STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315229		C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

(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	E 000		
	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.			
F 000	INITIAL COMMENTS	F 000		
	Complaint # NJ00155798 Survey Date: 8/31/22 Census: 182 Sample: 37 plus 3 closed records 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 2 of 3 residents, Residents #66, and #67 reviewed for falls.	F 641	IMMEDIATE ACTION On 8/11/2022 residents # 66 and #67 MDS Assessment was modified to capture the falls that occurred in the past for both residents. IDENTIFY OTHERS: MDS coordinator initiated to review all falls on 9/13/2022 from January 2022 to	11/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/23/2022

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 641	Continued From page 1 This deficient practice was evidenced by: 1. On 8/9/22 at 10:46 AM, the surveyor observed Resident #66 laying in bed awake with his head at the foot of the bed watching TV (television). The resident told the surveyor that the staff is very nice and helps them when they call for assistance. The surveyor reviewed the medical records of Resident #66: The Admission Record (face sheet/admission summary) showed that the resident was admitted to the facility with diagnoses including, but not limited to, [redacted], and [redacted]. The incidents and accidents investigation showed that the resident had [redacted] falls dated as follows: [redacted], and [redacted] The resident sustained no injuries from the falls. The Annual (Comprehensive) MDS (CMDS) dated [redacted] indicated Resident #66 had a Brief Interview for Mental Status score of [redacted] out of [redacted] meaning the resident's cognition was [redacted]. Under [redacted] titled Health Conditions- any falls since admission to the facility or prior assessment. [redacted] was entered as NO, meaning Resident #66 had no falls since admission or prior assessment although the resident had a fall on [redacted].	F 641	present to ensure all falls were captured on MDS assessments. Any negative findings will be corrected accordingly. INSERVICES: On 9/15/2022 In-service Coordinator/designee initiated in service to MDS Coordinator and all unit managers to capture any falls on MDS assessment during real time. In-service will continue until all staff receives the education. QAPI: MDS Coordinator/designee will perform weekly audits on MDS assessments to ensure all falls are captured for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by MDS Coordinator and reported to the Director of Nursing & the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the MDS Coordinator and will be ongoing until 100 percent compliant attained.	

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F 641	Continued From page 2	F 641		

The most recent quarterly MDS (qMDS) dated [redacted] indicated the resident had a BIMS score of [redacted] out of [redacted] meaning the resident's cognition was [redacted].

Resident #66's personalized care plan included a focus on falls with appropriate interventions. The care plan also showed updates following [redacted], [redacted], and [redacted] falls.

On 8/11/22 at 11:45 AM, the surveyor reviewed Resident #66's medical records again and revealed that the CMDS dated [redacted] that was previously reviewed by the surveyor was modified on [redacted]. The modified [redacted] MDS under [redacted] titled Health Conditions-any falls since admission or prior assessment was now coded YES. The [redacted] CMDS was modified after the surveyor's inquiry.

During an interview with the surveyor on 8/18/22 at 11:03 AM, the MDS Coordinator, employed since 12/2019, stated that if a resident had a fall, he will "usually" be informed about it in the morning clinical report and/or from Risk Management. The MDS Coordinator stated that he will check to make sure that an incident report was completed and that the resident's care plan was updated with new interventions.

On that same date and time, the MDS Coordinator stated that [redacted] of the MDS is where a resident's fall will be documented. The MDS Coordinator added that after a resident encounters a fall, the unit managers will initially update [redacted] in the MDS and enter the code for a fall. The MDS Coordinator further stated that he would then check [redacted] in the MDS and

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F 641	Continued From page 3 code correctly if not coded or updated correctly. On that same date and time, the surveyor reviewed Resident #66 falls with the MDS Coordinator. The surveyor asked the MDS Coordinator why the resident's CMDS dated [redacted], which originally had indicated in [redacted] NO for falls, was modified on [redacted] in [redacted] and now coded YES for falls after the surveyor's inquiry. The MDS Coordinator stated that we sometimes do random chart audits and a chart audit was recently done on Resident #66. The MDS Coordinator stated that during the chart audit, it was discovered that the Annual MDS dated [redacted] was coded incorrectly for falls "so I did the modification." 2. On 8/03/22 at 10:40 AM, during the initial tour of the facility Resident #67 was observed in bed, awake. There was a fall mat in the room on the floor next to the resident's bed. The resident told the surveyor he/she did get up to walk to the bathroom when needed. The surveyor reviewed the medical records of Resident #67. The Admission Record showed that the resident was admitted to the facility with medical diagnoses including, but not limited to, [redacted] The most recent qMDS dated [redacted] 2 indicated the resident had a BIMS score of [redacted], meaning the resident was [redacted]. The resident's functional status was one-person physical assistance for dressing, personal hygiene, and	F 641		

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F 641	Continued From page 4 toileting. Under [redacted], titled health conditions-fall since admission to the facility, the area marked zero, meaning the resident had not fallen since admission to the facility. The incidents and accidents for the past six months for Resident #67 showed that the resident had two falls, one fall on [redacted] and one fall on [redacted] The resident had no injuries from both falls. Resident #67's personalized care plan showed updates following the [redacted] and [redacted] falls. On 8/16/22 at 12:50 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. The DON acknowledged the above concerns concerning the accuracy of capturing the fall incidents in the MDS. During an interview with the surveyor on 8/18/22 at 11:58 AM, the Director of Nursing (DON) stated that when a resident falls, the fall would be documented in the progress notes and an incident report completed. The DON added that if the resident's MDS was due for an update, the unit managers would code a fall in the [redacted] of MDS. The DON stated that if the resident's MDS was due for an update, the MDS Coordinator would also follow up and check to make sure that [redacted] was coded correctly for a fall. The DON further stated that the MDS Coordinator was ultimately responsible to make sure falls were documented and coded correctly in [redacted] of the MDS for each resident.	F 641		
	NJAC 8:39-11.1			
F 658 SS=E	Services Provided Meet Professional Standards	F 658		11/11/22

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F 658	Continued From page 5 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) follow acceptable professional standards of clinical practice by discontinuing a duplicate physician's order to [redacted] from [redacted] 2 until the surveyor's inquiry in [redacted] and discontinuing a duplicate physician's order for [redacted] from [redacted] until surveyor's inquiry [redacted] b.) not following physician's order for the correct [redacted] for [redacted] of [redacted] residents (Resident #153 and #91), and c.) follow through with the Registered Dietitian's (RD's) recommendations for [redacted] residents (Resident #174) reviewed for enteral feed physicians' orders, 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 and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	IMMEDIATE ACTION: 1. MD was notified of the duplicate [redacted] orders of [redacted] hrs and [redacted] every [redacted] hrs and both [redacted] were signed as administered every 4 hrs by the nurse for resident # 153. No negative effect noted. A new order received to discontinue the [redacted] ml every [redacted] hrs dated [redacted]. 2. On 8/18/2022, MD was notified that resident # 91 has duplicate orders of [redacted] ml/can [redacted] five times a day dated [redacted]. [redacted] ml after each [redacted] to provide [redacted] per day and another order dated on [redacted] of [redacted] with [redacted] ml via [redacted] times a day related to [redacted], add [redacted] [redacted] ml/hr. MD was also made aware that the available [redacted] and the [redacted] r is still on back order. LPN #3 received an order [redacted] from MD to discontinue the order dated on [redacted] of [redacted] ml via [redacted] times a day related to [redacted] add [redacted] ml [redacted] ml/hr. No negative effect noted.	

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F 658	Continued From page 6 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 8/3/22 at 1:10 PM, the surveyor observed Resident #153 in their room lying in bed on an air mattress. The surveyor was unable to interview the resident. On 8/4/22 at 11:52 AM, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) who stated that Resident #153 was [redacted] received [redacted], and was being administered a [redacted] The surveyor reviewed the medical record for Resident #153. The Admission Record (face sheet/admission summary) revealed that the resident was admitted to the facility with diagnoses that included [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the	F 658	3. Central Supply staff checked and confirmed that there are enough supplies of [redacted] and to notify nursing and dietitian once the [redacted] is available. 4. Dietitian reviewed the weight of resident #174 with an initial order on [redacted] nutritional supplement but indicating to start on [redacted] was also reviewed. No weight loss indicated. IDENTIFY OTHERS: 1. Nursing reviewed all residents on [redacted] and [redacted] for duplicate orders. No further duplicates identified. 2. All residents were reviewed for any queued orders. No other residents with queued orders noted. 3. All [redacted] were checked and were available. [redacted] with [redacted] is still on backorder. 4. Dietitian reviewed all dietary recommendations not answered. No further recommendations not answered timely. INSERVICES: 1. In-services Coordinator/ designee initiated on 9/15/2022 to all nursing staff to ensure to discontinue duplicate [redacted] orders. Notify Dietitian and MD if the [redacted] is not available and to discontinue duplicate [redacted] order. Administration in serviced the central supply staff to ensure there is enough [redacted] in the back up supply and to notify dietitian and	

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F 658	Continued From page 7 management of care, dated [redacted] reflected the resident was [redacted] in a [redacted], and had no Brief Interview for mental status (BIMS) completed. The current physician's orders (PO) revealed a PO dated [redacted] for [redacted] every [redacted] with [redacted] milliliters (ml) [redacted]." In addition, another PO dated [redacted] Order every [redacted] give [redacted] ml [redacted] hours after each [redacted] A review of the current [redacted] electronic Medication Administration Record (eMAR) revealed the above duplicate PO for [redacted] after each [redacted] -PO dated [redacted] for [redacted] Order [redacted] with [redacted] after each [redacted] -PO dated [redacted] for "[redacted] Order [redacted] via [redacted] after each [redacted]." The [redacted] eMAR revealed that the nurses were signing for the administration of both above POs indicating that the [redacted] ml and [redacted] ml [redacted] were being administered [redacted] at the times of administration for 5:00 AM, 9:00 AM, 1:00 PM, 5:00 PM, 9:00 PM, and 1:00 AM. Further review of the [redacted] eMARs reflected that the above two (2) PO for the [redacted] were both being signed as administered every [redacted] hours. The interdisciplinary care plan (IDCP) reflected	F 658	nursing if the ordered supply is on backorder. Dietitian was given in service by the Administrator to ensure to review with the nurse of recommendations written or in queued order and address recommendations monthly if not answered. In-service will be ongoing until all staff are educated. QAPI: 1. Unit manager / designee will perform weekly audits on [redacted] and [redacted] weekly for 3 months then quarterly thereafter to ensure no duplicate orders. Central supply staff/ designee will perform audits on [redacted] weekly to ensure there is enough supply. 2. Dietitian/ designee will audit weekly for 3 months then quarterly to ensure that all queued orders/ recommendations are answered and submit audit to administrator. 3. Any negative findings will have immediate corrective action completed and reported to the Director of Nursing & the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Unit Manager, Central Supply and Dietician and will be ongoing until 100 percent compliant attained	

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F 658	Continued From page 8 that a focus with an initiation date of [redacted] was that the resident required a [redacted] for [redacted] and the interventions included providing [redacted] as ordered. On 8/9/22 at 12:08 PM, the surveyor, with LPN#2, reviewed the eMAR which reflected the two PO for [redacted] to be administered [redacted]. LPN#2 stated that the PO for the [redacted] ml [redacted] should have been discontinued when the new order for the [redacted] was ordered. LPN#2 then stated that she would get in touch with the dietician and physician to discontinue the [redacted] ml [redacted] PO. On 8/16/22 at 09:31 AM, the surveyor, in the presence of the survey team, interviewed the Registered Dietician (RD) who stated that for the [redacted] floors she reviewed recommendations with the Nurse Practitioner (NP) and would then enter the recommendation electronically into a queue (the highlighted area where orders would wait to be approved by the physician). The RD added that putting the recommendation in the queue would make the nurses aware of a recommendation that needed to be verified by the physician to obtain a PO. The RD further stated that she was unable to discontinue an old PO and that she can only put it in the queue for a new recommendation. The RD also stated that the nurse would contact the physician to obtain a new PO and would also obtain a PO to discontinue an old PO. The RD was unable to speak to the two PO for [redacted] for Resident #153 because she wanted to review the resident's chart. On 8/16/22 at 10:17 AM, the surveyor interviewed the RD who stated that the current PO for the [redacted] should have been for [redacted] m[redacted]. The RD explained that the PO for the [redacted] ml [redacted] was	F 658		

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F 658	Continued From page 9 older and had not been discontinued. The RD added that it was "probably an oversight" that the [redacted] ml PO was not discontinued. On 8/16/22 at 12:50 PM the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON acknowledged that there were duplicate PO for [redacted] for Resident #153. The DON stated that the nurses had not discontinued the old PO to [redacted] ml when the new PO for [redacted] ml was received. 2. On 8/16/22 at 11:33 AM, the surveyor observed Resident # 91 out of bed seated in a wheelchair inside his/her room. The resident was [redacted]. The surveyor observed [redacted]) in use [redacted] ml/hr (milliliters per hour). The [redacted] infusing was [redacted]. On 8/17/22 at 11:35 AM, two surveyors observed Resident # 91 awake out of bed seated in a wheelchair inside their room. The surveyors observed that the [redacted] infusing was [redacted] at [redacted] ml/hr. The surveyor reviewed the medical record for Resident # 91. The resident's Admission Record reflected that the resident had diagnoses that included but were not limited to [redacted], and	F 658		

