STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey Census: 66 Sample Size: 20+3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. Complaint # NJ 161715, NJ 159810, NJ 159141, NJ 159435, NJ 161936	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		8/8/23

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

Electronically Signed | 07/07/2023

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ00161715 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) as required and according to the facility's policy "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" for 1 resident (Resident #364) reviewed for accidents. The deficient practice was evidenced by the following: A review of Resident #364's 5-day Minimum Data Set (MDS, an assessment tool) dated [redacted] revealed under [redacted] that he/she had a brief interview for mental status score of [redacted] indicating his/her cognition was severely impaired. The MDS further revealed under [redacted] that he/she [redacted] prior to admission and had two or more [redacted] with injury since admission.	F 609	Corrective Action: Resident number 364 no longer resides at the facility. Identification of At-Risk Resident: The facility has determined all residents have the potential to be affected by this deficient practice. Systemic change An in person in-service education program was conducted with all direct care staff and administration addressing circumstances that require reporting including appropriate time frames by 8-8-23. An in-service on new company policy regarding reportable events will be conducted with all employees by 8-8-23. Quality Assurance: The Director of nursing, or designee, will conduct random audit of five residents	

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F 609	Continued From page 2 A review of Resident #364's diagnoses located in the Electronic Medical Record (EMR) revealed diagnoses of but not limited to: [redacted] A review of Resident #364's Progress Notes located in the EMR revealed a "General Nurses Note" written on [redacted] at 1:50 AM that revealed Resident #364 had an unwitnessed fall. The note further revealed that Resident #364 was unable to report what lead to the [redacted]. Lastly, the note revealed Resident #364 had [redacted] A review of Resident #364's Progress Notes located in the EMR revealed another "General Nurses Note" written on [redacted] at 6:00 AM that revealed Resident #364 had an unwitnessed [redacted]. The note further revealed that Resident #364 was unable to report what lead to the [redacted]. Lastly, the note revealed Resident #364 had [redacted] A review of Resident #364's Physician's Orders located in the Electronic Medical Record (EMR) revealed an order on [redacted] to send the resident to the Emergency Department for status-post [redacted] and rule out an [redacted]. A review of the facility-provided reported events to	F 609	weekly for four consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. Findings of this audit will be discussed weekly in morning meeting and will be reported to administration weekly and quarterly to the QAPI committee meeting until consistent substantial compliance has been met.	

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F 609	Continued From page 3 the NJDOH between NJ EX Order 264(1) and NJ EX Order 264(1) did not reveal any reported events regarding Resident #364. On 6/23/2023 at 10:01 AM, during an interview with the Surveyor, the Licensed Nursing Home Administrator stated, "Even though we knew why he fell, we should've reported it." A review of the undated facility policy titled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" revealed under "Policy" that, "It is the policy of the facility to report all allegations of abuse/neglect/exploitations or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes." NJAC 8:39-9.4(f)	F 609		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		8/8/23

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F 656	Continued From page 4 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #NJ161715 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to develop and implement a comprehensive	F 656	Corrective Action: Care plan(s) of the residents identified A#6, #364, #41, and #44 were reviewed and updated as indicated.	

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F 656	Continued From page 5 person-centered care plan for 4 of 20 residents (Resident #6, Resident #364, Resident #41, and Resident #44) reviewed for comprehensive care plans. The deficient practice was evidenced by the following: 1.) On 06/13/2023 at 08:44 AM, Surveyor #1 observed Resident #6 sitting up in bed eating breakfast. The resident was able to state his/her name but could not remember why he/she was in the facility or for how long. On 06/20/2023 at 12:20 PM, Surveyor #1 observed Resident # 6 sitting in a wheelchair in the resident's room eating his/her lunch meal. The resident was feeding himself/herself. While smiling, Resident #6 stated that he/she was doing well. According to the Admission Record, Resident #6 was admitted to the facility on [redacted] with diagnoses which included, but were not limited to, [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that Resident #6 had a Brief Interview for Mental Status score of [redacted] which indicated that the resident's cognition was [redacted]. The MDS also revealed that Resident #6 received [redacted], that they needed [redacted] from [redacted] staff members to transfer (from the bed to a	F 656	Identification of At-Risk Resident: The facility determined that all residents have the potential to be affected by this deficient practice. Systemic Change: All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the new facility policy and procedure for developing comprehensive care plans. New process utilizing base line care plans implemented and all staff will be trained on the new policy and procedure for base line care plans. Quality Assurance: Care plans will be reviewed weekly in accordance with the care plan review schedule by the interdisciplinary team. All care plans will be updated as indicated. The Director of Nursing, or designee, will complete random weekly audits of care plans for six consecutive care plans are developed for residents within the appropriate timeframes and will include pertinent diagnosis. Audit records will be reviewed by risk management/QA committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

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wheelchair) and did not walk in their room during the assessment window of the MDS.

Review of the Physician's Order Form indicated that Resident #6 had active physician orders for the following: a) NJ EX Order: 264b1 Oral Tablet [redacted] MG give [redacted] tablet by mouth one time a day for [redacted] (NJ EX Order: 264b1), dated [redacted]; b) Offer patient a snack HS (hours of sleep) at bedtime for AM NJ EX Order: 264b1), dated [redacted]; c) B NJ EX Order: 264b1 NJ EX Order: 264b1 NJ EX Order: 264b1 one time a day for diabetes, dated [redacted]

Review of the Physician's progress note (PN) dated [redacted] 3 indicated that the resident was being assessed for a NJ EX Order: 264b1 [redacted] event during his/her [redacted] therapy session. Resident #6 had become [redacted] and feeling like he/she wanted to [redacted] The PN indicated that it was the first episode of NJ EX Order: 264b1) experienced by the resident after an NJ EX Order: 264b1 on [redacted]. The physician's plan was to continue trending Resident #6's [redacted], provide a bedtime snack along with regular meals to prevent future episodes of NJ EX Order: 264b1

Review of the Physician's PN's dated [redacted] NJ EX Order: 264b1 and [redacted] all indicated that Resident #6 continued with NJ EX Order: 264b1 in the morning and the physician NJ EX Order: 264b1 doses accordingly.

