagnoses included, [redacted] The Admission Minimum Data Set (MDS) an assessment tool used to prioritize care, dated [redacted], revealed that Resident #18 had a BIMS of [redacted] This score was indicative of severely impaired cognition. Resident #18 was [redacted] upon staff to NJ EX Order: 264b1 with all activities of daily living (ADL). The resident care plan dated [redacted] had a focus for Activities: "Limited participation". The goal was for Resident #18 to receive [redacted], NJ EX Order: 264b1 to maintain current level of socialization within the next 90 days. Interventions included, "Provides [redacted] support. Communicate with Interdisciplinary team any changes in mood and behavior". The surveyor observed Resident #18 on 07/19/22 at 11:47 AM, and noted that Resident #18 was laying on their [redacted] facing the wall. The television on the wall was turned off and the wall was bare with no visual items on the wall to look at when he/she was awake. An observation on 07/20/22 at 9:45 AM, revealed Resident #18 laying on the bed, the head of the bed was elevated and Resident #18 was able to respond to the surveyor's greeting. Resident #18 was looking at the bare wall and the television	F 679	The recreation staff schedule will be reviewed and posted two weeks in advance. The Recreation Director is responsible to hire and orient staff needed to cover all activities and will fill in or secure additional hours if needed for coverage. On a monthly basis the Recreation Director will audit activity participation in large and small group activities, frequency of room visits and status of staffing and ability to execute activity calendar. All residents will receive a monthly satisfaction survey which will have space for individual comments and suggestions. The results of the audits will be presented to the Quality Assurance Committee for 3 months and the committee will make recommendations for additional audits as needed.	

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was turned off.

Further review of Resident #18's EMR revealed that section F of the MDS which referred to "Preferences for Customary Routine and Activities" was not completed.

On 07/28/22 at 9:04 AM, an interview with the Activity staff assigned to conduct activities on the B-Wing revealed that Resident #18's Initial Recreation Assessment was not completed. She went on to state that some activities program could not be provided because the facility did not have enough staff. She went on to state, " Prior to COVID-19, the facility was able to provide different activities. We used to have a nice social. We will have staff to go in each wing and we will stay there or we will have program in the main recreation room. In the morning we will have mass, we will do Trivia, food, cooking programs, speakers, entertainers, arts and crafts, travel program and educational programs. We will sit with the residents to talk and identify their interests. We will bring items from home to make the facility a home like environment. We will have tea party, invite friends and family to do food tasting". The Activity staff went on to state, "now we have less people to do the activities and it depends on the time. We do not have an Activity Director (AD). For instance I am in charge of all the books, I have to cover for the AD, therefore I do not have enough time for the residents. I informed the administrator and the DON [Director of Nursing] that I could not provide the activities because we do not have the staff". She added that Nursing staff should be able to assist and that nursing and recreation had to communicate and identify what can be done for the resident that NJ EX Order. 264b1. "I am very limited by

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what I can provide. I have the materials but not the staff. On the weekend sometimes we do have church. Church took place on July 6 and 16. We do not have activity on the weekend now. Today we had only 2 staff, not much can be done. We do not have a calendar of activities provided. The restriction had not been lifted since COVID. That will be a question for the Administrator to answer why the restriction was not lifted after COVID".

An interview with the Licensed Nursing Home Administrator (LNHA) on 07/28/22 at 9:56 AM, revealed that the activity department was supervised by Occupational Therapy (OT). The Administrator added that OT attended Care Conference meeting and worked closely with activity. The LNHA went on to state that he was aware of some restrictions in activity related to COVID-19 and that the restrictions were lifted. The LNHA stated he could not provide the date the restriction were lifted. He added that he distributed the CMS [Centers for Medicare & Medicaid Services] guidance related to dining and group activities, met with OT Director and discussed which activities that could be provided. He stated he also provided the CMS guidance to all departments. He was aware that the activity program was not listed on the calendar but was not aware that evening activities had not been provided. He added that a program of activities were necessary to keep residents engaged and enjoy their stay.

The surveyor then asked the LNHA should evening activities be offered/provided based on the regulations. The LNHA stated, "yes", the facility was to provide evening activities. The regulation at 483.24 (c) indicated the following: "The facility must provide, based on the

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comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community".

The LNHA stated that he did look at the calendar and acknowledged there was room to provide more and different types of activities. He added that he could schedule a resident council meeting so the facility could get input from the residents. The LNHA informed the surveyor that he was not aware of the staffing issues with activity.

An interview with the Unit Manager assigned to the [redacted] Wing on [redacted] at 9:16 AM, revealed that nursing was not involved in any activity with residents directly. She acknowledged that she took some of the residents on the patio on [redacted].

On 08/02/22 at 10:07 AM, the surveyor observed Resident #18 in bed and able to answer to surveyor's greeting. The Admission MDS reflected that preference for daily activity was not completed either by resident or resident representative although the facility documented that the [redacted] was very involved in the resident care. From 07/19/22 to 08/02/22, the surveyor observed Resident #18 in bed, looking at the bare wall with his/her eyes opened.

On 08/02/22 at 11:30 AM, the surveyor spoke with the Activity staff regarding activity notes entered in the clinical record. The activities notes did not contain any evidence of Resident #18 having participated in any facility sponsored

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activities. The surveyor observed Resident #18 in bed most of the shift looking at the bare wall. According to the Certified Nursing Assistant who cared for Resident #18 most of the time, Resident #18 had not been Out of bed (OOB) nor participating in any facility sponsored activities.

On 08/02/22 at 11:49 AM, the surveyor interviewed the MDS Coordinator about Resident #18's activity assessment [redacted] on the MDS. The MDS Coordinator acknowledged that the activity assessment for Resident #18 was not completed in the MDS. She stated that the former Activity Director would complete the MDS Section F for activities. The Initial Recreation Assessment was not completed until [redacted]

The facility was made aware of the above concerns on [redacted]. On [redacted] the LNHA confirmed that the Initial Recreation Activity Assessment along with [redacted] on the MDS, was not completed. No further information regarding activity was provided.

b) On 07/19/22 at 9:57 AM, Surveyor #2 conducted an initial tour on [redacted] wing and observed Resident #101 sitting in the day room with other residents. Resident #101 was at a table alone. There were birthday balloons tied to the back of the wheelchair. Surveyor #2 observed that there was no staff interaction observed with the residents. There were music videos playing on the television (TV). The surveyor observed the activity calendar that was posted on the wall in the hallway on the unit. The activities listed for [redacted] included: Ice Cream Day, AM Activities, Chronical & Coffee Delivery, Interesting Ice Cream Facts around the world, Ice Cream

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Detective, Afternoon Highlights and Strolling Ice Cream Cart. There were no times listed for the activities.

On 07/20/22 at 11:23 AM, Surveyor #2 observed Resident #101 in the [redacted] wing day room at a table alone and was facing the TV. There were other residents present in the room. There was music videos playing on the TV and the residents did not appear to be watching the TV.

On 07/21/22 at 9:42 AM, Surveyor #2 observed Resident #101 sitting in a wheelchair inside the A wing day room. The resident's eyes were closed and the resident appeared to be sleeping. At 9:50 AM, Surveyor #2 observed the nurse transport the resident in the wheelchair to the resident's room and then administered medications. At 9:56 AM, the nurse returned Resident #101 to the day room and placed them at a table facing the TV. At that time, there were nine residents in the day room. There were music videos on the television. The residents did not appear to be watching the TV. A Certified Nursing Assistant (CNA) was sitting in the corner of the room coloring with one of the residents. The other residents did not have coloring material in front of them. Surveyor #2 continually observed the residents in the [redacted] wing Day room, and Resident #101 from 9:42 AM through 10:32 AM from a clear unobstructed view through the window of the day room. The surveyor did not observe the CNA who was sitting in the day room, engage or interact with any of the other residents, or Resident #101.

On 07/21/22 at 10:18 AM, Surveyor #2 observed an Activity Staff (AS) #1 transport a resident, in a wheelchair, from the [redacted] wing day room to the main recreation room (MRR). Surveyor #2 did not

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F 679	Continued From page 46 observe AS#1 ask resident #101, or any of the other residents in the room if they wanted to attend the activity. On 07/21/22 at 10:28 AM, Surveyor #2 interviewed the Provisional Nursing Assistant (PNA), who was sitting in the day room with the residents. She stated that her duty was to observe the residents to make sure that no one would [redacted]. She stated that the residents in the day room were all assessed as being [redacted]. She stated resident #101 was a [redacted], and was also usually in the day room. On 07/21/22 at 10:32 AM, Surveyor #2 observed five residents in the MRR attending a singing activity and singing along with the music, "Proud to be an American." The MRR was a large room with several empty tables. Review of the July 2022 Activity Calendar located in the hallway across from the MRR, had documented for 7/21/22: AM Activities, Chronical & Coffee Delivery, ADMIT categories, Afternoon Highlights, Entertainment in the MRR. There were no times noted for the listed events. On 07/21/22 at 10:45 AM, Surveyor #2 interviewed the Licensed Practical Nurse (LPN#1) from A wing who stated that the residents in the [redacted] wing day room were "[redacted]" and that there was always a CNA or AS in the room with them to redirect the residents as needed. When the surveyor asked how she knew what time the activities were that were listed on the Activity calendar, she stated she did not know the schedule, however, activities staff would know. Surveyor #2 reviewed the electronic medical record for Resident #101 which revealed the	F 679		

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following:

According to the Admission Record, Resident #101 was admitted to the facility with diagnoses that included but were not limited to, [redacted].

According to the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #101 had a Brief Interview for Mental Status (BIMS) score [redacted] 5, which indicated that Resident #101 had a NJ EX Order. 264b1 . The MDS documentation indicated that Resident #101 required extensive staff assistance for Activities of Daily Living (ADLS).

Review of the Care Plan dated [redacted] revealed Focus Activities: ...exhibits a preference of own room and pursues leisure activities watching TV in room ...would benefit from encouragement, redirection and reminders from staff to promote participation. Staff will encourage to attend and participate in activities with peers. Staff will redirect as needed with a need for decreased stimulation.

Review of the Initial Recreation Assessment form created on [redacted] revealed Activity Interests-Past and Current included: Arts/Crafts, Exercise, Music, Spiritual/religious activities, trips/shopping, walking/wheeling outdoors, talking/conversing, parties/socials, special event/entertainment, animals, and some/what watching TV. In the past interest was cooking and reading/writing. The preferred activity setting: own room.

On 07/21/22 at 12:35 PM, Surveyor#2 observed Resident #101 in [redacted] wing day room eating lunch.

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F 679	Continued From page 48 At 1:47 PM, the resident was observed in the A wing day room. The television was on playing music videos. There was no staff interaction observed. On 07/22/22 at 9:17 AM, Surveyor#2 observed Resident #101 sitting in the wheelchair in the hallway outside of the resident's room with a bed side table (BST) in front of the resident. There was nothing on the BST. On 07/22/22 at 9:24 AM, Surveyor#2 interviewed CNA#1 who stated that before the current COVID-19 outbreak, the CNAs took turns monitoring the day room to make sure the residents did not [redacted]. He stated that the residents were now sitting in the hallway so everyone could see them because they were [redacted] risks. On 07/22/22 at 10:57 AM, Surveyor#2 observed Resident #101 sitting in the wheelchair near the doorway of the resident's room. There was no music or TV on. No staff interaction with the resident was observed. During an interview with the survey team on 07/26/22 at 11:31 AM, AS #3 stated that the residents were provided with the "Daily Chronical" (DC). For residents that cannot read the DC, she could not identify what would be done. During an interview with the survey team on 07/26/22 at 12:08 PM, AS#1 stated that the AM activity listed daily on the Activity Calendar included passing out the DC and providing coffee. When asked by the survey team, how do you determine which residents attended activities, she stated "I asked the resident if they want to attend but if a resident is confined to their room, we	F 679		

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asked nursing if they could attend the activity. She further stated that if the resident was a [redacted], they must be seated at a table in the recreation room. When the survey team asked AS#1 about the times not being listed on the Activity Calendar, she stated that afternoon highlights that were listed daily on the calendar were for the [redacted] wing day room. AS#1 could not provide a time for the activity.

On 07/27/22 at 10:03 AM, Surveyor #2 observed Resident #101 sitting in a wheelchair in the hallway outside of the resident's room with an empty bed side table (BST) in front of the resident. At that time, Surveyor #2 interviewed Resident #101's assigned CNA #2. CNA #2 stated that Resident #101 was in the hallway because of being [redacted]." She stated that the resident was usually in day room but due to the current COVID-19 outbreak, the resident stayed in the hallway so the resident could be observed by staff and redirected as needed. CNA#2 stated that Resident #101 liked activities such as coloring and loved to listen to music. At 10:16, CNA#2 provided Resident #101 with markers and a picture to color. CNA#2 showed the resident what to do with the markers but Resident #101 did not use them.

On 07/27/22 at 10:17 AM, the surveyor observed AS#2 provide a cup of coffee to Resident #101 in the hallway. Resident #101 sipped the coffee. No other interaction from AS#2 was observed at that time.

On 07/27/22 at 10:25 AM, Surveyor #2 interviewed LPN#2, who was assigned to Resident #101. LPN#2 stated that the resident was a [redacted] and was usually in the dayroom but

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was currently sitting in the hallway due to the recent COVID-19 outbreak. LPN#2 stated that Resident #101 liked to watch movies. She stated we can offer the residents things to color, snacks, coffee, tea, or hot chocolate. LPN#2 stated when the fall risk residents were in the [redacted] wing day room they could watch TV but due to the recent COVID-19 outbreak the [redacted] wing day room was closed.

On 07/27/22 at 10:40 AM, Surveyor #2 interviewed the Unit Manger/Licensed Practical Nurse (UM/LPN) #1 who stated that Resident #101 was usually in the day room because the resident was a line of sight due to being a [redacted]. She stated that they used the day room because of the windows and residents could be observed by everyone. She stated that residents could be given crayons to color a picture.

On 07/27/22 at 10:56 AM, Surveyor #2 observed Resident #101 in a wheelchair in the hallway with an [redacted]. The resident's eyes were closed. The resident appeared to be sleeping. At 12:36 PM, the resident was observed sitting in the hallway with an empty lunch tray on the [redacted].

On 07/27/22 at 1:16 PM, Surveyor #2 interviewed the Acting Director of Recreation/Occupational Therapist (ADR/OT) who stated that she updated the resident's care plan goals at the care plan meetings to make sure they were up to date with the resident's needs. The ADR/OT stated that she thought her staff had access to the care plans. At 2:07 PM, the ADR/OT confirmed that the activity staff did not have access to the resident's activity care plans. When the surveyor asked why the calendar listed activities without time, the ADR/OT stated that it had been this way and

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stated that the times were removed since COVID-19. She stated that activities are usually held at 10:00 AM and 2:00 PM on the units.

On 07/28/22 at 1:05 PM, Surveyor #2 interviewed AS #2 who stated that every morning the recreation staff delivered coffee and the DC to residents. She stated because of COVID-19 they have not been allowed to have gatherings, except for bingo. AS#2 stated that room visits were completed daily with residents at 10:00 AM and 2:00 PM. When the surveyor asked how much time was spent in the rooms, she stated sometimes it was quick and it would depend on what the resident needed. AS #2 stated that sometimes residents were sleeping, or they would want to talk. When the surveyor asked if activities were important, she stated to keep the resident's mind going, to keep them engaged and prevent depression. AS#2 stated that Resident #101 loved coffee, to talk on the phone, and to listen to music.

On 08/02/22 at 10:22 AM, Surveyor #2 interviewed the Registered Nurse Educator (RNE) who stated that her role was to educate nurses on policy & procedures on the activities of this building. She stated that the residents in [redacted] Wing Day room were a very [redacted]. She further stated, "We put them together in the day room so that they can be observed to keep from falling. Staff should interact with them or give them a book or drawing to make sure that they have something in front of them to keep them from getting bored."

c) On 07/19/22 at 11:07 AM, Surveyor #3 observed Resident #239 in bed with eyes closed. The room was not personalized.

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F 679	Continued From page 52 On 07/20/22 at 12:55 PM, the surveyor reviewed Resident #239's medical record. The Resident Face Sheet indicated that Resident #239 was admitted with diagnoses that included, but was not limited to, NJ EX Order. 264b1 [redacted]. The Physician Order Activity Detail Report revealed an order, dated [redacted] at 7:43 PM, for Therapeutic Recreation as Tolerated. The Care Plan (CP) was reviewed. The CP included the following Focus areas: [redacted] NJ EX Order. 264b1 [redacted]. There was no Activity CP to ensure the staff were aware of Resident #239's activity preferences. On 07/21/22 at 8:28 AM, Surveyor #3 observed Resident #239 in bed, [redacted] were elevated. The resident had his/her eyes open and did not respond when spoken to. The room was not personalized, there were no activity calendars in the room and the resident was not engaged in an activity. On 07/26/22 at 11:13 AM, Surveyor # 3 interviewed the Occupational Therapist/AD, in the presence of the survey team, regarding her role as the Activity Director. The OT/AD stated she was currently functioning as an occupational	F 679		

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F 679	Continued From page 53 therapist and had a modified case load. The OT/AD stated she had not received specialized training in activities and was involved with the restorative program (assist with helping residents maintain physical function and limit deterioration). She stated that a new Director was supposed to start in [redacted]t, however, she had been in the role from [redacted]. She stated the activity staff completed the Activity Calendars and stated, "I don't sign off on the calendar", and the activity staff were responsible for completing the activity assessments. On 07/26/22 at 11:31 AM, Surveyor #3 interviewed Activity Staff #3, in the presence of the survey team, regarding her job functions. AS #3 stated she went to the floors, completed one-to- one resident visits, delivered mail, passed out beverages, entertainment. Surveyor #3 inquired as to how AS #3 knew what the residents liked to do. She stated that she knew that "the alert ones" mostly liked arts and crafts, and for the dementia residents we do coloring, balloon toss, sensory activities, sensory blocks, and puzzles. Surveyor #3 asked who would complete the activity assessments on the residents to determine what activity they liked. She stated that was on one of her computers. Surveyor #3 asked who assigned the activity staff their assignments and AS #3 stated, "well, we don't have our own boss" and stated two of the other activity staff would determine that. Surveyor #3 asked AS #3 if she every spoke to families about the residents. She stated she never talked to the families. She stated, she used to work in the evenings, but the schedule has changed since COVID and there was no evening bingo because of COVID.	F 679		

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Surveyor #3 asked AS #3 if she utilized the activity assessments to determine what types of activities resident's like and what activities would be provided. She stated she never looked at the activity assessment and stated we provided a daily chronical, or a newspaper daily, coloring and trivia. She stated we could read the chronical to them and read the date and year to the people in the room, and they had a radio that they put in the ventilator unit to play music for people.

On 07/26/22 12:08 PM, Surveyor # 4, in the presence of the survey team, interviewed AS #1, who stated she had worked at the facility for 22 years as a recreation assistant (activity staff). AS #1 stated we tried to address each resident's needs, read the assessments, and established relationships with the residents. The AS #1 stated the LHNA and AA were overseeing the Activity Department at present, and the LHNA was new. She stated they currently provided the LHNA and AA with the Activity Calendar for review and the OT/AD was not involved with the process. The AS #1 stated there were things that the AS wanted to do, and there were something's that they wanted to do and they had to wait on because of management. The AS #1 provided an example regarding the snacks the residents had requested for happy hour. She stated she would hand the list over to the Food Service Director (FS). The surveyor inquired if the FSD would respond back and she stated, "I don't know how it works", maybe it went to the upper management. She stated she was unaware who was responsible or how to follow-up with resident food complaints, since the FSD would inform her that he would take care of the complaints. The surveyor inquired to AS #1 how it would be determined who would attend an activity. She stated that she

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would ask nursing, since they could not go room to room and they tried to do one on one resident room visits, but sometimes they could not do it. She stated they would call family for residents who were unable to speak. When asked where the documentation would be to confirm that she had contacted a resident's family, she stated that it was not documented anywhere, and she was not aware that she would have to document it. The surveyors inquired about the facility having any resident trips. She stated "we haven't because of COVID and the former LHNA told them, no outside trips would be allowed because the van was too small. She stated that the activity staff did not complete the MDS section for the residents. The surveyor inquired if weekend activities were conducted. The AS #1 stated that there were scheduled independent resident activities for the weekend, which may include a packet of word games. The surveyor asked the AS #1 to review the July 2022 Activity Calendar dated "21" and to explain what "ADMIT Categories" was as listed on the calendar and was untimed. She stated that she did not know what that activity was.

Surveyor #3 reviewed the July 2022 Activity Calendar for the following Saturdays which revealed the following activities 07/07/22, Int'l [international] Joke Day, AM Activities, Chronical & Coffee Delivery, Grins & Groans, Searching for Laughter, Afternoon Highlights, Funny Letters of Complaints (All untimed), 07/09/22, AM Activities, Afternoon Highlights, Chronical & Coffee Delivery, Anything Goes Exercise, It's Puzzling, Afternoon Highlights, Group Up (All untimed).

Surveyor #3 requested the resume for the OT/AD and it was provided on 07/27/22 at 1:15 PM, by

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the LHNA. The resume revealed the OT/AD did not have any documented work experience or training in activities or therapeutic recreation. The OT/AD was the "Interim Director of Recreation" from NJ EX Order. 264b1 and from NJ EX Order. 264b1: "Lead and oversee the personnel and facilitates organization of the recreation department".

On 07/27/22 2:07 PM, Surveyor #3, in the presence of the survey team interviewed the Occupational Therapist/ Activity Director (OT/AD) about her job function as the Activity Director. The AD/OT stated she completed the activity care plans and added interventions on the care plans. She stated she did not speak to resident families often, did not reach out to contact resident families, and would base her activity interventions for the CP on what the activity staff did with the resident. The AD/OT stated she did not provide oversight for the activity program assessments, and she did not complete any of the activity assessments. The AD/OT confirmed that she "never" reviewed activity assessments that were completed by the activity staff. and stated she had attended to the interdisciplinary meetings and completed activity care plans. The AD/OT also confirmed that there were no activities scheduled with other departments and stated they it should be. The AD/OT was not involved with budgeting, since everything was directed to the prior LHNA. The AD/OT stated there used to be activities planned outside and she was not sure about that now. She stated Surveyor #3 inquired to the AD/OT about what her role was to lead and oversee the personnel and facilitates organization of the recreation department. She stated the activity staff created the activity calendars, and that she "just" completed care plans and went to

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the interdisciplinary meetings.

On 07/28/22 at 8:26 AM, Surveyor #3 toured the B-Wing and observed a large July activity calendar affixed to the wall in hallway. The activities listed for the 28 th were: "Star of the Month", "[redacted]", "AM Activities", Chronical & Coffee Delivery", "[redacted] Packet", "Afternoon Highlights", "Perfect Puzzles", all were un-times. The Lower portion of the calendar revealed, "all activities are subject to change, Religious/Spiritual needs met throughout the month (no specifics indicated), Calendar subject to change per State, Dept. of Health, CDC guidelines and CMS Regulations, Independent Leisure & Materials Provided, In-room Exercise Encouraged, Video Chat/Phone Assistance Available, Heart to Heart Moments & Sensory Stimulation offered daily, Mail delivered daily"

On 07/28/22 at 8:30 AM, Surveyor #3 interviewed the B-Wing nurse unit Manager (UM). The UM stated she had been the UM since [redacted] Surveyor #3 inquired about the resident activity program and what activities were provided for the residents. The UM stated that activity staff would come around and usually pass around the Chronical (a one-page document with facts) and offer coffee. She stated that since she had been employed at the facility, the [redacted]-Wing Day room had not been used for unit activities. Surveyor #3 inquired to the UM if there were times for the activities listed on the calendar. The UM looked at the activity calendar posted to the wall and stated, "no it does not". The UM stated that to her knowledge the calendar has never had times listed. Surveyor #3 had observed a large outside courtyard with access from the [redacted]-Wing dayroom. Surveyor #3 inquired to the UM if residents were

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ever taken outside to use the courtyard. The UM stated if residents could go outside on their own, they were allowed to; and if a resident would ask, nursing would try to take them if they had time. Surveyor #3 inquired if a resident was unable to ask to go outside, would they be provided outside time, and she stated that she could not say they would be taken outside. Surveyor #3 inquired if the residents had ever gone on trips. The UM stated they used to go to the dollar store, but "no trips anymore".

On 07/28/22 at 9:39 AM, Surveyor #3 entered Resident #239's room with a Licensed Practical Nurse (LPN). The resident was in bed, with eyes open and did not respond to the nurse. The room was not personalized, the resident was not engaged in an activity, no music was playing, and there was no activity calendar posted in the room.