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F 658	Continued From page 10 [redacted]. According to the resident's qMDS dated [redacted] reflected that the resident's [redacted] for daily [redacted] were [redacted]. Further review of the MDS reflected that the resident had a [redacted]. The [redacted] Medication Review Report (MRR) reflected a Physician's Order (PO) dated [redacted] for [redacted] Order [redacted] times a day [redacted] ml/[redacted] [redacted] [redacted] with [redacted] ml of [redacted] after each [redacted] to provide [redacted] per day. Further review of the [redacted] MRR revealed a second PO dated [redacted], for [redacted] with [redacted]) give [redacted] ml via [redacted] six times a day related to [redacted] status add [redacted] run at [redacted] ml/hr ([redacted]). The [redacted] eMAR reflected the above two corresponding POs. Further review of the [redacted] eMAR revealed that both POs were documented as administered. The resident's personalized Care Plan (CP) date initiated on [redacted], reflected a focus area that the resident has [redacted]. The interventions for the resident's CP indicated providing [redacted] ml with [redacted] ml [redacted] at [redacted] ml/hr, [redacted] times a day. The Nutritional/Diet Recommendations dated [redacted] provided by the RD indicated to change	F 658		

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F 658	Continued From page 11 the [redacted] ml with [redacted] ml [redacted] [redacted] at [redacted] ml/hr, [redacted] times a day at (12 AM, 4 AM, 8 AM, 12 PM, 4 PM, and 8 PM). On 8/17/22 at 11:26 AM, the surveyor interviewed the assigned LPN#3 for Resident #91. LPN #3 in the presence of the surveyor reviewed the electronic PO and acknowledged that there was [redacted] POs; one dated [redacted] and one dated [redacted]. She also acknowledged that the resident was getting the wrong [redacted]. She stated that "somebody changed the order and didn't discontinue the old order." She said that the process was that the RD and doctor should have been notified to clarify the order. She could not speak to why the two [redacted] orders were not clarified by the RD and the doctor. LPN #3 also confirmed that the resident was receiving [redacted]. On 8/17/22 at 12:40 PM, the surveyor interviewed the RD who stated and acknowledge that there should not be two [redacted] POs and that she would have to look into it. She further stated that once the [redacted], order was entered into the electronic medical record, then the [redacted], the order should have been discontinued. She then stated that the orders were probably changed because the [redacted] may not have been available. On 8/17/22 at 2:00 PM, the RD returned to speak with the surveyor who stated that the [redacted] PO was from [redacted] She provided a copy of a [redacted] Nutritional/Diet Recommendation which indicated that she recommended changing the [redacted] to [redacted] The RD further stated and acknowledged that the resident had a duplicate	F 658		

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F 658	Continued From page 12 [redacted] order and acknowledged that the resident was not receiving [redacted] as per the [redacted] PO. She further stated, "because the distributor doesn't always have the [redacted] product and they send what they have." On 8/17/22 at 2:35 PM, the surveyor interviewed the DON who acknowledged that the [redacted] PO should have been discontinued and stated she will look into who entered the order and why the order was not discontinued. She further stated that the 11-7 nurse conducts the order recaps and should have picked up on the duplicate [redacted] orders. On 8/18/22 at 12:01 PM, the surveyor interviewed the Director of Central Supply in the presence of the survey team. He acknowledged that he ordered the [redacted] and was familiar with [redacted] and the [redacted]. He stated, that the [redacted] has "been on backorder" and then stated, "only this week" he ordered a case of [redacted] for the week and did not have any [redacted] in backup supply. He stated he orders "just what is needed to stay on budget. I communicate to the dietician so she can change the orders." He further stated, "this week was the first time we did not get the [redacted]." On 8/18/22 at 12:38 PM, the surveyor met with the LNHA and the DON. The DON acknowledged there were two [redacted] physician orders and she stated, "the old order was continued and should have been discontinued." She further stated that the physician's order for [redacted] should have been changed since the distributor could not send the [redacted] and that the RD and doctor should	F 658		

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have been notified. The LNHA and DON acknowledged that the distributor sends what they have and do not always have [redacted]

3. On 8/4/22 at 10:24 AM, the surveyor observed the resident in their room, [redacted] and about to receive care from a Respiratory Therapist (RT).

On 8/10/22 at 10:25 AM, the surveyor observed the resident inside their room in a wheelchair. The resident was [redacted] to the surveyor. The surveyor observed that the resident was receiving th [redacted] through a tube [redacted] being infused at a rate of [redacted] ml per hour.

The surveyor reviewed the medical records of Resident #174.

The Admission Record reflected that the resident had diagnoses that included but were not limited to [redacted]

The resident's qMDS dated [redacted] reflected that the resident had [redacted]. It also reflected that the resident had a [redacted] by which he/she was totally [redacted].

The resident's Order Summary Report (OSR) for [redacted] reflected that there was a PO for [redacted] liquid [redacted]. The OSR reflected that [redacted] ml

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should be given [redacted] times per day at an infusion rate of [redacted] ml per hour. The OSR indicated an initial order date for [redacted] and the start date was not indicated until [redacted]

Further review of the resident's OSR dated [redacted], reflected that there was a physician's order for [redacted] ml to be given [redacted] times per day at an infusion rate of [redacted] ml per hour. This order was queued by the RD on [redacted] at 12:39 PM, it was indicated as an active order by the Medical Director on [redacted] at 12:36 PM, and was created by LPN#4 on [redacted] PM.

A review of the resident's Progress Notes (PN) reflected the following:

A nursing PN dated [redacted] at 5:22 AM reflected that Resident #174 returned to the facility from a hospital stay at 3:45 AM.

An RD re-admission nutrition assessment dated 7/13/22 at 12:28 PM reflected that the resident was re-admitted with a [redacted] order for [redacted] ml via the [redacted] 0 ml/hour, [redacted] times per day. The RD recommended changing this to [redacted] at [redacted] ml/hour, [redacted] times per day.

A nursing PN dated [redacted] at 23:26 PM reflected that [redacted] increased as per order, [redacted] m[redacted] times a day at [redacted] ml/hr."

An RD progress note dated [redacted] at 9:05 AM reflected that the resident weighed [redacted] pounds on [redacted] and [redacted] pounds on [redacted].

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There was no further documented evidence provided by the facility to explain why there was a delay in carrying out the physician's order promptly from the initial RD recommendation on [redacted].

On 8/16/22 at 9:31 AM, the surveyor interviewed the RD who stated that if a [redacted] resident was assessed and required a change in approach for medical nutrition therapy, she would discuss this with the NP. The RD would then enter the recommendation in the electronic medical record (EMR) as a queue (which was a set of orders that required approval). She further stated that this would have been reflected in the PN. She also stated that she reviewed this with the NP before completing the readmission assessment.

On that same date and time, the RD stated that she would expect that by the end of the day the queued order would be active, and the previous order would have been discontinued. She further stated that at this time she did not have a process to follow up if recommendations were carried out prior to her next assessment.

On 8/16/22 at 10:35 AM, the surveyor interviewed the RD who stated that she could not remember writing the order in the que and further stated that the nurses, NP, and physician were expected to review her PN.

On 8/16/22 at 11:00 AM, the surveyor interviewed LPN #2 who stated that an RD recommendation needed to be reviewed by the NP and/or Physician before an order change was created.

On 8/17/22 at 2:32 PM, the surveyor interviewed the DON in the presence of the LNHA and the

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F 658	Continued From page 16 survey team. She stated that the 11 PM-7 AM nurse/nursing supervisor was responsible to review and ensure physicians' orders and change requests were reviewed and carried out promptly. In addition, she stated that if there were any questions or concerns that it would be the nurse's responsibility to call the physician for clarification. On 8/18/22 at 10:23 AM, the surveyor interviewed the RD in the presence of the survey team. The RD acknowledged that she queued a change in [redacted] order on [redacted], which was not created till [redacted] and not started until [redacted]. The RD stated that she discussed her recommendations with the NP prior to queuing the order change and discussed this with the Unit Manager or nurse to ensure that they were aware. She further stated that "it's all in my notes." On 8/18/22 at 11:55 AM, the surveyor interviewed the DON in the presence of the survey team. She stated that when the RD queued a nutritional order change, she communicated that to the nurse so she could review and verify approval with the physician and create the change. The DON stated that if the physician did not approve the recommendation that the nurse should have written a progress note. On that same date and time, the DON further stated that the que would then "go away" and the RD should have been notified. We reviewed the Order Audit Report and the DON acknowledged that the RD queued the recommendation on [redacted] and the order was not created by the nurse until [redacted]. She could not speak to delay and stated that the RD probably did not communicate with the nurse. She stated that she	F 658		

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would investigate what occurred.

On 8/19/22 at 10:31 AM, the surveyor interviewed the DON. The DON stated that she interviewed LPN#4 who acknowledged that she received the physician's order from the NP to create a change for a [redacted] order for Resident #174 in accordance with the RD recommendation. However, LPN #4 could not speak to the delay.

A review of the facility policy "Nutrition Assessment Policy" with a revision date of 6/2022, reflected that the RD "will complete a comprehensive medical nutrition therapy assessment for each individual that is referred or identified for assessment." It further reflected that the RD "will identify nutritional risk factors and nutrition diagnosis and recommend nutrition interventions based on each individual's medical condition, needs, desires and goals."

A review of the facility policy "Nutrition Recommendation Policy" with a revision date of 1/2022, reflected that the RD "will write the recommendation on the Nutritional Recommendation form or queued on EMR." It also reflected that the RD "will review recommendation with the nurse on the floor after submitting the form or queuing the recommendation on EMR. The nurse will need to follow up on the recommendations, writing in a comment as to whether it was completed, or if the physician deferred the recommendation, and the reason for deferring it, if one was given. The nurse will document accordingly in the resident's medical record after verifying with the physician." It further reflected that the RD "will address those recommendations not answered during monthly weight assessment if there is a significant

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F 658	Continued From page 18 change." Review of the facility policy "Physician Orders" with a revision date of 3/2022, reflected that "Any order that is in question must be repeated to the physician." It also reflected to "Notify nursing administration and medical director whenever an order that is questioned, cannot be verified, or carried out." It reflected that "Nurse carrying out orders will enter date and time the order was carried out." In addition, it reflected that " ...orders must be signed electronically by nurse within 7 days, except for orders for non-prescription drugs or treatments, which shall be signed at the physician's or advanced practice nurse's next visit to the resident." It reflected that "Nursing will then follow up through on the order." It also reflected that "Night shift nurses will review orders entered for the day by verifying orders and reviewing that all orders are entered in accurately in EMR." Lastly, it reflected that "If night shift nurses find discrepancy, night shift nurse will reach out to MD for verification." NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 686 SS=D	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 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		11/11/22

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F 686	Continued From page 19 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, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) follow a Physician's Order (PO) for the treatment of a [redacted] in accordance with professional standards of practice and b.) ensure a resident received treatment and services to promote healing of a [redacted]. This deficient practice was identified during the [redacted] treatment observation for one of four residents, (Resident #153) reviewed for [redacted]. The deficient practice was identified by the following: On 8/03/22 at 01:10 PM, the surveyor observed Resident #153 laying in bed on an [redacted] in their room. The surveyor further observed that the resident had [redacted]) and was [redacted] On 8/17/22 at 12:20 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) prior to the [redacted] treatment observation. The LPN stated the resident had a [redacted] on the [redacted] of his/her [redacted] that was [redacted] to [redacted] and the [redacted] in size. The LPN further told the surveyor that the resident required total care with Activities of Daily Living (ADLs) and was unable to move	F 686	IMMEDIATE ACTION On 8/17/2022 LPN assigned to do the wound treatment for resident #153 was in serviced to ensure she follows physician order. Resident # 153 was seen by [redacted] doctor on [redacted] to assess resident's [redacted] and recommend new treatment. IDENTIFY OTHERS: On 9/14/2022 Unit Managers/designee reviewed all [redacted] treatment orders to ensure residents are receiving treatment and services to promote healing of [redacted] facility acquired [redacted] Any negative findings will be corrected accordingly. INSERVICES: On 9/15/2022 In-service Coordinator/designee initiated in services to all licensed nurses on the policy on [redacted] Policy and Procedure. [redacted] treatment competencies for all licensed nurses were initiated on 9/15/2022 and will continue until all nurses have received education and completed competencies. QAPI: Assistant Director of Nursing/designee will perform weekly audits on [redacted] treatment observations for the first 3	

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F 686	Continued From page 20 without assistance from staff. At 12:30 PM, the surveyor observed the LPN with assistance from the Respiratory Therapist (RT) [redacted] of the resident's [redacted]. The surveyor observed the [redacted] and surrounding skin on the [redacted] of the resident's [redacted] and asked the LPN to describe what the [redacted] looked like. The LPN stated that the [redacted] and the [redacted] was healing. The surveyor then observed the LPN remove a piece of [redacted] meant to absorb [redacted] to promote healing. The material is used as a primary dressing, only to be placed on the [redacted] and not on the surrounding skin). The surveyor further observed the LPN place the [redacted] dressing directly on top of a [redacted] dressing [redacted] dressing) and place the [redacted] dressing in direct contact with the back of the resident's [redacted] which consisted of the resident's [redacted] and surrounding skin. The LPN secured the dressing in place with assistance from the RT and completed the [redacted] treatment for Resident #153 in the presence of the surveyor. At 12:45 PM, the surveyor reviewed the PO for the treatment in the presence of the LPN. The PO indicated to cleanse the [redacted] pat dry, apply an [redacted] dressing pad, and [redacted]. The LPN stated that the expectation when performing a treatment on a [redacted] was to follow the PO. The LPN further stated that she thought [redacted] and [redacted] were the same dressing. At 12:47 PM, the surveyor interviewed the Licensed Practical Nurse/Clinical Nurse Manager	F 686	months then quarterly thereafter. Assistant Director of Nursing/designee will perform weekly audits on ensuring all [redacted] have appropriate treatment in place for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Assistant Director of Nursing and reported to the Director of Nursing & Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Assistant Director of Nursing and will be ongoing until 100 percent compliant attained.	