Review of Resident #6's care plan did not include that the resident was [redacted], on [redacted] or having episodes of NJ EX Order: 264b1 [redacted]

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F 656	Continued From page 7 During an interview with Surveyor #1 on 06/21/2023 at 08:48 AM, the Licensed Practical Nurse/Unit Manager #1 (LPN/UM #1) stated resident base line care plans were on paper, and then at the end of [redacted] the care plans were entered back into the electronic medical records. She added that in [redacted] days after admission the comprehensive care plan would be completed. On admission, the electronic medical records triggered five focus issues to care plan such as, falls, pain, activities of daily living (ADL's), skin, and discharge. Residents receiving [redacted] medications would have to be added to the care plan on admission. The LPN/UM #1 revealed that [redacted] and/or [redacted] was not care planned and would only be care planned if there was a problem discussed or identified at a care conference. Unit Managers review the care plans the next day or the Monday after the weekend to make sure the 5 focus areas were triggered in the care plans. The LPN/UM #1 stated that the comprehensive care plan should be completed in 48 hours after admission, and that the unit manager (UM) or any nurse can add to the resident's care plan if an issue is identified. During an interview with Surveyor #1 on 06/21/23 at 09:43 AM, the Director of Nursing (DON) stated that the current process for care plans was that on admission the resident's electronic medical record would initiate 5 main triggers to care plan. After observations, the nurse can add additional problems such as [redacted], and [redacted]. The DON revealed that if a resident was diabetic or on insulin it would be care planned. The DON added that the care plans should be updated by the UM and reflect any new medical issues of the	F 656		

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resident. The DON stated that she was aware there was a problem with the care plans and the staff had to be re-educated on the process.

During an interview with Surveyor #1 on 06/22/2023 at 01:03 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the DON stated that resident issues of NJ EX Order: 264b1 and [redacted] should be care planned on the resident's baseline and comprehensive person-centered care plan. The DON added that the care plan should be updated within 24 to 72 hours after admission.

A review of the facility's care plan policy titled, "Care Plan Preparation, Long Term Care," with a review date of 05/20/22, indicated, but were not limited to, The care plan must be person-specific and include measurable objectives and time frames in order to reflect the resident's progress toward goals. An interdisciplinary team works together to create a comprehensive care plan that guides a resident's care from admission to discharge.

2.) A review of Resident #364's closed-record 5-Day Minimum Data Set (MDS; an assessment tool) dated [redacted] revealed, under [redacted] that he/she had a brief interview for mental status score of [redacted] indicating his/her [redacted] The MDS revealed further under [redacted] that Resident #364 received anticoagulant medication (medication used to [redacted] medication (medication used to promote increased [redacted]).

A review of Resident #364 diagnoses located in

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the Electronic Medical Record (EMR) revealed diagnoses of but not limited to, hereditary and [redacted] some [redacted].

A review of Resident #364's Physician Orders in the EMR revealed orders for [redacted] tablet [redacted] mg (milligram; medication used to [redacted]) ordered [redacted] tablet [redacted] mg (medication used to [redacted]) ordered [redacted] and [redacted] tablet [redacted] (medication used to [redacted]) ordered [redacted].

A review of the Physician's Progress Note dated [redacted] revealed dictation to, "monitor for bleeding related to [redacted] therapy."

A review of Resident #364's Care Plan with an initiation date of [redacted] did not reveal a care plan focus or interventions for [redacted].

A review of Resident #364's Care Plan with an initiation date of [redacted] did not reveal a care plan focus or interventions for [redacted] and [redacted]

On 6/21/2023 at 9:22 AM, during an interview with surveyor #2, Licensed Practical Nurse/Unit Manager #1 stated, when asked by surveyor #2 if there should be a care plan for [redacted], "Not at first. That is not one we would do unless it was an issue."

On 6/21/2023 at 9:44 AM, during an interview

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with surveyor #2, the Director of Nursing (DON) stated, "Yes." when asked if a resident is admitted on an NJ EX Order 264b1 should they have a care plan. She further stated, "The care plan must be updated for a new diagnosis. The care plan should reflect what they had as a readmission." when asked if a resident is sent to the hospital and returned, would the care plan be updated.

On 6/22/2023 at 12:58 PM, during an interview with surveyor #2, the Assistant Director of Nursing stated the Care Plan should be updated to include NJ EX Order 264b1. During the same interview, when asked what the facility's time frame for the Care Plan update should be, the DON stated, "24 to 72 hours."

A review of the undated facility policy titled, "High Risk Medications - NJ EX Order 264b1" under section, "Policy Explanation and Compliance Guidelines" number 4 revealed, "The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with NJ EX Order 264b1 include: a. [redacted] and NJ EX Order 264b1 [redacted], b. Fall in NJ EX Order 264b1, c. NJ EX Order 264b1

A review of the facility policy titled, "Care plan preparation, long-term care" with a review date of NJ EX Order 264b1 revealed under "Elements of a Care Plan" that, "Each resident's care plan should be based on assessment of the resident, effective clinical decision making, and must be compatible with current standards of clinical practice."

3.) On 6/14/2023 at 09:25 AM surveyor#4 observed Resident #41 in their room during the

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initial tour of the facility. Resident #41 stated that he/she had been [redacted] greater than [redacted] and utilized NJ EX Order. 264b1 [redacted] management method where someone with [redacted] determines their NJ EX Order. 264b1 [redacted] needs based on [redacted] and their current NJ EX Order. 264b1.

According to the Admission Record Resident #41 was admitted to the facility with the following but not limited to diagnoses: NJ EX Order. 264b1 [redacted]) NJ EX Order. 264b1.

A review of the Minimum Data Set (MDS), a screening tool, dated NJ EX Order. 264b1 revealed that Resident #41 had a Brief Interview for Mental Status score of [redacted] indicating he/she was NJ EX Order. 264b1 [redacted] revealed that Resident #41 required limited assistance with most activities of daily living. [redacted] revealed an active diagnosis of NJ EX Order. 264b1 and [redacted] indicated that Resident #41 had received NJ EX Order. 264b1 for [redacted] days of the [redacted] day observation period.