On 07/28/22 at 9:48 AM, Surveyor #3 interviewed the LPN in the hallway outside of the day room. Surveyor #3 interviewed the LPN about the activities provided to the [redacted] wing residents. The LPN stated there "used" to be activity calendars in each room. The LPN, who stated she had worked at the facility for [redacted] proceeded to point to an empty white board affixed outside of the [redacted]-Wing day room. She stated there used to be an activity calendar posted there (on the white board). The LPN stated activities would offer coffee to residents, and the rehabilitation residents on [redacted]-Wing did not mingle with the residents downstairs. The LPN stated that the activity staff "would do what they can."

On 07/28/22 at 9:59 AM, Surveyor #3 interviewed AS #2 regarding her job functions. The AS #2 stated she would complete activity assessments

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F 679	Continued From page 59 for the [redacted]-Wing residents when they were admitted, since the residents were mostly [redacted]e ([redacted]residents. AS #2 stated she was responsible for mostly all of the resident activity assessments. AS #2 stated she began completing the activity assessments for the residents as the activity staff diminished. She stated that the assessment was supposed to be completed within 5 days, and that she was unable to complete all the assessments timely because she would be pulled to work on the units. Surveyor #3 inquired to AS #2 regarding an activity assessment and activity care plan for Resident #239. The AS #2 stated that she really did not know what Resident #239 liked to do, because she did not spend a lot of time on [redacted]Wing. The AS # stated, "like I said, we are real thin". The AS #2 stated "I am not allowed" to complete resident CP and she stated she had no access to them on the computer. Surveyor #3 inquired to AS #2 if there was a Care Plan for Resident #239's activity interests and she reviewed the CP in the presence of Surveyor #3. The AS #2 could not locate a Care Plan for activities for Resident #239. The AS #2 reviewed the activity assessment for Resident #239 that was completed February 28, 2022. She stated that the assessment indicated that family was not contacted and had been unable to be reached for preferences related to activities and she had used information from the resident's medical record to complete the assessment. On 0728/22 at 10:13, Surveyor #3 was provided with the most recent completed Admission MDS for Resident #239, dated [redacted]. The MDS revealed the resident was [redacted] has [redacted] and has an [redacted]	F 679		

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F 679	Continued From page 60 [redacted]. Activity preferences section of the MDS indicated that it was very important for the resident to listen to music the resident likes and be around pets. Surveyor #3 reviewed Resident #239's Progress Notes (PN), dated [redacted] at 3:45 AM through [redacted] at 1:01 PM. There were no Activity PN observed. A Social Service PN dated [redacted] at 1:27 PM revealed the Social Worker had a telephone call with the family member. On 07/28/22 at 11:22 AM, Surveyor #3 interviewed the LHNA, who stated he had been at the facility for less than one month and that the OT/AD was overseeing the Activity Department. The LHNA stated, that to his knowledge and per the system put into place by the former LHNA, the OT/AD was completing the activity assessments, completing the MDS, CP's and met with the residents. Surveyor #3 inquired to the LHNA what the role of the Activity Director should entail and the LHNA stated that the Activity Director should complete resident assessments, complete the MDS and develop an Activity Calendar that meets the needs of the residents, keeps the residents engaged and fulfilled. A review of the facility provided policy, "Activities and Social Events" with an effective date 08/2021, revealed Policy: All residents have the right to choose the types of activities and social events in which they wish to participate. Procedure: 1. Residents are encouraged to choose the types of activities and social events in which they prefer to participate; 2. When developing the residents' activity and social care plan, the resident should be given an opportunity to choose when, where, and how he or she will	F 679		

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F 679	Continued From page 61 participate in activities and social events. Activities, social events and schedules are developed in conjunction with the resident's interests, activities, at or away from the facility, are encouraged to do so, 6. Daily activities, including those on weekends and holidays, are provided as well as scheduled religious and social activities ... A review of the facility provided policy, "Care Plan" Policy, Effective 07/2022 revealed Purpose: To develop and implement a care plan for each resident/patient that includes the interventions needed to provide effective and person-entered care of the resident/patient that meet professional standards of quality of care. The Care Plan will be consistent with the resident/patient rights that include measurable objectives and time frames to meet a resident's/patient's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Scope: All clinical departments and resident/patient care areas of nursing and rehabilitation facilities. NJAC 8:39-7.3(a); 4.1(a)24, 28	F 679		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on	F 680		9/21/22

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F 680	Continued From page 62 or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the activities program was directed by a qualified therapeutic recreation specialist or activity professional. The deficient practice was evidenced by the following: Refer to 679F On 07/26/22 at 10:30 AM, the surveyor conducted a resident meeting with six alert and oriented residents. Resident (R1) stated that the facility has not had a Director of Recreation for about six months, and it had affected the residents. R #1 stated that the residents had felt that they were not getting enough activities, and there were no activities during the weekend. R #1 stated "we just sit here". R #1 stated there was not much offered during the week, and "once a week we might do a craft". R1 stated that there were no outside trips since the pandemic began (approximately a two-year time span). R #1 stated the resident council was concerned and wanted to know what the facility was providing to ensure the confused residents received activities since the alert and oriented residents were not being provided with resident activities. R#1 stated the facility did not offer any activities in the	F 680	The new Activity Director meets the requirements outlined in 483.24(c)(2). All residents have the potential to be affected by the deficient practice. The Activity Director, with input from the Resident Council, will develop and post the monthly Activity Calendar, which will include times and locations of all events. The Activity Director will ensure calendars are posted in all resident rooms and common areas as well as distributed and reviewed with all residents, regardless of abilities. The Recreation Director will audit and report on the Activity Department including resident participation, staffing, upcoming calendars and events and resident satisfaction and suggestions. These reports will be reviewed by the Quality Assurance Committee on a monthly basis, for three months. The QA Committee will make recommendations on the need for continued audits.	

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evening. Six of Six residents in attendance agreed with R #1's statements. Another resident, (R #2) stated that he/she could not remember the nursing staff member's name, however, stated that he/she had been told by nursing staff to find things keep him/herself busy, and that was what R #2 had tried to do.

On 07/26/22 at 11:13 AM, the surveyor interviewed the Occupational Therapist/Activity Director (AD/OD), in the presence of the survey team, regarding her role as the Activity Director. The OT/AD stated she was currently functioning as an occupational therapist and had a modified case load.

The OT/AD stated she had not received specialized training in activities and was involved with the restorative program (assist with helping residents maintain physical function and limit deterioration). She stated that a new Director was supposed to start in August, however, she had been in the role from NJ EX Order. 264b1 and from NJ EX Order. 264b1. She stated the activity staff completed the Activity Calendars and stated, "I don't sign off on the calendar", and the activity staff were responsible for completing the activity assessments.

On 07/26/22 at 11:31 AM, the surveyor interviewed AS #3, in the presence of the survey team, regarding her job functions. AS #3 stated she went to the floors, completed one- to- one resident visits, delivered mail, passed out beverages, entertainment. The surveyor inquired as to how AS #3 knew what the residents liked to do. She stated that she knew that "the alert ones" mostly liked arts and crafts, and for the dementia residents we do coloring, balloon toss, sensory

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activities, sensory blocks, and puzzles. The srveyor asked who would complete the activity assessments on the residents to determine what activity they liked. She stated that was on one of her computers. The surveyor asked who assigned the activity staff their assignments and AS #3 stated, "well, we don't have our own boss" and stated two of the other activity staff would determine that. The surveyor asked AS #3 if she every spoke to families about the residents. She stated she never talked to the families. She stated, she used to work in the evenings, but the schedule has changed since COVID and there was no evening bingo because of COVID. The surveyor asked AS #3 if she utilized the activity assessments to determine what types of activities resident's like and what activities would be provided. She stated she never looked at the activity assessment and stated we provided a daily chronical, or a newspaper daily, coloring and trivia. She stated we could read the chronicle to them and read the date and year to the people in the room, and they had a radio that they put in the ventilator unit to play music for people.

On 07/26/22 12:08 PM, a surveyor, in the presence of the survey team, interviewed AS #1, who stated she had worked at the facility for 22 years as a recreation assistant (activity staff). AS #1 stated we tried to address each resident's needs, read the assessments, and established relationships with the residents. The AS #1 stated the LHNA and AA were overseeing the Activity Department at present, and the LHNA was new. She stated they currently provided the LHNA and AA with the Activity Calendar for review and the OT/AD was not involved with the process. The AS #1 stated there were things that the AS wanted to do, and there were something that they wanted to

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do and they had to wait on because of management. The AS #1 provided an example regarding the snacks the residents had requested for happy hour. She stated she would hand the list over to the Food Service Director (FS). The surveyor inquired if the FSD would respond back and she stated, "I don't know how it works", maybe it went to the upper management. She stated she was unaware who was responsible or how to follow-up with resident food complaints, since the FSD would inform her that he would take care of the complaints. The surveyor inquired to AS #1 how it would be determined who would attend an activity. She stated that she would ask nursing, since they could not go room to room and they tried to do one on one resident room visits, but sometimes they could not do it. She stated they would call family for residents who were unable to speak. When asked where the documentation would be to confirm that she had contacted a resident's family, she stated that it was not documented anywhere, and she was not aware that she would have to document it. The surveyors inquired about the facility having any resident trips. She stated "we haven't because of COVID and the former LHNA told them, no outside trips would be allowed because the van was too small. She stated that the activity staff did not complete the MDS section for the residents. The surveyor inquired if weekend activities were conducted. The AS #1 stated that there were scheduled independent resident activities for the weekend, which may include a packet of word games. The surveyor asked the AS #1 to review the July 2022 Activity Calendar dated "21" and to explain what "ADMIT Categories" was as listed on the calendar and was untimed. She stated that she did not know what that activity was.

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F 680	Continued From page 66 The surveyor requested the resume for the OT/AD which was provided on 07/27/22 at 1:15, by the LHNA. The resume revealed the OT/AD did not have any documented work experience or training in activities or therapeutic recreation. The OT/AD was the "Interim Director of Recreation" from NJ EX Order: 264b1 and from NJ EX Order: 264b1: "Lead and oversee the personnel and facilitates organization of the recreation department". On 07/27/22 at 1:15 PM, the Licence Nursing Home Administrator (LHNA) provided the surveyor with the unsigned/undated Recreation Director Job Description, with a grayed out DRAFT typed over the document. The document revealed. Job Summary: The Recreation Director provides an ongoing program of activities designed to meet, in accordance with a comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Essential Generic Job Functions: 1. Assess resident needs and develops resident activity goals for the care plan, 2. Encourages resident participation in activities and document outcomes, 3. Reviews goals and progress notes, 4. Provides a plan of activities appropriate to the needs of the residents including but not limited to group social activities, indoor and outdoor activities community activities, and spiritual programs, 6. Coordinates the activities program with other departments in the facility, 7. Recruits, trains, and supervises volunteers, 8. Properly documents MDS (Resident assessment tool), 9. Participates with administrator in developing a budget, 10. Fosters family and community support for the activity program, 11. Contributes to facility efforts to maintain and improve quality	F 680		

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of care through participation in care plan meetings. Contacts: 1. Regular contact with residents, resident's family/significant others and visitors...Knowledge, Education and Skills Required: 1. Education: Minimum: High school diploma or equivalent and satisfactory completion of a training course for activity directors approved by the Department of Health & Human Services...

On 07/27/22 at 2:07 PM, The surveyor, in the presence of the survey team, conducted an additional interview with the Occupational Therapist/Activity Director (OT/AD) about her job functions as the Activity Director. The AD/OT stated she completed the activity care plans and added interventions on the care plans. She stated she did not speak to resident families often, did not reach out to contact resident families, and would base her activity interventions for the CP on what the activity staff did with the resident. The AD/OT stated she did not provide oversight for the activity program assessments, and she did not complete any of the activity assessments. The AD/OT confirmed that she "never" reviewed activity assessments that were completed by the activity staff. and stated she had attended to the interdisciplinary meetings and completed activity care plans. The AD/OT also confirmed that there were no activities scheduled with other departments and stated they it should be. The AD/OT was not involved with budgeting, since everything was directed to the prior LHNA. The AD/OT stated there used to be activities planned outside and she was not sure about that now. The surveyor inquired to the AD/OT about what her role was to lead and oversee the personnel and facilitates organization of the recreation department. She stated the activity staff created the activity calendars, and that she "just"

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completed care plans and went to the interdisciplinary meetings (The AD/OT failed to meet all of the the requirements for the facility Recreation Director Summary of Duties, which included: Assess resident needs and develops resident activity goals for the care plan, 2. Encourages resident participation in activities and document outcomes, Reviews goals and progress notes, Provides a plan of activities appropriate to the needs of the residents including but not limited to group social activities, indoor and outdoor activities community activities, and spiritual programs, Coordinates the activities program with other departments in the facility, Recruits, trains, and supervises volunteers, Properly documents MDS (Resident assessment tool), Participates with administrator in developing a budget).

On 07/28/22 at 8:26 AM, the surveyor toured the B-Wing and observed a large July activity calendar affixed to the wall in hallway. The activities listed for the 28th were: "Star of the Month", "[redacted]", "AM Activities", Chronicle & Coffee Delivery", "[redacted] Packet", "Afternoon Highlights", "Perfect Puzzles", all were un-times. The Lower portion of the calendar revealed, "all activities are subject to change, Religious/Spiritual needs met throughout the month (no specifics indicated), Calendar subject to change per State, Dept. of Health, CDC guidelines and CMS Regulations, Independent Leisure & Materials Provided, In-room Exercise Encouraged, Video Chat/Phone Assistance Available, Heart to Heart Moments & Sensory Stimulation offered daily, Mail delivered daily"

On 07/28/22 at 8:30 AM, the surveyor interviewed the [redacted]-Wing nurse unit Manager (UM). The UM

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stated she had been the UM since [redacted]. The surveyor inquired about the resident activity program and what activities were provided for the residents. The UM stated that activity staff would come around and usually pass around the Chronicle (a one-page document with facts) and offer coffee. She stated that since she had been employed at the facility, the [redacted]-Wing Day room had not been used for unit activities. The surveyor inquired to the UM if there were times for the activities listed on the calendar. The UM looked at the activity calendar posted to the wall and stated, "no it does not". The UM stated that to her knowledge the calendar has never had times listed. Surveyor #3 had observed a large outside courtyard with access from the [redacted]-Wing dayroom. The surveyor inquired to the UM if residents were ever taken outside to use the courtyard. The UM stated if residents could go outside on their own, they were allowed to; and if a resident would ask, nursing would try to take them if they had time. Surveyor #3 inquired if a resident was unable to ask to go outside, would they be provided outside time, and she stated that she could not say they would be taken outside. The surveyor inquired if the residents had ever gone on trips. The UM stated they used to go to the store, but "no trips anymore".

On 07/28/22 at 9:48 AM, the surveyor interviewed the LPN in the hallway outside of the day room. The surveyor interviewed the LPN about the activities provided to the [redacted]-Wing residents. The LPN stated there "used" to be activity calendars in each room. The LPN, who stated she had worked at the facility for [redacted], proceeded to point to an empty white board affixed outside of the [redacted]-Wing day room. She stated there used to be an activity calendar posted there (on the white

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board). The LPN stated activities would offer coffee to residents, and the rehabilitation residents on [redacted]-Wing did not mingle with the residents downstairs. The LPN stated that the activity staff "would do what they can."

On 07/28/22 at 9:59 AM, the surveyor interviewed AS #2 regarding her job functions. The AS #2 stated she would complete activity assessments for the [redacted]-Wing residents when they were admitted, since the residents were mostly NJ EX Order. 264b1) residents. AS #2 stated she was responsible for mostly all of the resident activity assessments. AS #2 stated she began completing the activity assessments for the residents as the activity staff diminished. She stated that the assessment was supposed to be completed within 5 days, and that she was unable to complete all the assessments timely because she would be pulled to work on the units. The surveyor inquired to AS #2 regarding an activity assessment and activity care plan for Resident #239. The AS #2 stated that she really did not know what Resident #239 liked to do, because she did not spend a lot of time on [redacted]-Wing. The AS # stated, "like I said, we are real thin". The AS #2 stated "I am not allowed" to complete resident CP and she stated she had no access to them on the computer.

On 07/28/22 at 11:22 AM, the surveyor interviewed the LHNA, who stated he had been at the facility for less than one month and that the OT/AD was overseeing the Activity Department. The LHNA stated, that to his knowledge and per the system put into place by the former LHNA, the OT/AD was completing the activity assessments, completing the MDS, CP's and met with the residents. The surveyor inquired to the

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F 680	Continued From page 71 LHNA what the role of the Activity Director should entail and the LHNA stated that the Activity Director should complete resident assessments, complete the MDS and develop an Activity Calendar that meets the needs of the residents, keeps the residents engaged and fulfilled. A review of the facility's policy, "Activities and Social Events" with an effective date 08/2021 revealed Policy: All residents have the right to choose the types of activities and social events in which they wish to participate. Procedure: 1. Residents are encouraged to choose the types of activities and social events in which they prefer to participate; 2. When developing the residents' activity and social care plan, the resident should be given an opportunity to choose when, where, and how he or she will participate in activities and social events. Activities, social events and schedules are developed in conjunction with the resident's interests, activities, at or away from the facility, are encouraged to do so. 6. Daily activities, including those on weekends and holidays, are provided as well as scheduled religious and social activities ... NJAC 8:39-7.3(a); 4.1(a)24, 28	F 680		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		9/13/22

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F 686	Continued From page 72 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that from [redacted] through [redacted] the facility failed to properly assess a [redacted] the [redacted] immediately upon identification, obtain treatment orders, and consistently implement timely interventions in adherence with the facility wound evaluation policy, physician's orders and the resident's care plan to prevent the development of a [redacted] This deficient practice occurred for 1 of 2 residents reviewed, who were previously identified as being at risk for the development of a [redacted] and for [redacted] management (Resident #73). The deficient practice was evidenced by the following: Reference: [redacted] The updated [redacted] system includes the following definitions: [redacted] is localized damage to the [redacted] and [redacted] usually over a [redacted] or related to a medical or other	F 686	A root cause analysis was conducted to identify the underlying cause of the deficient practice. The deficient practice was failure to follow up on the [redacted] related to inadequate communication process on reporting [redacted]. Resident 73's [redacted] has been assessed and treated and has been receiving the appropriate treatment to the [redacted]. Full [redacted] check was performed by the [redacted] nurse and no further [redacted] breakdown identified. All residents with [redacted] alteration have the potential to be affected by the deficient practice. The wound care team, led by the DON/designee, has audited residents current skin integrity by reviewing the TAR's, visualizing every current [redacted] alteration, and speaking with direct care staff to ensure al [redacted] alterations are identified and being proactively addressed. A full [redacted] check on all residents was performed by the unit managers to make sure that there are no unreported [redacted] alteration concerns. The Nurse Management team have been in-serviced on incident reporting and follow up requirements. On a daily basis the DON/designee will review any new incident reports related to [redacted] alterations.	

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F 686	Continued From page 73 NJ EX Order. 264b1. The injury can present as NJ EX Order. 264b1 The injury occurs as a result of intense and/or prolonged NJ EX Order. 264b1 e in combination with NJ EX Order. 264b1 r. The tolerance of NJ EX Order. 264b1 for NJ EX Order. 264b1 may also be affected by NJ EX Order. 264b1 NJ EX Order. 264b1 . NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 with a localized area of NJ EX Order. 264b1 , which may appear differently in NJ EX Order. 264b1 . Presence of NJ EX Order. 264b1 or changes in NJ EX Order. 264b1 , or NJ EX Order. 264b1 may precede visual changes. Color changes do not include NJ EX Order. 264b1 NJ EX Order. 264b1 ; these may indicate NJ EX Order. 264b1 NJ EX Order. 264b1 . NJ EX Order. 264b1 s NJ EX Order. 264b1 of NJ EX Order. 264b1 with NJ EX Order. 264b1 The NJ EX Order. 264b1 , and may also present as an NJ EX Order. 264b1 . NJ EX Order. 264b1 is not NJ EX Order. 264b1 and NJ EX Order. 264b1 are not visible. NJ EX Order. 264b1 , NJ EX Order. 264b1 and NJ EX Order. 264b1 are not present. These injuries commonly result from adverse NJ EX Order. 264b1 in the NJ EX Order. 264b1 the NJ EX Order. 264b1 in the NJ EX Order. 264b1 . This stage should not be used to NJ EX Order. 264b1) including NJ EX Order. 264b1	F 686	All nosocomial wounds will be discussed by the IDC team in the clinical morning meeting to make sure the team is aware of the plan of care that has been put in place. Any new wounds will be thoroughly investigated by the DON/designee per policy and a root cause analysis will be completed. On a weekly basis, the DON/designee will review all NJ EX Order. 264b1 in the building with the Interdisciplinary Care Team (IDC team) and the NJ EX Order. 264b1 Care Consultants. All nursing staff were in-serviced on communication and the NJ EX Order. 264b1 prevention policy. The DON /designee will review any new skin incidents ongoing to ensure completeness and accuracy and to make sure there is appropriate treatment to the NJ EX Order. 264b1 checks of all residents to be conducted by NJ EX Order. 264b1 nurse/designee monthly to ensure that there are no unreported NJ EX Order. 264b1 alteration concerns. Results of all audits will be reported by the DON/designee to the QAPI committee monthly and to the QAA committee quarterly.	

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NJ EX Order. 264b1

NJ EX Order. 264b1 in which adipose (fat) is visible in the NJ EX Order. 264b1 and NJ EX Order. 264b1 are often NJ EX Order. 264b1 may be visible. The depth of t NJ EX Order. 264b1 damage varies by anatomical location; areas of significant NJ EX Order. 264b1 can develop NJ EX Order. 264b1 NJ EX Order. 264b1 and f NJ EX Order. 264b1 may occur. Fascia, NJ EX Order. 264b1 and/or NJ EX Order. 264b1 are not exposed. If NJ EX Order. 264b1 obscures the extent of t NJ EX Order. 264b1 this is an NJ EX Order. 264b1.

NJ EX Order. 264b1 and NJ EX Order. 264b1

NJ EX Order. 264b NJ EX Order. 264b1 with exposed or directly NJ EX Order. 264b1 in the NJ EX Order. 264b1 NJ EX Order. 264b1 and/or NJ EX Order. 264b1 r may be visible, NJ EX Order. 264b1, NJ EX Order. 264b1 and/or NJ EX Order. 264b1 often occur. Depth varies by NJ EX Order. 264b1. If NJ EX Order. 264b1 obscures the extent NJ EX Order. 264b1 this is an NJ EX Order. 264b1.

NJ EX Order. 264b1 and NJ EX Order. 264b1

On 07/19/22 at 11:14 AM, during the initial tour of the the facility, the surveyor observed Resident #73 seated in a wheelchair at the bedside. The resident stated that he/she developed a NJ EX Order. 264b1 NJ EX Order. 264b1 about a year ago, and did not receive immediate treatment after the resident's Certified Nursing Assistant (CNA) had reported a wound that was on his/her NJ EX Order. 264b1 to nursing. Resident #73 stated the NJ EX Order. 264b1 then grew in size and resulted in the resident being hospitalized with a diagnosis of NJ EX Order. 264b1

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resulting from the presence of harmful NJ EX Order. 264b1 the NJ EX Order. 264b1, potentially leading to the malfunctioning of various NJ EX Order. 264b1 and [redacted]).

Review of Resident #73's Face Sheet (an admission summary) revealed that the resident was readmitted to the facility in NJ EX Order. 264b1, with diagnoses which included but were not limited to: NJ EX Order. 264b1 due to NJ EX Order. 264b1 (results from disruption of normal healthy NJ EX Order. 264b1 [redacted], often from NJ EX Order. 264b1 but can also be transmitted from NJ EX Order. 264b1 ([redacted]NJ EX Order. 264b1, NJ EX Order. 264b1 NJ EX Order. 264b1 of NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1 of NJ EX Order. 264b1 (when a person lacks NJ EX Order. 264b1 [redacted] (an impairment in the way the NJ EX Order. 264b1 [redacted], and NJ EX Order. 264b1 NJ EX Order. 264b1 the NJ EX Order. 264b1

Review of Resident #73's quarterly Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that the resident was NJ EX Order. 264b1 Further review of the MDS revealed that the resident required NJ EX Order. 264b1 assistance of one person for bed mobility, toileting, personal hygiene, required limited assistance of one person for transfers and had a NJ EX Order. 264b1 and was occasionally NJ EX Order. 264b1 of NJ EX Order. 264b1. The surveyor reviewed the resident's previous quarterly MDS dated NJ EX Order. 264b1, which identified that the resident was identified to have been at NJ EX Order. 264b1 NJ EX Order. 264b1 and did not have a NJ EX Order. 264b1, NJ EX Order. 264b1 or any NJ EX Order. 264b1 at that time. Further review

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of the MDS revealed that the resident had an NJ EX Order. 264b1 placed in the NJ EX Order. 264b1 into a NJ EX Order. 264b1) and was occasionally NJ EX Order. 264b1.