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F 686	Continued From page 21 (LPN/CNM) who stated the expectation for the nurse while performing a [redacted] care treatment was to follow the PO. The surveyor reviewed the medical record for Resident #153. The Admission Record for Resident #153 reflected that the resident had resided at the facility for over a decade and had diagnoses that included but were not limited to [redacted] The resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated that the resident was in a [redacted] iousness. A further review of the resident's MDS, [redacted] - Skin Conditions reflected that the resident was at risk for [redacted], had one [redacted] injury, and the treatments provided included the application of nonsurgical dressings. According to the resident's [redacted] Order Summary Report (OSR) reflected a PO dated [redacted] to cleanse [redacted] on the back of the [redacted] with [redacted], pat dry, apply [redacted] dressing, pad with [redacted] every day and evening shift for reopen area and evaluate the [redacted] weekly. The resident's [redacted] Treatment Administration Record (TAR) reflected that the nurses were signing on the day and evening shifts that they were cleansing the [redacted] on the	F 686		

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F 686	Continued From page 22 back of the resident's [redacted] with [redacted], pat drying, applying [redacted] dressing and padding the [redacted] with [redacted] dressing. A review of the resident's personalized Care Plan revised on [redacted] revealed a focus area that the resident was at risk for skin breakdown secondary to the presence of a [redacted]. The focus area further reflected that the resident had a reopened area to the back of their [redacted]. The goal of the resident's Care Plan indicated that the resident's skin and [redacted] would be free from further breakdown and the [redacted] would heal before the next review date. Interventions in the resident's Care Plan included applying treatment as ordered and observing skin integrity every shift. On 8/18/22 at 12:48 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident's physician had ordered the [redacted] dressing and the treatment order that was performed on the resident should have reflected the PO. At that time, the facility's Administrator provided the surveyor with e-mail correspondence with the facility's [redacted] and Product Specialist who provided the facility with their [redacted] care products. A review of the e-mail provided by the [redacted] and Product Specialist dated [redacted] and timed at 9:18 AM indicated that aquacel was a brand name product and [redacted] was a generic name product. Each product's purpose was to remove [redacted] from the [redacted] and absorb	F 686		

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F 686	Continued From page 23 moisture to promote [redacted] healing. The e-mail provided by the [redacted] care specialist indicated that the dressing should only be placed on the [redacted] and not on the [redacted] (surrounding) skin because it could cause [redacted] On 8/19/22 at 12:09 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the resident's [redacted] was [redacted] and opened on [redacted]. The ADON told the surveyor that she followed the resident's [redacted] weekly and identified that the resident's [redacted] was decreasing in size, so the same treatment order was continued. The ADON further stated that the nurses should have performed the appropriate PO when performing the [redacted] care treatment and the dressing applied to the back of the resident's [redacted] should have only been applied to the resident's [redacted] bed and not on the resident's surrounding skin. A review of the resident's weekly [redacted] update sheet provided by the ADON indicated that the resident's [redacted] had decreased in size since 6/27/22. A review of the facility's Dressing Changes [redacted] Treatment Policy and Procedure dated 11/23/2010 indicated that it was the facility's policy that, "Dressing changes [redacted] care will be completed per physician order and documented on resident's treatment record and weekly [redacted] progress report." NJAC 8:39-27.1(a,e)	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		11/11/22

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F 688	Continued From page 24 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to a.) provide an appropriate services to a resident with a [redacted]) order and recommendations for [redacted] residents (Resident #40 and #174) and b.) ensure that the [redacted] for Resident #80 and [redacted] for Resident # 86 and were consistently applied for [redacted] management for 2 of 8 residents reviewed for a [redacted] This deficient practice was evidenced by the following: 1. On 8/3/22 at 10:49 AM, the surveyor observed Resident #40 in bed with their eyes closed. The	F 688	IMMEDIATE ACTION On 8/16/2022 residents #40 and #174 were provided with [redacted] by their assigned CNA but there is no area on the task to record. Assigned CNAs were in-serviced to follow the physician order for PROM. On 8/16/2022 LPNs assigned for residents #80 and #86 were in serviced on ensuring [redacted] are applied per physician□s order. Nursing assessed resident #40, #174, #80 and #86 for any negative affect and no negative findings observed. IDENTIFY OTHERS: On 9/15/2022 Unit Managers/designee reviewed all orders for [redacted] and [redacted]	

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F 688	Continued From page 25 resident was on a [redacted] and was breathing easily. The surveyor reviewed the medical records of Resident #40. The Admission Record (face sheet/admission summary) indicated that the resident was admitted to the facility with diagnoses that included [redacted]. The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that Resident #40's Brief Interview for Mental Status (BIMS) was unable to be completed due to [redacted] of the MDS the functional status assessment for [redacted] indicated that Resident #40 had impairment of the [redacted] and [redacted] Resident #40's personalized Care Plan had a focus area dated [redacted] for physical and [redacted] that contained a goal for Resident #40 to tolerate [redacted] to be used while in bed while in the [redacted] position, without adverse reactions via staff observation and report. One of the interventions that were dated [redacted] was for staff to perform gentle [redacted] to above [redacted] as tolerated before	F 688	to ensure staff were following the physician order. Any negative findings were corrected accordingly. Facility added a section in the EMR (electronic medical record) for CNAs to document when they have performed [redacted] under their task on 9/23/2022. INSERVICES: On 9/15/2022 In-service Coordinator/designee initiated in services to all nursing staff to ensure all orders for splints are being applied and recorded on EMR (electronic medical record) . On 9/23/2022 In-service Coordinator/designee initiated in services to all CNAs on where to now document on their task record after completing [redacted] as ordered by the physician. QAPI: Director of Nursing/designee will perform weekly audits on ensuring all residents with [redacted] orders are applied for the first 3 months then quarterly thereafter. Director of Nursing/designee will perform weekly audits on ensuring all CNAs are recording [redacted] under their tasks. Any negative findings will have immediate corrective actions taken by Director of Nursing and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Nursing and will be ongoing until 100 percent compliant attained.	

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F 688	Continued From page 26 applying [redacted] during AM and PM care. Resident #40's [redacted] Order Summary Report (OSR) revealed that Resident #40 had an order dated [redacted] for [redacted] every day and evening shift perform gentle [redacted] to above [redacted] as tolerated especially [redacted] before applying [redacted] A review of the [redacted] Task List Report (TLR) which is a list of daily tasks performed by Certified Nursing Assistants (CNAs) revealed a task for "Every day and evening shift perform gentle [redacted] to above [redacted] as tolerated especially [redacted] before applying [redacted] " The [redacted] Task Care Record under "every day and evening shift perform gentle [redacted] to above [redacted] as tolerated especially [redacted] before applying [redacted] " revealed no initials of CNAs who performed the task. On 8/16/22 at 11:15 AM, the surveyor interviewed the Pediatric Physical Therapist (PPT) who stated that the resident "maxed out" of physical therapy and that the resident has been endorsed to nursing for [redacted] He stated that therapy had nothing in place to oversee and to make sure that nursing is performing [redacted]. He stated that this program is overseen by nursing. Nursing will reach out to therapy if they have a concern with a resident but "usually" residents are screened quarterly or when they are admitted or re-admitted to the facility. On 8/16/22 at 12:10 PM, the surveyor interviewed	F 688		

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F 688	Continued From page 27 Resident #40's Certified Nursing Assistant#1 (CNA#1) who stated that she performs PROM with her residents. The surveyor asked the CNA to show him how she documents that she performed [redacted]. The CNA stated that she does not document when she performed [redacted]. 2. On 8/03/22 at 12:16 PM, the surveyor observed that Resident #80 was laying on the bed. The resident was [redacted] the [redacted] was positioned [redacted], and [redacted] on the side and bent at the [redacted] The resident's [redacted] were observed to be bent at the [redacted] and the resident's [redacted] were bent to the [redacted] in front of the resident and the [redacted] behind the resident [redacted]. No [redacted] or supportive positioning devices were observed that were used for the [redacted] limitation. On 8/4/22 at 12:38 PM, the surveyor observed Licensed Practical Nurse#1 (LPN#1) wearing an N95 mask and goggles (eye protection) with a medicine cart (med cart) in front of Resident #80's room. LPN#1 informed the surveyor that the resident was on the window bed. LPN#1 then provided the surveyor with an isolation gown. At that same date and time, the surveyor observed Resident #80 laying on the bed with the head of the bed elevated approximately 30 degrees. The resident did not have a [redacted] or assistive device in use for their [redacted] with limitations. There were [redacted] on top of the table with the resident's name on it and underneath was the [redacted] assistive device. The surveyor reviewed the medical record of Resident #80.	F 688		

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F 688	Continued From page 28 The Admission Record indicated the resident was admitted to the facility with diagnoses that included but were not limited to [redacted]. The [redacted] QMDS indicated a Cognitive Skills for Daily Decision-making were [redacted]. According to [redacted], OSR included a physician order dated [redacted] for [redacted] one time a day, on after AM care when in bed r out of bed in a wheelchair, or as tolerated, Off during PM care, except when an acute medical condition exists and inspect skin before applying and after removing [redacted] The order for the [redacted] was transcribed to the electronic Treatment Administration Record (eTAR) for [redacted] and signed by nurses as administered or applied. The personalized care plan focus on significant [redacted] and progressive [redacted] date initiated on [redacted]. The interventions/tasks included: to follow instructions for wearing the schedule and [redacted] and [redacted] to be worn AM to PM care when going out of bed except if an acute medical condition exists. Further review of the [redacted] through [redacted] medical records showed that there was no further documentation that indicates that the resident	F 688		

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F 688	Continued From page 29 declined the use of the [redacted], was unable to tolerate them, and complained of [redacted] On 8/9/22 at 12:00 PM, both the surveyor and LPN#1 entered Resident #80's room and both observed that the resident did not have [redacted] in use. There were three (3) pieces of paper posted on the wall of the resident near the resident's headboard that included device: [redacted] (with a picture of the resident's [redacted] in use while on a bed) to be used: on after AM care when in or out of bed as tolerated, without the [redacted], except when an acute medical condition exists. On that same date and time, during an interview of the surveyor with LPN#1, the LPN indicated that the [redacted] should have been placed. The surveyor then asked the LPN why it was not in use today. LPN#1 stated that she was busy admitting a resident that came in last night. Furthermore, the surveyor asked LPN#1 why the [redacted] were also not in use when the surveyor observed the resident on [redacted] at 12:38 PM when the surveyor observed the LPN in front of the resident's room on that day. The LPN had no answer. On 8/9/22 at 12:25 PM, the surveyor informed the Licensed Practical Nurse/Unit Manager about the above concern. On 8/15/22 at 12:17 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and both were made aware of the above concerns.	F 688		

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F 688	Continued From page 30 On 8/16/22 at 12:50 PM, the survey team met with the LNHA and the DON. The LNHA informed the surveyors that LPN#1 acknowledged that the [redacted] should have been placed according to the physician's orders and that the nurse was provided an in-service and education. 3. On 8/03/22 at 11:00 AM, during the initial tour of the facility, Resident #86 was observed in the bed with their eyes open. The resident's [redacted] were [redacted] and there were no adaptive devices ([redacted]) observed in the resident's [redacted]. The surveyor reviewed Resident #86's medical records. According to the Admission Record, Resident #86 was admitted to the facility with medical diagnoses including, but not limited to [redacted]). The Admission Minimum Data Set (AMDS) dated [redacted] indicated that Resident #86 BIMS was unable to be completed due to [redacted] The resident's functional status was one person assistance for dressing, personal hygiene, eating, and toilet. [redacted] of the MDS functional status assessment and [redacted] indicated that Resident #86 had impairment of the [redacted]. The resident's personalized care plan had the following focus: Patient presents with	F 688		

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contractures to [redacted] and [redacted], and the following goal: Resident will tolerate [redacted] without adverse reaction via staff observation/report, the care plan was initiated [redacted]. The intervention for the care plan was to apply [redacted] from AM to PM care except if an acute medical condition exists.