A review of the Order Summary Sheet, dated [redacted] revealed the following physician orders for Resident #41:

NJ EX Order. 264b1 [redacted] as per NJ EX Order. 264b1 [redacted] before meals [redacted] order date NJ EX Order. 264b1.

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NJ EX Order. 264b1 NJ EX Order. 264b1 at NJ EX Order. 264b1 (NJ EX Order. 264b1), order date NJ EX Order. 264b1

Surveyor #4 reviewed the NJ EX Order. 264b1 Medication Administration Record (MAR) for Resident #41. The MAR indicated that Resident #41 received NJ EX Order. 264b1 NJ EX Order. 264b1 for NJ EX Order. 264b1 on the following dates: 6/2/2023, 6/3/2023, 6/4/2023, 6/7/2023, and 6/8/2023. Resident #41 refused on the following dates: 6/1/2023, 6/5/2023, 6/6/2023, 6/9/2023, 6/10/2023, and 6/11/2023. Order was discontinued on 6/12/2023 at 1344. Order was NJ EX Order. 264b1 on NJ EX Order. 264b1 and Resident #41 received the new dosage on 6/12/2023, 6/13/2023, 6/16/2023, 6/17/2023, 6/18/2023, 6/20/2023, and 6/21/2023. Resident #41 refused medication on 6/14 and 6/15/2023. The MAR also revealed that Resident #41 received NJ EX Order. 264b1 checks daily at NJ EX Order. 264b1, and NJ EX Order. 264b1 and was provided NJ EX Order. 264b1 per NJ EX Order. 264b1 parameters.

Surveyor#4 reviewed Resident #41's comprehensive care plan on 06/15/23 at 09:50 AM. Review of the comprehensive care plan revealed that Resident #41 had no care plan addressing diabetes mellitus or the use of insulin.

On 06/20/2023 at 12:08 PM surveyor#4 conducted an interview with RN#2. Surveyor#4 asked RN#2 how care plans are developed when a resident is admitted to the facility and who is responsible for developing the care plan. RN#2 told the surveyor, "The PCC program (PointClickCare, a full medication and treatment

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

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administration system that is securely accessed over the internet for real time accuracy and dependability with the option to integrate with your pharmacy where available) admit/readmit screener will automatically trigger care plans for pain, fall risk, skin integrity, etc. Also, the nurse will be responsible for updating care plans if a new fall occurs or a skin issue changes. The unit manager the next day (after admission) is responsible for the development of the comprehensive care plan."

On 06/22/2023 at 09:29 AM Surveyor#4 conducted an interview with LPN/UM#1 of the [redacted] Floor. Surveyor#4 asked LPN/UM#1 who in the facility was responsible for the development of the comprehensive care plans. LPN/UM#1 told surveyor#4, "It started off at first under the care plan section in PCC but under assessments there is also a baseline care plan in assessments, and they used that up until the day [redacted] care conference. It (baseline care plan) would then be discontinued, and I would look in [redacted] of the MDS for what was triggered, and I would develop the comprehensive care plan after that." Surveyor#4 then asked LPN/UM#1 if the use of insulin should be care planned for a resident prescribed [redacted]. LPN/UM#1 stated that insulin is a care plannable treatment in her opinion and that, "Yes, [redacted] use is something we usually care plan. It's on the baseline care plan under medications and [redacted] in there."

On 06/23/2023 at 10:02 AM during a meeting with the Regional Nurse, facility LNHA, and facility DON, the DON and LNHA admitted that "We discovered we had issues with the new baseline care plan process in [redacted] and it is ongoing. We identified that the electronic format is not working.

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We are in the process of trying to merge the two at this time. It's an issue because sometimes we get admissions at 12 or 1 AM in the morning."

Surveyor #4 reviewed the facility provided policy titled ProMedica Senior Care, Care plan preparation, long-term care, Reviewed: May 20, 2022. The following was revealed under the heading Introduction:

"The resident's interdisciplinary team must develop a baseline care plan within 48 hours after the resident's admission to the facility. On completion of the comprehensive care plan, the facility must provide the resident and the resident representative, if applicable, with a written summary of the baseline care plan. The interdisciplinary team then collaborates with the resident and reviews and revises the care plan, as necessary, to meet the resident's needs throughout the stay in the facility. This document becomes part of the resident's permanent medical record." The following was revealed under the heading Documentation:

"Document all pertinent resident problems, expected outcomes, interventions, and evaluations of expected outcomes. Write the care plan clearly and concisely so that other members of the health care team can understand it. Record the resident's progress (or lack of progress) toward meeting set goals."

4.) On 6/14/2023 at 12:57 PM, during the initial tour of the facility, Surveyor #3 observed Resident #44 in his/her room sitting in a chair with a meal in front of him/her. The resident was pleasant and able to conduct an interview.

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A review of Resident #44's diagnosis located in the Electronic Medical Record (EMR) revealed a diagnosis that included but was not limited to, NJ EX Order. 264b1 .

A review of Resident #44's Physician Orders in the EMR revealed orders for NJ EX Order. 264b1 G (milligrams) ML (milliliters) NJ EX Order. 264b1 used to every hours for NJ EX Order. 264b1 and .

A review of Resident #44's Minimum Data Set (MDS) an assessment tool, dated , revealed under (Medications), that Resident #44 received medication (medication used to thin NJ EX Order. 264b1 .

A review of Resident #44's Care Plan with an initiation date of , did not include a Care Plan focus or interventions for .

On 6/21/2023 at 9:22 AM, during an interview with Surveyor #3, the Licensed Practical Nurse/Unit Manager #2 stated that she was recently advised that she has not been doing the Care Plans correctly but has yet to be in-serviced on the correct process.

On 6/21/2023 at 9:44 AM, during an interview with the team, the Assistant Director of Nursing (ADON) stated that the charge nurses were not

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educated to do Care Plans and that it's been a problem. The ADON further stated that a resident on an NJ EX Order 264b1 should have a Care Plan to monitor for risk associated with NJ EX Order 264b1 such as NJ EX Order 264b1.

A review of the facility policy titled, "Care Plan Preparation, Long-Term Care" with a review date of May 20, 2022, revealed under "Elements of a Care Plan" that, "Care planning is driven by a resident's conditions and issues as well as a resident's unique characteristics and ... based on assessment information with necessary monitoring and follow-up."