Review of Resident #73's Care Plan Activity Report (CPAR) revealed an entry dated NJ EX Order. 264b1 8, which detailed that the resident's NJ EX Order. 264b1 Integrity was at risk for NJ EX Order. 264b1 based on the NJ EX Order. 264b1 (a tool for predicting NJ EX Order. 264b1), and the score was not specified, NJ EX Order. 264b1 [sic.] (NJ EX Order. 264b1 NJ EX Order. 264b1 ...Interventions included but were not limited to: Routine NJ EX Order. 264b1 assessments twice a week. Report signs and symptoms of early NJ EX Order. 264b1 breakdown to the NJ EX Order. 264b1 nurse. On NJ EX Order. 264b1 an intervention was added to notify the resident or POA (power of attorney) and the doctor about significant changes in NJ EX Order. 264b1 n condition or care. Use NJ EX Order. 264b1 cream to NJ EX Order. 264b1 area (the region NJ EX Order. 264b1 by the NJ EX Order. 264b1 in NJ EX Order. 264b1 and by the NJ EX Order. 264b1 the NJ EX Order. 264b1). On NJ EX Order. 264b1, the NJ EX Order. 264b1 Care Nurse NJ EX Order. 264b1 documented that the resident's NJ EX Order. 264b1 remained without breakdown. Will continue current plan of care. On NJ EX Order. 264b1, the NJ EX Order. 264b1 documented that the resident's NJ EX Order. 264b1 integrity was well maintained, care plan reviewed and will continue.

Further review of Resident #73's CPAR revealed an entry dated NJ EX Order. 264b1 that was entered by the NJ EX Order. 264b1 and demonstrated the following: NJ EX Order. 264b1 Integrity: NJ EX Order. 264b1 -resident has a NJ EX Order. 264b1 related NJ EX Order. 264b1 that evolved

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from an NJ EX Order. 264b1, with NJ EX Order. 264b1 ..Interventions that accompanied the entry included but were not limited to: Apply treatment to affected area as ordered. Re-evaluate periodically. Refer to Specialist as needed. Refer to Rounds Team as needed. NJ EX Order. 264b1 (help treat NJ EX Order. 264b1 by providing NJ Ex Order. 264b1 that expand and contract on an NJ EX Order. 264b1. Minimize NJ EX Order. 264b1 area to maximize . Keep NJ Ex Order. 264b1 garment loosed [sic.] while in bed to allow air circulation to the affected area. Assess for least every shift. Offer medication before treatment as needed. The added a note to the entry which specified: Resident is f/u (following up) weakly [sic.] on rounds. treatment and plan of care was adjusted to resident needs. Resident is also NJ EX Order. 264b1 and was scheduled for NJ EX Order. 264b1 to NJ EX Order. 264b1 NJ EX Order. 264b1 is stable with no s/s (signs and symptoms) of .Further review of the revealed that on at 11:26 AM, the documented that the resident had an NJ EX Order. 264b1 with NJ EX Order. 264b1 to the NJ EX Order. 264b1 NJ EX Order. 264b1 just below NJ EX Order. 264b1 NJ Ex Order. 264b1

Review of the Progress Notes (PN) contained within the Electronic Health Record (EHR) revealed that on the following dates:

-02/22/2022 at 3:44 AM
-02/23/2022 at 2:34 AM
-02/27/2022 at 2:32 AM
-02/28/2022 at 2:41 AM
-03/04/2022 at 3:12 AM

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F 686	Continued From page 78 -03/08/2022 at 3:14 AM -03/09/2022 at 4:05 AM Licensed Practical Nurse #1 (LPN#1) documented that Resident #73 had a [redacted] on the NJ EX Order. 264b1, and a [redacted] on the [redacted] and indicated that a [redacted] was applied. On 03/22/2022 at 11:57 AM, the Licensed practical Nurse/Unit Manager (LPN/UM) documented that she was asked by the night nurse to have the [redacted] Care Nurse [redacted] take a look at Resident #73's [redacted]). The [redacted] care nurse was made aware of the request and assessed the resident. The LPN/UM documented that the [redacted] then called her (LPN/UM) into the resident's room, and the LPN/UM observed that the resident had a [redacted] on the [redacted] Further review of Resident #73's PN revealed that on 03/22/2022 at 1:00 PM, the WCN documented that the resident had NJ EX Order. 264b1 to the NJ EX Order. 264b1 that measured about [redacted] cm, base NJ EX Order. 264b1 with NJ EX Order. 264b1), surrounding [redacted]) with no [redacted] non-door [sic.] The [redacted] asked the resident when the [redacted] developed? The resident stated that it had started a NJ EX Order. 264b1 the NJ EX Order. 264b1. The [redacted] documented that the [redacted] was documented in [redacted] due to [redacted] (excess NJ EX Order. 264b1 due to NJ EX Order. 264b1). The surveyor reviewed Resident #73's paper medical record which contained a typed letter	F 686		

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written by the resident's attending physician, dated [redacted], which revealed the following: In [redacted] the resident had [redacted] and has since lost approximately [redacted] (lbs.) Resident continued to [redacted] on his/her own. The resident has had complications in relation to [redacted], and has been treated for [redacted] under [redacted], the [redacted], and most recently developed an [redacted] in relation to his/her [redacted] causing [redacted] and [redacted]e. (He/she was hospitalized from [redacted] in relation to [redacted] in the [redacted]). During that time, the [redacted] worsened, and continued to need regular [redacted] to promote [redacted]. The physician requested consideration for removal of [redacted] that was now medically necessary to [redacted], future [redacted] and to provide a better quality of life.

Further review of the paper medical record revealed a Consultation Report Form dated [redacted] in which the [redacted]y Group documented that Resident #73 was seen and examined and the chart was reviewed. The Impression was: [redacted] with [redacted] surface of [redacted], some [redacted] ([redacted] surrounding [redacted] was surrounded by [redacted], redundant [redacted] and [redacted] of the [redacted] and [redacted] noted (s/p [redacted]). Plan: Patient is not a good medical/surgical candidate for [redacted] over [redacted] and [redacted] advancements with anticipated [redacted] complication including [redacted]. Also, it

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was unclear if removal of NJ EX Order 264b1 would NJ EX Order 264b1 of NJ EX Order 264b1. Recommend continued local care to NJ EX Order NJ EX Order 264b1 and consider NJ EX Order 264b1 protection of NJ EX Order with NJ EX Order cream, as per NJ EX Order care team.

On 07/26/2022 at 11:07 AM, the surveyor interviewed the LPN/UM who stated that on NJ EX Order 264b1 during the night shift, Resident #73 who was oriented, requested that the Licensed LPN #1 look at a NJ EX Order on his/her NJ EX Order 264b1 LPN #1 discovered an NJ EX Order 264b1 on the resident's NJ EX Order 264b1 and failed to document the finding as required. The LPN/UM stated that LPN #1 had informed her about the NJ EX Order in the morning before he signed off duty, and he requested that she contact the NJ EX Order. The LPN/UM stated that to her knowledge the NJ EX Order was a NJ EX Order 264b1. The LPN/UM stated that when she looked at the NJ EX Order herself, it was opened. The LPN/UM stated that a review of a NJ EX Order Assessment dated NJ EX Order 264b1, revealed that a NJ EX Order 264b1 was previously identified. The LPN/UM stated that Registered Nurse (RN #1) documented that the resident had a NJ EX Order. 264b1 and should have known the process for NJ EX Order care documentation and reporting. She further stated that RN #1 should have alerted the LPN/UM at that time, as well as the doctor, NJ EX Order and supervisor. The LPN/UM stated if RN #1 had followed the policy and procedure for notification, it would have initiated a Care Link (a computerized incident report) and also a NJ EX Order Integrity Packet could have been initiated. LPN/UM acknowledged that as a result of RN #1's failure to follow the facility policy and procedures, there was a delay in reporting the resident's NJ EX Order and also in obtaining and

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F 686	Continued From page 81 implementing a treatment order for the [redacted] as was required. On 07/26/22 at 1:37 PM, the surveyor interviewed the Registered Nurse/Educator (RN/E) regarding what the process would entail when a new [redacted] was discovered. The RN/E stated that when a nurse identified a new [redacted] they were expected to inspect the area, and then initiate a treatment based on what they observed, then they should call the doctor and validate that the treatment option was appropriate for the resident, write a PN, initiate a Care Link, and complete a [redacted] Packet. She stated that the facility utilized both paper and computerized incident reports which doubled the work. She then stated that the [redacted] also would receive a message to evaluate the, and that by that time, a treatment should have already have been initiated. The doctor and family notification and [redacted] note were part of the Care Link. The RN/E stated that the CNA's (Certified Nursing Assistant) were also required to write a statement and document what they observed in their own words. She stated that skin assessments were completed on shower days and required a 72 hour look back to see if they could have prevented any [redacted] injuries. The RN/E stated any finding discovered on the night shifts should have been passed onto the day shift in report which would ensure that it would be followed through. It should also have been discussed in the morning huddle (a daily clinical meeting) to ensure the supervisor could make rounds as needed and follow-up. She stated, [redacted] issues were not just a little blurb." The RN/E further stated that if RN #1 had identified a [redacted] issue on 0[redacted], she should have passed it on in the report, and also have	F 686		

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documented the finding in the PN. She stated that the [redacted] evaluated the resident on [redacted] at 9:46 AM, and documented the specifics related to an [redacted]. The RN/E stated that the CNA who first observed the [redacted] should have written a statement, which should have been included in the 72 hour look back. The RN/E stated that the CNAs should have lifted that [redacted] on the resident's intergluteal cleft to clean it at the very least. The RN/E further stated that Resident #73 was a good historian, and he/she could remember what they ate last week. The RN/E stated that when interviewed, the resident had recalled that the [redacted] had been in place on his/her [redacted] prior to the [redacted] which was inserted in [redacted]. The RN/E stated that the [redacted] may have developed in [redacted]. The RN/E reviewed the EHR in the presence of the surveyor and stated the following: On [redacted] 1 the resident's [redacted] was intact. On [redacted], an [redacted] was identified at the [redacted] by RN #1. The RN/E stated that further review of the EHR revealed that there were no [redacted] related documented interventions in response to the newly discovered [redacted], and "nothing was documented" by the [redacted] regarding the finding. The RN/E further stated, "if the resident's [redacted] was not addressed from [redacted] through [redacted] that was a very long time."

On 07/26/22 at 2:26 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who provided the surveyor with a typed, "Investigation Summary and Conclusion" dated [redacted] which indicated that the Event Date was [redacted] The surveyor asked the LNHA for clarification about the delay in the investigation from the time of discovery of the [redacted] and he

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stated he was not familiar with the investigation as it was completed under the previous LNHA. The RN/E was present and presented the surveyor with Resident #73's "Clinical Assessment" form which had a hand written date on it of 1[redacted], and contained the following entry: "[redacted]" was documented on the form.

Review of Resident #73's "Investigation Summary and Conclusion" revealed that on[redacted], the LPN/UM documented the following: Situation: [redacted] Integrity: On 1[redacted], RN #1 did a Care Link for a [redacted] integrity [redacted] found to the [redacted] The [redacted] Score was [redacted] low risk...The 3-11 CNA was interviewed and the resident had something [redacted] on his/her [redacted] in [redacted]r. The CNA reported it to the nurse and the nurse initiated a Care Link. After that, the CNA stated that she reported it to multiple nurses over the next couple of months and even told the nurses that it was getting worse. She applied [redacted] (used to treat [redacted] with [redacted] to the area as ordered and encouraged the resident to remind the nurse to look at it when they administered medications to the resident. The following time line was included in the investigation: On [redacted] a skin assessment was done and showed that the resident had a [redacted], [redacted] assessment showed a [redacted] to the [redacted] was inserted. Prior to the [redacted], the resident was a [redacted] with some [redacted] episodes. On [redacted] a [redacted] assessment showed a [redacted], and [redacted]. On [redacted], RN #1 noted an [redacted] to the [redacted] which was addressed with treatment

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recommended by the [redacted] and MD (medical doctor) and the [redacted] after a few weeks. On [redacted], [redacted] assessment was rendered and it showed [redacted] to the area, On [redacted] LPN #1 asked the LPN/UM to have the [redacted] look at the resident's [redacted]. The WCN called the LPN/UM into the resident's room and she observed a [redacted] to the [redacted] and the supervisor was made aware.

Further review of the "Investigation Summary and Conclusion" revealed the following Conclusion/Recommendations: Resident was seen by [redacted] to [redacted] and observed about [redacted] with [redacted], no [redacted] [sic.] [redacted] vessels into [redacted]). [redacted] l (helps remove [redacted] and aid in [redacted]) applied and covered with a 4[redacted] dressing and will continue daily and as needed per MD. On [redacted], resident was seen by [redacted] Team which included [redacted] Care Consultant Nurse Practitioner [redacted]), who saw the resident and an [redacted] (no [redacted] was identified) to [redacted] that measured [redacted] cm, was noted. Treatment continued. Specialty mattress updated to [redacted] to promote [redacted]. Reinforced the importance on side lying while in bed and to keep the region clean and dry to avoid [redacted] under [redacted]. Care Plan discussed with the resident and nursing staff.

Further review of the "Investigation Summary and Conclusion" revealed that on [redacted],

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Resident #73 complained of not feeling well and the vital signs were: blood pressure: [redacted], heart rate[redacted] respirations [redacted] temperature [redacted] SPO2 (measures level of circulating level of oxygen circulating in the blood with the use of a probe placed on the fingers) on room air was [redacted]. The resident was sent to the Emergency Room and was admitted with a [redacted] and [redacted] and returned to the facility on [redacted]. The [redacted] Team and [redacted] followed up on [redacted], and documented an [redacted] and noted that it had worsened s/p recent hospitalization after the resident spent [redacted] days in the [redacted] and the [redacted] into a [redacted] On the day of discharge the resident had a bedside [redacted] (the removal of[redacted] to promote[redacted]). Today on assessment the [redacted] measured [redacted] and [redacted] which increased the [redacted] .. [redacted], no [redacted], [redacted] present...Area will be difficult to heal due to [redacted] from [redacted] [redacted] covered the [redacted]. The resident should be seen by a [redacted] or [redacted] n to have the [redacted] to [redacted]. Ongoing weekly [redacted] follow-up to continue.

On 07/26/22 at 12:58 PM, the surveyor conducted a telephone interview with LPN #1 who confirmed that he terminated his employment with the facility on [redacted] He stated that he recalled that,"Resident #73 had a [redacted] that was a [redacted] than the [redacted] of his/her [redacted] that was [redacted] [redacted]." He stated that one of the 3:00 PM to 11:00

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PM CNAs brought it to his attention, although he did not recall her name. He stated that he inspected the [redacted] himself, wrote a report, and brought it to the attention of the LPN/UM. He stated that the report that he wrote was paper based and was filed with management. He stated that the resident complained of [redacted] at the sight of the [redacted] He stated that the WCN was required to complete the [redacted] assessment and update the residents [redacted]. LPN #1 stated that he was required to document the finding in the Progress Notes (PN) which included documentation of a [redacted] abnormality, who had been notified of the finding, and any actions that were taken. He stated that both the physician and the LPN/UM were required to be notified. The surveyor informed LPN #1 that review of the Shift Assessment that he completed on [redacted] at 2:30 AM, on the date that he reported the finding to the LPN/UM, revealed that he documented that the resident's [redacted] were as follows: [redacted] r appropriate to [redacted] and [redacted] and failed to document the [redacted] or required interventions as he previously described. He stated that the Shift Assessment was documented prior to the CNA bringing the [redacted] to his attention. The LPN#1 stated that he did not recall seeing the [redacted] prior to [redacted], and that was when he reported it.

On 07/27/2022 at 10:00 AM, the surveyor conducted a phone interview with CNA #1 in the presence of the survey team. She stated that on the 3:00 PM to 11:00 PM shift she was responsible to shower the residents and to report any [redacted] abnormalities to the nurse. CNA #1 stated that Resident #73 was assigned to her in [redacted]. She stated that the resident developed a little hole on his/her [redacted] and she

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reported it for the first time to LPN #1 because he was the resident's assigned nurse at that time. CNA #1 stated that she asked LPN #1 for permission to apply [redacted] cream to the area on the resident's [redacted] CNA #1 stated that she reported the finding to him, and what he did with the information was not part of her job. CNA #1 stated that she had written a statement and provided it to the LPN/UM (statement dated [redacted]. CNA #1 stated that LPN #1 was the first nurse that she had reported it to, and that she had also worked with RN #1 and also had reported the [redacted] to her. CNA #1 explained that she had to lift the resident's [redacted] in order to see the area because the resident [redacted] and the resident's skin flopped on the butt. CNA #1 further explained that in order to see the [redacted], you must lift the resident's [redacted] up, and then look at the area [redacted] r the [redacted] when care was provided.

On 07/27/2022 at 11:15 AM, the surveyor conducted a phone interview with Resident #73's attending physician, who stated that about six months ago, the facility alerted him that the resident had a NJ EX Order. 264b1 [redacted]. He stated we did our best with body repositioning, but the resident had NJ EX Order. 264b1 [redacted] and also had NJ EX Order. 264b1 [redacted] He stated that he doubted that the resident's [redacted]. He stated that he last saw the [redacted], about [redacted] months ago, it had looked the same. The physician described the [redacted] as an [redacted] area with a little bit of contamination, and had both NJ EX Order. 264b1 [redacted] coming from the [redacted] He further stated that he reviewed the [redacted] s notes, and the LPN/UM always had called him about the [redacted].

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F 686	Continued From page 88 On 07/27/2022 at 12:10 PM, the surveyor interviewed the [redacted] via telephone. She stated that her colleague who was assigned to Resident #73 completed an initial consult with the resident on [redacted], and the [redacted] was deemed to be [redacted] with [redacted] She stated that the assigned NP last saw the resident on [redacted], and was currently out on leave. The [redacted] stated that she had not seen the resident in her colleague's absence since that time because the resident had orders from the [redacted], and she had wanted to avoid having two providers looking at the [redacted]. She stated based on the notes written by the previous [redacted], the following [redacted] treatment was recommended: Cleanse with [redacted] solution, pat dry, lightly [redacted] (treatment for at risk [redacted] and cover with [redacted] dressing [redacted] daily due to [redacted]. She stated the [redacted] was [redacted] a [redacted] because there was [redacted]. She stated the [redacted] was in a difficult area, and was not necessarily a [redacted] injury, there was [redacted] and [redacted] related to [redacted] to the [redacted]. The [redacted] stated that the facility [redacted] also would monitor the [redacted] but she has been on vacation. On 07/27/2022 at 12:32 PM, the surveyor interviewed Resident #73 who stated that CNA #1 first identified that she had observed a little [redacted] on the resident's [redacted] The resident was unable to provide the date CNA #1 observed the [redacted]r. The resident stated that CNA #1 kept checking it and had reported it to the nurse. The resident stated that CNA #1 and CNA #2 put cream on it and informed the assigned nurse.	F 686		

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The resident stated that the [redacted] had gotten bigger, and bigger and there was [redacted] when he/she wiped that area. The resident stated that by that time, it "got [redacted] and really infected and went into my [redacted] The resident stated that his/her [redacted] went very low ,and the vitals were off, "so I was sent out to the hospital that night with a diagnosis of [redacted] Resident #73 stated, that while at the hospital, "I was in the [redacted] and was on a [redacted]. The infection came around to the front of my [redacted] from the [redacted]." The resident [redacted], and stated the [redacted] who was out on leave came in to see him/her a couple of weeks ago, and the facility [redacted] was currently on vacation. The resident "was concerned" that no one had looked at the [redacted] recently except for the facility nurses. The resident further stated that the [redacted] had been postponed as the doctor had not granted medical clearance for the resident to have the procedure.

On 07/27/2022 at 1:01 PM, the surveyor interviewed the LPN/UM who reviewed the EHR in the presence of the surveyor and confirmed that Resident was #73 last seen by the [redacted] on [redacted], [redacted] y days prior, and the [redacted] was also present during [redacted] rounds on that date. The surveyor asked for clarification of the date that the resident's [redacted] was initially identified. The LPN/UM stated that on [redacted], the DON and she typed up a statement and there was also an incident report completed related to Resident #73's [redacted] The LPN/UM stated that the resident's primary nurse, RN #1, documented a [redacted] abnormality on [redacted], and "was supposed to" initiate an incident report. She stated that to her knowledge, there was no [redacted] treatments

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rendered to the resident's [redacted] between [redacted] and [redacted]. She stated that the DON was notified. She stated that both she and the facility [redacted] looked at the [redacted] together, and when I saw it, "I was like wow!" The LPN/UM stated that when we lifted and inspected the [redacted] I could see that it was opened. She clarified that LPN #1 had just informed her that there was "something there" but I had not expected for the [redacted] to have been opened. The LPN/UM stated that when RN #1 was interviewed during the investigation conducted on [redacted], she stated that she informed the [redacted] via e-mail and notified her directly of the resident's [redacted] in [redacted] The LPN/UM stated that she informed RN #1 that nursing was required to inform the Unit Manager, and she should have initiated a treatment, notified the [redacted] completed a Care Link and notified the Supervisor. The LPN/UM further stated that RN #1 should have also notified the doctor, and was also required to write a PN as she was the initial nurse that had observed the [redacted]

On 07/27/2022 at 1:28 PM, the DON presented the surveyor with another investigation that pertained to Resident #73's [redacted]. He stated that [redacted] and a [redacted] were in place for the Resident #73 prior to [redacted]. He stated on [redacted], it was documented that there was "some opening" on the resident's [redacted] in the PN. He stated that per [redacted] assessments, a [redacted] issue on the [redacted] was documented off and on. On [redacted] the [redacted] was asked to see the resident related to a [redacted] found on the groin area, and she did not document that she had assessed the resident's sacrum at that time, though she had discontinued

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the [redacted] protectant) that was previously ordered, and had added [redacted] c (prevents [redacted] r [redacted]) instead. He stated that LPN #1 verbally reported a concern on the resident's [redacted] to the LPN/UM on [redacted] and the WCN was notified. He stated that the LPN #1 documented that he could not tell if the [redacted] was opened or the [redacted] of the [redacted]. The DON stated that CNA#1 documented that she notified both LPN #1 and RN #1 in December 2021. The DON stated that CNA #1 documented, "I have been reported it as part of my job." He stated that RN #1 should have documented changes in the resident's [redacted] and a [redacted] Packet (form of an incident report) should have been completed so that we could have investigated the matter further. He stated that RN #1 was also required to inform the Supervisor and [redacted] The physician should also have been contacted if a treatment order was needed. He stated that RN #1 failed to complete the [redacted] packet, and as a result, the treatment was not immediately identified. The DON stated that he was unable to confirm if RN #1 attempted to notify the facility [redacted] via e-mail of the finding. The DON stated that there was a [redacted] coming to see the resident's [redacted] weekly. The surveyor informed the DON that through investigation, it was determined that the [redacted] had not come into the facility to see the resident's [redacted] since [redacted], to which he responded he was not aware of.

On 07/27/2022 at 10:07 AM, the surveyor reviewed Resident #73's hospital records related to admission date of [redacted], which revealed the following: Review of the hospital record revealed that on [redacted], the following was documented: [redacted] ..There was a [redacted] centimeter area of NJ EX Order. 264b1 with

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F 686	Continued From page 92 a NJ EX Order. 264b1, that was tender to touch...Further review of the Hospital Medicine History and Physical dated NJ EX Order. 264b1, indicated that Resident #73 presented to the emergency department from a long-term care facility, with a chief complaint of NJ EX Order. 264b1...Resident had a NJ EX Order. 264b1 and complained of NJ EX Order. 264b1. The resident endorsed NJ EX Order. 264b1 of the NJ EX Order. 264b1 and wheelchair usage. Plan of Care included: Resident with NJ EX Order. 264b1, and NJ EX Order. 264b1 and was admitted to the hospital for: NJ EX Order. 264b1 NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order. 264b1 was consulted for a NJ EX Order. 264b1 t and a NJ EX Order. 264b1 care consult was ordered. Diagnosis included but was not limited to:...NJ EX Order. 264b1, NJ EX Order. 264b1 NJ EX Order. 264b1 2 at 12:15 PM, the Physician documented the following: NJ EX Order. 264b1 and NJ EX Order. 264b1 m. Neuro: Resident was NJ EX Order. 264b1 and NJ EX Order. 264b1. Resident was scheduled to be readmitted to the facility on NJ EX Order. 264b1 The surveyor reviewed Resident #73's December 2021 Treatment Administration Record (TAR) which revealed an order for NJ EX Order. 264b1 to NJ EX Order. 264b1 l area every shift that had a start date: NJ EX Order. 264b1. The surveyor observed 11 instances during the month of December when the treatment was not documented as administered according to the attached Legend which referenced the - symbol was not documented. -12/03/2021 on the 3:00 PM to 11:00 PM shift. -12/04/2021 on the 3:00 PM to 11:00 PM shift. -12/07/2021 on the 11:00 PM to 7:00 AM shift. -12/12/2021 on both the 3:00 PM to 11:00 PM	F 686		

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shift and the 11:00 PM to 7:00 AM shift.
-12/13/2021 on the 3:00 PM to 11:00 PM shift.
-12/16/2021 on the 3:00 PM to 11:00 PM shift.
-12/17/2021 on the 3:00 PM to 11:00 AM shift.
-12/18/2021 on the 3:00 PM to 11:00 AM shift.
-12/22/2021 on the 3:00 PM to 11:00 PM shift.
-12/24/2021 on the 3:00 PM to 11:00 PM shift.