The [redacted] physician's orders showed the following:
1. [redacted] one time a day for [redacted] Perform gentle [redacted] to both [redacted] and [redacted] as tolerated prior to applying [redacted] during AM or PM care, except if an acute medical condition exists.
2. [redacted] one time a day PUT ON DURING AM care when out of bed, except when an acute medical condition exists. OFF DURING PM CARE when going back to bed. and remove per schedule
3. [redacted] every day shift. To be worn AM TO PM CARE AND OR AS TOLERATED, EXCEPT IF AN ACUTE MEDICAL CONDITION EXISTS.

The [redacted] eTAR showed that the nurse signed that the hand rolls were applied including on [redacted] in the AM.

On 8/09/22 at 12:42 PM, the surveyor observed the resident in bed with their eyes open. The resident had [redacted]. The resident did not have [redacted] placed as signed on the eTAR.

On 8/10/22 at 11:08 AM, the surveyor reviewed the eTAR, and [redacted] were not signed as

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F 688	Continued From page 32 applied at the time of review of the eTAR on [redacted] On 8/10/22 at 11:52 AM, the surveyor reviewed eTAR, AM [redacted] were not signed as applied as of the time of the review. On 8/11/22 at 12:20 PM, the surveyor observed Resident #86 sitting in a chair on the right side of the bed. The resident did not have [redacted] in place on their [redacted]. The surveyor observed one [redacted] on an overbed table and one [redacted] on the nightstand to the left side of the bed. On that same date and time, the surveyor interviewed CNA#2 regarding Resident #86 [redacted] CNA#2 told the surveyor, "I only saw one in the room, and this is the first time I ever saw them with the resident". The surveyor asked if CNA#2 had ever seen [redacted] on the resident and she said, "the resident has been here about a week in a half, and no I have not." On 8/11/22 at 12:45 PM, the surveyor interviewed LPN#2 regarding [redacted]. The LPN said the CNA was responsible to apply the resident's [redacted] At that time, the surveyor asked LPN#2 to accompany the surveyor into Resident #86 room and showed the LPN the [redacted] on the overbed table and the nightstand. The LPN said to the surveyor, "they ain't doing no good there," and then the LPN applied the [redacted]. On 8/11/22 at 12:49 PM, the surveyor reviewed the eTAR and the [redacted] were not signed as applied for 8/11/22.	F 688		

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F 688	Continued From page 33 On 8/16/22 at 11:50 AM, the surveyor met with the LNHA. The LNHA acknowledged that the resident was observed by the surveyor without [redacted] on 8/3, 8/9, 8/10, and 8/11. The LNHA indicated that the resident should have a hand splint on those identified dates. 4. On 8/3/22 at 11:11 AM, the surveyor observed Resident #174 in bed and unable to respond appropriately to the surveyor's questions. The resident was observed on a [redacted], and was breathing easily. The surveyor reviewed Resident #174's medical records. The Admission Record indicated that the resident was admitted to the facility with a diagnosis that included [redacted], and age-related [redacted]). The QMDS dated [redacted] indicated that Resident #174's BIMS was unable to be completed due to [redacted]. [redacted] of the MDS the functional status assessment for ROM indicated that Resident #174 had impairment of the [redacted] and [redacted]. Resident #174's's personalized Care Plan had a focus area dated [redacted] for "[redacted] and [redacted] limiting optimal position" that contained a goal for Resident #174 to maintain [redacted] and prevent progression of [redacted] with a	F 688		

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F 688	Continued From page 34 target date of [redacted] One of the interventions that were dated [redacted] was for the resident "to perform [redacted] to the above [redacted] as tolerated during AM/PM care except when an acute medical condition exists." The Pediatrics (Peds) Occupational Therapy/Physical Therapy (OT/PT) screen with an effective date of [redacted] revealed that the resident was not tolerating the [redacted] support intended to control the position and [redacted] of the [redacted] compensate for [redacted] or [redacted]) and the therapy screen comments included, " ...Continue [redacted] of [redacted] during AM and PM care to prevent progressive [redacted] development ...." Resident #174's [redacted] OSR revealed an order dated [redacted] for [redacted] one time a day perform gentle [redacted] to above [redacted] as tolerated during AM/PM care except when an acute medical condition exists." The [redacted] TLR revealed a task to "perform gentle [redacted] to above [redacted] as tolerated during AM/PM care except when an acute medical condition exists." The [redacted] Task Care Record under "perform gentle [redacted] to above [redacted] as tolerated except when an acute medical condition exists" revealed no initials of CNAs who performed the task which means that there was no accountability that the [redacted] was being done. On 8/16/22 at 11:15 AM, the surveyor interviewed the PPT who stated that the resident maxed out of PT and that the resident has been endorsed to nursing for [redacted] When the surveyor asked the	F 688		

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F 688	Continued From page 35 PPT if his department oversees the Restorative care program, he stated that therapy had nothing in place to oversee this program and that the restorative program is overseen by nursing. He also stated that nursing will reach out to therapy if they have a concern with a resident but usually residents are screened quarterly or when they are admitted or re-admitted to the facility. On 8/16/22 at 12:10 PM, the surveyor interviewed Resident #174's CNA. CNA#1 stated that she performs [redacted] with her residents. The surveyor asked the CNA where she documents that she performed [redacted] to Resident #174. CNA#2 stated that she does not document when she performed [redacted] When the surveyor asked the CNA if she performs [redacted] with the resident's [redacted], the CNA stated "no" and that she works "only" with the resident [redacted]. On 8/16/22 at 12:15 PM, the surveyor interviewed LPN #3. LPN #3 showed the surveyor the order for Resident #174 and stated that she will perform [redacted] during morning care. She also stated that she signs off on the eTAR. On 8/16/22 at 12:30 PM, the surveyor reviewed the [redacted] eTAR for Resident #174 which revealed no documentation that the [redacted] was being done. On 8/17/22 at 1:45 PM, the surveyor met with the facility LNHA and DON. The LNHA stated that [redacted] is done by the CNAs. The order will be under CNAs Task on the electronic medical record. The LNHA stated that daily CNAs assignments (Kardex) will be printed out and will be placed at the time clock in the nursing station.	F 688		

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F 688	Continued From page 36 She further stated that CNAs know that they will have to check for their daily assignments. On that same date and time, the LNHA further stated that the CNAs will perform the [redacted] during morning care and stated that they don't sign off after performing [redacted]. The LNHA and DON were unable to tell the surveyor how the facility accounting for the task is being performed when there are no initials from the CNAs who provided the task. A review of the facility Orthotic Devices Policy with the last review date of 5/22, provided by the LNHA included "Orthotic devices include but are not limited to the following: Resting hand splints, Comfy hand splint, Wrist cock up splint, Ankle Foot Orthosis AFO, Knee Immobilizer...When a splint has been issued, an Adaptive Equipment Form will be issued to notify nursing of the type of splint along with the wearing schedule as well as my special instructions in its use or care. Devices will be monitored by nursing....Procedure: ...4. The CNA performs the [redacted] during ADL Care." A review of the facility [redacted] Policy with the last review date of 5/22, provided the LNHA included in the Policy "In an effort to maintain the resident's available [redacted], the residents will be assessed on an ongoing basis to determine appropriatness for [redacted]) protocol. The decision to place a resident on a Nursing Rehabilitation [redacted] is made by the therapist," "The decision to place a resident on a [redacted] program will be based on the following criteria: * The resident is not able to independently	F 688		

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F 688	Continued From page 37 perform [redacted] exercises of one or more [redacted] * The resident displays [redacted] in one or more joints." " Under procedure: 4. The certified Nursing Assistant (CNA) performs the [redacted] during ADL care."	F 688		
F 695 SS=D	NJAC 8:39-27.2 (m) 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 observations, interviews, and record review it was determined that the facility failed to clarify physician orders for [redacted] therapy and develop a personalized care plan for [redacted] of [redacted] residents (Resident #86) reviewed for [redacted] care. This deficient practice was evidenced by the following: On 8/03/22 at 11:15 AM, during the initial tour of the facility, Resident #86 was observed in the	F 695	IMMEDIATE ACTION On 8/15/2022, resident #86 [redacted] order was clarified by physician and order reads as needed for [redacted] or [redacted] less than [redacted] and [redacted] care plan was updated. IDENTIFY OTHERS: On 8/16/2022 Unit Managers/designee reviewed all PRN [redacted] physician orders to ensure there is clarification on the parameters of [redacted] level on when to	11/11/22

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F 695	Continued From page 38 room. The resident was not wearing [redacted] at the time of the observation. There was an [redacted]) in the resident's room that was not in use. The [redacted] was inside a bag on top of the [redacted] The surveyor reviewed Resident #86's medical records. According to the Admission Record (face sheet/admission summary), Resident #86 was admitted to the facility with medical diagnoses including, but not limited to [redacted] The Admission Minimum Data Set (AMDS) dated [redacted] indicated that Resident #86 BIMS was unable to be completed due to [redacted] The Physician Order Sheet (POS) dated [redacted] showed an order for [redacted] at [redacted] for [redacted]. The order read as follows: MAY USE [redacted] and the other end tubing to the [redacted] machine) AS NEEDED FOR [redacted] The electronic Medical Record (eMR). The eMR showed that between the dates of [redacted] to [redacted] the resident's [redacted] ranged from [redacted] percent and the [redacted] was checked a total of 42 times through that period.	F 695	apply [redacted] on resident and reviewed all [redacted] care plans are updated and in place. Any negative findings were corrected accordingly. INSERVICES: On 9/15/2022, In-service Coordinator/designee initiated in services to all nurses to ensure all PRN [redacted] physician order has clarification on the parameters of [redacted] level on when to apply [redacted] on resident and that all [redacted] care plans are in place. In services will be ongoing until all staff are educated. QAPI: Director of Nursing/designee will perform weekly audits on ensuring all residents with PRN [redacted] order have clarification by physician and [redacted] care plan is in place. Any negative findings will have immediate corrective actions taken by Director of Nursing and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Nursing and will be ongoing until 100 percent compliant attained.	

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F 695	Continued From page 39 Further review showed that on all but three of the days the resident was not wearing [redacted] when the [redacted] was checked. The three days the resident was wearing [redacted] were the following: 8/2/2022 at 07:59 [redacted] % [redacted] 8/1/2022 at 22:03 [redacted] % 7/22/2022 at 17:50 [redacted] % The graphic sheet did not indicate the amount of [redacted] the resident was wearing [redacted] at the time the resident's [redacted] level was checked. The personalized care plan did not show a focus plan for [redacted] and [redacted] care. The electronic Treatment Administration Record (eTAR) for [redacted] indicated that [redacted] was not used from [redacted] to the date of the review. The surveyor then reviewed the eTAR for [redacted] which showed that the [redacted] was not applied to the resident although the graphic chart indicated that the resident was wearing [redacted] on 7/22/22, 8/1/22, and 8/2/22. On 8/9/22 at 12:47 PM, the surveyor observed Resident #86 in the bed, the resident was not wearing [redacted] at the time of the observation and there was no longer an [redacted] in Resident #86 room or any [redacted]. On 8/10/22 at 12:25 PM, the resident was observed in bed with their eyes open. There was no [redacted] in the room. The surveyor asked Licensed Practical Nurse#1 (LPN #1), who was the resident's primary nurse if the resident wore [redacted]. LPN #1 told the surveyor the resident does not wear [redacted] and "has not since being admitted." The nurse could not speak about the one day in July or the two days in August when [redacted] was applied to	F 695		

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F 695	Continued From page 40 Resident #86. On 8/15/22 at 10:40 AM, the surveyor interviewed the resident's nurse regarding [redacted]. The surveyor asked if the resident wore [redacted] and LPN #2 said "no." Then, the surveyor asked LPN#2 to look at the physician's order and to show the surveyor the order for [redacted]. LPN#2 reviewed the [redacted] order and stated, "oh there is a PRN (as needed) order," for [redacted]. The surveyor asked what a [redacted] was and when would you apply the [redacted] to the resident, and LPN#2 said, "usually [redacted], but I would need another order." LPN#2 acknowledged that the order should be clarified to make it clear. On 8/15/22 at 12:15 PM, the surveyor spoke with the Licensed Nursing Home Administrator (LNHA) regarding the [redacted]. The LNHA said she would investigate it. On 8/16/22 at 10:40 AM, the LNHA presented the surveyor with a folder with a Quality Assurance Performance Improvement plan that was initiated on [redacted] after the surveyor's inquiry on Resident #86's [redacted] order that the order should have been clarified.	F 695		
F 761 SS=D	NJAC 8:39-27.1 (a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		11/11/22

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F 761	Continued From page 41 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to a.) secure 1 of 4 medication rooms, b). properly dispose of expired medications in 1 of 4 medication storage rooms, and c). disposed of expired medications in 2 of 7 medication storage carts inspected. This deficient practice was evidenced by the following: 1. On 8/17/22 at 10:30 AM, two surveyors entered the Central Supply Room (CSR) in the presence of the Head of Central Supplies (HCS). The surveyor observed that the CSR door was unlocked and they were no staff inside. The CSR contained the facility supply of over-the-counter (OTC) medications (which are non-prescription	F 761	IMMEDIATE ACTION On 8/17/2022, the Head of Central Supply was in-serviced by the Administrator to remind to always keep central supply room door closed and locked when unattended. Central Supply disposed all expired OTC medications found inside central supply room in the designated compactor. The expired [redacted] found on the [redacted] floor was removed from medication cart on 8/18/2022 and discarded in the designated compactor. IDENTIFY OTHERS: On 8/17/2022 Central Supply staff completed an audit on all medications stored in the central supply room to ensure all medications were unexpired.	