NJAC 8:39-11.2(e)

4.) On 6/14/2023 at 12:57 PM, during the initial tour of the facility, Surveyor #3 observed Resident #44 in his/her room sitting in a chair with a meal in front of him/her. The resident was pleasant and able to conduct an interview.

A review of Resident #44's diagnosis located in the Electronic Medical Record (EMR) revealed a diagnosis that included but was not limited to, NJ EX Order. 264b1

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NJ EX Order. 264b1

A review of Resident #44's Physician Orders in the EMR revealed orders for NJ EX Order. 264b1 NJ EX Order. 264b1 MG (milligrams) NJ EX ML (milliliters) (NJ EX Order. 264b1 used to prevent NJ EX Order. 264b1 every NJ EX hours for NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order. 264b1 .

A review of Resident #44's Minimum Data Set (MDS) an assessment tool, dated NJ EX Order. 264b1, revealed under NJ EX Order. 264b1 (Medications), that Resident #44 received NJ EX Order. 264b1 medication (medication used to NJ EX Order. 264b1 and NJ EX Order. 264b1 NJ EX Order. 264b1

A review of Resident #44's Care Plan with an initiation date of NJ EX Order. 264b1, did not include a Care Plan focus or interventions for NJ EX Order. 264b1 .

On 6/21/2023 at 9:22 AM, during an interview with Surveyor #3, the Licensed Practical Nurse/Unit Manager #2 stated that she was recently advised that she has not been doing the Care Plans correctly but has yet to be in-serviced on the correct process.

On 6/21/2023 at 9:44 AM, during an interview with the team, the Assistant Director of Nursing (ADON) stated that the charge nurses were not educated to do Care Plans and that it's been a problem. The ADON further stated that a resident on an NJ EX Order. 264b1 t should have a Care Plan to monitor for risk associated with NJ EX Order. 264b1 such as NJ EX Order. 264b1 .

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F 656	Continued From page 18 A review of the facility policy titled, "Care Plan Preparation, Long-Term Care" with a review date of May 20, 2022, revealed under "Elements of a Care Plan" that, "Care planning is driven by a resident's conditions and issues as well as a resident's unique characteristics and ... based on assessment information with necessary monitoring and follow-up."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently document in the Treatment Administration Record (TAR) for 1 of 1 resident (Resident #28) reviewed for pressure ulcer. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing,	F 658	Corrective Action: Resident #28 and Resident #15's Gaps in treatment administration record was reviewed and the nurses with the omissions in documentation were addressed, Statements obtained that their treatments were rendered, counseling completed and re-in-serviced on documentation of services provided. Identification of At-Risk Resident: All residents have the potential to be affected by this deficient practice. Systemic Change: The wound treatment records for all residents receiving treatments will be	8/8/23

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F 658	Continued From page 19 and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 06/13/2023 at 9:38 AM, the surveyor observed Resident #28 lying in bed, awake and alert,with his/her [redacted] at the bedside. The [redacted] stated that the resident had a [redacted] on his/her [redacted] and that the treatment was just done. The surveyor observed an [redacted] on the bed. According to the Admission Record, Resident #28 was admitted with medical diagnoses which included but not limited to: NJ EX Order. 264b1 [redacted]. Review of the Resident #28's [redacted] Order Summary Report and the [redacted] TAR for Resident#15 revealed that there was no documentation to indicate treatments were administered as ordered on the following dates and times:	F 658	reviewed for appropriate documentation. All nurses were in-serviced on documentation of treatments administered directly after rendering treatments and to double check for completion prior to the end of their shift. Quality Assurance: The Adon will review Tars weekly for 3 months, then biweekly for 3 months and then monthly for completed documentation. The Adon will report findings to DON monthly and to the QAPI committee quarterly over the next year.	

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F 658	Continued From page 20 CARE TO NJ EX Order. 264b1) - Apply NJ EX Order. 264b1 , QD(every day)/PRN(as needed) every night shift for NJ EX Order. 264b1 , ordered 05/31/2023: 7PM-7AM: 06/04/2023, 06/09/2023, 06/10/2023, 06/14/2023, 06/15/2023, and 06/18/2023 CARE NJ EX Order. 264b1 - NJ EX Order. 264b1 - Cleanse with NJ EX Order. 264b1 y and dressing, QD & PRN every night shift for , ordered 7PM-7AM: 06/04/2023, 06/09/2023, 06/10/2023, 06/14/2023, 06/15/2023, and 06/18/2023 CARE TO - surrounding NJ EX Order. 264b1 - Apply QD/PRN every night shift for ordered 7PM-7AM: 06/04/2023, 06/09/2023, 06/10/2023, 06/14/2023, 06/15/2023, and 06/18/2023 Cleanse NJ EX Order. 264b1 and dry completely. Apply NJ EX Order. 264b1 BID and PRN for every day and night shift for Care Prophylaxis AND as needed for Care, ordered 03/ Day Shift: 06/10/2023 Night Shift: 06/04/2023, 06/09/2023, 06/10/2023, 06/14/2023, 06/15/2023, and 06/18/2023 NJ EX Order. 264b1 UNIT/Gram(GM) ( ) Apply to under left NJ EX Order. 264b1 every day and night shift for AND Apply to NJ EX Order. 264b1 every day and night shift for AND Apply to every day and night shift for , ordered 02/28/2023: Day Shift: 06/10/2023 Night Shift: 06/04/2023, 06/09/2023, 06/10/2023, 06/14/2023, 06/15/2023, and 06/18/2023	F 658		

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During an interview with the surveyor on 06/21/2023 at 11:20 AM, the Registered Nurse (RN) stated that a resident's treatment would be located on the TAR. When a treatment was completed, the nurse would document (sign their initials) in the TAR. If there were blanks in the TAR(not signed off) the nurse would not know if the treatment was administered. The RN stated, "if it wasn't signed off, it wasn't done." The RN further stated that it was important to sign off the treatments in the TAR to show that the treatment was completed, and it is a physician's order.