During an interview with the [redacted] on [redacted] at 10:54 AM, the WCN stated that the CNAs applied the [redacted]d treatment to the resident during care and nursing was responsible to sign out the treatment after it was confirmed that the treatment was applied to the resident. She was unable to explain why the treatment was not documented by nursing on the TAR.

On 07/28/2022 at 12:28 PM, the surveyor reviewed Resident #73's PN(s) and noted that on [redacted] at 11:01 AM, the [redacted] documented a [redacted] assessment in the resident's EHR. She documented that the resident's [redacted] was s/p NJ EX Order. 264b1 the [redacted] now categorized as a [redacted] that measured NJ EX Order. 264b1 with NJ EX Order. 264b1 (able to be felt) with NJ EX Order. 264b1 improved. [redacted] detached from base.

On 07/28/2022 at 12:31 PM, the surveyor phoned the [redacted] who stated that the DON contacted her yesterday and requested that she come into the facility and look at Resident #73's [redacted] today. She stated that she already had seen the resident and the [redacted] had actually measured smaller than previously documentated, and had no signs of infection. She further stated that she

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would return to the facility next week to see the resident. Further review of the PN revealed that the resident was initially seen by the [redacted] on [redacted] at 3:44 PM, and at that time, the [redacted] was described as [redacted] of the [redacted] that measured [redacted] and the [redacted] contained [redacted] with [redacted] and was [redacted]. Further review of the Assessment revealed the following: New [redacted] present. Resident had a [redacted], recent, desired [redacted] with [redacted] present in the [redacted] which had been [redacted] and caused [redacted] to the [redacted] The WCC/NP documented that the [redacted] was more related to [redacted] as a result of [redacted] as opposed to [redacted]e. The Plan: [redacted] with [redacted] and pat dry. Apply [redacted] with [redacted] dressing daily.

On 07/29/2022 at 12:40 PM, the surveyor interviewed the facility Medical Director in the presence of the survey team. He stated that he would have expected that Resident #73's physician would have assessed the resident's [redacted] weekly, especially if it were a [redacted] He stated that the facility consulted with a [redacted] service who kept the attending physician abreast of the resident's status. He stated that the facility also had a dedicated [redacted] He stated that when nursing identified as [redacted] or greater they were expected to notify the physician. He stated that it could not be generalized whether or not the [redacted] was avoidable. He stated that he used to participate in [redacted] rounds. He further stated that he absolutely thought that the attending physician should have been aware that the resident had a [redacted], and know the difference between a [redacted] and a [redacted]

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COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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because there "was a definite difference."

On 07/29/2022 at 1:02 PM, the surveyor interviewed CNA #2 on speaker phone with her permission, in the presence of the survey team. She stated that she reported r[redacted] on the resident's[redacted] to Resident #73's assigned nurse, though she could not recall if it were LPN #1 or RN #1. CNA #2 further stated that at that time, she also provided a statement of the observation, though she was unsure of how long ago it was. CNA #2 stated that the resident complained of[redacted] there, and that was why she looked at the area. She stated that she had to lift up the[redacted] on the resident's[redacted] in order to see the[redacted] since the resident had [redacted] a lot of[redacted] CNA #2 stated that she observed a[redacted] and a patch on the[redacted] after she had reported the finding.

On 08/02/2022 at 8:55 AM, the surveyor spoke with RN #1 in the presence of the survey team via a speaker phone, with her permission. RN #1 stated that one night, date not specified, CNA #1 notified her that she noticed a[redacted] on Resident #73 when she had changed the resident. RN #1 stated that she looked at it and noted a[redacted] on the resident's NJ EX Order: 26401. RN #1 stated that the resident did complain of "a lot of [redacted]" in the[redacted]. RN #1 stated that she informed the resident that the[redacted] would be notified of the finding. RN #1 stated that she NJ EX Order: 26401 (a liquid NJ EX Order: 26401 to the[redacted]. She stated that she completed a Care Link, which was an incident report. There was a skin packet that we also have to complete and she also completed that. RN #1 stated that she gave the documentation to the Supervisor. She stated that

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F 686	Continued From page 96 she notified the [redacted] via e-mail. RN #1 did not recall whether she notified the LPN/UM. She stated that she just remembered the LPN/UM coming to her long after the incident had occurred, and she asked her if I notified the [redacted] since the [redacted] had gone unnoticed and nothing was being done for the resident's [redacted] She stated, "in terms of the [redacted], it was not addressed." She stated that she had the original e-mail that she sent to the [redacted]. She stated that she did not receive a response, or speak with the [redacted] to confirm receipt of the e-mail notification. The LPN/UM informed RN #1 that the [redacted] never received the e-mail. She stated no one told me her anything else after that. She stated that she could not recall if she had observed the wound thereafter. She stated that after she spoke with the LPN/UM (date not specified), a treatment was ordered for the resident. RN #1 agreed to furnish the surveyor with the original e-mail that she sent to the [redacted] when the [redacted] was first discovered. On 08/04/2022 at 3:05 AM, RN #1 forwarded the e-mail to the surveyor. Review of the e-mail revealed that RN #1 e-mailed the [redacted] on [redacted] at 3:50 AM, RN #1 informed the [redacted] that on [redacted], the aide called her in and notified her of a new opened wound on Resident #73. RN #1 documented that the [redacted] was on the resident's NJ EX Order 264b1 t and skin protectant was applied. RN #1 also forwarded an additional e-mail to the surveyor dated [redacted] at 3:59 AM, which contained confirmation that she submitted a Care Link and was assigned a reference number for her file. Review of the document revealed the following: "Your submission helps us improve our organization's overall safety."	F 686		

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F 686	Continued From page 97 On 08/02/22 at 10:16 AM, the surveyor interviewed the LNHA who stated that he did not have a statement that pertained to the CNA #2's initial discovery of Resident #73's NJ EX Order: 264b1. He stated that he looked, but was unable to locate one. He stated that the facility NJ EX Order had returned from vacation and was available for interview. The surveyor also requested a copy of the 24 hour report (filled out by nurses daily to monitor and document any changes in resident status) for NJ EX Order: 264b1. At 10:43 AM, the surveyor received the requested 24 hour report and Resident #73 was not referenced in the report. On 08/02/2022 at 10:54 AM, the surveyor interviewed the NJ EX Order who stated that she was away on vacation from 7/07/2022 through 08/01/2022. She stated that she kept a paper file related to Resident #73's wound, but was unable to locate it right now. She stated that on NJ EX Order: 264b1, she was informed by the LPN/UM that there was a report from the night nurse, LPN #1, that the resident had something going on on his/her NJ EX Order: 264b1. She stated she took the resident into the bathroom and the resident stood in order to be examined. The NJ EX Order stated that when she pulled up the NJ EX Order: 264b1 on the resident's NJ EX Order and was like, "OK"! She stated that at the NJ EX Order: 264b1 area she found a NJ EX Order: 264b1 that penetrated through the NJ EX Order to the NJ EX Order: 264b1 NJ EX Order: 264b1. She stated that she called the LPN/UM so that she could observe it. She stated that we notified the DON, then phoned the physician for a NJ EX Order: 2 treatment order, and NJ EX Order: was ordered. She stated that she saw the resident prior on NJ EX Order: 264b1, after she received a notification from the night nurse that the resident	F 686		

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had an [redacted] on the NJ EX Order. 264b1. She stated that when she checked the resident's [redacted] she noted that the resident had a recurrence of a [redacted] that resulted from the NJ EX Order. 264b1. The [redacted] stated that [redacted] was ordered at that time in order to dry and help NJ EX Order. 264b1. The WCN stated that she did not assess the resident's [redacted] where the [redacted] was located at that time, because the resident did not complain about it to her during the examination. The surveyor asked if the [redacted] ever received an e-mail from RN #1 with the initial discovery of the NJ EX Order. 264b1 [redacted] on [redacted]. She stated that RN #1 completed a Care Link and when the [redacted] looked back for the e-mail that was allegedly sent to me on [redacted] on [redacted] when the LPN/UM brought it to my attention, "I looked back and found the e-mail unopened." The surveyor clarified that the e-mail was received, but had been missed by the [redacted]

The WCN further stated that if RN #1 completed a [redacted] Packet after discovery of Resident #73's [redacted] she was then required to provide it to the LPN/UM, from there it went onto the Supervisor, DON and the WCN for review. The WCN stated that NJ EX Order. 264b1) was originally ordered for the resident when the resident was a [redacted] prior to NJ EX Order. 264b1 and was designed to prevent NJ EX Order. 264b1 [redacted] to the NJ EX Order. 264b1 care. She stated that it was later discontinued and on [redacted] and "[redacted] was added instead, after the resident developed an NJ EX Order. 264b1 because the [redacted] were too tight." She stated that it helped heal the area quickly. The [redacted] also explained that when the [redacted] documented that the resident had an [redacted] I

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F 686	Continued From page 99 [redacted] it meant that the[redacted] was hard to find and the etiology was hard to determine. She stated that she could not say if the [redacted] was avoidable. She further stated that she would have had to have seen the [redacted] when it was first identified on [redacted], in order to make that determination as she did all of the facility[redacted] assessments and measurements. On 08/03/2022 at 12:02 PM, during the exit conference, the DON stated that if RN #1 had completed a [redacted] Packet, there would have been an opportunity for Resident #73's skin issue to have been brought to the attention of administration in a timely fashion, and that appeared to have been the missing piece. He further stated that the Care Link that RN #1 initiated was available to be viewed by Risk Management and Administration upon submission. The surveyor reviewed the facility policy titled, '[redacted] Evaluation" (Last Revised 08/2021) which revealed the following: Purpose: To ensure the identification and evaluation of resident risk factors and conditions for NJ EX Order. 264b1 injury[redacted]) and/or development, using industry-standard terminology. This includes the type of wound, [redacted] healing progress, intrinsic/extrinsic obstacles to [redacted] healing or development. Obstacles to healing/development may include end-of-life circumstances, infection, and/or refusal of recommended care. Appropriate care will be provided regardless of where or when a[redacted] was acquired, or if it was avoidable or unavoidable.	F 686		

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Residents/patients with NJ EX Order. 264b1 injury and/or wound will receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers/injuries from developing.

The facility will assess/evaluate, identify, and document on resident's/patient's [redacted] condition on admission and at least weekly.

Procedure:

The nurse will perform a [redacted] evaluation: Within 8 hours of admission, repeated the following day, twice weekly, and as needed.

Findings of the [redacted] assessment/evaluation will be documented in the medical record by the nurse.

Any identified wounds of concern will be reported by the nurse to his/her supervisor and referred to the [redacted] nurse and/or consultant.

The surveyor reviewed the facility policy titled, [redacted] Management" (Last Revised 10/2021) which revealed the following:

Purpose: To promote the healing of existing [redacted] prevent deterioration of existing [redacted] /injury [redacted] address pain associated with [redacted] care, and provide guidance for consistent [redacted] care in accordance with professional standards of practice.

Based on the comprehensive

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F 686	Continued From page 101 assessment/evaluation of a resident/patient, the facility will ensure that: A resident/patient receives care, consistent with professional standards of practice, to prevent NJ EX Order. 264b1 injury and does not develop NJ EX Order. 264b1 injuries unless the individual's clinical condition demonstrates that they were unavoidable/and A resident with NJ EX Order. 264b1 injuries received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new [redacted]s from developing ...Notify the provider: IMMEDIATELY...If there is any other deterioration in [redacted] status including: NJ EX Order. 264b1) NJ EX Order. 264b1), sudden increase in NJ EX Order. 264b1 at [redacted] site To obtain order for [redacted] specialist consultation for wounds that are difficult to manage. The surveyor reviewed the facility policy titled, "Medication Administration" (Last Revised 02/2020) revealed the following: ...Topical medications used in treatments should be recorded in the resident's treatment administration record (TAR). NJAC 8:39-27.1(e)	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		9/13/22

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F 692	Continued From page 102 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to ensure: 1.) a resident who required NJ EX Order. 264b1 support via a NJ EX Order. 264b1 provided NJ EX Order. 264b1) and sustained a NJ EX Order. 264b1 t days was re-weighed per facility policy, and 2.) conduct a nutrition assessment upon admission and assess and report a NJ EX Order. 264b1 pounds (lbs). This deficient practice was identified for (Residents #239 and #114) 2 of 7 residents reviewed for nutrition/hydration and [redacted]. The deficient practice was evidenced as follows:	F 692	Resident #239 was re-weighed per facility policy. The [redacted] order was adjusted by the Registered Dietician and the physician and resident representative were notified. Resident #114 was assessed by the Registered Dietician and the [redacted] order was adjusted. The physician and resident representative were notified of the changes. Any residents with significant [redacted] changes or who were recently admitted have the potential to be affected. Residents with significant [redacted] changes in the past 4 weeks were reviewed by the Registered Dietician to ensure re-weights were completed per policy. All new or	

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F 692	Continued From page 103 1) On 07/19/22 at 11:07 AM, the surveyor observed Resident #239 in bed, with eyes closed, appeared thin, and EN support was being infused at [redacted] (milliliters) [redacted] via [redacted] On 07/20/22 at 12:55 PM, the surveyor reviewed the medical record for Resident #239, which revealed the following: The Resident Face Sheet revealed diagnoses that included, but were not limited to, [redacted]. Review of the Nursing Progress Admission Note dated [redacted] at 3:45 AM, revealed the resident was [redacted] and had a [redacted] with a NJ EX Order. 264b1" (received NJ EX Order. 264b1 and received NJ EX Order. 264b1 into the [redacted]) and the usual body weight was [redacted] lbs. There were no current weights documented. A Medical Progress Note dated [redacted] at 3:17 PM and signed by a Nurse Practitioner, revealed a current weight of [redacted] lbs, to monitor routine weights, and document, and no recent significant [redacted]. Review of a Nutrition Assessment completed on [redacted] by the Registered Dietitian (RD), indicated Resident #239's weight was [redacted] lbs. A review of the Care Plan Activity Report for Resident #239 revealed a Focus area of: NJ EX Order. 264b1 Support/Risk for [redacted] Intervention: Monitor weights as per MD (physician) order. A review of the weight record for Resident #239 dated [redacted], revealed a weight of [redacted] lbs. There was no additional weights documented in the medical record (this weight indicated a [redacted] from [redacted] through [redacted] On 07/21/22 at 10:03 AM, the surveyor	F 692	re-admissions for the past 4 weeks were reviewed by the DON/designee to ensure the Registered Dietician completed an assessment per policy. All nursing staff have been in-serviced by the Registered Dietician/designee on policies related to admission/readmission weights, weekly/monthly weights, reweights and significant [redacted] changes. On a weekly basis the Registered Dieticians will lead the [redacted] meeting to review admission/readmission weights, weekly/monthly weights, reweights, significant weight changes and RD assessments. Any significant weight changes, missing weights or missing assessments will be investigated and addressed immediately. Notifications will be audited by the DON/designee to ensure completion. On a monthly basis the Administrator/designee will audit the results of the weight meetings and report them to the Quality Assurance Committee for 3 months. The QA Committee will make recommendations on the need for continued audits.	

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interviewed the RD, who stated she was covering for the RD who completed Resident #239's nutrition assessment. The surveyor inquired to the RD regarding the nutrition assessment process. The RD stated weights would be completed upon admission and daily for two or three days, to check for accuracy of weights, and that would be dome for everyone. The RD reviewed Resident #239's Nutrition Assessment and the surveyor inquired to the RD regarding Resident #239's weight history. The RD stated the [redacted] weight was [redacted] lb and stated the [redacted] lbs weight was documented on the Nursing Shift Assessment dated [redacted] at 8:43 AM. The RD confirmed that there were only the [redacted] lbs and [redacted] lbs weights available since the resident had been re-admitted the RD was unable to locate any additional Nutrition Notes for the resident. The RD stated she was made aware of the [redacted] on [redacted] in the afternoon (two days after the [redacted] was identified), and stated the resident was on her "to-do list" and would follow-up with the resident as soon as possible.

On 07/21/22 at 10:29 AM, the surveyor interviewed the Unit Manager, Registered Nurse, Assistant Director of Nursing (UM/RN/ADON) regarding the weight process. The UM/RN/ADON stated that residents should be weighted upon admission, then daily for three days and weekly after. The UM/RN/ADON was unable to locate any additional weights for Resident #239 in the weight book and on the Certified Nurse Aide (CNA) assignment sheet. The UM/RN/ADON stated Resident #239 weighed [redacted] lbs per review of a [redacted] nursing note. The UM/RN stated "we should reweigh" the resident and if the CNA weighed the resident, they should have notified

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the nurse right away of the weight.

On 07/21/22 at 10:45 AM, the UM/RN/ADON provided the surveyor with a copy of the [redacted], Significant Unplanned Policy, Initital Date: December 1999, from a policy binder located at the [redacted]-Wing nursing station.

On 07/21/22 at 11:53 AM, the UM/RN/ADON was observed exiting Resident #239's room. The UM/RN/ADON stated Resident #239 was weighed and the weight was [redacted] lbs (This was a [redacted] pound weight increase over t[redacted] days).

On 07/22/22 at 10:55 AM, the surveyor reviewed the RD progress notes which revealed that the RD completed a consultation related to Resident #239's (approximate)[redacted] lb [redacted] since readmission. The progress note indicated, "per documented wt [weight] of [redacted]8# [pound] on [redacted]. Reweigh of [redacted]# on [redacted] confirmed wt [redacted]."

A review of the Dietary note, dated [redacted], revealed that a dietary consult was ordered for calorie increase recommendations related to [redacted]. The consult documentated that Resident #239 had a[redacted] lb [redacted] after readmission. The consult recommended an increase in the EN to provide additional [redacted] and to continue to weigh the resident twice a week. This recommendation was discussed with the resident representative and was implemented.

On 07/21/22 at 1:23 PM, the LHNA stated the facility was working on the draft policy for the weights. The LNHA presented a draft policy and stated that the policy was not done. The LNHA

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further stated that the policy the facility had was the policy that was used.

On 07/26/22 at 10:07 AM, during an interview with the surveyor, the DON stated the staff should have reweighed the resident and informed the physician and family. The DON further stated that regarding resident [redacted], the RD was usually in the building Monday through Friday, and stated "it should have been done sooner" regarding the reweight.

2) On 07/20/22 at 8:58 AM, during the tour of the facility, the surveyor observed the [redacted] in the room of Resident #114. The surveyor observed no [redacted] was [redacted] at that time. The surveyor observed the resident lying in bed, eyes closed.

A review of the medical records revealed that Resident #114 had been recently admitted to the facility with diagnoses which included but were not limited to [redacted] due to underlying condition with [redacted] without coma, and [redacted].

A review of the facility provided, "Clinical Monitoring Detail Report", dated [redacted] through [redacted], revealed a weight on [redacted] of [redacted] lbs, and on [redacted], one week later, a weight of [redacted] lbs. Which indicated a significant unplanned [redacted] lbs.

A review of the 07/01/22 Dietary Progress Notes by the RD for Resident #114, with significant change revealed: Nutrition Note for MDS Significant Change in Status:(Resident #114) was

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now receiving [redacted] services. She/he continues EN support as ordered: EN support remains at [redacted] ml total volume and [redacted] ml [redacted] via [redacted]. CBW (current body weight) [redacted] lbs and BMI (body mass index) [redacted]. No significant wt [weight] change in [redacted] month, [redacted] month, and [redacted] year lookback period. Noted [redacted] significant [redacted] in previous [redacted] months, please refer to previous dietary notes...Reviewed careplan, proceed with POC (plan of care). Monthly weights per [redacted] guidelines. RD will f/u (follow up) as needed.

The surveyor was unable to locate any nutrition admission assessment by the RD, any progress notes regarding any assessment of the [redacted] lb [redacted] by the staff, or any documentation that the physician or [redacted] agency had been notified of the [redacted].

A review of the facility provided [redacted] Notes from [redacted] through [redacted], did not reveal any notation that [redacted] had been made aware of the resident's [redacted] lbs [redacted].

A review of the most recent Significant Change Minimum Data Set (MDS -an assessment tool) dated [redacted], revealed under [redacted] that Resident #114 was totally dependent on staff for Activities of Daily Living. [redacted] revealed that the resident weighed [redacted] lbs, required a [redacted] and obtained [redacted] or more of [redacted] and [redacted] cubic centimeters (cc) [redacted] the [redacted].

A review of the Physician's Orders included the following: an order dated [redacted] to [redacted] milliliter (ml) at [redacted] and down at [redacted] pm or until

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NJ EX Order 264b1 NJ EX Order 264b1 Document downtime and amount infused. An order dated NJ EX Order. 264b1 eval (evaluation) and treat. An order dated NJ EX Order. 264b1 to weigh the resident every month on NJ EX Order. 264b1.

A review of the facility provided Active Care Plan included but was not limited to a focus area of NJ EX Order. 264b1 (Resident #114) was at risk for unavoidable NJ EX Order. 264b1 related to NJ EX Order. 264b1 effective NJ EX Order. 264b1. This focus area included that the NJ EX Order. 264b1 team and facility team will collaborate.. regarding nutrition support.

On 07/22/22 at 10:14 AM, during an interview with the surveyor, the CNA stated Resident #114 required total care, and that she does not touch or do anything with the NJ EX Order. 264b1 or the NJ EX Order.

On 07/22/22 at 11:08 AM, during an interview with the surveyor, the Registered Nurse (RN) caring for Resident #114, stated NJ EX Order. 264b1 comes to see the resident, if there are any changes in the resident status, we (facility) inform NJ EX Order. 264b1 and if we need to see what hospice did, we check the book NJ EX Order. 264b1 book). The RN stated they keep in close communication with NJ EX Order. 264b1. The RN further stated there had been no issues with the resident's NJ EX Order. 264b1.

On 08/02/22 at 8:33 AM, during an interview with the surveyor, the UM/RN/ADON stated that resident weights were done on admission, two days consecutively after, and weekly. If there was a NJ EX Order. 264b1 or above NJ EX Order. 264b1 or NJ EX Order. the staff would need to reweigh the resident. She further stated she was responsible to be to be sure the reweighs were done. The UM/RN/ADON stated NJ EX Order. 264b1 follows weights and they are here

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F 692	Continued From page 109 (at the facility) daily. She stated the facility needs to let [redacted] know but [redacted] can also look in the computer as well. The ADON UM and the surveyor reviewed the [redacted] book. The UM/RN/ADON acknowledged there was no documentation about the [redacted] ain of [redacted] lbs. She stated the dietician also looks daily at the weights and would address it (the [redacted] lb [redacted]). The surveyor asked to be shown documentation in computer that the facility staff informed [redacted] or RD about the [redacted]. The UM/RN/ADON was unable to find any documentation. On 08/02/22 at 8:47 AM, the RD stated the process was that weights would be done on admission and orders for two days and weekly. She stated that missing [redacted] or fluctuations of [redacted] pounds would be reported to her and she would request a reweigh. The RD stated that [redacted] residents have an order for monthly weights. The RD stated Resident #114 was on [redacted] and that the nurses should let the [redacted] staff know and that the staff did not report the [redacted] to her. She further stated the weight would have to be reported to her because she doesn't just check . On 08/02/22 at 9:33 AM, the DON stated a weight discrepancy [redacted] lbs either way (loss or gain), would be reported. He stated that any staff could obtain weights. The DON stated that the nurses should report changes to the RD and that was done verbally. The DON stated [redacted] would be made aware of weight changes by the nurse and that it was important to keep [redacted] in loop because they ensure what's being done for a proper end of life experience.	F 692		

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The above concerns were shared with the facility on 08/02/22. On 08/03/22, the surveyor was provided a communication form that the [redacted] agency was informed of the [redacted] on 08/03/22 after the surveyor brought it to their attention. The facility informed the surveyor that Resident #114 should have had a nutrition assessment completed upon admission to the facility, but was unable to provide one.