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F 761	Continued From page 42 medications) and two bags of expired OTC medications which were in the process of being disposed of per facility policy. They were no residents observed in the vicinity of the central supply room which was in an employee only section of the facility. At that time, the surveyor interviewed the HCS who stated that the Central Supply Room should be locked when they are no employees present. The Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) who were both present, stated that the CSR should be locked at all times. 2. On 8/17/22 at 10:15 AM, the surveyor inspected the OTC medication backup supply in the CSR in the presence of the HCS, DON, and LNHA. The surveyor observed four (4) unopened bottles of [redacted] that were expired (2 bottles on 5/22 and 2 bottles on 6/22) and 12 bottles of [redacted] that expired on 7/22. At that time, the surveyor interviewed the HCS who stated that all expired medication should have been removed from the active medications. On 8/17/22 at 1:45 PM, the surveyor met with the LNHA and DON. No further information was provided by the facility. 3. On 8/18/22 at 10:35 AM, the surveyor, with the third floor Registered Nurse/Unit Manager (RN/UM) performed an inspection of the medications stored in the [redacted] locked treatment cart which revealed one (1) opened a bottle of [redacted] with 4 [redacted] with an expiration date of March	F 761	No negative findings. On 8/18/2022 Unit Managers/designee completed an audit for all medication and treatment carts to ensure no medications were expired. No negative findings. INSERVICES: On 9/15/2022 Inservice Coordinator/designee initiated in services to all nurses to ensure all medication are unexpired on the units. Administrator in serviced all central supply staff to ensure all medication stored in central supply room are unexpired and central supply door is always locked when unattended. In-services will be ongoing until all staff are educated. QAPI: Unit Managers/designee will perform weekly audits on all medication on units to ensure all are unexpired for the first 3 months then quarterly thereafter. Central Supply/designee will perform weekly audits on ensuring all medications inside central supply room are unexpired for the first 3 months then quarterly thereafter. Director of Nursing/designee will perform weekly audits to ensure central supply room door is locked when unattended for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Unit Managers and Central Supply and reported to Director of Nursing and the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Nursing and will be ongoing until 100 percent	

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F 761	Continued From page 43 2022. The bottle had no labeling of a resident's name. The RN/UM stated that the [redacted] bottle was expired and should have been removed from the treatment cart. On that same date and time, the RN/UM stated that usually the night shift nurses check the expiration date of the medications and remove any expired medications. The RN/UM further stated that the opened bottle of [redacted] was a house stock medication and was not labeled for a specific resident. The RN/UM was unable to speak to which residents had a physician's order (PO) for [redacted] to be applied. At that time, the RN/UM asked the south side medication Licensed Practical Nurse (LPN) about which residents had a PO for [redacted] The LPN stated that there were no residents on the south side with a PO for [redacted]. The RN/UM was unable to speak to why the [redacted] remained in the treatment cart. On 8/18/22 at 11:05 AM, the surveyor, with HCS and Central Supply Staff (CSS), inspected the CSR which contained the house stock medications which revealed that there was no [redacted] in storage. Both the HCS and the CSS stated that they ordered house stock medications and had a list of the house stock medications but were unable to speak to if [redacted] was previously ordered. On 8/18/22 at 1:46 PM, the LNHA provided the surveyor with the facility Do Not Supply list of medications that were considered house stock and stored in Central Supply. The list provided revealed that [redacted] was not on the list.	F 761	compliant attained.	

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F 761	Continued From page 44 On 8/18/22 at 12:41 PM, the survey team met with the LNHA and the DON. The DON stated that the nurses were responsible for removing expired medications that were on the unit. On 8/19/22 at 10:17 AM, the survey team met with the LNHA and DON. The DON was unable to speak to why [redacted] was in the treatment cart. On 8/19/22 at 11:52 AM, the surveyor reviewed the Monthly Nursing Station Inspection Medication Storage and Labeling report dated 7/25/22 that was provided by the LNHA and completed by the Consultant Pharmacist (CP). The report revealed that the refrigerator, emergency kit, medication rooms, cupboards, drawers, and carts were inspected. There was no indication that treatment carts were inspected. On 8/19/22 at 1:00 PM, the surveyor interviewed the CP via telephone. The CP stated that he performed unit inspections every month and completed a report for each unit for the facility. The CP added that treatment carts were not always completed as part of the unit inspection. The CP also stated that the medication storage room and refrigerator, along with medication carts were inspected as indicated on the reports. A review of the facility's policies for Medication Storage dated June 2022 that was provided by the LNHA indicated the following: "Policy: Medications must be stored in accordance with manufacturer's specifications and secured in locked storage areas in compliance with State and Federal requirements and accepted professional standards of practice.	F 761		

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F 761	Continued From page 45 Access to medications is limited to only authorized personnel." "6. Prior to and after opening, all medications shall expire on the date specified by the manufacturer on the product label, unless the manufacturer has specifically indicated a shortened expiration once opened on the product label itself." "a. In accordance with expiration date labeling practices, if the manufacturer only specifies the month and year of expiration, this means the product expires on the last day of the calendar month indicated. (e.g.: a product labeled "Exp 03/2025" means the expiration date is March 31, 2005)." NJAC: 8:39-29.4 (a)(d)(g)(h)	F 761		
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 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	F 880		11/11/22

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F 880	Continued From page 46 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. (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.	F 880		

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F 880	Continued From page 47 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that: a.) appropriate hand hygiene was performed by 2 of 16 staff observed during recreation activity and care, b.) PPE (personal protective equipment) is properly disposed of for 1 of 7 receptacles in accordance with the Centers for Disease Control and Prevention (CDC) guidelines for infection control and facility policies, c.) the Covid-19 testing wait time was followed according to the facility's posted instructions and the manufacturer's Covid-19 instruction card for COVID-19 testing for 1 of 10 visitors, d.) staff performed daily COVID-19 screening and monitoring for 3 of 5 staff reviewed, e.) residents received daily COVID-19 Screening and Monitoring every shift for [redacted] residents reviewed (Resident #7, #23, #80, #153, #629, and #630) to mitigate the spread of infection and COVID-19. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included,	F 880	IMMEDIATE ACTION On 8/4/2022 the activity staff was in-serviced on performing hand hygiene in between resident contact and touching mask. All residents that were in contact with activity staff were assessed and monitored for any new on-set illness, all [redacted] were performed and were [redacted] On 8/8/2022 assigned CNA for resident #7 was in serviced on performing hand hygiene before donning and after doffing PPE. Resident #7 was assessed and monitored for any new on-set illness and [redacted]. On 8/8/2022 facility purchased covered garbage bins for every resident's room to ensure there is no overflow of PPE inside the garbage bins. On 8/3/2022 the Administrator in serviced the Infection Preventionist Nurse that she needs to wait 15 minutes after performing the [redacted] before clearing a visitor to go on unit regardless of if the negative sign appears. On 8/23/2022 in services were provided to PTA, HK#1 and HK#2 by their directors to ensure they are completing the screening	

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F 880	Continued From page 48 "..When to Perform Hand Hygiene? Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient...Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal....." According to the U.S. CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities Updated Feb. 2, 2022, included, "..Testing: Create a Plan for Testing Residents and HCP for SARS-CoV-2 "Expanded screening testing of asymptomatic HCP should be as follows:..In nursing homes, HCP who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week. If these HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift).... Evaluating and Managing Personnel and Residents:..Evaluate Residents at least Daily ...Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection ...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	F 880	form prior to starting their shift. On 8/16/2022, staff assigned to record the vital signs for residents #7, #23, #80, #153, #629 and #630 were in serviced to remind them they need to check all vitals and record the vital signs for all residents q shift. All identified residents' vitals were taken and no negative findings. IDENTIFY OTHERS: On 8/22/2022 Infection Preventionist Nurse/ Designee initiated hand hygiene competencies for all staff. Director of Housekeeping/designee reviewed all garbage cans on 8/9/2022 to ensure all uncovered garbage bins were replaced with covered garbage bins inside residents' rooms. Infection Preventionist Nurse/designee performed competencies to all staff assigned to perform [redacted] on 8/22/2022. On 8/23/2022 Infection Preventionist Nurse/designee reviewed all employee covid screening log to ensure all staff were compliant with COVID-19 screening and vital signs for all residents were completed q shift. All negative findings will be corrected accordingly. INSERVICES: On 9/15/2022 Inservice Coordinator/designee initiated in services to all staff on Hand Hygiene policy, in services to all staff to ensure all disposable PPE must be discarded inside the covered garbage bins in the rooms after removing PPE, in-services to all staff that performs rapid test, they must wait 15 minutes as per manufacturer instructions before validating results, in-serviced entire	

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F 880	Continued From page 49 assessment of oxygen saturation via pulse oximetry ..." According to US CDC COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 2/2/22, showed "...1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. HCP [Health Care Provider] should report any of the 3 above criteria to occupational health or another point of contact designated by the facility, even if they are up to date with all recommended COVID-19 vaccine doses. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2..." 1. On 8/03/22 at 9:47 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON). The LNHA stated that visitors and staff must wear a surgical mask and eye protection when in the common area of the facility. The LNHA further stated that visitors and staff must wear an N95 mask and full PPE including gown, gloves, and eye protection when inside a PUI and COVID-19 resident room. On 8/03/22 at 10:33 AM, the surveyor met with the LNHA and Director of Nursing (DON) for an entrance conference. The LNHA stated that the	F 880	staff on COVID-19 screening must be completed prior to starting scheduled shift, in-services to all nurses to ensure vital signs are being taken and recorded q shift for all residents. In-services will be ongoing until all staff are educated. QAPI: Infection Preventionist Nurse /designee will perform weekly audits on COVID-19 screening logs for employees to ensure all staff are completing the COVID-19 screen prior to start of their assigned shift and weekly audits on vital signs for all residents to ensure it is being completed q shift for the first 3 months then quarterly thereafter. Infection Preventionist Nurse /designee will perform monthly audits on hand hygiene and rapid test performance competencies for the first 3 months then quarterly thereafter. Director of Housekeeping/designee will perform weekly audits to ensure all garbage bins have covers in residents' rooms. Any negative findings will have immediate corrective actions taken by Infection Preventionist Nurse or Director of Housekeeping and reported to the Director of Nursing & Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Infection Preventionist and will be ongoing until 100 percent compliant attained.	

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F 880	Continued From page 50 facility was in an ongoing COVID-19 outbreak. The LNHA and the DON confirmed the website outbreak most recent posted was [redacted] At the same time, the LNHA stated that the last date of COVID-19 positive for both resident and staff was on [redacted]. The LNHA further stated that the outbreak included [redacted] staff cases (out isolating) and [redacted] resident cases of COVID-19 in unit [redacted] The COVID ActNow Community Risk Level for [name redacted] provided by the LNHA and updated on [redacted] indicated that the community risk level for [name redacted], the county in which the facility was located, was high. On 8/4/22 at 12:12 PM, the surveyor observed the Activity Staff (AS) wearing an N95 mask and a face shield while providing an activity to the 7 residents inside the [redacted]-floor room on the right side upon exiting the elevator. The surveyor observed the AS did not perform hand hygiene in between direct contact with Residents #35, #148, #161, #29, and #43. On that same date and time, the surveyor observed the AS was fixing and touching the middle part of his N95 mask without performing hand hygiene before and after touching his N95 mask. During an interview of the surveyor with the AS, the AS stated that he's been working in the facility for "almost three (3) months," and was educated about hand hygiene by the Infection Preventionist Nurse (IPN). The surveyor asked the AS if he should have performed hand hygiene in between direct contact with the residents and if he should	F 880		

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F 880	Continued From page 51 be fixing his N95 mask without performing hand hygiene before and after touching his N95 mask. The AS stated, "I will need to refer your question to the handbook because things change sometimes." On 8/4/22 at 12:26 PM, the surveyor was unable to find and talk to [redacted]-floor staff at this time regarding the above concerns because the nurses were attending to an emergency and another facility staff was distributing lunch trays. Immediately, the surveyor went to the LNHA and discussed the above concerns. The LNHA stated that the AS was new and that he should have performed hand hygiene. The LNHA further stated that she will now go and talk to the AS about it. On 8/15/22 at 12:17 PM, the survey team met with the LNHA and the DON, and both were made aware of the above concerns with hand hygiene. On 8/16/22 at 11:11 AM, the surveyors interviewed the IPN regarding facility practice with regard to hand hygiene. The IPN stated that it was expected that the staff washes their hands when caring for residents and when there is direct contact between residents. At the same time, the surveyor informed the IPN of the above concerns with the AS. The IPN stated that the "same thing," the AS should sanitize their hands between direct contact with residents. She further stated that the AS received the same education as nursing staff with regard to their mask and eye protection, and the expectation should be for the staff to perform hand hygiene in between each activity.	F 880		

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F 880	Continued From page 52	F 880		

On 8/16/22 at 12:50 PM, the surveyor met with the LNHA and DON. The LNHA stated that the AS acknowledged that he should have performed hand hygiene in between direct contact with the residents and about his N95 mask on 8/4/22. The LNHA further stated that the AS forgot and was nervous when the AS mentioned that he will refer to the employee handbook when asked if he should have performed hand hygiene in between direct contact with residents and about his N95 mask.