During an interview with the surveyor on 06/21/2023 at 11:25 AM, the Licensed Practical Nurse Unit Manager (LPN/UM #2) stated that the nurses would look at the TAR for treatment orders. After completing a treatment order, the nurses would document in the TAR as completed and should also document in the progress notes or skilled nursing notes. If the treatment order was not signed off as completed the nurse would need to investigate if the treatment was done during [redacted] rounds, if the treatment was completed by another nurse, or review the progress notes to see if it was documented that the treatment was completed. If the nurse didn't sign off that the treatment was completed it would look like it wasn't done. LPN/UM #2 further stated that it was important to sign off the treatments in the TAR to make sure that the resident's treatment was done in a timely manner.

During an interview with the surveyor on 06/21/2023 at 11:25 AM, the Director of Nursing (DON) stated that after a treatment was performed the nurses would document in the TAR. The way to check and see if a treatment

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F 658	Continued From page 22 was completed would be to check the TAR that the treatment was signed off and review the skilled nursing notes or the progress notes to see if the nurse documented about the treatment. The nurse could also check the [redacted] for the date the dressing was completed. The DON further stated that it was important to sign off the treatment in the TAR so that you know that the treatment was done. The TAR had codes the nurses should use if the resident refused or was unavailable and that "the TAR should not be left blank." Review of Resident #28's progress notes for [redacted] did not reveal any documentation that the treatments were adminsitered or refused on the above dates. Review of the policy titled "Charting and Documentation," undated, revealed that documentation of procedures and treatments will include: (a) the date and time the procedure/treatment was provided and (g) the signature and title of the individual documenting.	F 658		
F 812 SS=E	NJAC 8:39- 29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		8/8/23

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F 812	Continued From page 23 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 6/13/2023 from 9:05 to 9:43 AM the surveyor, accompanied by the District Manager (DM) and the Food Service Director (FSD), observed the following in the kitchen: 1. On the Metro Storage Rack stacks of what the FSD described as dessert plates, desert bowls, and salad bowls were cleaned and sanitized. The plates and bowls were not covered and were not in the inverted position leaving the cleaned and sanitized dishware exposed to contamination. On interview the FSD was not aware at the time that cleaned and sanitized equipment needs to be covered/inverted to not expose the equipment to contamination. 2. On a middle rack of a multi-tiered cart in the walk-in refrigerator a 1/2 pan of scalloped potatoes had no use by date. The FSD stated, "we made that last night. They didn't put a label	F 812	1)The FSD was notified and had all the plates and Bowels washed and sanitized again. All the residents can be affected by this deficient practice. The FSD and all the dietary staff were inserviced on storing of clean and sanitized dishes and equipment. The FSD will be doing weekly checks for 4 weeks and monthly for 3 months for any clean or sanitized kitchen equipment not stored properly and will report her findings by the monthly QAPI meeting. 2)The FSD had the half pan of scalloped potatoes thrown away. The FSD made sure that all the sponge cakes that had been previously opened were thrown away. All the residents can be affected by this deficient practice. The FSD and all the dietary staff were	

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F 812	Continued From page 24 on it." The surveyor asked the FSD what the facility process was for labeling and dating of foods. The FSD responded, " Our process is everything has to be labeled and dated, yes" 3. In the walk-in freezer on a middle shelf a sponge cake was previously opened and replaced. The cake had no dates. On an upper shelf (2) additional sponge cakes were removed from their original container and had no dates. When interviewed the DM stated, "We'll do an in-service on that." On 6/19/2023 at 11:09 AM the surveyor observed the 2nd floor pantry. During the observation the surveyor asked the Licensed Practical Nurse/Unit Manager (LPN/UM#1) who was responsible for monitoring personal room refrigerators in the facility. LPN/UM#1 responded that she thought dietary is responsible for monitoring the pantry and monitoring refrigeration temperatures. LPN/UM #1 then stated I believe housekeeping is responsible for monitoring the refrigerator temps in the resident rooms. On 6/19/2023 at 11:20 AM LPN/UM#1 confirmed with the surveyor that housekeeping is responsible for monitoring in room refrigerator temperatures for personal refrigerators. The surveyor then requested to see the refrigeration temperature log for personal refrigerators in resident rooms for the facility. On 6/19/2023 at 11:31 AM the Plant Operations/Director of Maintenance (PO/DOM) explained to the surveyor that personal in room refrigerator checks are completed daily by the housekeeping staff assigned to those rooms. The PO/DOM provided the surveyor with a copy of the June 2023 Patient Room Refrigerator/Freezer Log for the [redacted] floor of the facility.	F 812	inserviced on the label and dating policy of all prepared and opened foods. The FSD will be doing weekly checks for 4 weeks and monthly for 3 months for any food products in the kitchen that have not been labeled and dated and will report her findings by the monthly QAPI meeting. 3)The Plant Operations/Director of Maintenance was inserviced on the facility policy of safe and sanitary use of resident refrigerators, and recording daily temperatures on a temperature log. Since all the resident rooms have refrigerators, this has the ability to affect all of our residents. All the housekeeping and Maintenance staff were inserviced on the facility policy of safe and sanitary use of resident refrigerators, and recording daily temperatures on a temperature log. The Plant Operations/Director of Maintenance will be doing weekly checks for 4 weeks and monthly for 3 months to make sure that all temperature logs are completely filled out and will report his findings by the monthly QAPI meeting.	

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Review of the 2nd floor log revealed that no temperature checks were completed for the dates of 6/1/2023 through 6/13/2023. Review of the [redacted] floor temperature log revealed that no temperatures had been recorded for the dates of 6/1/2023 through 6/13/2023. The surveyor asked the PO/DOM why no temperatures were recorded for the 6/1/2023 through 6/13/2023 period. The PO/DOM responded, "We had some challenges at the end of the pandemic but were good now." The surveyor asked the PO/DOM if temperatures should have been monitored and recorded on a daily basis. The PO/DOM responded, "Yes, the temps should have been done every day. The Housekeeping supervisor should be monitoring the temps and ensuring they are completed on a daily basis. It's a responsibility of both of us." Observation of the [redacted] Floor Patient Room Refrigerator/Freezer Log revealed at the top of the log: "Check temperature daily. Refrigerator temperature must remain between 32 degrees & 40 F (Fahrenheit) and Freezer Temperature must remain between -10 & 0 F. Deviations must be reported to Plant Operations.