A review of the facility provided, "Weight Loss or Gain, Significant Unplanned", revised 03/2010, included Purpose: residents will not experience an unplanned or unexplained weight loss or gain; Policy: all resident's weights will be obtained initially upon admission and then weekly for the first 30 days unless needed more frequently; Procedure: 1. review all residents' weights and compare to previous and current recorded weights. A discrepancy of 5 lbs or greater between previous and current weight requires a reweigh. 2. An "Alert Event Report" is to be completed on all residents with an unplanned weight variance of 5 percent or more in 30 days, 7.5 percent in 90 days or 10 percent in 180 days. 3. Notify physician of significant unplanned weight variance. .6. notify the Dietitian. 7. Dietitian will respond and address issues. ..10. A nutritional care plan will be initiated and revised quarterly and as needed.

A review of the facility provided, [redacted] Program" dated 8/2021, included but was not limited to: Procedure: 5. responsibility of the facility to meet the resident's .. personal care nursing needs in coordination with the hospice representative, and ensure ..level of care..based on (CP)
5. c.: notifying the hospice about the following:

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i: a significant change in the residents physical, mental, social or emotional status
coordinated care plan: 12: coordinated care plan revised and updated as necessary to reflect current status including but not limited to e. nutrition and hydration needs.

A review of the facility provided, "Job Description Dietitian" revised 08/31/21, included but was not limited to Job Summary: the Dietician role serves as a liaison between the patient, nursing and medical staff..regarding optimal nutrition care for the patient. S/he assesses the nutritional needs, develop individualized dietary plans, provides dietary counseling.. Essential Generic Job Functions: 2. Assure that nutrition assessments, reassessments and care plans are completed to meet each patient's identified needs.

A review of the facility provided, "Job Description RN" revised May 2019, included but was not limited to Job Summary: As part of a multidisciplinary team to deliver patient-centered nursing..services to patients...Provides the highest level of service to all patient's..to ensure satisfaction. Responsible for ensuring all assigned residents receive all medications, treatments, and nursing care as ordered. Essential Generic Job Functions: 5. Maintains accurate informative records on all patients in the unit. 6. Identify and report all real or potential problems regarding the development or administration of patient care...9. Identify and assess any changes in patient conditions/needs and report to charge nurse/supervisor.

A review of the facility provided, "Job Description Unit Manager RN" not dated, included but was not limited to Job Summary: ..Monitors staff to

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F 692	Continued From page 112 ensure all facility policies and procedures are followed. Acts as a liaison between resident, families, other departments, and outside services to meet resident needs. Essential Generic Job Functions: 4. Works with interdisciplinary team to ensure quality services are provided. 11. Accountable for 24-hour resident care provided on assigned unit. NJAC 8:39-11.2(e), 17.1(c), 27.1(a)	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 693	Resident #239's bed was repaired and	9/13/22

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F 693	Continued From page 113 and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident was properly positioned while the resident received NJ EX Order. 264b1 via a NJ EX Order. 264b1 (a form of nutrition that is delivered into the NJ EX Order. 264b1 as a NJ EX Order. 264b1 for 1 of 4 residents reviewed for NJ EX Order. 264b1 (Resident #239). This deficient practice was evidenced by the following: On 07/19/22 at 11:07 AM during the initial tour, the surveyor observed Resident #239 in bed with ENS being administered at [redacted] ML (milliliters) per NJ EX Order. 264b1 and the resident appeared [redacted]. 07/20/22 at 12:55 PM, the surveyor reviewed Resident #239's medical record. The Resident Face Sheet indicated that Resident #239 was admitted with diagnoses that included, but were not limited to, NJ EX Order. 264b1). The Physician Order Activity Detail Report revealed an order, dated NJ EX Order. 264b1 at 1:34 PM, for Diet: NJ EX Order. 264b1 and an order, dated NJ EX Order. 264b1 at 10:47 AM, for NJ EX Order. 264b1 ml at NJ EX Order. 264b1 hour NJ EX Order. 264b1 and NJ EX Order. 264b1 (next day) or until NJ EX Order. 264b1 ml NJ EX Order. 264b1. Document downtime and amount NJ EX Order. 264b1 Schedule: Every Day at 2:00 am-4:00 am. The resident's Care Plan (CP) had a focus of NJ EX Order. 264b1 effective NJ EX Order. 264b1 The interventions on the CP indicated that the head of bed was to be kept at NJ EX Order. 264b1 degrees during the NJ EX Order. 264b1 and one hour after. On 07/21/22 at 8:28 AM, the surveyor entered	F 693	the resident was repositioned. Residents receiving NJ EX Order. 264b1 are at risk to be affected by the deficient practice. An audit was conducted on residents receiving NJ EX Order. 264b1 by the Registered Dietician revealed no additional residents were affected. All nursing staff were in-serviced by the Registered Dietician/designee on proper positioning of residents receiving NJ EX Order. 264b1 with emphasis on NJ EX Order. 264b1 g. The Registered Dieticians/designee will audit residents receiving NJ EX Order. 264b1 3x per week for proper positioning and report the results to the DON/designee. The Dietician/designee will report the results of the NJ EX Order. 264b1 positioning audits to the Quality Assurance Committee for three months. The Quality Assurance Committee will make recommendations on the need for continued audits based on the reports.	

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Resident #239's room and observed that the resident was being administered [redacted] through a [redacted]. The resident's head of bed was not observed to be at a [redacted] degree angle and the [redacted] that the resident was lying on appeared to be deflated. Resident #239 appeared to be sunken into the bed. Resident #239's [redacted] appeared elevated and the surveyor did not hear any alarms sounding while inside the resident's room, from either the bed or the [redacted], and did not hear any sound coming from the bed.

On 07/21/22 at 8:34 AM, the surveyor exited the room and interviewed the Licensed Practical Nurse (LPN #1) assigned to Resident #239. LPN #1 stated she worked for an agency and was she was "just here today". LPN #1 stated that Resident #239's [redacted] was running when she had started working that day.

On 07/21/22 at 8:40 AM, LPN #1 accompanied the surveyor to Resident #239's room and observed the resident had [redacted] elevated, the bed was sunken in, and the head of bed did not appear to be at a [redacted] degree angle. LPN #1 confirmed that the resident was being administered [redacted] at that time [redacted]. The surveyor inquired to LPN #1 regarding what degree the head of bed should be when a [redacted] was being [redacted] LPN #1 stated that the head of bed should be up 30 degrees when a [redacted] was [redacted]. LPN #1 and the surveyor both observed that the resident's head of bed was not elevated to [redacted] degrees, the resident's [redacted] were elevated and the [redacted] on the bed was sunk in. The surveyor then inquired to LPN #1 if that was acceptable and LPN #1 stated asked " No", "I would not have

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[the resident] like this." LPN #1 then stated that it didn't look like the air mattress was functioning, because the head of the bed was [redacted]. LPN #1 confirmed that the resident's [redacted] was not turned on, and she then proceeded to push the button that inflated the [redacted] and stated "there it goes" and the [redacted] then started to inflate. LPN #1 then confirmed that the mattress was now working properly and admitted that it was a concern if the resident was in that position with the head of the bed less then [redacted] degrees, with the bed [redacted] elevated and LPN #1 stated the resident could have [redacted] or [redacted].) She then stated that the Certified Nursing Assistants (CNAs) must have performed care for the resident but that no one had told her that the [redacted] was deflated, or that the residents head of bed was below [redacted] degrees with both feet raised. She also stated that it was not on the shift-to-shift report that the resident was "like" that and LPN #1 then proceeded to elevate the residents head to [redacted] degrees and elevated the bed to the proper position.

On 07/21/22 at 9:26 AM, the surveyor interviewed the Director of Nursing (DON). The surveyor asked the DON what position should a resident be in while being administered a [redacted]. The DON stated that a resident's head of bed should be at a [redacted] degrees when being administered ENS. The surveyor inquired as to why the head of bed should be at [redacted] degrees and the DON stated, "to prevent [redacted]. The DON also admitted that it was a concern that Resident #239 was positioned with the head of bed less than [redacted] degrees, feet elevated and bed deflated, because of the

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F 693	Continued From page 116 potential risk of [redacted] and [redacted]. The DON then stated he would get the policy for resident on [redacted] and check the [redacted] integrity also. On 07/21/22 at 9:37 AM, the DON provided a copy of the [redacted] policy to the surveyor and confirmed that the head of bed should be elevated at a [redacted] degree angle. On 07/21/22 at 10:45 AM, the surveyor observed a maintenance employee (ME) exiting Resident 239's room and the surveyor interviewed the ME at that time regarding Resident #239's bed. The ME #1 stated the [redacted] needed a controller and then it would not deflate. On 07/26/22 at 1:35 PM, the surveyor interviewed the Plant Operations Manager who confirmed that the bed motor "was bad", and that was why Resident #239 had his/her head down and feet were up. He stated that he was not aware of this prior to the surveyor bringing it to the nurses attention on [redacted] He stated that the staff could have called him at any time, because they keep spare motors at the facility. On 07/28/22 at 9:30 AM, the surveyor entered Resident #239's room and observed the [redacted] was being administered at [redacted] ml [redacted], the resident's [redacted] appeared elevated. On 07/28/22 at 9:39 AM, the surveyor entered Resident #239's room with the assigned LPN (LPN #2). LPN #2 observed Resident #239's [redacted] and stated they were too high. LPN #2 proceeded to use the bed controller and lower the resident's [redacted] LPN #2 stated the elevated	F 693		

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F 693	Continued From page 117 could compress the stomach and affect the digestion of the . LPN #2 stated the legs were not like that before the Nurse Aide (CNA) completed the resident's morning care and there was no order for the to be elevated and she would educate the CNA. The facility policy dated 05/2022 and titled, " and Medication Administration for Adults" indicated that the purpose for this policy was to provide safe protocols regarding practices in the skilled nursing facility. The is nutrition provided through the or that delivers nutrients to the cavity. The policy specifically indicated: 7. Elevated head of bed (HOB) to at least degrees and preferably degrees, 11. Maintain the head of bed at degrees. NJAC 8:39-27.1(a)	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation review and clinical record review, it was determined that the facility failed to provide	F 695	Resident #89's setting was adjusted to the correct setting per the physician order. Resident #89 had the	9/13/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 118 oxygen therapy consistent with physician orders and infection control measures. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] therapy, Resident #89 and was evidenced by the following: On 07/19/22 at 9:45 AM during the initial tour of the facility, the surveyor observed ([redacted] Wing) and Resident #89 sitting in a chair next to the bed receiving [redacted] at a NJ EX Order. 264b1 per NJ EX Order. 264b1 by way of a [redacted]r. The NJ EX Order. 264b1 was observed on the floor and not labeled or dated. There was no signage at the door to alert of [redacted]n being in use. On 07/19/22 at 11:57 AM, the surveyor observed Resident #89 sitting on the bed eating lunch, their [redacted] noted on the floor. On 07/19/22 at 1:15 PM, the surveyor observed Resident #89 sitting in the chair in the room. The surveyor observed the [redacted] setting [redacted] . On 07/20/22 at 9:07 AM, the surveyor observed Resident #89 in his/her room, awake and alert. There was no signage posted to reflect that [redacted] was in use. The [redacted] was on the floor. The [redacted] was set to deliver [redacted] at a NJ EX Order. 264b1 . On 07/20/22 at 10:40 PM, the surveyor briefly reviewed the Resident #89's current medical record which revealed that Resident #89 was admitted to the facility with diagnoses which included but not limited t NJ EX Order. 264b1 [redacted] .	F 695	[redacted] changed. Resident #89 was educated on how to coil the [redacted] to keep it off the floor. Resident #89 was in-serviced on the risks and benefits associated with keeping the [redacted] off the floor. Residents on [redacted] therapy via [redacted] are at risk to be affected by the same deficient practices. Residents on [redacted] therapy were reviewed and settings were confirmed to be correct per physician order. Nursing staff have been in-serviced on monitoring [redacted] equipment and providing [redacted] per physician order. Physician orders for [redacted] therapy have been updated to include daily checks of [redacted] and equipment cleanliness by the nurse. The Supervisor of RespiratoryTherapy/designee will conduct rounds 3x per week and audit residents on NJ EX Order. 264b1 to ensure the [redacted] equipment is not visibly soiled and the physician order for [redacted] administration is followed. The results of the audits will be reviewed with the DON, who will follow up with any non-compliance. The DON/designee will present the findings from the audits to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee will review the findings and make recommendations on the need for continued audits.	

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	315252	A. BUILDING _____ B. WING _____	C 08/03/2022

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Further review of the clinical record revealed a Physician Order Sheet (POS) dated [redacted] timed 03:25 PM that contained the following order: "Apply NJ EX Order. 264b1 [redacted] continuously".

The most recent quarterly Minimum Data Set (MDS, an assessment tool) with an (Assessment Reference Date) ARD [redacted] coded Resident #89 as having a Brief Interview of Mental Status (BIMS) score of [redacted] indicating [redacted].

On 07/20/22 at 11:26 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 assigned to the [redacted] Wing. The LPN verified on the electronic record that the order was for Resident #89 to receive [redacted] at a [redacted] NJ EX Order. 264b1. The surveyor entered Resident #89's room with LPN #1 and we both observed that the concentrator setting was for [redacted] to be delivered at [redacted] and the [redacted] was noted on the floor. LPN #1 stated that he verified the order and that Resident #89 was ordered NJ EX Order. 264b1 as was set on the [redacted] LPN #1 then went to the room and adjusted the NJ EX Order. 264b1 [redacted] to reflect the physician order.

On 07/20/22 at 11:29 AM, LPN #1 acknowledged that the physician orders must be followed. The nurse added that the [redacted] should not be on the floor for infection control prevention because the floor was contaminated.

On 07/21/22 at 7:34 AM, the surveyor observed Resident #89 sitting in a chair next to the bed. The [redacted] was observed lying on the floor. The [redacted] was set to deliver [redacted] of

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[redacted]

During an interview with the surveyor, Resident #89 at 7:35 AM revealed that he/she was not made aware that the [redacted] could not be on the floor. He/she also acknowledged that he/she never changed or touched the [redacted].

On 07/21/22 at 7:36 AM, during an interview with the surveyor, the 11:00 PM-07:00 AM nurse (LPN #2) revealed that she did not check the [redacted] during her shift. She also stated she was unsure of the physician's order and it " Could be [redacted]. The surveyor accompanied LPN #2 to the room where we both observed the [redacted] at a NJ EX Order: 264b1 the [redacted] LPN #2 left the room and did not adjust the [redacted] depict the physician's order.

On 07/22/22 at 9:08 AM, the surveyor observed Resident #89 sitting in the room eating breakfast. The [redacted] was on the floor. The [redacted] was [redacted] to deliver NJ EX Order: 264b1 via the [redacted]

On 07/26/22 at 9:30 AM, the surveyor observed Resident #89 standing in the room and was [redacted]. The surveyor could not read the [redacted] for the setting on the [redacted]. The surveyor alerted the LPN/UM [Unit Manager] who was at the medication cart in the hallway. The LPN/UM entered the room and verified that the [redacted] was turned off. The LPN/ UM turned on the [redacted] and set the [redacted] NJ EX Order: 264b1 as ordered by the physician.

On 07/26/22 at 9:35 AM, during a follow up interview with the surveyor, the LPN/UM stated

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that she did not get report from the 11:00 PM-07:00 AM nurse. She added that the LPN/UM in training received report and she did not checked the [redacted]. She added that sometimes if the resident was being assisted to the chair, staff would turn the concentrator in the room off and used the portable [redacted] attached to the wheelchair. She could not provide the rationale for why the [redacted] had been turned off.

On 07/26/22 at 9:40 AM, during an interview with the surveyor, the LPN/UM in training revealed that she did not check the [redacted] after receiving report nor did a walking round with the 11:00 PM- 07:00 AM nurse. She added that she was not aware that the [redacted] was turned off.

On 07/26/22 at 12:46 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) who cared for Resident #89 revealed that Resident #89 can assist with care, had no behaviors, and had a [redacted] cared for by the nurse. The CNA added that Resident #89 was also receiving [redacted] and that the nurses were responsible for the [redacted]. She indicated that she did not touched the [redacted].

On 07/27/22 at 8:38 AM, the surveyor observed Resident #89 sitting on the bed eating breakfast. The [redacted] was on the floor, not labeled or dated, and the [redacted] had been set to deliver [redacted] at a [redacted] via the [redacted].

During the pre-exit conference on 08/02/22 at 1:30 PM, the Licensed Nursing Home Administrator (LNHA), the Assistant (LNHA), the Director of Nursing (DON), and the Regional

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F 695	Continued From page 122 nurse were informed of the findings. No further information was provided. The regional nurse told the survey team that the nurse who worked on the 11:00 PM- 07:00 AM shift was an agency nurse and she would be educated. A review of the facility's policy titled, [redacted] Therapy" last revised September 2008, read in part. The purpose of [redacted] therapy is to administer [redacted] in cases where insufficient [redacted] is carried to the NJ EX Order: 264b1. [redacted] therapy is administered only as ordered by a physician or as an emergency measure until an order can be obtained. The physician's order will specify the [redacted] of [redacted]. Rules: [redacted] in the resident's room is prohibited while [redacted] is in use. Make sure NJ EX Order: 264b1 and [redacted] remain as ordered by the physician. Under procedure for administering [redacted] the following were noted: 1. label [redacted] and [redacted] with date. 2. Place [redacted] in use" sign on outside of the room, if an [redacted] is being used. 3. Apply [redacted] and [redacted] as ordered. Under guidelines for administering [redacted] it is stated, "[redacted] changed every 7 days. Date when changed." NJAC 8:39-11.2 (b) 27.1 (a)	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		9/13/22

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§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

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F 758	Continued From page 124 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and the review of the medical record and other facility documentation, it was determined that the facility failed to provide a gradual dose reduction (GDR) of NJ EX Order. 264b1 medication in the absence of behaviors and ensure the appropriate use and monitoring of NJ EX Order. 264b1 medications for 1 of 5 (Resident #81) residents reviewed for NJ EX Order. 264b1 medications and was evidenced by the following: On 07/19/2022 at 10:00 AM during tour, the surveyor observed Resident #81 in bed with the head of bed up, NJ EX Order. 264b1 with NJ EX Order. 264b1. The resident was not tracking (scanning) the surveyor with his/her eyes and had a blank gaze in his/her eyes. The surveyor was unable to interview the resident due to NJ EX Order. 264b1 . The resident was observed with a t NJ EX Order. 264b1 make through the NJ EX Order. 264b1 and into the NJ EX Order. 264b1)) and a NJ EX Order. 264b1 means of providing NJ EX Order. 264b1 d into the NJ EX Order. 264b1) was hanging on a pole next to the resident's bed. The surveyor also observed that a NJ EX Order. 264b1 that NJ EX Order. 264b1 was on the bottom of the bed. The Resident Face Sheet reflected that Resident	F 758	An RCA was conducted to identify the underlying cause of the deficient practice. The team failed to follow the policy on Unnecessary drugs - NJ EX Order. 264b1 Resident #81- The antidepressant NJ EX Order. 264b1 was decreased to mg for days then discontinued.. The resident was monitored for possible side effects of GDR and the plan of care was updated. The resident's NJ EX Order. 264b1 was notified of the GDR and the updated plan of care. All residents on psychotropic medication have the potential to be affected by the deficient practice. All residents on NJ EX Order. 264b1 medications were assessed by the DON/designee for appropriate use of medication and if there is a behavior or symptoms being monitored to justify the use of it. On a monthly basis the Pharmacy and Therapeutics Committee will review the list of residents on psychotropics and any residents scheduled for a GDR will be attempted during that month. Any residents not receiving a scheduled GDR will be reviewed and discussed with the Medical Director and NJ EX Order. 264b1 The DON/designee will keep the list of	

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F 758	Continued From page 125 # 81 was admitted to the facility with the diagnoses that included and was not limited to; NJ EX Order. 264b1). The significant change Minimum Data Set (MDS) an assessment tool dated NJ EX Order. 264b1, indicated that Resident #81 required total care with all aspect of activities of daily living (ADLs) and had NJ EX Order. 264b1. The MDS did not reflect that the resident exhibited any behaviors. On 07/19/2022 at 11:18 AM, the surveyor reviewed the Medication Administration Record (MAR) which revealed that Resident # 81 was on the following psychoactive medication: NJ EX Order. 264b1 mg (NJ EX Order. 264b1 (milliliters) (4 NJ EX Order. 264b1 solution Dispensed: NJ EX Order. 264b1 mL NJ EX Order. 264b1) NJ EX Order. 264b1 give NJ EX Order. 264b1) by NJ EX Order. 264b1 once daily in the morning. Start Date: NJ EX Order. 264b1 2 03:01 pm. The medication NJ EX Order. 264b1 is classified as an NJ EX Order. 264b1 medication. The surveyor reviewed the original standing physician's order dated NJ EX Order. 264b1 for NJ EX Order. 264b1 mg give NJ EX Order. 264b1 capsule NJ EX Order. 264b1 once daily. The Physician's Order Sheet (POS) dated NJ EX Order. 264b1 had an order for NJ EX Order. 264b1 0 mg/5 ml NJ EX Order. 264b1 milliliters NJ EX Order. 264b1 mg) by NJ EX Order. 264b1 route one daily in the morning for the diagnoses of NJ EX Order. 264b1.	F 758	psychoactive medications and GDR's up to date. All nursing staff will be educated on the Unnecessary drug - NJ EX Order. 264b1 s. The Unit manager/designee will audit 5 residents/patients on psychotropics for behavior and symptom monitoring and this will occur monthly and on going. The results of the audit will be submitted to the DON/ administrator monthly. On a monthly basis for 3 months the DON will update the Quality Assurance Committee on the status and compliance with GDR's. The QA Committee will review the findings and make recommendations on the need for continued audits.	

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F 758	Continued From page 126 The Care Plan (CP) dated 02/03/22 reflected a focus: Resident was on an antidepressant prior to admission. Resident currently in [redacted] and medication will be reviewed regularly for indication by [redacted] The CP goals indicated that the resident would utilize the lowest needed dose of medication to effectively manage the disease process. There was no behaviors documented on the CP. The CP meeting note dated [redacted], indicated that there were "questions regarding [redacted]" and that the resident was not able to follow commands. The CP meeting note date [redacted], indicated that the resident was in a [redacted] and was not responding to [redacted], and not [redacted]. The CP meeting notes dated [redacted] and [redacted] reflected that the resident was in a [redacted]. The surveyor did not find any documentation in the clinical medical record on what specific behaviors Resident #81 was exhibiting or that the facility was monitoring the [redacted] medication for side effects or effectiveness. The Admission Checklist dated [redacted] indicated that there was a consult ordered for physiatrist, however the surveyor could not find a physician's order for a psychiatric consult or documentation that the resident was evaluated by a [redacted]	F 758		

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On [redacted] at 11:38 AM, the surveyor reviewed the Pharmacy Consultant Review (PCR) which reflected that the pharmacy consultant (PC) reviews the residents' medications monthly. The PCR sheets revealed the following:

On [redacted] the PC documented the resident was receiving [redacted] and that this medication was not approved by the Food and Drug Administration for [redacted] and for the physician to please document the rational at the bottom of the form. The surveyor could not find any documentation from the physician for the rational on the form or in the clinical medical record.

The PCR dated [redacted] reflected a recommendation from the PC to consider a trial decrease in the resident's [redacted] mg daily and that changes to this dose was not attempted since [redacted]. The physician documented that the half life of [redacted] was unavailable to skip the dose without exacerbation of symptoms however there is no documentation in the resident's medical records to indicate what symptoms or behaviors the resident was exhibiting.

On 07/20/22 at 01:02 PM, the surveyor interviewed a Licensed Practical Nurse (LPN#1) on the A-wing who stated that she was familiar with Resident #81 and that the resident was [redacted] required complete care and was on [redacted]. LPN #1 stated that Prozac was an [redacted] and she stated that she does not know why the resident is on the [redacted] medication as the resident did not exhibit any behaviors.