2. On 8/8/22 at 12:45 PM, the surveyor observed Resident #7 in bed awake with two nursing staff at the resident's bedside. Both nursing staff was wearing an N95 mask, gown, gloves, and face shields, while washing, dressing, and adjusting Resident #7's [redacted]. One of the nursing staff members, Certified Nursing Assistant#1 (CNA#1) stated that they were preparing Resident #7 for transfer into the wheelchair.

On that same date and time, the surveyor observed that CNA#1 removed her gown and gloves, discarded the gown and gloves in a black trash bin at the resident's doorway, and exited Resident #7's room without performing hand hygiene. CNA#1 then grabbed the Hoyer lift (electronic body lift) in the hallway and pushed the Hoyer lift down the hall toward Resident #7's room positioning the Hoyer lift outside the resident's room.

The surveyor reviewed the medical records of Resident #7.

The Admission Record (face sheet/admission record) reflected Resident #7 was admitted to the

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F 880	Continued From page 53 facility with medical diagnoses, which included, but were not limited to, [redacted].	F 880		

The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected a BIMS (Brief Interview for Mental Status) score of [redacted] out of [redacted], which indicated that Resident #7's [redacted].

During an Interview with the surveyor on 8/10/22 at 11:40 AM, the ADON, employed at the facility since [redacted], stated that the IPN was responsible for educating the staff on hand hygiene, Covid-19, and Infection Control Practices.

On that same date and time, the ADON stated that currently, the staff on the second-floor pediatric unit are to wear an N95 mask and eye protection in the hall, and full PPE, an N95 mask, eyewear, gown, and gloves when entering all resident's rooms. The ADON further stated that before entering a resident's room, staff should perform hand hygiene first and then don (apply) the disposable blue gown and gloves, in addition to the N95 mask and eyewear, such as a face shield or goggles. Furthermore, the ADON stated that before exiting a resident's room, staff should doff (remove) their gown and gloves, discard them in the black trash bin near the doorway inside the resident's room, and then perform hand hygiene before exiting the resident's room. The ADON added that if the staff was giving direct

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F 880	Continued From page 54 care to a resident and/or gloves were soiled after care, staff should wash hands before exiting the resident's room. At that time, the surveyor informed the ADON of the surveyor's observation on 8/8/22 of CNA#1 giving direct care to Resident #7, removing and discarding her PPE in the black trash bin inside the resident's room, exited Resident #7's room without performing hand hygiene, and then grabbed the Hoyer lift in the hallway to position outside Resident #7's room. The ADON stated that the CNA should have performed hand hygiene after removing and discarding his/her gown and gloves, and before exiting Resident #7's room. The ADON stated that hand hygiene is important to prevent the spread of infection and for the protection of Resident #7 and the other residents on the unit. 3. On 8/03/22 at 10:15 AM, the surveyor during the initial tour observed resident rooms had an open trash receptacle and PPE was overflowing in them, and outside the room in the hallway were 6 covered trash cans, one had PPE in it. On 8/03/22 at 10:45 AM, the surveyor observed an uncovered hamper lined with a clear trash bag being utilized as a trash can for PPE in front of the elevator in unit [redacted]. On 8/04/22 at 12:11 PM, the surveyor interviewed the Unit Manager of the [redacted] floor regarding the uncovered hamper used as a receptacle for used PPE. The Unit Manager stated, "it is for staff to doff (remove)," and "for visitors who accidentally walked out of a resident's room with PPE on." The Unit Manager further stated that she was not sure who placed the uncovered hamper in front of	F 880		

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F 880	Continued From page 55	F 880		

the elevator "over the weekend."

On that same date and time, the surveyor asked the Unit Manager should the uncovered hamper be in front of the elevator. The Unit Manager stated, "no. they should be doffing in the resident's room."

On 8/04/22 at 12:12 PM, the surveyor interviewed the IPN. The IPN stated that she was not aware of the hamper that was being used as trash can and it was possibly being used by recreation and visitors to doff their PPE prior to getting on the elevator.

On 8/04/22 at 13:12 PM, the surveyor interviewed the LNHA. She stated, "housekeeping frequently changes the bags in the trash cans in the resident's room. We have always used open trash receptacles."

4. On 8/03/22 at 9:02 AM, the surveyor observed the facility posted instructions in the facility front lobby indicating the requirements for visitors to perform a 15-minute rapid test before visitations regardless of their vaccination status.

On 8/3/22 at 9:12 AM, the surveyor observed a visitor who entered the designated Covid testing room after the visitor completed the Covid 19 screening questionnaires and then proceeded to wait in the lobby. The visitor informed the surveyor that he/she was Resident #629's representative (RR) and was visiting the resident in the [redacted]-floor unit. The RR informed the surveyors that he/she had been "frequently" visiting the resident and "usually" waited for 5 minutes after getting tested for Covid-19 before being allowed to go to the resident's room.

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F 880	Continued From page 56 On that same date at 9:17 AM, during the surveyor's interview, the IPN informed the RR that he/she was "ok" and was negative for Covid-19. On that same date at 9:22 AM, the surveyor asked the IPN why the 15 minutes waiting time for the Covid-19 rapid test result was not followed when she instructed Resident #629's RR to proceed for visitation within his/her 5 minutes wait time after Covid-19 rapid test was performed. The IPN stated, "that was ok because the negative result showed up already." On that same date at 9:47 AM, the surveyor informed the LNHA and ADON about the above concerns. The LNHA and ADON did not provide an answer to the surveyor. On 8/18/22 at 12:42 PM, the LNHA provided the surveyor with the Covid-19 Ag (antigen) test Card that was utilized for Covid-19 testing which reflected the manufacturer's Procedure Card instructions with a four-step sample test procedure. It was indicated in step four of the instructions, under "Part 1- Sample Test Procedure," to read the result in the card window 15 minutes after closing the card. It also reflected "In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before." On 8/23/22 at 9:43 AM, the surveyor conducted a post-survey interview with the IPN [redacted] concerning the facility's posted instructions of 15 minutes wait time for COVID-19 testing that was not followed. She indicated that it was previously discussed by surveyors on the day it happened.	F 880		

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F 880	Continued From page 57 She also stated that she should have followed the protocol for testing. 5. On 8/17/22 at 12:20 PM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) to provide the facility's documents for screening COVID-19 of Housekeeper#1 (HK#1), HK#2, and the Physical Therapist Assistant (PTA) for dates [redacted] and [redacted]. The surveyor asked the LNHA for a copy of [name redacted] Rapid Antigen Testing form (RATf) The surveyor reviewed the facility Employee Temperature Log-Covid 19 (ETL=a form that showed the name of employees, the shift they worked, and the temperature. The ETL also included two questions: asking if the staff was experiencing Covid-19 symptoms and if the staff was scheduled to get tested today that day), the Bi-weekly Schedule from [redacted] to [redacted], 2022 schedule of Housekeepers, the Rehab Department schedule on [redacted], Vaccination for COVID-19 Staff log, Payment Based Journal (PBJ-attendance records), and the RATf that was provided by the LNHA. The documents included the following information: HK#1 was on the schedule for [redacted] and [redacted] and had the RATf completed on [redacted] but there was no documented evidence in the ETL that the screening was done at the start of the shift on [redacted] and [redacted]. HK#1 was up to date with his COVID-19 vaccines. HK#2 was on the schedule for [redacted] and [redacted] and had the RATf completed on [redacted] but there was no documented evidence on the ETL that the screening was done at the start of the shift on [redacted]	F 880		

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F 880	Continued From page 58 and [redacted]. HK#2 was up to date with his COVID-19 vaccines. The physical Therapist Assistant (PTA) was on the schedule for [redacted] and had the RATf completed on [redacted] but there was no documented evidence on the ETL that the screening was done at the start of the shift on [redacted]. The PTA was up to date with his COVID-19 vaccines. On 8/23/22 at 9:43 AM, the surveyor interviewed the IPN about the missing staff screenings. The IPN stated that she was aware of the concern and confirmed that staff must sign before their shift start, and the screening for COVID-19 should be for all staff. The IPN was aware also of the three staff who did not screen for COVID-19 before their shift and confirmed that the three staff identified, HK#1, HK#2, and PTA did not screen but did complete COVID-19 tests with negative results. On 8/23/22 at 11:59 AM, the surveyor completed a post-survey interview with the PTA. The PTA stated that when he came to the facility in the morning, he "normally" do a temperature check and completed the Covid screening in the front desk lobby, and do the Covid testing on the testing day. The PTA informed the surveyor that he did not work on [redacted] but stated "I believe August [redacted] I was in the building." On that same date and time, the surveyor asked if he was in the facility on [redacted] working and he responded," I don't remember exactly, but it was the Monday, so I was most likely here." The surveyor asked the PTA if he remembered completing the Covid-19 screening	F 880		

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F 880	Continued From page 59	F 880		

questionnaires on [redacted]. He stated that he does not remember and stated, "I have poor memory as it is anyway."

On 8/23/22 at 2:13 PM, the surveyor completed a post-survey interview with HK#1. HK#1 stated that no matter what day it was, the protocol was immediately upon entering the building at the receptionist desk, he will use the sign-in log, where his temperature was checked before signing in, then put his temperature on the form. He stated if the temperature was fine then he will go and punch in and added that he does Covid testing on Mondays if he works. When asked by the surveyor if he worked on [redacted], the staff could not recall if he worked on [redacted]

On 8/24/22 at 02:47 PM, the surveyor conducted a post-survey interview with HK#2. HK#2 stated that whenever she entered the facility to work, she will check her temperature, sign in, and answers a couple of questions on the log before she punched in. HK#2 further stated that once a week on Mondays, she is being tested for COVID-19 on the main floor of the building and had to wait for 15 minutes for the results before she could proceed onto the floor.

On that same date and time, the surveyor asked HK#2 if she worked on [redacted] and [redacted], and if she remembered using the log for COVID-19 screening for staff. HK#2 stated that she was "definitely" working on Monday, [redacted] but was not sure about [redacted] if that was her Sunday off. Then, HK#2 stated, "yes I believe that was my weekend," and added that HK#2 "usually uses the log every day."

A review of the facility policy, "COVID-19/Testing

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F 880	Continued From page 60 of Facility Personnel" updated 3/22/22 reflected Addendum: 2. Regardless of the required frequency of testing, the vaccination status of staff or facility's Covid-19 status, facilities must continue to screen all persons entering the facility including all staff, visitors and residents daily for signs and symptoms of covid-19 as outlined in ED 20-026. 6. On 8/16/22 at 12:07 PM, the surveyor reviewed the electronic medical records and showed that [redacted] out [redacted] residents were not monitored for signs and symptoms of COVID-19 every shift (q shift) when the facility was on continued outbreak from [redacted] through [redacted] according to the facility provided outbreak letter from [redacted] through [redacted]. The surveyor reviewed the [redacted] and [redacted] electronic Medication Administration Record (eMAR), electronic Treatment Administration Record (eTAR), Weights & Vitals record, and facility provided documentation and revealed the following: Resident#7's vital signs (v/s) i.e. (that is) temperature (temp), blood pressure (BP), pulse, respiratory rate (RR), and oxygen saturation (O2 sat) were not checked q shift from [redacted] through [redacted] not until [redacted] Resident#23's v/s were not checked q shift from [redacted] through [redacted] not unti[redacted] Resident#80's BP was not checked as part of v/s q shift from [redacted] through[redacted] not until [redacted] Resident#153's BP was not checked as part of	F 880		

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F 880	Continued From page 61 v/s q shift from [redacted] through [redacted] not until [redacted] Resident#629's v/s were not checked q shift from [redacted] through [redacted] not until [redacted] Resident#630's BP was not checked as part of v/s q shift from [redacted] through [redacted] not until [redacted] On 8/18/22 at 12:17 PM, the survey team met with the LNHA and the DON, and they were made aware of the above concerns. On 8/23/22 at 9:43 AM, during a telephone interview of the surveyor with the IPN, the IPN stated that she was aware of the residents that were not being monitored q shift for signs and symptoms of COVID-19 during an outbreak. When the surveyor asked the IPN if the residents should have been monitored q shift for COVID-19, the IPN stated "absolutely," residents should be monitored for signs and symptoms of COVID 19 every shift per facility protocol. A review of the facility's Hand Washing/Hand Hygiene Policy dated 4/31/11 by the LNHA included "Policy: Hand hygiene is a basic requirement for infection prevention. It is the facility's policy that all staff is trained in proper technique and is monitored for proper hand hygiene practices....Use of Alcohol Based Hand Rubs: 1. Hands should be decontaminated with alcohol based rubs at the following times: ....b. Before having direct contact with patients....d. After contact with a patient's intact skin (e.g. when taking a pulse or BP, and lifting a patient.). e. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound	F 880		