On 6/19/2023 from 11:00 to 11:13 AM the surveyor, accompanied by the FSD, observed the following in the kitchen:

1. In the Three Door Reach-In refrigerator on a top shelf, a hard, clear, plastic container contained pear halves. The container was labeled, "Made on: 6/17/23" and "Used by: 6/19/23" The FSD removed the pears to the trash

The surveyor reviewed the facility policy titled Resident Refrigerators, undated. The following was revealed under the heading Policy: This facility does provide a refrigerator in each

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F 812	Continued From page 26 resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident refrigerators. The following was revealed under the heading Policy Explanation and Compliance Guidelines: 2. Maintenance and or housekeeping staff shall record refrigerator temperatures daily on a temperature log. The surveyor reviewed the facility policy for Dishmachine Washing, Manual Warewashing, and Storage, dated 2010. Under the Storage heading the following was revealed: "Glasses, cups, and dishware should be stored upside-down." N.J.A.C. 18:39-17.2(g)	F 812		
F 880 SS=D	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 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		8/8/23

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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.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 28 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain infection control standards and procedures by failing to follow appropriate hand hygiene practices and perform [redacted] treatment in a safe and sanitary manner for 1 of 1 resident (Resident #28) reviewed for [redacted]. This deficient practice was evidenced by the following: On 06/13/23 at 9:38 AM, the surveyor observed Resident #28 lying in bed, [redacted], with his/her [redacted] at the bedside. The daughter stated that the resident had a [redacted] on his/her [redacted] and that the treatment was just done. The surveyor observed an [redacted] on the bed. According to the Admission Record, Resident #28 was admitted with medical diagnoses which included but not limited to: [redacted]. Review of Resident #28's Quarterly Minimum data Set (MDS), an assessment tool, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that	F 880	Corrective Action: Resident #28 □ The Unit Manager and PA were re-in-serviced immediately regarding the treatment procedure and handwashing. Retraining and competencies completed. Identification of At-Risk Resident: All residents have the potential to be affected by this deficient practice. Systemic Change: All staff were in-serviced on proper treatment procedures and handwashing techniques. All personnel will be in-serviced on the facility□s policy for hand hygiene. In-service training to include random observations of personnel performing hand hygiene procedures according to facility policy. Findings reviewed will all personnel. Corrective action is provided as needed. Quality Assurance: IP will complete competencies on handwashing and treatment procedures for 4 staff a week for 3 months, then 4 staff biweekly for 3 months, and then 4 staff monthly to assure that the proper procedures are completed by all staff.	

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F 880	Continued From page 29 the resident was NJ EX Order: 264b1. Further review of the MDS indicated that the resident needed NJ EX Order: 264b1 of [redacted] people for bed mobility and personal hygiene and was non-ambulatory. [redacted] the MDS revealed that the resident had NJ EX Order: 264b1 [redacted] r and NJ EX Order: 264b1. Review of the Resident #28's Treatment Administration Record, dated [redacted], revealed the following [redacted] care orders: [redacted] CARE TO NJ EX Order: 264b1 ([redacted] Apply NJ EX Order: 264b1 used for NJ EX Order: 264b1), [redacted] (dressing), NJ EX Order: 264b1 NJ EX Order: 264b1 QD (every day) /PRN(as needed) every night shift for NJ EX Order: 264b1, ordered [redacted] [redacted] CARE TO NJ EX Order: 264b1 - Cleanse with NJ EX Order: 264b1), apply [redacted] and NJ EX Order: 264b1, QD & PRN every night shift for NJ EX Order: 264b1, ordered [redacted] [redacted] CARE TO [redacted] surrounding NJ EX Order: 264b1 Apply NJ EX Order: 264b1 /PRN every night shift for NJ EX Order: 264b1, ordered [redacted] On 06/20/23 at 10:20 AM, the surveyor observed the Licensed Practical Nurse Unit Manager (LPN/UM#2) and the Physician Assistant [redacted] Care Consultant (PA) completing [redacted] rounds on the [redacted] floor. Resident #28's [redacted] was present in the room and both the resident, and the [redacted] agreed that the surveyor could observe the [redacted] treatments. The LPN/UM #2 stated that during [redacted] rounds the PA would remove the [redacted] and obtain	F 880	The IP will report findings monthly to DON and Quarterly to the QA committee over the next year.	

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[redacted] measurements and the LPN/UM#2 would document the measurements and any new [redacted] treatment orders that were recommended.

The surveyor observed the PA perform handwashing which included the following: turned on the faucet, wet both hands, applied soap, lathered outside the stream of water for 10 seconds, turned off the faucet with his hand, opened the cabinet that contained the paper towels with his hand, pulled out the paper towel, then dried both hands with the paper towel.

The surveyor observed the LPN/UM#2 perform handwashing which included the following: turned on the faucet, wet both hands, applied soap, lathered both hands outside the stream of water for 20 seconds, turned off faucet with her left elbow, opened the cabinet that contained the paper towels with her hand, pulled out the paper towel, then dried both hands with the paper towels

At 10:20 AM, the surveyor observed the following during [redacted] care treatment: The PA and the LPN /UM#2 donned (put on) a pair of gloves and the resident's [redacted] r also donned a pair of gloves.

1.The PA was standing on the resident's right side; he removed the [redacted] from the [redacted] area and placed the dressing on resident's bed sheet by the resident's [redacted]. The PA then obtained the [redacted] measurement using a paper [redacted]. The LPN/UM#2 then removed the glove from her right hand and used a pen to document the measurement and the recommended treatment on a piece of paper.
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2. At 10:24 AM, the PA and the daughter repositioned the resident onto the resident's right side, opening the [redacted] and exposing the [redacted]. The PA then walked to the resident's left side and removed the old [redacted] from the [redacted], placed the soiled [redacted] on the bedsheet without changing gloves and preforming hand hygiene. The PA then obtained the measurement of the [redacted] using the same paper measuring tape and the same gloved hands.

3. Using the same gloved hands, the PA then removed the dressing from a [redacted] located on the Resident#28's [redacted]. The PA obtained the [redacted] measurements using the same gloved hands and the same paper measuring tape. The PA then gathered all the soiled dressings that were on the bedsheet and disposed them in the trash can located under the sink.