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F 758	Continued From page 128 On [redacted] at 01:07 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for the [redacted] wing who stated that Resident #81 was in a [redacted]), had a trach, required total care and was on [redacted] services. The LPN/UM added that the resident did not exhibit any behaviors but that the resident made [redacted] at times. The LPN/UM explained that when a resident was on an [redacted] medication, the medication was reviewed quarterly by the [redacted] or the attending physician. The LPN/UM could not find any clinical documentation in the medical record that the resident was evaluated by a [redacted] or why the resident was on the medication [redacted] The LPN/UM also stated that when a resident was on any type of [redacted] medications such as an [redacted] that the facility would do a monthly [redacted] summary. The LPN/UM could not provide the surveyor with any documentation that a monthly [redacted] summary was done for the use of [redacted] for Resident #81. The LPN/UM could not find that a gradual dose reduction was attempted. On 07/20/22 at 01:41 PM, the surveyor interviewed Licensed Practical Nurse (LPN#2) who stated that when any resident was on an NJ EX Order. 264b1 or an [redacted] that a monthly [redacted] summary was scheduled on the MAR and that the nurses were responsible to document what the [redacted] medication was being used for, behaviors that the resident was exhibiting and if the resident had any improvement or decline with the use of the medication.	F 758		

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On 07/21/22 at 08:45 AM, the surveyor interviewed the Director of Nursing (DON) on what the facility process was when a resident was on psychoactive medication and what the nurses were responsible to document in the clinical record related to the use of this classification of medication. The DON explained that the nurses were responsible to document the resident's behaviors and the reason for the need of the psychoactive medication including a monthly psychoactive medication summary. He explained that the monthly [redacted] summary was a cumulative note regarding behaviors and side effects and effectiveness of medication. The DON stated that Resident #81 was diagnosed as being in a NJ EX Order. 264b1. He stated that he was not sure why resident #81 was on the medication [redacted] or why Resident #81 was not seen by a [redacted]. He stated that when a resident was admitted to the facility on a [redacted] medication that the resident was usually seen by the [redacted] to assure that the medication was still needed. The DON stated that the resident should have been seen by a [redacted] and there should have been documentation of what behaviors were being exhibited and that the medication should be monitored. The DON also stated that a gradual dose reduction (GDR) was done two times and year. The DON could not provide the surveyor with any documentation as to why Resident # 81 was on an [redacted] medication, what behaviors the resident was exhibiting, if the resident was evaluated by a [redacted] or why a GDR was not attempted since the resident had been on the medication since 04/16/2021. The DON provided the surveyor with documentation that Resident # 81 had been on [redacted] ([redacted] mg once daily since [redacted].

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F 758	Continued From page 130 On [redacted] at 10:00 AM, the surveyor conducted a telephone interview with Resident #81's physician who stated that the resident had a [redacted], required full care with activities of daily living (ADLs) and was dependent upon the staff to provide all of his/her needs. The physician stated that the term [redacted]" was just a term used when there was [redacted] He stated that the resident did not exhibit behaviors and was on the medication because he/she had a "past history" of [redacted] prior to his/her current condition of being in a [redacted]. He stated that the nurses could monitor the medications effectiveness by taking the residents vital signs. The physician was unable to give the surveyor specifics on what [redacted] behaviors the resident exhibited or explain to the surveyor as to why the resident was being given an [redacted] medication in the absence of behaviors or communication. The physician stated that the resident [redacted] at times but could not explain if this was a indication that the resident was [redacted]. The physician could also not provide a reason as to why there was not clinical documentation in the resident's medical record on a rational as to why a GDR was not attempted since the resident had been on the medication since [redacted] [redacted] at 10:54 AM, the surveyor conducted a telephone interview with [redacted] Manager of Clinical Practice (MCP) and the [redacted] DON who both agreed that the resident had a [redacted] was [redacted]. "We usually review the medications to determine if there was a need	F 758		

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for the meds." The MCP stated that she did not have any information documented on the [redacted] clinical records on what behaviors the resident was exhibiting indicating that the resident was [redacted]. MCP stated that if a resident was on a [redacted] medication, they would make sure that the resident was seen by a [redacted]. The MCP could not find documentation that this resident was evaluated by a [redacted] for the use of [redacted]. The MCP stated that the registered nurse that comes into the facility had a conversation with the family and that the family wanted to continue all medications.

On [redacted] at 01:18 PM, the surveyor telephone interviewed the Pharmacy Consultant (PC) who could not provide any information regarding [redacted] use for Resident #81.

On 08/03/22 at 09:35 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) stated that he would investigate the process regarding [redacted] medication usage and did not have any additional information.

The facility policy dated 03/2022 and titled, "Unnecessary Drugs [redacted]". Purpose: the policy indicated that the facility would ensure that each resident's entire drug/medication is managed and monitored to promote or maintain the resident's highest practical. Mental, physical, and psychological well-being. The policy indicated that based on a comprehensive assessment of a resident the facility must ensure the following:
1.) Residents who have not used [redacted] drugs are not given these drugs unless the medication is necessary to treat a specific

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F 758	Continued From page 132 condition as diagnosed and documented in the clinical record. 2.) Residents who use [redacted] drugs receive a gradual dose reduction, behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 3.) Use of [redacted] medication for each resident will be evaluated for appropriate indication and diagnoses. 4.) Residents using [redacted] medications will be monitored for efficacy and adverse consequences. 5.) [redacted] medication orders will be routinely re-evaluated to determine whether prolonged or indefinite use is indicated. 6.) Resident prescribed [redacted] medications will receive dose tapers or GDR's unless clinically contraindicated with the goal of seeking an appropriate dose and duration and minimizing the risk of adverse consequences. 7.) Residents admitted on or initiated on a psychotropic medication will have an initial progress note entered into their medical record. 8.) Residents on a [redacted] medication will be evaluated by their primary physician/psychiatrist for pharmacological necessity of medication as necessary. 9.) Residents will be monitored for effectiveness and potential adverse consequences related to [redacted] medication use. 10.) A Psychoactive Drug Monitoring Summary progress note will be completed monthly. 11.) A GDR will be attempted for all [redacted] medication based on CMS state operations manual requirements. N.J.A.C. 8:39-29.3(a)	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		9/13/22

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F 804	Continued From page 133 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent facility documentation it was determined that the facility failed to consistently a.) serve foods at temperatures preferred by residents for 5 of 6 residents at the Resident Council Meeting that complained of undesirable food temperatures. b.) serve hot and cold foods at acceptable temperatures, and c.) follow the facilities policy for Food holding. The deficient practice was observed in 1 of 1 test trays on 1 of 4 units (B-Wing) and was evidenced by the following: On 07/26/22 at 10:31 AM, the surveyor conducted the Resident Council Meeting with six (6) alert and oriented residents in which 5 of 6 unsampled residents at the meeting complained that the food did not always get delivered fast enough to the residents, so sometimes the food was cold. They stated that the food was delivered on time from the kitchen, but then once the food truck was on the unit, the nurses and certified nursing assistants do not pass them out quickly enough so that the food temps were not palpable.	F 804	Residents were offered new food trays which were checked for appropriate temperatures prior to distribution. Residents who may have consumed food which was above or below required temperature were observed for any signs or symptoms of food borne illness with none observed. All residents have the potential to be affected by the deficient practice. The facility has implemented a process whereby the kitchen announces when the food carts are leaving the kitchen to alert the nursing staff of their pending arrival. The Unit Manager/Nurse Supervisor, Nurses and Nursing Assistants will immediately deliver the food trays when they arrive on the unit. The Food Service Director/designee will complete two test trays per week to ensure foods are distributed timely and meet the required temperatures. The results of the test trays and meal	

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F 804	Continued From page 134 On 08/02/22 at 11:39 AM, two surveyors observed that test trays were being prepared in the kitchen. The two surveyors observed that a plate was retrieved from a plate warmer and placed on a heated tray warmer and the food was placed on the plate. One test tray was a regular consistency diet, and the other test tray was a puree diet. Both food trays contained one hot dog, stewed tomatoes and macaroni and cheese. There was also a milk placed on the tray as well as a 4-ounce carton of cranberry juice. On 08/02/22 at 11:40 AM, the two surveyors observed the test tray being put into the insulated food truck that would be delivered to the B-wing Unit. On 08/02/22 at 11:41 AM, the surveyors observed the food truck containing the test trays leaving the kitchen to be delivered to the B- wing Unit. On 08/02/22 at 11:43 AM, the surveyor interviewed the Food Service Director (FSD) who stated that acceptable hot foods temperatures were served over 140 degrees and acceptable cold foods were served below 40 degrees. On 08/02/22 at 11:44 AM, the surveyors observed the food trays delivered to the B-wing Unit. On 08/02/22 at 11:45 AM, the Certified Nursing Assistant (CNA) stated that the trays for residents requiring assistance with feeding remain on the insulated food cart until the residents were ready to be fed by the staff. The surveyor then observed the CNA take a tray off the food cart. On 08/02/22 at 11:52 AM, the surveyors observed the Licensed Practical Nurse Unit Manger	F 804	observation audits will be presented to the Quality Assurance Committee on a monthly basis for 3 months. Based on the results of the audits the Quality Assurance Committee will determine the need for continued audits. The Administrator and Food Service Director will continue to attend Resident Council meetings on an ongoing basis to hear feedback and make improvements to the meal distribution process as necessary.	

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(LPN/UM) take the last tray off the food truck.

On 08/02/22 at 11:53 AM, the surveyor along with the FSD took the temperatures of the test tray and the temperatures were as follows:

The regular textured meal temperatures were taken and the results were as followed:

Stewed tomatoes were 136.2 degrees according to the surveyor's thermometer and 131.5 according to the FSD thermometer. The FSD stated that the temperature of the stewed tomatoes was "too cold".

The hot dog's temperature was taken and according to the surveyor the temperature of the hot dog was 135.6 degrees and the FSD thermometer read the hot dog at 133 degrees. The FSD stated that the hot dog's temperature was "too cold".

The surveyor took the temperature of the 4-ounce carton of milk and a 4-ounce carton of cranberry juice along with the FSD and the surveyor got a temperature of 53.9 degrees for the milk and 52.2 degrees for the cranberry juice and the FSD obtained a temperature of 53.9 for the milk and a temperature of 51.6 for the cranberry juice. The FSD stated that the milk and cranberry juice were too warm.

On 08/02/22 at 11:56 AM, the surveyors interviewed the FSD who stated that the food temperatures were "off" because it took too long for the staff to pass the food trays out to the residents that required to be fed.

The undated facility policy titled, "Food Holding"

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F 804	Continued From page 136 indicated that the purpose of the facility policy was to ensure that all hot foods and cold foods are held at the proper temperature to prevent food born illness. The policy indicated that all hot food must be held at or above 140 degrees and all cold foods must be held between 32 degrees and 41 degrees. NJAC 8:39-4.1	F 804		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, the resident council meeting, review of medical records and other pertinent facility documentation it was determined that the facility was not consistently offering	F 809	The residents who attended resident council and any residents on A Wing who were not scheduled to receive a nighttime snack had their records reviewed and	9/13/22

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F 809	Continued From page 137 nighttime snacks to all residents on a nightly basis. This deficient practice was identified for 9 of 47 unsampled residents on 1 of 4 units (A-wing) and was evidenced by the following. On 07/26/22 at 10:31 AM, the surveyor conducted the Resident Council Meeting with six (6) alert and oriented residents. The residents at the resident council meeting were all in agreement that snacks were not consistently being offered at night. On 07/29/22 at 10:01 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) on the A-Wing who stated that she worked 12 hour shifts, "usually" 7:00 AM to 7:00 PM and had seen that trays of snacks were delivered approximately 7:00 PM in the evening right before she was ready to leave for the night. However, she added that she was not in the facility when snacks were being handed out to the residents so she was not sure who was offered snacks at night. She stated that snacks that were labeled with resident's names were delivered to residents and are signed out in the Medication Administration Record (MAR) that the resident received the snack and how much was consumed. She was not sure what the process was for the other residents on the unit or if the other residents were offered snacks or not. On 07/29/22 at 10:02 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) #1 who was currently on orientation on B-Wing who stated that resident snacks were delivered to each individual unit from the kitchen and that the nursing staff on the units were not required to sign any "particular" form that they received them. She stated that the	F 809	updated to include a nighttime snack. All residents have the potential to be affected by the deficient practice. All resident records have been reviewed and updated to include a nighttime snack to be offered and documented. All residents/resident representatives had their snack preferences reviewed and updated by the dieticians. Residents who request or are required to have nighttime snacks will have their snack delivered at 7pm and documented by their medication nurse. Snack distribution documentation will be audited by the Dieticians 3x per week for 4 weeks, 1x weekly for 4 weeks and 1x monthly for 1 month. The Food Service Director will interview 10 alert and oriented residents per week to ensure snacks are being distributed as preferred or required. On a monthly basis the Administrator and Food Service Director will attend the Resident Council meeting to ensure snacks are being offered nightly as preferred or required. The results of these audits will be presented to the Quality Assurance Committee monthly for 3 months. Based on the results, the Quality Assurance Committee will make recommendations on the need for continued audits.	

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residents that have assigned snacks or physician ordered snacks were provided with the snack and it was signed out in the MAR that the resident received them. She then added that residents that are not assigned snacks and do not have a name on the snack she was not sure if residents were offered because she did not work at night. The current LPN/UM #2 on B-wing stated that she doesn't work at night so she didn't know if all the residents were offered snacks at night, but was sure that if a resident requested a snack that the nurse would call the kitchen and get the resident a snack of choice.

On 07/29/22 at 11:00 AM, the surveyor interviewed the facility's Registered Dietician (RD) who stated that she had been employed since March 2022. The RD stated that residents with weight loss issues, potential weight issues or diabetics were ordered snacks by the physician which were signed out by the nurse in the MAR that the resident received the snack and how much snack the resident consumed. These snacks were recommended by the dietician and were ordered by the physician. The RD stated that all residents should be offered snacks at night, not just the residents that had physician ordered snacks. She added that she did not know why some residenst had an order on the MAR to offer snacks and some do not. She stated that she would get the surveyor the facility policy and the information.

The surveyor reviewed the Physician Orders (PO), MAR and Treatment Administration Record (TAR) for 47 unsampled residents on the A-wing and determined that 9 unsampled residents did not have documentation on the MAR, TAR or PO that they were offered a nighttime snack. The

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surveyor reviewed the 47 unsampled residents MAR which revealed that 38 residents had an order on the MAR which read to offer a nighttime snack and 9 residents did not have a order on the MAR to offer the resident a nighttime snack.

On 07/29/2022, the Food Service Director (FSD) provided the surveyor with a facility policy dated 10/2021 titled, "Nightly Snack Policy". The purpose of the policy was to ensure that all patients/residents are offered nutritious snacks at bedtime and there is more than 14 hours between the dinner and breakfast meals. The policy specified that if there was more than 14 hours between a substantial evening meal and breakfast that a nourishing snack must be offered at bedtime following procedure:
-Upon admission add order to MAR/TAR for a nutritious snack to be offered nightly.
-Document performances.
-Distribute snack carts at approximately 07:00 PM.
-The policy indicated that snacks would be offered and/or served to each patient/resident at approximately 07:00 PM by dietary aid or nursing team and that each resident would be offered and served snacks depending on their diet and texture.
-The policy also indicated that snacks would be documented in the MAR/TAR which snack each resident selected and if they selected or declined the nutritious snack.

On 08/02/22 at 12:59 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was not familiar with the facility's policy on snacks and would investigate the concerns. The surveyor interviewed the Director of Nursing (DON) at the

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F 809	Continued From page 140 same time who stated that there were residents that had snacks ordered but was not familiar with the facility's policy on snacks. On 08/03/22 at 09:42 AM, the LNHA admitted that the facility did not have a system in place for snacks and that the snacks system would be revamped, but at this point the facility would be assuring that all residents will be offered snacks at night. NJAC 8:39-17.4(b)	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation it was determined that the	F 812	All areas noted in the Statement of Deficiencies were addressed by the Food	9/13/22

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F 812	Continued From page 141 facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) failed to maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 07/19/22 from 9:47 AM until 11:17 AM, the surveyor toured the kitchen in the presence of the Director of Dietary Services (DDS) and observed the following: 1. The DDS wearing a surgical mask with short facial hair observed on both cheeks and long white facial hair observed on his chin hanging out of the bottom of the surgical mask. 2. In walk-in refrigerator #3, there was one box filled with individual containers of cream cheese with no dates on the box and no dates on the containers. There was one black quarter container of individual cream cheese with no dates. There were six boxes of 720 count individual containers of butter with no dates on the boxes and no dates on the individual butters. The DDS acknowledged that there were no dates on the cream cheese nor on the butter and stated that they should have been dated when they were delivered. The DDS further stated that it was important to date the items to prevent expired items from being served to the residents. 3. In walk-in refrigerator #2, there were six sealed clear plastic bags that contained chopped celery	F 812	Service Director. The Food Service Director trimmed the facial hair and wears a beard protector at all times. The undated cream cheese and butter containers were discarded. The undated chopped celery was discarded. The undated ground beef was discarded. The convection ovens were cleaned. The standing mixer was cleaned. The stove top was cleaned. The white storage containers were emptied, cleaned and dated. The ice machine was emptied and cleaned. The cutting boards were cleaned. The unlabeled packages in the freezer were discarded. The dented cans were removed from inventory and placed in the dented can section. The employees wearing hairnets incorrectly were in-serviced and immediately corrected their hairnets. The food items identified on 7/25/22 in refrigerator #1 were discarded. The roll of food service film on the prep table was discarded and a new one was provided with appropriate covering. All residents have the potential to be affected by the deficient practice. The Food Service Director received in-service education from the Dietician on policies/procedures for Hairnets and Gloves, Refrigerated Storage, Frozen Storage, HMNR Dry Food Storage, Food Labeling, Labeling Policy, Refrigerator & Freezer Storage Chart, Cleaning and Sanitizing Food Contact Surfaces, Prep Cook's Daily Task and Cleaning Log, and Ice Infection Control. The	

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F 812	Continued From page 142 with no label and no dates. The DDS acknowledged that the bags should have been dated and should have had a label. 4. In walk-in refrigerator #1, there was one box that contained two sealed 5 pound packages of ground beef marked use by 7/11/22, and two boxes that each contained four sealed 5 pound packages of ground beef marked use by 7/18/22. The DDS acknowledged that the ground beef should not be in the refrigerator and that it would be thrown away. The DDS further stated that it was important to not serve outdated food because you don't want to contaminate the residents with bacteria in bad food. 5. In the top convection oven, on the inside doors there was black greasy debris and black debris resting on the oven floor. In the bottom convection oven, on the inside doors there was black greasy debris and black debris resting on the oven floor. The DDS acknowledged that the debris should not be there and stated that it was important to keep the ovens clean so debris didn't get into food and for the prevention of cross contamination. 6. The standing mixer was covered with a plastic bag. The DDS removed the bag which revealed white debris and white dried drippings on the motor and the bowl, on the back of the machine and on the back shield. The DDS acknowledged the debris and told the cook to reclean the mixer. The DDS stated that it was important to keep the mixer clean to prevent cross contamination with bacteria and fresh food. 7. The stove top was observed with brown, white, and black debris and the back of the stove with	F 812	dietician/designee will conduct a walkthrough inspection of the kitchen, with the Food Service Director, 3 times per week for the next 30 days, 1x per week for 4 weeks and 1x per month for 1 month to ensure compliance with the policies and procedures. A written report summarizing the inspections will be submitted to the Administrator weekly for four weeks. On a monthly basis the Dietician will present the results of the audits to the Quality Assurance Committee for 3 months. The QA committee will review the reports and make recommendations on the need for additional audits as required.	

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white greasy drippings. The DDS acknowledged the debris and stated that the stove was not cleaned in days and that it should all have been wiped down and that the burners should have been placed in the dishwasher.

8. There was a large white covered bin that contained brown rice which was labeled rice with no dates. The DDS discarded the rice and acknowledged that the bin should have been dated to show how old the rice was.

9. The ice machine was filled with ice. There was black debris along the underside of the lid. The DDS acknowledged that the debris should not have been there and stated that it was from condensation.

10. On the clean rack were three large white cutting boards all with black smudges, brown smudges, and black marks. The DDS acknowledged that the marks should not have been on the cutting boards and that they should have been clean to prevent cross contamination.

11. In the freezer was one sealed resealable plastic bag with seven pieces of square breaded meat that the DDS identified as breaded cod with no label and no dates. There was one opened 10 pound box labeled Italian style chicken breast meat that contained: one opened, unsealed clear plastic bag that contained eight pieces of tan meat that were visible and exposed to air with no date, and one opened clear plastic bag wrapped in clear plastic that contained eight pieces of tan meat with no date. The DDS acknowledged that the food items should not have been stored that way and stated that it was important to wrap, label and date all the food correctly so everyone

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would know how old the food was, to prevent freezer burn, and to make sure the quality of the product was still good.

12. On a metal rack in the dry storage room there was one dented 6.38 pound can of stewed tomatoes, one dented 6.56 pound can of corn, and one dented 6.6 pound can of crushed tomatoes. The DDS acknowledged that the cans were dented and stated that they should have been on the dented can rack. The DDS removed the cans and stated that it was important to not use the dented cans because they could have caused botulism.

On 07/19/22 at 11:09 AM, the surveyor interviewed the DDS on the hairnet policy in the kitchen who stated that everyone had to wear a hairnet or a hat, and that all hair had to be covered. The DDS acknowledged that he was wearing a surgical mask and that his facial hair was not covered and stated that it was important to cover all hair so it didn't contaminate the food.

On 07/20/22 from 11:56 AM until 12:23 PM, the surveyor toured the kitchen in the presence of the DDS and observed the following:

1. Five staff members on the tray line that prepped and prepared trays for lunch. One dietary aide (DA#1) on the tray line who prepped the food trays with coffee and cream, removed and replaced covers from the plates, and placed trays on the food cart, was wearing a hairnet that covered the back of her hair with the front sides and top of her hair exposed. One DA#2 on the tray line who prepped the food trays at the prep refrigerator, placed milk, juice, and desserts on trays, was wearing a hairnet that covered the top

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of her hair and her ponytail with the back of her hair exposed.

2. On a metal prep table there was one box of 12 inch x 2000 foot roll of food service film that was open and exposed to air. The DDS stated that the film was for wrapping sandwiches once they were prepped and that it should have been covered so no debris would get into the food.

On 07/20/22 at 12:21 PM, the surveyor interviewed DA#1 who stated that hairnets were always to be worn in the kitchen and that she was wearing it correctly. DA#1 was then observed pulling the front of her hairnet down over the exposed hair on the top and sides of her head and stated, "I fixed it." DA#1 then further stated that it was important to cover all hair with the hairnet so hair doesn't get into the food. DA#1 was then observed removing her gloves and handwashing at the sink for 28 seconds before donning new gloves.

On 07/20/22 at 12:23 PM, the surveyor interviewed DA#2 who stated that everyone was to wear a hairnet in the kitchen and that her hair was short and that was why it fell out of the hairnet and that she needed to put her hair inside the hairnet. DA#2 further stated that it was important to wear the hairnet correctly because some hair may land on the tray and that would be dirty because the resident could eat it.

On 07/25/22 from 9:58 AM until 10:12 AM, the surveyor toured the kitchen in the presence of the DDS and observed the following:

1. On a metal shelf in refrigerator #1 there was one 10.75 pound box of sealed packaged beef

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cubes that was dated that it was received 7/19/22, with no pulled or use by dates. The DDS stated he did not know when the beef cubes were pulled, did not answer when asked when they should be used by, then stated they were good for 7 days. There was one hotel pan covered with clear wrap that the DDS identified as baked ziti, with no label and no date. The DDS acknowledged that it should have been dated and told the cook to discard it. The DDS stated that the ziti should have had a tag with the date and that it would only be good for three days. On the bottom shelf of a metal rack was one box that was labeled and stamped that it was packaged on 7/6/22, that contained two sealed clear bags that contained 10 pounds boneless skinless chicken thighs in pink liquid that were in an opened blue plastic bag, with no pulled or use by dates. The DDS acknowledged the chicken was not labeled correctly and stated that he did not see a tag on the box and that he was unsure when the chicken was pulled. The DDS then removed the box from the refrigerator and disposed of it in the garbage. The DDS further stated that the box of chicken should have been labeled with the delivery date when it was received, and that it was important to label things correctly so everyone would know when to get rid of food before it spoiled.

On 07/25/22 at 10:12 AM, the surveyor observed the DDS wearing a surgical mask with long white hair exposed from his chin under the surgical mask. The DDS acknowledged he was not wearing a beard guard and stated that if he was in the kitchen he should have worn a beard guard. The DDS stated that it was important to cover all hair because hair would fall into people's food.

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On 08/02/22 at 1:21 PM, the Team Coordinator presented the kitchen findings to the Licensed Nursing Home Administrator (LNHA).

On 08/03/22 at 10:09 AM, the surveyor interviewed the LNHA on the kitchen hairnet policy. The LNHA stated that everyone should have worn a hairnet in the kitchen and that if there was facial hair that a beard guard should have been worn. The LNHA acknowledged that the kitchen staff should have had all their hair covered for infection control so that no hair escaped into the food.