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F 880	Continued From page 62 dressing if hands are not visibly soiled...g. After contact with inanimate objects in the immediate vicinity of the patient..." According to facility's Outbreak Plan E.D. 20-026 that was provided by the LNHA on 8/8/22 at 8:46 AM showed that "...Implement the isolation protocol in the facility (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the facility's infection prevention and control plan and/or recommended by local, state, or federal public health authorities...Evaluation and Management of Residents and Healthcare Personnel: During an outbreak, facility will assess close contacts including HealthCare Personnel (HCP) and other residents based on their exposures to positive case(s) of the infectious disease.....Facility conduct active screening of all residents: Nursing staff will monitor residents every shift for symptoms of the ID and any other illness. Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry....Facility shall screen and log HCP and everyone entering the facility for symptoms of the infectious disease. Screening will include: a. Temperature checks including subjective and/or objective fever equal to our greater than 99.5 degrees Fahrenheit or as further restricted by the facility. b. Completion of questionnaire about symptoms and potential exposure which shall include at a minimum: 1. Exhibit signs and symptoms of and infectious disease, including COVID-19, such as fever equal to or greater than 99.5, chills, cough, shortness of breath or difficulty of breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea....."	F 880		

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F 880	Continued From page 63 According to Occupational Safety and Health Administration (OSHA), Disposal of blood and other potentially infectious materials (OPIM) (1910.1030 1910.1030(d)(4)(iii)(B)(1)(iii) 1910.1030(d)(4)(iii)(C) In general, regulated wastes, other than contaminated sharps, must be placed in containers which are: (i) Closable; (ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping; (iii) Labeled or color-coded in accordance with paragraphs (g)(1)(i); (iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping [29 CFR 1910.1030(d)(4)(iii)(B)(1)(i)-(iv)]. A regulated medical waste is any solid waste, generated in the diagnosis, treatment (for example, provision of medical services), or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals, that is not excluded or exempted under (b) below, and that is listed or meets any waste characteristic classification criteria described in the following table: "6 .Isolation Wastes Biological waste and discarded materials contaminated with blood, excretion, exudates, or secretions from humans who are isolated to protect others from certain highly communicable diseases, or isolated animals known to be infected with highly communicable diseases." N.J. Admin. Code § 7:26-3A.6 The following web sites can be accessed for additional information: Regulated Medical Waste Regulations: N.J.A.C. 7:26, Subchapter 3A. Guidance Document for Regulated Medical Waste: https://www.state.nj.us/dep/dshw/rrtp/rmw.htm	F 880		

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F 880	Continued From page 64 OSHA Standard 1910.1030 - Bloodborne Pathogens: https://www.osha.gov/laws regs/regulations/standard number/1910/1910.1030 OSHA Control and Prevention Guidance for COVID-19 https://www.osha.gov/SLTC/covid-19/controlpreve ntion.html#health USDOT - Definition of an Infectious Substance, Division 6.2 https://ecfr.io/Title-49/se49.2.173_1134 According to Occupational Safety and Health Administration (OSHA), Disposal of blood and other potentially infectious materials (OPIM) (1910.1030 1910.1030(d)(4)(iii)(B)(1)(iii) 1910.1030(d)(4)(iii)(C) In general, regulated wastes, other than contaminated sharps, must be placed in containers which are: (i) Closable; (ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping; (iii) Labeled or color-coded in accordance with paragraphs (g)(1)(i); (iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping [29 CFR 1910.1030(d)(4) (iii)(B)(1)(i)-(iv)]. A regulated medical waste is any solid waste, generated in the diagnosis, treatment (for example, provision of medical services), or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals, that is not excluded or exempted under (b) below, and that is listed or meets any waste characteristic classification criteria described in the following table: "6 .Isolation Wastes Biological waste and discarded materials contaminated with blood, excretion, exudates, or secretions from humans who are isolated to protect others from certain highly	F 880		

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F 880	Continued From page 65 communicable diseases, or isolated animals known to be infected with highly communicable diseases." N.J. Admin. Code § 7:26-3A.6 The following web sites can be accessed for additional information: Regulated Medical Waste Regulations: N.J.A.C. 7:26, Subchapter 3A. Guidance Document for Regulated Medical Waste: https://www.state.nj.us/dep/dshw/rrtp/rmw.htm OSHA Standard 1910.1030 - Bloodborne Pathogens: https://www.osha.gov/laws regs/regulations/standard number/1910/1910.1030 OSHA Control and Prevention Guidance for COVID-19 https://www.osha.gov/SLTC/covid-19/controlpreve ntion.html#health USDOT - Definition of an Infectious Substance, Division 6.2 https://ecfr.io/Title-49/se49.2.173_1134 NJAC: 8:39-19.4(a)(b)(l)(n)(2)	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in	F 886		11/11/22

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F 886	Continued From page 66 this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.	F 886		

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F 886	Continued From page 67 §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to provide biweekly COVID-19 rapid antigen testing from [redacted] through [redacted] for two ([redacted]) of three [redacted]) staff who are not up to date (up to date means a person has received all recommended vaccines & boosters when eligible) with COVID-19 vaccinations (Certified Nursing Assistant#1 (CNA#1) and CNA#2), in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and when the community transmission level was high. This deficient practice was evidenced by the following: According to the US CDC COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 02/02/22, showed "...1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. HCP [Health Care Provider] should report any of the 3 above criteria to occupational health	F 886	IMMEDIATE ACTION On 8/19/2022 Infection Preventionist Nurse in serviced CNA#1 and CNA#2 that they must be tested bi-weekly because they are not up to date with their COVID-19 vaccine status and as per the guidance on facility's community transmission level report. IDENTIFY OTHERS: On 8/19/2022 Infection Preventionist Nurse/designee reviewed all staff that are not up to date with their COVID-19 vaccine status to ensure those staff are being tested bi-weekly as per the guidance on facility's community transmission level report. All negative findings were corrected accordingly. INSERVICES: On 9/15/2022, Inservice Coordinator/designee initiated in services to all staff to remind staff that are not up to date with COVID-19 vaccination to ensure bi-weekly testing is being completed as per facility's community transmission level report. In-services will be ongoing until all staff are educated. QAPI:	

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F 886	Continued From page 68 or another point of contact designated by the facility, even if they are up to date with all recommended COVID-19 vaccine doses. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2..." On 8/02/22 at 8:46 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) for an entrance conference. The DON stated that the facility was in a COVID-19 outbreak that started on [redacted] with seven [redacted]) staff and [redacted] resident cases of COVID-19. The LNHA stated that COVID-19 positive staff members worked throughout the building and that some were direct care staff. On 8/02/22 at 01:20 PM, the surveyor interviewed CNA#2 who stated that she had been working in the facility for [redacted] years. She was wearing an N95 mask and face shield. She stated that she was vaccinated with the first and second doses of [name redacted] COVID-19 vaccines in the facility and has not received the booster yet. She stated that she was on [redacted] for two weeks and just returned "last Thursday" and was on light duty due to medical reasons. She stated that when she returned to work, she was reminded by the Infection Preventionist Nurse (IPN) of her Covid-19 booster and stated, "I have to get the booster outside the facility." She stated that she was tested for Covid once weekly in the first-floor testing room. She stated that she had to wait in the lobby for 15 minutes to get her results. A review of the COVID-19 Transmission levels as of [redacted], for [name redacted] was listed	F 886	Infection Preventionist Nurse/designee will perform weekly audits on all employee's test logs that are not up to date with their COVID-19 vaccine status and ensure they are testing twice a week for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Infection Preventionist Nurse and reported to the Director of Nursing and the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Infection Preventionist Nurse and will be ongoing until 100 percent compliant attained.	

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F 886	Continued From page 69 High, and as such, per CMS QSO-20-38 NH: In nursing homes located in counties with substantial to high community transmission, HCP not up to date with vaccination, should have a viral test twice a week. The surveyor reviewed the [name redacted] Rapid Antigen Testing form (RATf) for the biweekly testing, Payroll-Based Journal (PBJ-electronic submission of staffing hours), and COVID-19 Vaccination-Employees log that included CNA#1 and #2's information that was provided by the LNHA and showed the following: CNA#1 received her COVID-19 vaccines on 01/6/22 and 02/10/22 that completed her primary COVID-19 vaccines. CNA#1 worked on 7/02/22, 7/03/22, 7/06/22, 7/08/22, 7/13/22, 7/16/22, and 7/27/22. She was tested for COVID-19 on 7/06, 7/13/22, and 7/27/22. All COVID-19 test results were negative. CNA#2 received her COVID-19 vaccines on 12/02/21 and 02/22/22 that completed her primary COVID-19 vaccines. CNA#2 worked on 7/02/22, 7/03/22, 7/05/22, 7/06/22, 7/07/22, 8/02/22, 8/03/22, and 8/04/22. CNA#2 was tested for COVID-19 on 7/02/22, 7/11/22, 7/19/22, and 8/02/22. All COVID-19 test results were negative. According to the above information, CNA#1 was eligible to receive a COVID-19 booster vaccine on 7/10/22 and CNA#2 on 7/22/22. The two staff were not up to date on their vaccinations and were not tested biweekly when the facility was in an outbreak and at a high community activity level. On 8/19/22 at 12:15 PM, the surveyor interviewed	F 886		

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PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 886	Continued From page 70 the LNHA who stated the process for COVID-19 rapid antigen testing is to be completed twice a week during the high community level. The LNHA confirmed that the facility remained in high status and was moved into high status since mid-July. On 8/19/22 at 12:39 PM, the surveyor informed the above concern to the LNHA and the DON. The DON stated that testing should be done in accordance with CDC testing specifications. A review of the facility policy, "COVID-19/Testing of Facility Personnel" updated 3/22/22 reflected number 3. Routine testing of unvaccinated staff should be based on the extent of the virus in the community. When determining the frequency of testing of unvaccinated staff, facilities should use regional positivity rate reported in the Covid-19 Activity Level index (CALI) weekly Report." NJAC 8:39-5.1 (a)	F 886		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility	F 888		11/11/22

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F 888	Continued From page 71	F 888		

or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care,

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F 888	Continued From page 72 treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and	F 888		

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F 888	Continued From page 73 (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that additional precautions for COVID-19 testing were implemented for 2 of 3 staff whose vaccinations were not up-to-date for COVID-19, b.) include the most up-to-date (Up to date means a person has received all recommended vaccines & boosters when eligible) COVID-19 Vaccine for Staff guidance in the	F 888	IMMEDIATE ACTION On 8/18/2022, CNA #1 and CNA #2 were in-serviced by Infection Preventionist Nurse to ensure that they need to be tested twice a week since they are both not up to date with their COVID-19 vaccine status. Facility' policy on COVID-19 Vaccination was updated to current regulation on 8/17/2022 by the	

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F 888	Continued From page 74 facility Policy, and c.) ensure that the facility's COVID-19 Vaccine for Staff Policy included contingency plans to mitigate the spread of COVID-19 according to Centers for Disease Control and Prevention (CDC) and facility policies. According to the US CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 2/2/22, included " ...Testing: Create a Plan for Testing Residents and HCP (Health Care Personnel) for SARS-CoV-2 ... In nursing homes, HCP who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: ....In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week. If these HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift) ...." This deficient practice was evidenced by the following: On 8/03/22 at 10:33 AM, the surveyor met with the LNHA and Director of Nursing (DON) for an entrance conference. The LNHA stated that the facility was in an ongoing COVID-19 outbreak. The LNHA and the DON confirmed the website outbreak most recent was 7/15/22. The LNHA stated that the last date of COVID-19 positive resident and staff was on 8/02/22. The LNHA stated that the outbreak included [redacted] staff (staff were out isolating) and [redacted] resident cases of COVID-19 in unit [redacted]	F 888	Administrator. IDENTIFY OTHERS: On 8/19/2022 Infection Control Preventionist/designee reviewed testing logs for all staff that are not up to date with COVID-19 vaccine status to ensure all staff in that category was tested twice a week. Any negative findings were corrected accordingly. On 9/2/2022 Administrator reviewed all Infection Control/COVID-19 policies to ensure all policies were updated to current regulations. Any negative findings were corrected accordingly. INSERVICES: On 9/15/2022 Inservice Coordinator/designee initiated in services to all staff to ensure that if any staff is not up to date with their COVID-19 vaccine status must test twice a week. Administrator in serviced Infection Preventionist Nurse to ensure to update Infection Control/COVID-19 policies as new guidelines are recommended by DOH and CDC. All in-services will be ongoing until all staff are educated. QAPI: Infection Preventionist Nurse/designee will perform weekly audits on all staff that are not up to date with COVID-19 vaccine status to ensure they are being tested twice a week and weekly audit to ensure if there are any new updates from CDC or DOH to update the Infection Control/COVID-19 policies for the first 3 months then quarterly thereafter. Any	

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F 888	Continued From page 75 On that same date and time, the LNHA further stated that the facility follows the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), New Jersey Department of Health (NJDOH), and local health department guidance for Infection Control policies and procedures. The surveyor reviewed the following documents that were provided by the LNHA and Infection Preventionist Nurse (IPN): The COVID ActNow Community Risk Level for [name redacted] provided by the LNHA and updated on 7/28/22 indicated that the community risk level for [name redacted], the county in which the facility was located, was high. The NJ COVID-19 Information Hub with the last update date of 3/03/22 that was provided by the IPN included "..Health Care Facilities and High-Risk Congregate Settings: NJ has announced that all workers in health care facilities and high-risk congregate settings will be required to be up to date with their COVID-19 vaccinations, including having received a booster dose and will no longer be permitted to submit to testing as an alternative to vaccination, except for the purposes of providing an accommodation for individuals exempt from vaccination. Workers in facilities subject to the federal CMS vaccine rule for settings that receive Medicare or Medicaid reimbursement must obtain their first dose of the primary series of a COVID-19 vaccination based on the timeframes set by CMS ... Workers who become newly eligible for a booster shot will be required to submit proof of their booster shot within three weeks of becoming eligible ..."	F 888	negative findings will have immediate corrective actions taken by Infection Preventionist Nurse and reported to the Director of Nursing & Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by Infection Control Preventionist and will be ongoing until 100 percent compliant attained.	

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F 888	Continued From page 76 The facility's COVID-19 Vaccine For Staff Policy and Procedure with an approved of 3/10/22 that was provided by the LNHA included "Policy: Per CMS Guidelines, all healthcare workers must be partially vaccinated (1 dose of 2 step series vaccine or booster vaccine not completed) by January 27th, 2022. All covered employees (including facility employees, licensed practitioners, students ....who are working under contracts in any department) must be up to date with primary and 1st booster vaccine by April 11, 2022 ....Procedure: Education: ....2. Staff will be informed that all employees are required to be fully vaccinated or at least one dose of the vaccine with COVID-19 by January 27, 2022, unless they meet the criteria for religious or medical exemption ..." The facility's Outbreak Plan E.D. 20-026 with a date of 4/1/2022 that was provided by the LNHA included "Emergency Staffing Contingency: ...Crisis capacity strategies include: a. Implementing regional plans to transfer patients with infectious disease, including COVID-19 to alternate care sites with adequate staffing. b. Implementing criteira to allow HCP with suspected or confirmed infectious disease, including COVID-19 who have not met Return to Work Criteria to work, in accordance with CDC guidelines ..." A review of the facility's COVID-19 Vaccine for Staff Policy and Procedure above did not show the CMS requirement and guidance for COVID-19 Vaccination of facility staff to include: A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all	F 888		

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F 888	Continued From page 77 staff who are not fully vaccinated for COVID-19; Contingency plans for staff who are not fully vaccinated for COVID-19; And Staff who are unable to furnish proper exemption documentation must be vaccinated or the facility must follow the actions for unvaccinated staff. The surveyor reviewed the facility provided COVID Vaccination - Employees records, Employee PBJ (Payroll Based Journal=work days), and Staff Testing Log by the LNHA and showed the following: Certified Nursing Aide#1 (CNA#1) COVID-19 primary vaccinations were on dates 12/02/21 and 02/22/22. CNA#1's PBJ were as follows: 7/02, 7/03, 7/05, 7/06, 7/07, 8/02, 8/03, and 8/04/22. CNA#1's testing logs included dates 7/02, 7/11, 7/19, and 8/02/22 were negative for COVID-19. CNA#1's above records revealed that CNA#1 was not up to date with her COVID-19 vaccinations and that CNA#1 was not being tested for COVID-19 twice a week. CNA#2 primary vaccinations were on dates 01/06/22 and 02/10/22. CNA#2's PBJ were as follows: 7/02, 7/03, 7/06, 7/08, 7/13, 7/16, and 7/27/22. CNA#2's testing logs included dates 7/06, 7/13, and 7/27/22. CNA#2's above records revealed that CNA#2 was not up to date with her COVID-19 vaccinations and that CNA#2 was not being tested for COVID-19 twice a week. On 8/18/22 at 8:17 AM, the surveyor informed the LNHA and the DON about the above concerns	F 888		

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F 888	Continued From page 78 and facility policies and procedures that were not up to date with current law, mandates, and guidance from the CMS and CDC with regard to COVID 19 Vaccine for Staff. On 8/17/22 at 02:07 PM, the survey team met with the LNHA and DON. The LNHA and the DON both acknowledged that the facility's policy for Infection Control including the COVID 19 Vaccine for Staff Policy should have been updated when it was reviewed on 4/22/22 to include the most updated and current mandates, memos, and guidance from the CMS, NJDOH, and CDC. On 8/23/22 at 9:43 AM, the surveyor received a return call from the IPN and the surveyor did the post-survey interview. The IPN stated that the facility's COVID 19 Vaccine for Staff policy should have been updated regularly and whenever new regulations and updates come out and should be included in the facility's policy and procedure.	F 888		
F 921 SS=D	NJAC 8:39-5.1(a); 19.4(a) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00155798 Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to a.) maintain a safe and sanitary environment by ensuring that a full sharps container (a puncture-resistant, leak-proof	F 921	IMMEDIATE ACTION On 8/18/2022, the identified full sharps container located on the respiratory treatment cart was removed by respiratory department and replaced with a new sharp□s container. Housekeeping	11/11/22

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F 921	Continued From page 79 container that can be closed for handling, storage, transportation and disposal of medical waste and sharp materials labeled as biohazard) was replaced with an empty one in a timely manner for 1 out of 2 treatment carts on the [redacted] floor (Cart [redacted]) and b.) maintain a safe and sanitary environment in 1 of 1 laundry rooms in accordance with the facility policy and procedures. This deficient practice was evidenced by the following: 1. On 8/9/22 at 12:15 PM, the surveyor observed a full and closed sharps container on treatment cart [redacted] on the [redacted] floor. There were no residents or visitors in the vicinity of the treatment cart and were no needles sticking out. On 8/17/22 at 12:11 PM, the surveyor had a second observation of a full and closed sharps container on treatment cart [redacted] on the [redacted] floor. There were no residents or visitors in the vicinity of the treatment cart and were no needles sticking out. The surveyor requested the Licensed Practical Nurse/Unit Manager (LPN/UM) observe treatment cart [redacted]. The LPN/UM stated, "that's not a nursing cart, that's a Respiratory Therapist treatment cart and that should have been removed and replaced with an empty one." The surveyor informed the LPN/UM that this was the second time since last week that the sharps container on treatment cart [redacted] was observed full. On that same date and time, the LPN/UM directed the surveyor to the Respiratory Therapist (RT). The surveyor interviewed the RT who stated that treatment cart [redacted] was used by the RT and that she was not responsible for removing the	F 921	department removed filled sharp receptacles and disposed in designated area. On 8/17/2022 all debris on the inside and outside of the laundry sink was removed and cleaned by housekeeping department. On 8/18/2022 Director of Maintenance called the washing machine company to work on leak identified for Washer #1. On 8/18/2022 The lint, medical gloves, and medical supplies in linen bags behind the three washers were removed. The debris were removed from under the pallet that stored nine boxes of detergent next to the washer room in the storage room by the housekeeping department. On 8/18/2022 The puddle found from washer #1 was removed to avoid any hazard of tripping and electrical shock. Cord was removed from the outlet when not in use to avoid tripping and causing electrical shock. Wet sign was in place. On 8/18/2022 the lint and debris found on the three dryers and three pipes running near the ceiling and electrical box on wall were removed by housekeeping department. On 8/18/2022 all PPE and hand lotion found on the clean linen shelf were removed from housekeeping department. IDENTIFY OTHERS: On 8/18/2022 Director of Housekeeping/designee reviewed all areas in the laundry room to ensure there were no other debris, lint or PPE items or safety hazard located inside the room. Any negative findings were corrected accordingly.	

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F 921	Continued From page 80 sharps container. She further stated that she would notify her manager that the sharps container needed to be replaced with a new one once it was full. On 8/18/22 at 9:35 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in presence of the survey team. Both the LNHA and the DON acknowledged that when a sharps container was full it should have been removed and replaced with an empty container and it should have been the responsibility of whoever was using the treatment cart. On 8/18/22 at 10:35 AM, the surveyor interviewed the Director of RT (DRT) in the presence of the survey team. He stated that when a sharps container was full the RT would be responsible to make sure the container was closed and locked and to then call housekeeping to come to replace it with a new one. The DRT stated that the RT should have called housekeeping or let the UM know the sharps container was full and needed to be replaced. On that same date and time, the DRT further stated that he would expect that the sharps container would be replaced with an empty one within an hour of notification that it was full. He also stated that the RTs did not use sharps frequently "so they must have overlooked it." The DRT stated that the sharps container should have been replaced once it was three-quarters full. 2. On 8/17/22 at 10:47 AM, the surveyor toured the laundry room with the Director of Environmental Services (DES) and in the presence of another surveyor. The surveyors	F 921	On 8/18/2022 all washers were checked by Director of Maintenance to ensure there was no other leak. No negative findings. On 8/18/2022 Nursing and Respiratory Therapists reviewed all their sharps containers on their carts to ensure there were not filled above ¿ of the container. Any negative findings were corrected accordingly. INSERVICES: On 9/15/2022 In-service Coordinator/designee initiated in services to all nursing and respiratory therapists on Sharps Disposal Policy and Procedure. On 9/20/2022, Housekeeping Director initiated in services to housekeeping and laundry department to ensure laundry and housekeeping room are kept clean and hazard free. A log was created for the cleanliness for the laundry room and will be completed weekly by housekeeping director/designee. In-services will be ongoing until all staff are educated. QAPI: Director of Housekeeping/designee will perform weekly audits on the cleanliness and safety of the environment inside the laundry room for the first 3 months then quarterly thereafter. ADON/designee will perform weekly audit on the sharps container on carts to ensure that it is not more than ¿ filled for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Housekeeping Department or ADON and reported to the	

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F 921	Continued From page 81 observed there were black debris and decolorization on the inside and outside of the sink of the laundry room where residents' gowns, bed sheets, linens, blankets, and towels were being washed. According to the DES, the sink with black debris and decolorization inside and out was where the laundry staff washes their hands. The surveyor asked the DES if there was a log for the cleaning of the utility sink. The DES stated, there was not a log and said, "they do it daily." When the surveyor asked when the last time sink had been cleaned, the DES stated he didn't know. At the same time, the surveyors observed a quantity of three washing machines in use. Washer #1 (closest to the laundry detergent storage room) was leaking from the door gasket causing a large puddle to form under and around the washer. When the surveyor asked when the last time the washer had been serviced, he deferred the answer to the maintenance department. DES stated, "they call an outside company as needed". When the surveyor asked the DES what might be the problem with that? The DES stated, "it is a hazard because of slipping when staff has to get something from the storage room". Then, the surveyors observed a washer drainage trough with a grate on top behind three (3) of three (3) washers. It was heavily soiled with lint, medical gloves, and paper debris. The DES stated, "there is not a cleaning log, but it is done as needed. It is caused by linens being mixed with gloves and medical supplies in linen bags". Next to the washer room, the surveyors observed there were black debris and decolorization in the	F 921	Director of Nursing & Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by Director of Housekeeping and ADON and will be ongoing until 100 percent compliant attained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315229		C 08/31/2022

NAME OF PROVIDER OR SUPPLIER
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F 921	Continued From page 82	F 921		

storage room and under a pallet that stored nine boxes of detergent. Upon interview, the surveyor asked if there was a log for the cleaning of the floor, the DES stated, that there was not a log, and he was unsure of the last time it was done.

In the soiled utility room, the surveyors observed a power washer and its outstretched cord running through the soiled utility doorway, through the puddle from washer #1and ran through the storage room doorway, ending in an outlet near the laundry soap in the storage room.
When the DES was questioned, he stated, "there is not an outlet in the soiled linen room, so they plug it in over in the other room". When the surveyor asked the DES what might be the problem with that? The DES stated, "it is a hazard because of tripping and electrical shock".

Then, the surveyor observed three (3) of three (3) dryers. In the Dryer room, there was a heavy buildup of lint and dust debris on three (3) of three (3) pipes running near the ceiling and the electrical box on the wall. Upon interview, the surveyor asked if there was a log for the cleaning of the pipes and electrical box, the DES stated, there was not a log, and he was unsure of the last time it was done.

In the clean linen folding area, the surveyor observed used personal protective equipment (PPE) goggles, N95 face mask, face shield, and facility-obtained hand lotion on the clean linen shelf near bath towels. When asked, the DES stated, "they should not be there, and it could cross contaminate with the clean linens".

On 8/17/22 at 12:50 PM, the surveyor interviewed the Maintenance Director about washer #1. He

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F 921	Continued From page 83 stated that there was no contract for monthly service, but the facility used an outside vendor [name redacted] for all as needed maintenance of the washer. The Maintenance Director stated that he would place a call to them regarding the water from washer #1 because someone could slip and fall. He further stated that the power washer cord should not be across the floor between rooms because it posed a tripping hazard to the staff. Review of the facility policy "Nursing Sharps Disposal" dated 6/2009, reflected that "When sharps receptacles are ¾ full, licensed staff close receptacle notify the designated department for a new receptacle." Review of the the facility policy revealed that the facility shall have a written schedule that determines the frequency of cleaning and maintaining all equipment, structures, areas, and systems. NJAC 8:39-31.4 (a)	F 921		