5. The LPN/UM #2, with the one left hand gloved, walked to the treatment cart that was in the hallway outside the resident's room. The LPN/UM#2 obtained the supplies for the [redacted] treatments without removing the glove and performing hand hygiene. The LPN/UM#2 then placed the [redacted] care supplies directly on the bedsheet where the soiled [redacted] were previously located (not on a clean field).

6. The PA removed both gloves from his hands, threw the gloves in the trash and donned a new pair of gloves without performing hand hygiene. The PA then went and positioned himself on the resident's right side.

7. The LPN/UM #2 removed the left glove and

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donned a new pair of gloves without performing hand hygiene

8.The LPN/UM #2 then applied the [redacted] to the gauze and cleansed the [redacted] then placed the soiled gauze directly on the bedsheet. The LPN/UM #2 then went to the treatment cart to obtain more [redacted] treatment supplies wearing the same gloves.

9. Using the same gloved hands, the LPN/Um #2 then used a wooden applicator to apply the [redacted] gel treatment to the [redacted] dressing then placed the dressing on the [redacted]. Another [redacted] dressing was then placed over the [redacted]. The [redacted] was not dated or initialed.

10. Without changing gloves and performing hand hygiene , the LPN/UM #2 then went to the cart again and obtained more supplies for the [redacted] treatment and placed the supplies directly on the bedsheet. The LPN/UM #2 then performed the [redacted] treatment to the right thigh [redacted] without changing gloves and performing hand hygiene. The dressing was not dated or initialed.

11.Using the same gloved hands, the LPN/UM#2 then applied [redacted] to the [redacted] area around the [redacted] dressing.

12. At 10:30 AM, the PA, with gloved hands, assisted the resident to reposition onto their back. The PA then removed his gloves and donned a new pair of gloves without performing hand hygiene.

13. At 10:36 AM, the PA then lifted the resident's

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[redacted] to expose the [redacted]. The LPN/UM #2, wearing the same soiled gloves, applied the [redacted] treatment to the right breast. The [redacted] was not dated or initialed.

14. The PA and the LPN/UM #2 then removed their gloves and disposed of them in the trash can. The surveyor observed LPN/UM #2 perform handwashing as follows: turned on the faucet, wet hands, applied soap, lathered for 28 seconds, turned off the faucet with her hand, opened the cabinet that contained the paper towels, obtained a paper towel, dried her hands, and discarded the paper towel in the trash can. The PA then performed handwashing as follows: turned on the faucet, wet hands, applied soap, lathered hands for 15 seconds, turned off the faucet with his hand, opened the cabinet with his hand to obtain the paper towels, dried his hands then disposed the paper towel in the trash can.

During an interview with the surveyor on 06/20/23 at 12:19 PM, in the presence of the PA, the LPN/UM #2 stated that the process for handwashing included the following steps: Turn on the water, rinse your hands, soap your hands for 30 seconds, rinse your hands, turn off the water with a paper towel, then use another paper towel to dry your hands. The LPN/UM#2 further stated that if you need to get more supplies for your treatment, you need to change your gloves. She further stated that "handwashing is completed when you go into a room and when you go out of a room."

The LPN/UM #2 stated the process for [redacted] care treatment included the following: knock on the resident's door and introduce yourself and ask if it is ok to change their [redacted]. When we

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do [redacted] rounds, the PA would remove the old [redacted] and obtain the [redacted], then the LPN/UM#2 would document the [redacted] and if the treatment would stay the same or a new order would be recommended. The LPN/UM#2 then stated she would don gloves, get the treatment supplies from the cart, apply a new pair of gloves, do the treatments as ordered then will date the [redacted] when completed.

The LPN/UM #2 further stated that gloves would be changed between every resident. "If I am doing multiple treatments on the same resident, I would use the same gloves to put on all the clean dressings. I would wear one pair of gloves to remove all the old [redacted] then one pair of gloves to apply all the new [redacted]." The PA then stated the gloves should be worn to remove [redacted] and take the [redacted], remove the gloves, wash your hands then put on new gloves to remove the next [redacted] and take [redacted]

During an interview with the surveyor on 06/20/23 12:59 PM, in the presence of the Assisted Director of Nursing (ADON) and the Infection Preventionist (IP,) the Director of Nursing (DON) stated that the process for handwashing included the following: turn on the faucet, apply soap, get a good lather and friction, sing happy birthday twice (15 plus seconds), rinse your hands, get a paper towel to turn off the faucet and another paper towel to dry your hands.

The DON further stated that the process for [redacted] treatment included the following: check the resident's ID, check the order for the treatments, assess the residents if they have any [redacted] and medicate if needed, makes sure there is

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a clean field by wiping down the table or using a chux, get your supplies and open your [redacted], label the [redacted] with date and time and set the supplies on the clean area. Perform handwashing, apply gloves, position the resident to do the treatment, remove gloves, handwash then put on new gloves, then start the treatment process and work quickly and efficiently so you don't expose the [redacted] for a long time.

The DON further stated that if the resident had multiple [redacted], the nurse would start with the least [redacted] then to most [redacted]. Gloves and hand hygiene should be performed for each [redacted] change and a disposable [redacted] tape for each [redacted]

At that time, the surveyor reviewed the [redacted] care observations with the DON, ADON and IP. The DON stated that removing all the old [redacted] at one time, wearing the same gloves, and using the same paper [redacted] tape can cause cross contamination. When there are multiple [redacted], each [redacted] treatment should be completed from start to finish at that time. The DON further stated that hand hygiene was to be performed and gloves were to be changed between each [redacted] site and the soiled [redacted] should be placed in a trash can once removed.

When asked what the PA and LPM/UM #2 should have done, the ADON stated " What the DON just said."

The facility provided the LPN/UM #2's hand hygiene and wound care treatment/technique competency dated 06/14/2022. The facility did not have a competency for the PA since he was a contracted employee.

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F 880	Continued From page 36	F 880		

A review of the facility's policy titled "Hand Hygiene,", undated, revealed that staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hand hygiene technique when using soap and water include wet hands with water, apply to hands the amount of soap recommended by manufacturer, rub hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers, rinse hands with water, dry thoroughly with a single use towel and use a clean towel to turn off faucet. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.