The surveyor reviewed the facility's undated policy, "Hairnets and Gloves," which revealed, Policy: While in the kitchen all team members must wear proper head wear (hairnets, hats, beard restraints, etc) to restrain hair ...Procedure: Step 1. Upon entering the kitchen all persons must put on a hairnet.

The surveyor reviewed the facility's undated policy, "Refrigerated Storage," which revealed, Procedure: Step 1. All items in the refrigerator must be labeled properly. They must follow the Food Labeling Policy.

The surveyor reviewed the facility's undated policy, "Frozen Storage," which revealed, Procedure: Step 1. All items in the freezer must be labeled in accordance with the Food Labeling Policy.

The surveyor reviewed the facility's policy, "HMNR Dry Food Storage," revised 03/2018, which revealed, Procedure: Step 1. All items in dry storage must be labeled in accordance with

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the Food Labeling Policy.

The surveyor reviewed the facility's undated policy, "Food Labeling," which revealed, Policy: All food must be labeled properly upon delivery and after preparation. If food is not properly labeled it will be discarded. Labeling Upon Delivery, Procedure: Step 1. Once any food products are received they must be dated and labeled immediately. 2. All items will be dated with the day it was received in the following fashion: MM/DD/YYYY. 3. If food is taken out of packaging that there is no label, they must be labeled what the product is. (Ground beef, chicken breast, parmesan cheese, etc.) 5. If applicable, the use by date must be labeled on the food item. Labeling After Food Preparation Delivery, Procedure: Step 1. After food preparation is complete and food will be stored for later cooking, reheating, or consumption items must be labeled with description, preparation date, and expiration date. All dates in the following fashion: MM/DD/YYYY. 6. Any items that are not labeled correctly must be discarded. 7. Any items that have past the date and time of expiration must be discarded.

The surveyor reviewed the facility's undated policy, "Labeling Policy," which revealed **All food must be labeled & dated with name of product, the date opened & the expiration date** Fresh meat (beef, lamb, steak, pork) 3-5 days. Fresh poultry (chicken, turkey) 1-2 days.

The surveyor reviewed the facility's document, "Refrigerator & Freezer Storage Chart," dated March 2018, which revealed, Raw Hamburger, Ground and Stew Meat: Hamburger and stew meats, refrigerator 1-2 days. Fresh Poultry:

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F 812	Continued From page 149 Chicken or turkey, whole or parts, refrigerator 1-2 days. The surveyor reviewed the facility's undated policy, "Cleaning and Sanitizing Food Contact Surfaces (Sample SOP)," which revealed, Purpose: To prevent foodborne illness by ensuring that all food contact surfaces are properly cleaned and sanitized. Instructions: 4. If State or local requirements are based on the 2001 FDA Food Code, wash, rinse, and sanitize food contact surfaces of sinks, tables, equipment, utensils, thermometers, carts, and equipment: ...Any time contamination occurs or is suspected. The surveyor reviewed the facility's document, "Prep Cook's Daily Task & Cleaning Log," dated 07/18/2022, which revealed, Prep cook's initials, next to Convi-Oven cleaned checked weekly, 8:00 am prep cook: check mark observed. The surveyor reviewed the facility's policy, "[redacted] Ice Infection Control," with a revision date of 08/2013, which revealed, Procedure: Step 2. Ice needs to be stored in a closed, sterilized, container. No dented can policy provided. NJAC 8:39 17.2(g)	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		10/3/22

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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 circumstances.

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F 880	Continued From page 151 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the implementation of surveillance techniques to minimize sources and transmission of COVID-19 virus (an acute disease in humans caused by a Coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) by not appropriately ensuring that residents were screened, in Phase 0 of reopening, in accordance with the requirements in the New Jersey Department of Health's (NJDOH) Executive Directive No. 20-026[1] and the Center for Disease Control and Prevention (CDC) guidance for 2 of 3 residents	F 880	Screening A root cause analysis was conducted to determine the underlying cause of the problem . The root cause was lack of oversight from the facility clinical team that led to failure to follow the outbreak screening requirements. Resident # 89 and #436 , An order on screening was clarified. An order to obtai [redacted] , and Monitor for signs and symptoms of COVID 19 every shift. Orders were entered into the resident□s electronic medical records of resident # 89 and # 436. An inservice was immediately provided to all nurses about the required frequency of screening of	

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F 880	Continued From page 152 (Resident #89 and #436) reviewed; b.) perform proper hand hygiene and perform a [redacted] treatment in a safe and sanitary manner to reduce the further spread of infection during a NJ EX Order. 264b1 Outbreak for 1 of 5 residents (Resident #19) reviewed for Transmission Based Precautions (TBP) ; and c.) ensure that the NJ EX Order. 264b1 was stored in a manner to prevent [redacted] for 1 of 5 residents (Resident #112) reviewed for NJ EX Order. 264b1. This deficient practice was evidenced by the following: 1. Reference: A review of NJDOH Executive Directive No. 20-026[1], updated 01/06/21, documented the following: Under Phases per this Directive: "Phase 0: Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS) ..." Under section IV. "Required standards for services during each phase. 1. Phase 0 ... iv. Facilities shall screen all residents, at minimum during every shift with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature and pulse oximetry. " Reference: A review of CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated 02/02/22, documented the following: Respond to a Newly Identified SARS-CoV-2-infected HCP or Resident. Because	F 880	residents vital signs and monitoring during an outbreak. All residents have potential to be affected by the deficient practice during COVID outbreak. Orders were obtained and entered for all residents to have VS (heart rate, blood pressure, temperature and pulse oximetry), and screening for s/s of COVID-19 every shift while the facility is considered in COVID-19 outbreak status. Screening information was entered into the patient/resident□s electronic medical record. Any findings indicative of possible COVID-19 infection will be reported immediately to the Nursing supervisor. The patient/resident□s primary physician will be notified and follow up testing/isolation will be completed per facility policy. All nurses were educated on the screening requirements for residents during the outbreak being done q shift. COVID screening during outbreak status will be audited weekly by the IP/designee. Ten resident□s electronic records will be audited monthly from each unit for the duration of the outbreak. Results of audits will be presented by the DON/designee monthly to the QAPI Committee and quarterly to the QAA committee. Wound Treatment Hand washing/hand hygiene A root cause analysis was conducted and	

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F 880	Continued From page 153 of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak ...Consider increasing monitoring of all residents from daily to every shift, to more rapidly detect those with new symptoms. On 07/26/22 at 02:01 PM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) provide documented evidence for the facility's screening for COVID-19 for three residents. On 07/27/22 at 8:45 AM, the surveyor reviewed the facility provided screening Progress Notes titled "Nursing Shift Assessment (NSA)." The NSA documented the resident's vital signs which included blood pressure, pulse, respiration, temperature and oxygen saturation. The NSA included a section "New/Suspected/Known Infection" which had listed under the following: Fever/Chills/Shivers, Cough or Shortness of Breath or Increased Sputum Production, Abdominal (Diarrhea/Nausea/Vomiting ...) The surveyor then reviewed each resident's screening documents provided which included the following: Resident #89 had a NSA done on [redacted] at 1:44 AM, 07/24/22 at 11:17 PM and [redacted] at 8:02 AM. There was not a NSA provided for [redacted] There was no documented evidence that the screening (NSA) was done every shift. Resident #436 had a NSA done on [redacted] 12:00 AM, [redacted] at 12:01 AM and [redacted] at 07:07 AM. There was not a NSA provided for [redacted]. There was no documented evidence	F 880	was identified by the team that deficient practice r/t resident #19 was due to lack of mindfulness of the nurse during [redacted] treatment observation. Resident #19 was immediately assessed for any signs and symptoms of infection related to poor infection practice by the nurse. The resident did not show any s/s of infection and the treatment was discontinued on [redacted]. The nurse who provided [redacted] change was immediately given an inservice with a return demonstration on appropriate hand hygiene and proper use of PPE particularly on donning and doffing of PPE. All residents receiving wound treatments and on transmission based precaution have the potential to be affected by the deficient practice. All nurses will receive competency/in-service education on hand hygiene and proper donning and doffing of PPE during [redacted] change. Each nurse will be observed by the wound nurse/designee to ensure a proper technique of hand washing and donning and doffing is applied during [redacted] change. Wound competencies will be performed during orientation of all new nurses. A [redacted] competency tool was modified for nurses to easily understand and comply. CMS video for front liners on handwashing and donning and doffing of PPE will provided to all staff are as follows:	

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F 880	Continued From page 154 that the screening (NSA) was done every shift. On 07/27/22 at 9:25 AM, during surveyor interview in the presence of the survey team, the LNHA stated that he was not the clinical person but that he believed that the screening was one time a day. On 07/27/22 at 9:30 AM, during surveyor interview, the Licensed Practical Nurse (LPN) stated that a full set of vital signs would be done one time a day. She then stated that the blood pressure may be done more times if the resident was on a blood pressure medicine and that the oxygen saturation was done every couple hours by the Respiratory Therapist. She then added that the nurses worked 12 hr shifts. On 07/27/22 at 9:55 AM, during surveyor interview, the Registered Nurse (RN) on [redacted] wing stated that the vital signs were obtained every day and that if anything was unusual then would ask all the questions. On 07/27/22 at 11:23 AM, the surveyor requested from the LNHA any guidance that the facility was following for the screening for COVID-19 that they were performing one time a day. The surveyor then asked the LNHA if the facility was currently in an outbreak. The LNHA confirmed that facility was in an outbreak since April, 2022. On 07/28/22 at 9:02 AM, the LNHA provided to the survey team the CDC guidance titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" which was updated [redacted] The surveyor reviewed the document which the facility marked to indicate the guidance	F 880	Donning and Doffing PPE in Clinical Laboratories: Removing Gown and Gloves Together https://www.youtube.com/watch?v=YFrRe16qgUE Hand Hygiene for Healthcare Workers/ Handwashing Soap and Water Technique Nursing Skill https://www.youtube.com/watch?v=G5-Rp-6FMCQ Episode 21: Do We Really Have to Talk About Hand Hygiene? Again? Yes! https://www.youtube.com/watch?v=n1oqVM-N3j8 Five staff members will be monitored weekly on all shifts for hand washing compliance by the Infection Preventionist/designee for one month, then monthly thereafter and then ongoing. [redacted] competencies will be completed semi-annually on all Nurses by the wound nurse/designee. Results of audits will be presented by the DON/designee monthly to the QAPI Committee and quarterly to the QAA committee. -Audits of 3 wound treatments will be performed weekly for one month by the [redacted] Care Nurse/designee, then monthly and ongoing. Results of audits will be presented by the DON/designee monthly to the QAPI Committee and quarterly to the QAA committee. [redacted] bags A root cause analysis was conducted by the team . It was determined that the	

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F 880	Continued From page 155 they were following in the following area: Evaluate Residents at least Daily...Actively monitor all residents upon admission and at least daily for fever (temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. The surveyor further reviewed the document which includes the following (if facility is in outbreak): Respond to a Newly Identified SARS-CoV-2-infected HCP or Resident. Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak ...Consider increasing monitoring of all residents from daily to every shift, to more rapidly detect those with new symptoms. On 08/01/22 at 9:21 AM, during surveyor interview, the Infection Control Manager stated that when in an outbreak, residents should be screened, by taking vital signs and observing if they have any symptoms of COVID-19, every shift if they are not showing symptoms. She then stated that if a resident was in quarantine or had symptoms then the vital signs are obtained every four hours. On 08/01/22 at 10:09 AM, the surveyor, in the presence of the survey team, told the LNHA the concern that the facility had not been screening the residents for COVID-19 every shift. On 08/02/22 at 1:35 PM, the facility provided the surveyor with additional documentation that the residents vital signs were obtained more than once a day. The surveyor reviewed the	F 880	NJ EX Order 264b1 are not easily and securely hung to the bed frame that led the [redacted] to be on the floor. Resident #112 - The NJ EX Order 264b1 was fully covered with a NJ EX Order 264b1 and repositioned off the floor. The staff members involved were immediately inserviced and did a return demonstration of proper NJ EX Order 264b1 positioning and application of NJ EX Order 264b1. All residents with NJ EX Order 264b1 are potential to be affected by the deficient practice, All patients/residents with an urinary NJ EX Order 264b1 were audited to ensure there was a NJ EX Order 264b1 in place and the [redacted] was off the floor. All nurses will be educated on the policy on NJ EX Order 264b1 1 with emphasis on not allowing drainage bags to lie on the floor. NJ EX Order 264b1 hanger to be installed on the bed frame to hang the [redacted] easily and make it secure. A [redacted] with a built in NJ EX Order 264b1 will be utilized if appropriate. All certified nursing aides will be educated on the importance of the NJ EX Order 264b1 not to lie on the floor and proper use of a NJ EX Order 264b1 for NJ EX Order 264b1. The nurse will visualize the NJ EX Order 264b1 [redacted] during the shift to shift hand off communication report to make sure the [redacted] is off the floor. Residents with a NJ EX Order 264b1 will be audited by the unit manager/ designee daily for one month then weekly for one month then monthly ongoing. Results of	

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F 880	Continued From page 156 documents which included the following: Resident # 89's blood pressure was obtained multiple times a day from [redacted] to [redacted] except for when it was obtained one time a day on [redacted] and [redacted]. Resident #89's oxygen saturation was obtained multiple times a day from NJ EX Order. 264b1. Resident #89's pulse was obtained multiple times a day from [redacted] to [redacted] except for when it was obtained one time a day on NJ EX Order. 264b1. Resident #89's temperature was obtained multiple times a day from [redacted] to [redacted] except for when it was obtained one time a day on [redacted] and [redacted]. Resident # 436's blood pressure, oxygen saturation and pulse were obtained multiple times a day from [redacted] to [redacted]. Resident #436's temperature was taken one time on [redacted] one time on [redacted], two times on [redacted], one time on [redacted], was not taken on [redacted], one time on [redacted], two times on [redacted] was not taken on 07/[redacted], two times on [redacted], was not taken on [redacted], one time on [redacted] and three times on [redacted]. The facility did not provide any additional documented evidence that the screening for signs and symptoms for COVID-19 were obtained more than one time a day. On 08/2/22 at 1:35 PM, during surveyor interview in the presence of the survey team, the Director of Nursing (DON) confirmed that the NSA which included the screening for signs and symptoms of COVID-19 was documented one time a day and that it was not documented every shift.	F 880	audits will be presented by the DON/designee monthly to the QAPI Committee and quarterly to the QAA committee. As part of the in-service education provided to staff the video□s listed below were used as required in the Directed Plan of Correction: Nursing Home Infection Preventionist Training Course: Module .1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the Training to: Topline staff and Infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out!! https://youtu.be/7srwrF9MGdw Provide the Training to: Frontline Staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents http://youtu.be/1ZbT1Njv6xA Provide the Training to: Frontline Staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/1081803/ Provide the training to: Topline staff, Infection Preventionist and nursing staff	

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F 880	Continued From page 157 A review of the facility provided policy titled, "HMNR Post-Acute and ALF COVID-19-Pandemic Preparedness Infection Control Plan," with an updated date of 04/21/22, which included the following: Screening of Resident/Patients LTC, Subacute, and Assisted Living (update 08/06/2021) Facilities will screen all residents/patients, at a minimum set by current NJDOH advisory or Network/facility policy with questions/observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded will include heart rate, blood pressure, respiratory rate-in addition, temperature and pulse oximetry. If any s/s [signs or symptoms] are noted, resident is to be immediately tested and considered a PUI until test results are received ...8/6/2021 update-screening of residents/patients as above is required at a minimum daily. b. On 07/19/2022 at 9:56 AM, during the initial tour of the facility, the surveyor observed that Resident #19's door was pulled closed and there was a Personal Protective Equipment (PPE - refers to protective clothing, gloves, facemasks and/or respirators and other equipment designed to protect the wearer from injury or the spread of infection) caddy that hung on the outside of the resident's door. A Stop Sign was secured on the door that cautioned of NJ EX Order. 264b1 [redacted] " Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering,	F 880	Nursing Home Infection Preventionist Training Course Module 4-Infection Surveillance https://www.train.org/cdctrain/course/1081802/ Provide the training to: Topline Staff and Infection Preventionist only. Nursing Home Infection Preventionist Training Course Module 7- Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: ALL staff including Topline Staff and Infection Preventionist Nursing Home Infection Preventionist Training Course Module 10C - Infection Preventionist during [redacted] Care https://www.train.org/cdctrain/course/course/1081811/ Provide the training to: Nursing staff, topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 10A - NJ EX Order. 264b1 [redacted] https://www.train.org/cdctrain/course/1081809/ Provide the training to: Frontline staff, topline staff and infection preventionist	

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transferring, changing linens, providing hygiene, changing briefs or assisting with toileting... [redacted] Care: any skin opening requiring a dressing. The surveyor interviewed Licensed Practical Nurse (LPN#1) who stated that the resident was on contact precautions for NJ EX Order. 264b1. She further explained that according to signage posted on the resident's door, a gown and gloves were only required to be worn in the room for direct contact with the resident and were not required to speak with the resident without direct contact. The resident received care during that time and was not available for interview.

On 07/20/2022 at 11:06 AM, the surveyor observed Registered Nurse (RN #1) as she exited Resident #19's room and immediately performed hand hygiene with alcohol based hand rub (ABHR) that was readily available outside of the resident's room. When interviewed, she stated that the resident had a [redacted], [redacted], on his/her [redacted] that was treated with NJ EX Order. 264b1. She explained that the facility provided in-service training to the staff because there were additional residents who tested positive for [redacted]. She stated that the resident's treatment was scheduled today at noon and she agreed to permit the surveyor to observe the treatment. She further stated that all of the resident's [redacted] care supplies were required to be stored in his/her room due to infection control practices.

Review of Resident #19's Face Sheet revealed that the resident was readmitted to the facility in NJ EX Order. 264b1 with diagnoses which included but were not limited to: [redacted] of th [redacted]).

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Review of Resident #19's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted]," which indicated that the resident was NJ EX Order. 264b1. Further review of the MDS revealed that the resident was totally dependent and required assistance of [redacted] persons for bed mobility and transfers and required total dependence of one person for toileting and personal hygiene.

Review of Resident #19's Care Plan Activity Report (CPAR) revealed an entry dated [redacted], titled, "Infection: NJ EX Order. 264b1 [redacted]. The entry detailed that the resident completed treatment and went to Infectious Disease on [redacted] 1, and [redacted] was suspected with no further treatment recommended and resident would be kept on NJ EX Order. 264b1. Interventions included but were not limited to: Administer topical treatments as ordered, maintain appropriate infection control practices to include proper handwashing, refer to [redacted] specialist as needed, assess, and address any predisposing factors as appropriate, and resident received treatment with NJ EX Order. 264b1 to the [redacted] which showed major improve [sic.], Will continue with current treatment. Additional interventions included: Maintain infection control practices through proper hand washing.

Review of Resident #19's Order Activity Detail Report (OADR) revealed the following order: NJ EX Order. 264b1 apply by topical route every other day. NJ EX Order. 264b1 [redacted] and

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NJ EX Order. 264b1). Diagnosis: NJ EX Order. 264b1 , unspecified. Original order date: NJ EX Order. 264b1 .

On 07/20/2022 at 12:04 PM, the surveyor observed RN #1 who performed hand hygiene with ABHR before she donned a gown and gloves prior to entry to Resident #19's room. RN #1 prepared a printed copy of the resident's treatment order before the surveyor arrived to the unit and she stated that she planned to review it with the surveyor at the bedside prior to the treatment. RN #1 entered the resident's room accompanied by the surveyor and requested permission for the surveyor to view the treatment. When interviewed, the resident agreed and stated that he/she developed the NJ EX Order. 264b1 of the NJ EX Order. 264b1 during NJ EX Order. 264b1 after his/her NJ EX Order. 264b1 were NJ EX Order. 264b1 .

Resident #19 had just finished eating lunch and he/she asked RN #1 to remove his/her clothing protector prior to beginning the treatment. RN #1 removed the clothing protector from the resident as requested. She proceeded to doff (remove) her gloves and gown and placed them in the trash can that was next to the resident's bed. She then went into the resident's bathroom and briefly (too brief to capture the time) and ran her hands under running water without soap application. She dried her hands on a paper towel, turned off the faucet with a second towel and donned another gown and gloves. The resident's phone rang, and RN #1 picked up the phone and answered it for the resident. RN #1 then proceeded to pull up the resident's blankets and exposed his/her NJ EX Order. 264b1 .

Resident #19's treatment supplies were stored on

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top of an overbed table in the resident's room. RN #1 obtained two small plastic bags and lifted the resident's [redacted] t one at a time and placed a bag under each [redacted] She then obtained a bottle of NJ EX Order. 264b1) and applied it to a [redacted] that she used to cleanse the resident's NJ EX Order. 264b1 y.

At 12:14 PM, RN #1 obtained a wash basin from the overbed table and took it into the resident's bathroom and rinsed the basin under running water. She then used a disposable washcloth to clean the inside of the basin prior to use.

At 12:15 PM, RN #1 doffed her gloves and washed her hands out of running water for seven seconds. She donned a new pair of gloves after.

At 12:16 PM, RN #1 poured two cups of vinegar and NJ EX Order. 264b1 into [redacted] She used an 8NJ EX Order. 264b1 . She stated that the Nurse Practitioner who showed the nursing staff how to do the treatment stated, "It was not an exact science." She then soaked [redacted] in the solution that was in the basin. She removed the [redacted] from the mixture and applied two NJ EX Order. 264b1 to the residents' [redacted] and then used [redacted] around the 4 NJ EX Order. 264b1 to secure them in place.

At 12:24 PM, RN #1 rinsed the basin out in the resident's bathroom sink, dried it out with a paper towel, and put it inside a plastic bag and then proceeded to place it on top of the resident's overbed table that held his/her treatment supplies.

At 12:25 PM, RN #1 lifted the resident's [redacted] and

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put each foot inside of a separate plastic bag.

At 12:26 PM, RN #1 doffed her gloves and rinsed her hands under running water without soap application for five seconds. She donned gloves after. Resident #19 observed the surveyor timing the hand washing observation on a stop watch and the resident stated, "Sing happy birthday two times when you wash your hands, when she timed you."

At 12:28 PM, RN #1 pulled up the trash bag up that was nearly full inside of the trash can and doffed her gown and gloves inside of it. She then went into Resident #19's bathroom and washed her hands for 13 seconds.

At 12: 29 PM, RN #1 obtained a glove and held it in her right hand and failed to donn (put on) the glove as she used her ungloved hands to tie up the trash bag and remove it from the trash can.

At 12:31 PM, the surveyor accompanied RN #1 to the soiled utility room where she punched in a code with her ungloved index finger prior to entry and discarded the trash bag into a receptacle. RN #1 washed her hands in the soiled utility room for eight seconds. RN #1 then agreed to meet with the surveyor in twenty minutes for removal of Resident #19's dressing.

At 12:55 PM, the surveyor met RN #1 outside of Resident #19's room and observed her as she donned a gown and gloves and failed to tie the gown in the back to secure it. RN #1 leaned over the [redacted] of the resident's bed and removed the plastic bags that were secured over top of the resident's feet. She proceeded to remove the silk tape that secured the dressings into place over

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top of the NJ EX Order 254(V) and discarded them into the trash can.

At 12:56 PM, RN #1 doffed her gloves and washed her hands for 9 seconds while she kept her gown on with the plastic loops in place that were secured over her thumbs bilaterally and prevented her from washing the full surface of both of her hands. She donned a new pair of gloves after.

At 12:57 PM, RN #1 doffed both her gown and gloves and placed them in the trash can. She then tied up the trash bag with her bare hands and carried it to the soiled utility room. RN #1 punched in a code to gain access to the room with her ungloved index finger and discarded the trash bag into a receptacle.

At 12:59 PM, the surveyor observed RN #1 as she washed her hands for 14 seconds before she exited the soiled utility room.

At 1:01 PM, the surveyor observed RN #1 as she signed out Resident #19's treatment orders in the computer.

At 1:02 PM, when interviewed, RN #1 stated that she was require to wash her hands for 15-20 seconds or sing happy birthday twice. RN #1 stated that she was required to turn on the faucet,wet her hands, apply soap,scrub her hands and scrub under her nails and wrists, then rinse her hands with her hands pointed downward into the sink, dry her hands with a paper towel, then turn off the faucet with a clean paper towel. RN #1 stated that she thought that she washed her hands for the appropriate length of time "most times" when the surveyor observed her. RN #1

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COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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stated that if there were ABHR in the resident room, there would have been a much less likelihood of her not washing her hands for the appropriate length of time.

RN #1 further stated that she thought that since Resident #19's feet were already in contact with his/her blankets before the treatment, that she was able to wear the same gloves that she used to answer the resident's phone and pull up the blanket to perform the treatment,"because the feet were already considered dirty." She stated that she realized after she washed her hands that she had forgotten to doff her gown first. She stated that if she failed to secure her gown in place prior to treatment removal and her uniform may have become contaminated. She further stated that when she did not wash her hands for at least 20 seconds after she touched the resident's feet, she risked the spread of infection.

On 07/21/2022 at 10:23 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the process to do a wound treatment was to: Wash your hands prior to entering the room. She then explained the hand washing process: Turn on faucet, wet hands, apply soap, lather with soap, clean under the finger nails and the wrists for 20-30 seconds "to really clean them", then rinse, pat dry and discard the paper towels, use a clean towel to turn off the faucet. Next, donn gloves. Then begin to gather the required supplies. First, clean the table to be used to place equipment on with bleach wipes and allow it to sit and dry for two minutes (the time recommended by the manufacturer to kill germs), apply a drape to the table, wash your hands after and donn a gown and gloves. Place a drape beneath the area to be

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treated on the resident's bed to protect the bed linens. Remove the dressing if applicable and wash your hands again. During dressing removal, fold the soiled dressing into the trash, do not just drop it in. Wash your hands and use a clean towel to tie the bag and do not touch the bag with your hands. Once tied, wash your hands again and obtain a clean paper towel to carry the bag to the soiled utility room. When you approach the key pad on the soiled utility door, one hand is clean and should be used to punch in the security code into the key pad. She stated that she would not have used her bare hands to handle the trash bag. She clarified that RN #1 should have had her gloves on when she tied up the trash because if not, it was an infection control issue.

The LPN/UM further stated that the RN #1 should have cleaned off Resident #19's table and applied a drape to the table prior to the wound treatment to prevent infection. The LPN/UM stated that the spread of infection was a concern if RN #1 did not wash her hands for at least 20-30 seconds. The LPN/UM stated that if RN #1's gown was not secured prior to the treatment, there was a risk that the [redacted] could have gotten onto her uniform and spread. The LPN/UM further stated that there was a risk of spread of infection if the trash bag that contained soiled dressings and PPE were mishandled and RN #1's hands were not washed for the appropriate length of time.

On 07/21/2022 at 11:39 AM, the surveyor interviewed the Director of Nursing (DON) who stated that he covered for the Infection Preventionist (IP) who was currently on vacation. He described the following process for a wound treatment: First, sanitize your hands prior to entry

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to the resident's room. He then described the process for hand washing: Turn the water on, wet your hands and apply soap and count for 20 seconds while all surfaces of the hands are scrubbed, then rinse the hands, obtain a paper towel to dry your hands and dispose of the towel after, then obtain another paper towel and turn the sink off and then throw the paper towel out. Next, assess the resident's pain level, medicate the resident if needed, wait and reassess the resident. Then, bring the bedside table close by. Perform hand hygiene and donn gloves. Clean the table with bleach wipes and allow for it to dry for two minutes. Once the table had dried, lay out a chux pad (disposable drape) on the table. Gather all needed supplies and place them on the drape in a clean manner.

The DON further stated that the nurse was required to put a chux down on the bed beneath the resident's [redacted] to protect the bed linens. Next, expose the resident's toes, apply the treatment and allow it to sit for 20 minutes as ordered. Then, remove the treatment by placing it on a chux and fold the chux in and around the soiled dressing to contain anything that may be contaminated. Then, dispose of the waste in the garbage. The DON stated that the resident should then be assessed for pain. Then, the nurse should have observed the resident's [redacted] for assessment purposes. The DON stated that the garbage bag should have been tied up while the nurse was still in her full PPE. Then, she should have doffed her PPE and washed her hands for 20 seconds. After, obtain a clean paper towel to remove the garbage and place the bag in the red bag trash in the soiled utility room. The DON stated that the nurse should have washed her hands before she left the clean utility room for

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at least 20 seconds.

The DON further stated that the Department of Health (DOH) provided the facility with guidance regarding [redacted] and specified that hand washing was the number one way to prevent infection. He stated that the problem was that RN #1 needed to be re-educated immediately because of poor handwashing, improper donning of PPE and numerous instances during Resident #19's treatment observation where she could have potentially spread [redacted]. He stated that the facility needed to ensure that everyone understood the importance of proper hand washing, and prepping for a treatment in order to prevent the spread of infection.

The Licensed Nursing Home Administrator (LNHA) provided the surveyor with documented evidence that RN #1 had [redacted] Dressing Change Competencies completed on [redacted] and [redacted] RN #1 also participated in an educational program titled, [redacted]," in which the course objectives were: understanding [redacted], [redacted], and the importance of hand washing and hand hygiene and disinfecting environment and equipment used for patient care to prevent the spread of [redacted].

The surveyor reviewed the facility policy titled, " Hand Washing/Hand Hygiene (Last Revised 03/2022) which revealed the following:

Hand washing and hand hygiene will be performed in accordance with the Center for Disease Control (CDC) guidelines.

Hands are a common transfer mechanism for

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F 880	Continued From page 168 potential pathogens from person to person or from a contaminated article to a person... ...Indications for hand washing/hand hygiene include, but are not limited to the following: Before and after touching wounds, whether surgical, traumatic or associated with an invasive device After touching inanimate sources that are likely to be contaminated with pathogenic microorganisms... After removing gloves Hand Washing Method: 1. Push up sleeves above the wrist prior to hand washing. 2. Stand well away from the sink in order to prevent getting splashed. 3. Turn on the water gently and adjust water temperature to a comfortable level. 4. Wet hands and wrists thoroughly. 5. Dispense soap. 6. Scrub each hand with the other, creating as much friction as possible by interlacing the fingers and moving the hands back and forth. 7. Scrub the hands for at least 20 seconds. 8. Rinse the hands thoroughly under running water, keeping the hands down below the level of the elbows. 9. Take care not to touch the surface of the sink, which is considered to be contaminated. 10. Dry the hands and wrists gently with a paper towel and discard into the wastebasket...11. Turn the faucet off with a new paper towel, as the faucet handles are considered to be contaminated. 12. Discard the paper towel into the wastebasket. Review of RN #1's Wound Dressing Change Competency Checklist revealed the following:	F 880		

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F 880	Continued From page 169 Perform hand hygiene upon entering room. Identified resident/patient using at least two identifiers. ...Prepared clean table and gathered all necessary supplies. ...Provided privacy. Positioned resident/patient comfortably, draped to expose only wound site... Placed disposable bag within reach, performed hand hygiene and put on clean gloves, applied necessary personal protective equipment (PPE)... Removed dressing one layer at a time, observed appearance and drainage of dressing... ...Folded soiled dressing with drainage side in, removed gloves inside out, folded gloves over soiled dressing if appropriate, disposed of gloves and dressing in appropriate receptacle, covered wound with gauze, performed hand hygiene . Applied clean gloves. ...Clean wound: Used gauze with saline, antiseptic, or wound cleanser... Disposed of gloves, performed hand hygiene. Applied clean gloves. Applied treatment, then dressing as ordered... Disposed of all treatment waste, removed PPE and disposed of it in appropriate receptacle. Helped resident/patient to a comfortable position.	F 880		

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F 880	Continued From page 170 Performed hand hygiene upon leaving the room. During the initial tour of the facility on 07/19/22 at 10:16 AM, the surveyor observed Resident #112 in bed. Resident #112 reported a delay in receiving care due to the facility being short of staff. The surveyor observed the [redacted] d with a [redacted]. The [redacted] was touching the floor. On 07/19/22 at 12:02 PM, the resident was observed in bed resting. The [redacted] was touching the floor and was only partly covered with the [redacted] On 07/20/22 at 9:05 AM, the surveyor entered the room and observed Resident #112 in bed. Resident #112 reported [redacted] at the [redacted]. Resident #112's nurse was informed. On 07/20/22 at 11:30 AM, the surveyor observed Resident #112 in bed. The [redacted] was observed in the [redacted] and positioned above the floor. On 07/21/22 at 7:05 AM, the surveyor observed the resident in bed and the resident acknowledged not feeling well. Resident #112 still reported discomfort at the [redacted]. The surveyor again observed the [redacted] and [redacted] placed directly on the floor. On 07/21/22 at 7:15 AM, the surveyor	F 880		

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accompanied the Licensed Practical Nurse (LPN) Unit Manager (UM) to the residents room where both observed the NJ EX Order. 264b1 and the NJ EX Order. 264b1 placed directly on the floor. Resident #112 occupied the bed by the door and visitors and staff in the hallway could easily visualize the NJ EX Order. 264b1 on the floor from the hallway. The Unit Manager stated, "I saw the problem already". The NJ EX Order. 264b1 should not be on the floor. The UM donned gloves and a PPE gown since the resident was on NJ EX Order. 264b1, entered the room and adjusted the NJ EX Order. 264b1 on the bed frame.

The surveyor reviewed Resident #18's electronic clinical record on NJ EX Order. 264b1. According to the admission Face Sheet, Resident #112 was readmitted to the facility on NJ EX Order. 264b1 with diagnoses which included but not limited to NJ EX Order. 264b1

The Admission Minimum Data Set (MDS) revealed that Resident # 112 was dependent upon staff for care. Resident #112 scored [redacted] on the Brief Interview for Mental Status (BIMS) which indicated NJ EX Order. 264b1. The MDS reflected that Resident #112 had a NJ EX Order. 264b1 directly into the NJ EX Order. 264b1

A care area assessment (CAA) associated with the admission MDS dated NJ EX Order. 264b1 specified Resident #112 had a diagnosis of NJ EX Order. 264b1. The resident was at NJ EX Order. 264b1 NJ EX Order. 264b1)s and injury related to NJ EX Order. 264b1.

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F 880	Continued From page 172 A care plan dated [redacted] identified Resident #112 at risk for [redacted] due to a history of [redacted] and the need for a [redacted] related to [redacted]. The care plan goal specified: Signs and symptoms of [redacted] will resolve within the course of [redacted] therapy. Interventions included, "Maintain adequate [redacted]. Ensure proper [redacted], monitor labs as ordered, maintain appropriate infection control practices". A review of Resident #112's medical record revealed the resident's [redacted] was diagnosed and treated on [redacted]. On 07/21/22 at 9:45 AM, a follow up interview with the UM revealed that the [redacted] should not be on the floor because this was an infection control issue. When inquired about the last in-service education done to address the issue with the [redacted] she added, "I will check for the last in-service on proper placement of the [redacted]". An interview was conducted 07/21/22 at 10:04 AM with the Certified Nursing Assistant (CNA) who cared for Resident #112 during the day shift. She stated that she had not provide care yet to Resident #112, and was not aware that the [redacted] was on the floor. The surveyor attempted to call the 11:00 PM -07:00 AM CNA several times, but she did not return the call. The UM informed the surveyor that the CNA would be re-educated. On 07/22/22 at 9:07 AM, the surveyor observed Resident #112 in bed with his/her eyes closed.	F 880		

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F 880	Continued From page 173 The surveyor observed the [redacted] in a [redacted] hung on the bed frame. On 07/22/22 at 12:17 PM, during a follow-up interview with UM LPN, she revealed in- service education regarding the [redacted] was done in [redacted] and during orientation for new hires. She added that she did not have the time to address the CNA who cared for the resident during the 11:00 PM-07:00 AM shift nor address the issue with the 11:00 PM-07:00 AM Nursing Supervisor. She added that the morning she came in she did not have the opportunity to go to Resident #112's room as the door was closed and staff was inside in the room providing care. The UM LPN further added that a verbal reminder was done on [redacted] around 6:15 AM regarding care of the [redacted]. The CNA who cared for Resident #112 revealed at that time that she was in a hurry and did not realized that the [redacted] was on the floor. The UM went on to state, " It was important to revisit the subject because of Infection control". On 07/26/22 at 10:58 AM, the surveyor interviewed the Nurse Educator (NE) and inquired on how issues with care had been addressed. The NE stated that her role was to educate all staff regarding issues with care on the unit and issues with care communicated by Unit Managers during leadership meetings by Supervisors every shift. She added that she should be aware of all issues with care by the end of the day. She went on to state that the protocol was to reeducate and if care issues were specific to one staff member, competency evaluations would be done. If the care issues were systemic, in-service education	F 880		

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will be done for all staff, and a sign-in sheet would be initiated to confirm that the issues were addressed. She further stated that care issues she had to address lately were [redacted] care and that [redacted] care and oxygen therapy had not been addressed as she was not made aware of any care issues.

A review of the facility's policy titled, [redacted]) Prevention Guidelines" dated 07/19 and last revised 09/20, included but was not limited to the following, Under Maintenance of [redacted]: All [redacted] systems should be maintained in a manner that prevents infection and cross contamination and promote patency of the system.
Strict adherence to standard Precautions must be followed, including hand hygiene immediately before and after any manipulation of catheter or collection system.
[redacted] System" Never allow [redacted] to lie on the floor".
Inspect [redacted] r and [redacted] every shift to ensure patency.
[redacted] must be covered for privacy.

The facility was made aware of the above concerns on 08/02/22 at 2:00 PM. on 08/03/22 the facility provided in-serviced education that was provided regarding care of the [redacted] No additional information was provided.

NJAC 8:39-19.4 (a) 5

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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 other facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This was evident for 4 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One 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	S 560	We conducted a root cause analysis to identify the underlying cause of the deficient practice to implement necessary corrective actions: Based on the RCA the team identified the cause of the deficient practice to be failure to staff the facility to appropriate ratios based on NJ guidelines due to an global acute shortage of staff, specifically certified nursing assistants. All residents have the potential to be affected. HMH implementation of referral bonus program and sign on bonus program to increase applicant pool and increase retention. CNA classes to convert Provisional Nursing Aides to CNAs and thus increase staff. Re-engineered hiring process to expedite on-boarding process. Market analysis of CNA rate of pay across the network Continued relationships with local CNA/Nursing schools to help build the applicant pool. Hackensack Meridian Health job fairs at local Community College. Offering critical shift pay to current staff,	9/13/22

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

Electronically Signed | 08/29/22

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S 560	Continued From page 1 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 "Nurse Staffing Report", completed by the facility for the weeks of 07/03/22 to 07/09/22 and 07/10/22 to 07/16/22, revealed the facility was deficient in CNA staffing for residents on 4 of 14 day shifts and deficient for CNAs to total staff on 2 of 14 evening shifts as follows: -07/03/22 had 13 CNAs for 133 residents on the day shift, required 17 CNAs, -07/05/22 had 16 CNAs for 133 residents on the day shift, required 17 CNAs. -07/13/22 had 5 CNAs to 16 total staff on the evening shift, required 8 CNAs. -07/14/22 had 5 CNAs to 15 total staff on the evening shift, required 7 CNAs. -07/16/22 had 13 CNAs for 139 residents on the day shift, required 17 CNAs. On 07/25/22 at 10:36 AM, Certified Nursing Assistant #1 (CNA#1) stated she believed the census on the B-wing was 62 but she was not sure. She further stated there were six (6) CNAs on the unit including herself and she was caring for eight residents. On 07/25/22 at 10:40 AM, the agency CNA on the B-wing stated she was not sure of the census but that she had a total of 10 residents and around 12 PM would be getting two (2) more as one staff member was going home. The agency CNA	S 560	including nurses working as CNAs to work additional hours while we look to fill vacancies through internal job postings, job fairs, and external job postings. Contract with an agency company. Onboard temporary CNAs who are now transitioning to become certified. Adding extra nurses on to work as CNAs on 7-3 and 3-11 shifts when CNA staffing does not meet the requirement. Staffing Coordinator or designee will complete an audit of staffing and ratio requirements daily for one month, then weekly for 2 months and then monthly for 12 months. Audit will be given to the Director of Nursing. The Director of Nursing will report all findings to the QAPI Committee Quarterly.	

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	061342	A. BUILDING: _____ B. WING _____	C 08/03/2022

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stated she generally has an average of ten (10) residents. She further stated the staff was equipped at least 75 percent of the time. The agency CNA concluded this was the most consistent it has been in the last year and it's "improving in a positive way."

On 07/25/22 at 10:43 AM, the B-wing License Practical Nurse/Unit Manager (LPN/UM) stated the census was 46 and the total staffing included six (6) CNAs, two (2) nurses plus one (1) UM. She stated the staffing hasn't been bad and typically the CNAs can have between eight to ten (8 to10) residents. The LPN/UM stated she believed the ratio was 1:8 day shift, 1:10 evening shift and 1:12 night shift. The LPN/UM concluded sometimes they have two to three (2 to 3) nurses on the floor and if there were any call outs, she would cover a cart.

On 07/25/22 at 10:54 AM, the A-Wing LPN stated the census was 50 with six (6) CNAs, two (2) nurses plus one (1) UM. She stated when it comes to staffing, "we all pitch in" but believed "the CNAs feels it more." The LPN stated the facility has changed but "we are adjusting" because "it's a big adjustment as people left during the change."

On 07/25/22 at 10:55 AM, CNA #2 stated on A-wing there were six (6) CNAs and that he had eight (8) residents. He further stated the average varied between eight to twelve (8 to 12) residents but emphasized not all were complete care. CNA #2 concluded "it's a hit or miss" on the staffing but it was not the building's fault, it's because of the call outs.

On 07/26/22 at 09:52 AM, the staffing coordinator (SC) stated she staffs the building to the best of

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her ability. She stated she does the state report and the staffing ratio she believed are nursing 1:20, CNAs day shift 1:8-10, evening shift 1:12-13 and night shift 1:10-13. The SC stated staffing has been challenging and there were quite of few staff members on leave of absence (LOA). She further stated because of the sale of the building the bulk of the staff left as they got nervous due to change and the unknown. The SC stated because staffing has been challenging lately, she mainly has been using agency staffing but preferred regular staff. The reasoning being "agency staff doesn't know the residents as well as the regular staff." The SC further stated they are looking for new staff as they have in-house referrals, open-houses, and they also have ads out. For the current staff she stated, she would go around to the units and talk to staff, she sent out text messages and called staff that were off to get those shifts covered. The SC stated that they offer to their regular staff critical pay (bonus) and that sometimes the incentives work and sometimes they don't. The SC emphasized unfortunately because of the pending sale; people were nervous to come on board. When asked about the pending sale, the SC stated, "we are in limbo and not sure when it will be finalized."

On 07/26/22 at 10:10 AM, the Director of Nursing (DON) stated for staffing they did their best to make sure all units were staffed. He stated staffing was challenging but they pulled on different resources to make sure they were providing "safe care" to their residents. The DON stated the resources they used were contracted agency staff who are contracted for a number of weeks and per diem agency staff. He further stated they will offer critical pay their full time, part time and per diem staff to work overtime (OT). The DON emphasized he didn't think there were

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S 560	Continued From page 4 any other resources they could pull from as sometimes the staff did not want to take the offer. The DON stated the staffing ratio for CNAs were 1:8 day shift, 1:10 evening shift and 1:14 night shift. The DON concluded that was the reasoning they used the bonuses, to ensure they met those ratios. On 07/27/22 at 9:15 AM, the License Nursing Home Administrator (LNHA) stated that staffing was challenging but they were doing the best they could do. He stated he was not sure of the staffing ratio but emphasized they are making sure they were "following the NJ regulations" for staffing. The LNHA stated they have been recruiting and posted ads. He further stated they are doing everything possible to get staff and to keep them. They offer sign on bonuses, critical shift pay, retention bonus, referral bonus "all to get staff and keep them." He concluded he felt the incentives have been helpful. NJAC 8:39-5.1(a)	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined	S 720	A root cause analysis revealed the facility did not have two evening activities	9/13/22

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S 720	Continued From page 5 that the facility failed to provide residents two evening activity programs per week. This deficient practice was identified for 3 of 4 months reviewed, May 2022, June 2022 and July 2022, as evidenced by the following: On 7/21/22 at 1:10 PM, the surveyor observed a large activity calendar for July 2022 on the wall across from Recreation room. Review of the calendar indicated there was only one evening activity scheduled for three weeks of the month. There was not any evening activity scheduled for one week of the month. On 7/21/22 at 1:20 PM, the surveyor asked the Assistant Licensed Nursing Home Administrator (ALNHA) to provide the surveyor the April through July 2022 activities calendars. On 7/21/22 at 1:28 PM, ALNHA provided the surveyors with the activities calendars. Review of the April 2022 activity calendar provided by the ALNHA indicated that there were two evening activities listed per week. The calendar did not list the time of the evening activities. Review of the May 2022 activity calendar provided by the ALNHA indicated that there were two evening activities listed on the week of May 1, May 15, May 22 and May 29. The calendar did not list the time of the evening activities. The week of May 8 did not have any evening activities listed. Review of the June 2022 activity calendar provided by the ALNHA indicated that there was only one evening activity listed per week. The calendar did not list the time of the evening	S 720	scheduled based on resident council preference. We have updated the calendar in August, and ongoing, to have two evening programs which meet the requirement. All residents have the potential to be affected by the deficient practice. On a monthly basis the activities calendar will be reviewed with the resident council and will include feedback from all residents via the Activity Satisfaction survey. The Recreation Director will schedule two (2) evening programs weekly and staff will be scheduled accordingly. On a monthly basis for 3 months the Activity Director will present the calendar to the Quality Assurance Committee and confirm the evening activity requirement is met. The Quality Assurance Committee will determine the need for continued audits after 3 months.	

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S 720	Continued From page 6 activity. Review of the July 2022 activity calendar provided by the ALNHA indicated that there was only one evening activity listed on the week of July 3, July 10 and July 17. The calendar did not list the time of the evening activity. The week of July 24 did not have any evening activities listed. On 7/26/22 at 10:31 AM, a surveyor conducted a Resident Council Meeting with six (6) alert and oriented residents. The residents confirmed that the facility did not have any activities at "night". On 7/26/22 at 11:13 AM, in presence of the survey team, the surveyor interviewed the Interim Director of Recreation (IDR). The IDR stated that she did not create the activities schedule but that two of the recreation staff created it. She added that she does not "sign off" on the calendar but that she reviewed it. The surveyor then asked the IDR if the facility had evening activities. The IDR stated that there was usually an evening bingo but was not sure if they had been able to staff the evening activity. She added that one of the staff was out on leave and that she was not sure if there was staff to fill in for the evening. The IDR then confirmed that the schedule that was listed on the July 2022 schedule was what had occurred. On 7/26/22 at 11:41 AM, the surveyor interviewed Recreation Assistant (RA) #1. RA #1 stated that the facility had only one evening activity which was bingo. She added that she did not know what the reason was that there was no longer a second evening activity. On 7/26/22 at 12:24 PM, the surveyor interviewed RA #2. RA #2 stated that until a week ago the	S 720		

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facility had an evening activity on Tuesday evenings. She added that the residents' said they were tired and that the facility gave them a choice on when to have activities. She then stated that the last 2 weeks there were no evening activities going on.

On 7/26/22 at 12:43 PM, the surveyor asked the RA #2 to provide the surveyor the recreation staff schedule for June 2022 and July 2022.

On 7/26/22 at 12:54 PM, RA #2 provided the surveyor the recreation staff schedules for June 2022 and July 2022. A review of the June 2022 schedule included the following: one staff member was scheduled to work 8:00-8:00 on one day of each week. There was not a second day of each week that had a staff member scheduled to work the evening. A review of the July 2022 schedule included the following: one staff member was scheduled to work 8:00-8:00 on one day (Tuesday) during the week of July 3. There was not a second day of that week that had a staff member scheduled to work the evening. The three remaining weeks of July did not have any staff member scheduled to work the evening on any day of the week. On the bottom of the July 2022 schedule included the following: HOURS FOR ALL STAFF ARE 8:00-4:30 UNLESS NOTED. RA #2 confirmed that for staff that did not have a time next to their name that the staff member worked 8-4:30.

On 8/02/22 at 1:29 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) confirmed that the facility did not have activities two evenings a week. The LNHA stated that at a resident council meeting the residents, that attended the meeting, did not want to have the second evening activity. The

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S 720	Continued From page 8 surveyor asked the LNHA how many residents were at the meeting and what the facility census was. The LNHA stated that 13 residents were at that meeting and that the census was 130. The surveyor then asked the LNHA if the 13 residents would represent all the residents of the facility. The LNHA stated that it would be a 10% sample but that it would not be representative. Review of the facility provided policy titled, "HMNR Activities and Social Events," with an effective date of 08/2021, included the following: 6. Daily activities, including those on weekends and holidays, are provided as well as scheduled religious and social activities. however, residents are free to choose whether or not they wish to attend any activity or other scheduled event(s). The policy did not address evening activities.	S 720		