A review of the facility's policy titled "Clean Dressing Change," undated, revealed that the facility will provide [redacted] care in a manner to decrease potential for infection and/or cross-contamination. Guidelines included but not limited to:
-Each wound will be treated individually
-When multiple [redacted] are being [redacted], the dressings will be changed in order of the least contaminated to most contaminated.
-Set up a field on the overbed table with needed supplies for wound cleansing and [redacted] application: if table is soiled, wipe clean, place a disposable cloth, or line saver on the overbed table, , place only supplies to be used per [redacted] on the clean field at one time, use no-touch techniques to remove ointments and creams from their containers (i.e., Use a tongue blade or applicator)
-Establish an area for soiled products to be placed (chux or plastic bag)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 -Wash hand and put on gloves -Place a barrier cloth or pad next to resident , under the [redacted] to protect the bed linen and other body sites -Loosen the tape and remove existing [redacted] -Remove gloves, pulling inside out over the [redacted]. Discard in the appropriate receptacle -Wash hands and put on clean gloves -Cleanse the wound as ordered, taking care to not contaminate other surfaces. Pat dry with gauze. -Measure the [redacted] using disposable measuring guide. -Wash hands and put on clean gloves -Apply topical ointments or creams and dress the w as ordered -Secure [redacted] -Discard disposable item and gloves into the appropriate trash receptable and wash hands. NJAC 8:39-27.1; NJAC 8:39-19.4(a) (1)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04007	A. BUILDING: _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day and evening shifts as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 3 of 14-day shifts and 7 of 14 evening shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for the deficient practice. SYSTEMIC CHANGE: The facility has contracted with a new portal online to hire more facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, shift differentials and referral bonuses are	8/8/23

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

Electronically Signed | 07/07/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04007	A. BUILDING: _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 05/28/2023 to 06/10/2023 revealed that the facility was deficient in CNA staffing for residents on 3 of 14-day shifts and deficient in CNAs to total staff on 7 of 14 evening shifts as follows: -05/29/23 had 7 CNAs to 16.5 total staff on the evening shift, required 8 CNAs. -06/01/23 had 6 CNAs for 56 residents on the day shift, required 7 CNAs. -06/01/23 had 5 CNAs to 11.5 total staff on the evening shift, required 6 total staff. -06/02/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs. -06/03/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs. -06/03/23 had 4 CNAs to 10 total staff on the evening shift, required 5 CNAs. -06/04/23 had 6 CNAs to 13.5 total staff	S 560	being utilized to become more competitive in the marketplace. Open shifts are posted in advance for facility staff and agency staff to pick up to help comply with staffing ratios. Bonuses are offered to facility staff and agency staff to incentivize working open shifts. In addition, the Director of Nursing will meet daily with the staffing coordinator to ensure appropriate staffing Quality Assurance The administrator or designee will review the staffing schedule weekly to monitor the staffing ratio on all shifts weekly x 90 days. The administrator will report findings to the QA committee on a quarterly basis x 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04007	A. BUILDING: _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

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S 560	Continued From page 2	S 560		

on the evening shift, required 7 CNAs.
-06/05/23 had 4 CNAs to 14.5 total staff on the evening shift, required 7 CNAs.
-06/08/23 had 7 CNAs to 15.5 total staff on the evening shift, required 8 CNAs.
-06/10/23 had 6 CNAs to 13.5 total staff on the evening shift, required 7 CNAs.

During an interview with the surveyor on 06/20/23 at 09:56 AM, the Licensed Nursing Home Administrator (LNHA) stated that she reports and communicates with the Staffing Coordinator (SC) daily regarding any staffing issues. The LNHA added that the SC had worked full-time for facility for one year. The LNHA was able to state the mandatory minimum requirement for ratio of CNA to resident as 1 CNA to 8 residents on day shift, 1 CNA to 10 residents on evenings, and 1 CNA to 14 residents on the night shift. The facility does use some agencies for both nurses and CNAs and added that most of our nursing positions are filled. The LNHA revealed that for most days she was meeting the minimum staffing requirements, "CNAs are the hardest to fill and there are no TNAs working in the facility." The LNHA stated that if there are staff call outs, they will schedule to meet the call outs and fill in the blanks. The LNHA revealed that she was always aware of any staffing issues because the facility's scheduling was electronic and both the LNHA and SC were able to see the same staff vacancies. The facility does provide monetary bonuses to the facility staff as incentive to work extra shifts and to fill in any staff vacancies. The LNHA stated that the facility encourages their own staff to fill in vacancies, advertise on a well-known job site, and use e-mail blasts to facilitate the hiring of CNAs.

During an interview with the surveyor on 06/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04007	A. BUILDING: _____ B. WING _____	C 06/23/2023

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S 560	Continued From page 3 at 11:57 AM, The SC stated that she had been employed at the facility for one year and that her job position was full-time Staffing Coordinator/Payroll Clerk. The SC stated that her job description was to coordinate the staffing of both nurses and CNAs. The SC was able to state the mandatory minimum staffing ratios for CNAs and was meeting the minimum staffing requirements by using agencies and facility staff as needed. The SC stated that she uses the facility census as a basis to staff the facility and communicated with the Director of Nursing (DON) for any special staffing needs or requirements. The SC also added that facility staff would receive monetary bonuses for any shifts worked over their normal scheduled hours. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
04007	A. Building B. Wing	8/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/08/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315513 Y1	A. Building B. Wing Y2	8/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUBACUTE AT AUTUMN LAKE HEALTHCARE	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0609	Correction	ID Prefix	F0656	Correction	ID Prefix	F0658	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.21(b)(1)(3)	Completed	Reg. #	483.21(b)(3)(i)	Completed
LSC		08/08/2023	LSC		08/08/2023	LSC		08/08/2023
ID Prefix	F0812	Correction	ID Prefix	F0880	Correction	ID Prefix		Correction
Reg. #	483.60(i)(1)(2)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Completed
LSC		08/08/2023	LSC		08/08/2023	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/23/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315513	A. Building B. Wing	8/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 08/08/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO