STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 000	INITIAL COMMENTS Survey Date: 02/14/2023 Census: 104 Sample: 21 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 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		3/17/23

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

Electronically Signed | 03/05/2023

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined that the facility failed to provide a resident with respect and a dignified existence by failing to provide adequate [redacted] care. This deficient practice was identified for one (1) of 21 resident's, (Resident #159) reviewed for respect and dignity and was evidenced by the following: Refer to F691 On 02/07/23 at 12:05 PM, the surveyor entered Resident #159's room and observed the resident lying flat in bed. The resident told the surveyor that he/she had been admitted to the facility about a week ago from the hospital and had a [redacted] condition in which [redacted] causing [redacted]	F 550	Concern Tag- F550 – SS=D RESIDENT RIGHTS Facility failed to provide a resident with respect and dignity as evidenced by resident #159 The [redacted] bag was leaking. Facility failed to provide a resident with respect and dignity as evidenced by failing to provide adequate [redacted] supplies. How the corrective action will be accomplished for any resident affected by deficient practice Resident was assessed and was sent out to the hospital for reevaluation of [redacted] and appropriate supplies. Nursing staff had in-service training on resident dignity and respect prior to	

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F 550	Continued From page 2 and had undergone surgery to create the [redacted]. At that time the, the resident pulled up the bed sheets that were covering his/her stomach and the surveyor observed the resident's [redacted] bag. The surveyor observed [redacted] liquid the same color as the [redacted] liquid in the resident's [redacted] bag on the resident's bed sheets. The resident further told the surveyor that the [redacted] care has been an "ongoing problem". The resident explained that one day he/she sat in bed for two hours with the [redacted] bag leaking on him/her. The resident told the surveyor that the hospital had sent him/her to the facility with [redacted] supplies, but the supplies were few, had run out, and the facility did not have the appropriate supplies that fit his/her [redacted] The resident further stated that he/she had told multiple people that he/she did not want to be staying in the facility anymore. The resident stated, "I just want to go back to the hospital and start all over again. I don't want to be here". The surveyor reviewed the medical record for Resident #159. A review of the resident's Admission Record reflected that the resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted], and [redacted]. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been admitted to the facility for less than 14 days.	F 550	providing direct-care responsibilities and have been re-educated regarding resident dignity and respect. Nursing staff in-serviced on timely response to call bells. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents. (current and future) Measures to ensure were/will be put into place to assist this area of concern. DON or designee to observe five (5) nursing staff daily during care of resident with ostomy x 4 weeks to ensure residents are being treated with dignity and respect. All Staff re-inserviced regarding dignity, respect and response to call bells. DON or designee will review clinical charts to ensure supplies are available in house prior to admission. Don or designee will check supplies PAR level with the Supply Coordinator weekly x 4 weeks. How the concern will be monitored and title of person responsible for monitoring. Results or findings will be discussed in monthly QAPI and this will be a part of	

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F 550	Continued From page 3 A review of the [redacted] Order Summary Report (OSR) reflected a Physician's Order (PO) dated [redacted] to change [redacted] every seven (7) days or as needed for [redacted] care. A review of the [redacted] Medication Administration Record (MAR) revealed that on [redacted] at 0900 (9:00 AM) and on [redacted] at 0900, a nurse had signed that the [redacted] bag was changed. The [redacted] MAR did not reflect that nursing staff had changed the [redacted] bag as needed. A review of the resident's Care Plan revealed a focus area that the resident had a [redacted] y related to [redacted] surgery. The goal of the resident's Care Plan was that the resident would be free from complications of [redacted] function and healing through next review. The interventions in the resident s Care Plan included [redacted] care each shift and as needed and to observe the [redacted] site each shift for signs and symptoms of irritation and infection. On 02/07/23 at 12:14 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that she had went into the resident's room and helped the resident with his/her [redacted] care because the resident was, "upset" about their [redacted]. The LPN/UM did not specify a date or time that she had assisted the resident with [redacted] care, The surveyor asked the LPN/UM what caused the resident to be upset and the LPN/UM stated the resident was, "concerned" about the [redacted] because it was a special device and the resident wanted to make sure that the facility had the	F 550	Center QA program. Dates when concern will be completed. March 17, 2023	

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F 550	Continued From page 4	F 550		

appropriate supplies to care for it.

On 02/09/23 at 10:01 AM, the surveyor interviewed one of the Certified Nursing Aide's (CNA)s on the subacute unit who stated that she never had the resident on her assignment but would answer the residents' call bell. The CNA told the surveyor that the resident expressed to her that [redacted] was [redacted] at the facility and wanted to go home. The CNA further stated that she would reposition the resident for comfort and the resident never expressed concerns to her about his/her [redacted] bag.

On 02/13/23 at 10:45 AM, the surveyor interviewed Licensed Practical Nurse (LPN) who stated that she had cared for the resident and the resident was [redacted]. The LPN told the surveyor that the resident was [redacted] The surveyor asked in what way did the resident demonstrate [redacted]. The LPN stated that the resident would say to her that he/she was hopeful to get better and wanted to go home. She explained that the resident came to the facility with [redacted] supplies and had a [redacted]. The LPN stated that the [redacted] bags that were sent from the hospital were [redacted] with a round lid on it, and the bag was able to be drained. The LPN told the surveyor that she recalled changing the resident's [redacted] bag on [redacted] and had used the last bag the resident had, which was sent from the hospital. The LPN stated that she believed on [redacted] when she cared for the resident that the facility was in the process of ordering supplies for the resident and was hoping that the supplies would be there soon

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F 550	Continued From page 5	F 550		

for the resident. The surveyor asked the LPN if the [redacted] bag ever leaked when she cared for the resident. The LPN stated, "Yes. The bag was leaking and that was why I changed it." The LPN explained that the bag was leaking because it was a [redacted] that stuck to the resident's skin and the skin needed to remain dry around the bag. The LPN stated that on [redacted] when she had changed the resident's bag it had been her second time changing it and both the bags were leaking. The LPN told the surveyor that if a resident had a [redacted] bag the expectation would be for the facility to have the appropriate supplies to care for the resident and the supplies should have been readily available.

On 02/13/23 at 11:32 AM, the surveyor conducted a follow up interview with the LPN/UM who stated that prior to the resident being admitted to the facility she reached out to management staff because she had concerns related to the resident's care, such as available [redacted] supplies. The LPN/UM stated that the resident was admitted from the hospital with [redacted] bags and that she, "was frustrated" because she was waiting for the supplies to come in for the resident. The LPN/UM stated that the resident, "definitely" had issues with the [redacted] bag leaking. She further stated that the resident came from the hospital with the 2 devices and when she went into the room on [redacted]), the resident did not have supplies left. The LPN/UM stated that when she went into the resident's room that [redacted], she had observed [redacted] on the resident's bed because the resident's [redacted] bag was leaking. She told the surveyor that her and another nurse cleaned up the resident and did the best they could to secure the [redacted] bag in place for the

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F 550	Continued From page 6 resident. On 02/13/23 at 12:30 PM, the surveyor conducted a telephone interview with the resident's representative who stated that the resident was sent from the hospital to the facility with "maybe" [redacted] bags and the facility ran out of [redacted] supplies. The resident representative told the surveyor that when he/she visited the resident on [redacted], the [redacted] bag was leaking everywhere, and he/she observed towels that were soaked in [redacted]. The resident representative further stated that the [redacted] bags had not arrived on Monday (02/06/23) or Tuesday (02/07/23) for the resident. On 02/16/23 at 11:08 AM, the surveyor interviewed the facility's Director of Nursing (DON) who stated that the resident had a long history of [redacted] and [redacted]. The DON further stated that the resident's [redacted] bag was leaking so the resident was sent out to the hospital. A review of the facility's Resident Rights Guidelines for All Nursing Procedures dated [redacted] indicated that prior to providing direct-care responsibilities for resident's, staff must have in-service training on resident dignity and respect. A review of the facility's Quality of Life - Dignity Policy and Procedure revised 02/23 indicated, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality." The facility's Quality of Life - Dignity Policy and Procedure further indicated that residents should be always treated	F 550		

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F 550	Continued From page 7 with dignity and respect. "Treated with dignity" meant the resident would be assisted in maintaining and enhancing their self-esteem, self-worth, residents would be groomed as they wished to be groomed, and staff would promptly assist the resident with standards of care that promote dignity such as toileting assistance.	F 550		
F 584 SS=D	NJAC 8:39 4.1(a)(11)(12),27.1(a) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		3/17/23

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F 584	Continued From page 8 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to provide a clean, comfortable, homelike environment for two (2) out of 21 resident's, (Resident #99 and Resident #158) reviewed and on one (1) unit, [redacted] unit) out of three (3) nursing units. The deficient practice was evidenced by the following: On 02/07/23 at 11:36 AM, the surveyor entered Resident #99 and Resident #158's room on the [redacted] unit at the facility and observed that the room was unkept. There was a crack in floor in the center of the resident's room, an another large, long crack which extended up the wall in the center of the resident's room. The surveyor observed that Resident #99 had tannish brown colored splatter underneath his/her [redacted] pole on the floor and directly on the base of the [redacted] pole. The surveyor saw a large amount of tannish brown liquid pooled on the floor underneath Resident #158's [redacted] pole. The	F 584	Concern Tag- F584 – SS=D Facility failed to provide a clean, comfortable, homelike environment for two (2) residents Resident #99 and resident #158 Resident #158 room was observed with crack in the floor in the center of the resident room. Resident #99 has a tannish brown colored splatter underneath his room [redacted] ([redacted] pole on the floor and directly on the floor underneath Resident #158's. How the corrective action will be accomplished for any resident affected by deficient practice Residents were moved to another room. All [redacted] poles were cleaned to remove tannish brown colored splatter underneath the [redacted] pole	

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F 584	Continued From page 9 surveyor further observed tannish brown splatter on the base of Resident #158's [redacted] pole. There were black smudges and indentations observed on the walls throughout the resident's room. The surveyor further observed spackle (a thick white coating used to cover up holes in walls) on the walls throughout the resident's room. The spackle had not been sanded down to be even with the walls exterior and was not painted over. Resident #158's resident representative was in the room who stated that he/she had come earlier and cleaned up the garbage that was on the floor. Resident #158 shook his/her up and down to indicate, "yes" the room was dirty and his/her representative had picked garbage up off the floor. The surveyor entered the resident's bathroom and observed no liner (garbage bag) in the garbage can. The garbage can was filled to the top. The surveyor saw paper towels and gloves on the floor in the resident's bathroom, not in the garbage can. The surveyor further observed uneven white plaster all over the walls in the resident's bathroom. On 02/08/23 at 12:03 PM, the surveyor observed tannish brown spillage on the bottom of Resident #99's [redacted] pole and on the floor underneath the resident's [redacted] pole. On 02/13/23 at 10:33 AM, the surveyor and the resident's Certified Nursing Aide (CNA) entered Resident #99 and Resident #158's room together. The CNA stated that the black indentations were observed on the walls in the resident's room, behind the resident's dresser, nightstands, and beds. The CNA told the surveyor that she observed the crack in the floor and up the wall in the resident's room along with the white spackle markings. The CNA stated that the housekeeping	F 584	No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future) Measures to ensure were/will be put into place to assist this area of concern. DON, Administrator and designee to make rounds to rooms on bi-weekly basis x 4 weeks to check room conditions. Maintenance director will be notified of any necessary repairs. Maintenance/ housekeeping Director and designee will round daily to care and cleanse reusable items and durable medical equipment. Housekeeping in-serviced regarding the importance of thorough daily cleaning to ensure an optimum level of cleanliness and sanitation. Resident care equipment including reusable items and durable medical equipment will be cleaned and disinfected according to CDC recommendations. Maintenance Director in-serviced regarding maintaining the building in good repair, including cracks, smudges on walls, spackling and painting	

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F 584	Continued From page 10 department was responsible for cleaning the resident's room and the maintenance department was responsible for maintaining the integrity of the walls and the floor in the facility. On 02/13/23 at 10:39 AM, the surveyor interviewed the housekeeper on the [redacted] unit who stated that she usually worked on another unit in the facility. The surveyor entered Resident #99's and Resident #158's room with the housekeeper who confirmed through observation that there were black indentations throughout the walls in the resident's room, white spackle on the walls, and a large crack in the floor and wall in the center of the room. The housekeeper stated that she was responsible for cleaning the [redacted] pole in the resident's room. On 02/13/23 at 11:44 AM, the surveyor entered the resident's room with the subacute Licensed Practical Nurse/Unit Manger (LPN/UM). The LPN/UM confirmed the observations that the walls in the resident's room had black indentations and markings throughout, white spackle on the walls, a crack in the floor in the center of the resident's room, and a crack up the wall in the center of the resident's room. The LPN/UM stated there should not be left over spillage from the [redacted] underneath or on the [redacted] pole and it was the housekeepers job responsibility to clean the resident's room and [redacted] pole. On 02/13/23 at 12:01 PM, the surveyor interviewed the facility's Director of Housekeeping who stated that he made daily rounds to all the resident's rooms to check for cleanliness. He further stated that it was the housekeeper's responsibility to clean the [redacted] poles in the	F 584	Necessary room repairs discussed daily in morning meeting. Housekeeping Director and designee will clean 5 rooms X 4 weeks for reusable items and medical equipment. How the concern will be monitored and title of person responsible for monitoring. Findings will be discussed in morning meeting for immediately resolution. This will be discussed in a monthly QAPI and this will be a part of quarterly QA. Dates when concern will be completed. March 17, 2023	

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F 584	Continued From page 11	F 584		

resident's rooms.

On 02/13/23 at 12:16 PM, the surveyor interviewed the facility's Maintenance Director (MD) who stated that the facility just had finished building a brand-new subacute unit that was going to open soon. The MD explained that he made daily rounds in which he checked the resident's rooms for comfortable room and water temperatures, checked to make sure the call bells were functioning properly, looked for holes in walls, would touch up walls with paint, and would fix things in the resident's rooms like the sink or toilet if it was broken. The MD stated that if he identified that the walls needed to be touched up with paint and had scuffs or indentations on them, he would spackle and paint over them. The MD told the surveyor that he had identified rooms that needed to be touched up, notified management of the repairs but as of now had been, "holding off on repair" because he was told by the facility's managemnt that a new subacute unit was going to open soon. The MD further told the surveyor that when he started working at the facility approximately six (6) months ago, he had noticed the cracks in the floor, indentiations, and spackle on the walls in the resident's room.

A review of the facility's, Cleaning and Disinfection of Resident-Care Items and Equipment Policy and Procedure revised 06/22 indicated, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard,"

A review of the facility's Resident Room Cleaning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 584	Continued From page 12 Housekeeping In-Service Training dated 02/14/22 indicated that daily cleaning would ensure an optimum level of cleanliness and sanitation, prohibit the spread of infection, bacteria, and maintain the outward appearance of the facility. The Resident Room Cleaning Housekeeping In-Service Training further indicated that housekeeping staff were responsible for cleaning surfaces in resident rooms, picking up debris, and washing the floor. A review of the facility's undated Day in the Life of an Executive Housekeeper job responsibilities indicated that the Director of Housekeeping was responsible for checking regular room cleaning. A review of the facility's Maintenance Director's Job Description dated 07/28/22 indicated that the Maintenance Director was responsible for keeping the building in good repair and maintained the building and grounds in compliance with Federal, State, and local laws. NJAC 8:39-31.4(a)(f)	F 584		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 691	Concern	3/17/23

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F 691	Continued From page 13 and review of pertinent facility documentation it was determined, that the facility failed to: a.) provide appropriate care for a resident with a new [redacted]) in accordance with professional standards of nursing practice. This deficient practice was identified for one (1) of 1 resident, (Resident #159) reviewed for [redacted] care and was evidenced by the following: Refer to F550 On 02/07/23 at 12:05 PM, the surveyor entered Resident #159's room and observed the resident lying flat in bed. The resident told the surveyor that he/she had been admitted to the facility about a week ago from the hospital and had a [redacted]) and had undergone surgery to create the [redacted]. At that time the, the resident pulled up the bed sheets that were covering his/her stomach and the surveyor observed the resident's [redacted] bag. The surveyor observed thin yellow liquid the same color as the thin yellow liquid in the resident's [redacted] bag on the resident's bed sheets. The resident further told the surveyor that the [redacted] care has been an "ongoing problem." The resident stated that the facility was trying to find a [redacted] device that fit, but it was taking time. The resident explained that one day he/she sat in bed for two hours with the [redacted] bag leaking on him/her. The resident told the surveyor that the hospital had sent him/her to the facility with [redacted] supplies, but the supplies were few, had run out,	F 691	Tag- F691 – SS=D Facility failed to provide appropriate care for a resident #159 with a new [redacted] due to unavailability of well fitted [redacted] supplies. How the corrective action will be accomplished for any resident affected by deficient practice. Resident #159 was reassessed and was sent to the hospital for admission due lack of well fitted [redacted] supplies. DON or designee to review hospital records for resident acuities to ensure any necessary supplies and equipment are available upon admission This deficient practice did not result in any harm. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Admission Coordinator and facility liaison will re in-service to communicate to Center Clinical staff to review prospective admission.	

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F 691	Continued From page 14 and the facility did not have the appropriate supplies that fit his/her [redacted]. On 02/07/23 at 12:14 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that she had went into the resident's room and helped the resident with his/her [redacted] care because the resident was, "upset" about their [redacted]. The LPN/UM did not specify a date or time that she had assisted the resident with [redacted] care, The surveyor asked the LPN/UM what caused the resident to be upset and the LPN/UM stated the resident was, "concerned" about the [redacted] because it was a special device and the resident wanted to make sure that the facility had the appropriate supplies to care for it. On 02/07/23 at 12:18 PM, the surveyor interviewed the facility's Social Worker (SW) who stated that she had been in communication with the resident and the resident's representative and had a family meeting scheduled for tomorrow, [redacted]) to address the resident's care and concerns at the facility. The SW told the surveyor that the resident came to the facility with [redacted] supplies from the hospital, the facility currently did not have the resident's [redacted] supplies, nursing had ordered more, and they were waiting for the supplies to arrive. On 02/08/23 at 12:01 PM, the surveyor observed a vacant bed where the resident had been staying the day before. At that time the surveyor interviewed a staff member who was walking by the resident's room who stated that the resident had been sent to the hospital and admitted with [redacted] (a [redacted] of an [redacted].)	F 691	DON or designee to review clinical records of prospective admission to ensure all necessary supplies are readily available. Unit Managers and nursing staff in-serviced regarding [redacted] care. All admissions to be discussed daily in morning meeting. Supply coordinator will order house supplies weekly and as needed. DON or designee to audit five (5) admission records weekly x 4 weeks to ensure supplies are readily available upon admission. Administrator or designee will check supplies par level weekly x 4 weeks. How the concern will be monitored and title of person responsible for monitoring. Results will be discussed in morning clinical meeting for immediate resolution and in monthly QAPI and this will be a part of Center QA program. Dates when concern will be completed. March 17, 2023	

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F 691	Continued From page 15 The surveyor reviewed the medical record for Resident #159. A review of the resident's Admission Record reflected that the resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted], and [redacted]. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been admitted to the facility for less than [redacted] days. A review of the [redacted] Order Summary Report (OSR) reflected a Physician's Order (PO) dated [redacted] to change [redacted] every seven (7) days or as needed for [redacted] care. A review of the [redacted] Medication Administration Record (MAR) revealed that on 02/01/23 at 0900 (9:00 AM) and on 02/07/23 at 0900, a nurse had signed that the [redacted] bag was changed. The [redacted] MAR did not reflect that nursing staff changed the [redacted] bag as needed. A review of the resident's Care Plan revealed a focus area that the resident had a [redacted] related to [redacted] surgery. The goal of the resident's Care Plan was that the resident would be free from complications of [redacted] function and healing through next review. The interventions in the resident s Care Plan included [redacted] care each shift and as	F 691		

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F 691	Continued From page 16 needed and to observe the [redacted] site each shift for signs and symptoms of irritation and infection. On 02/09/23 at 10:01 AM, the surveyor interviewed one of the Certified Nursing Aide's (CNA)s on the subacute unit who stated that she never had the resident on her assignment but would answer the residents' call bell. The CNA told the surveyor that the resident expressed to her that he/she was [redacted] at the facility and wanted to go home. The CNA further stated that she would reposition the resident for comfort and the resident never expressed concerns to her about his/her [redacted] bag. On 02/13/23 at 10:45 AM, the surveyor interviewed Licensed Practical Nurse (LPN)#1 who stated that she had cared for the resident and the resident was [redacted]. LPN#1 told the surveyor that the resident was [redacted]. The surveyor asked in what way did the resident demonstrate [redacted]. LPN#1 stated that the resident would say to her that he/she was hopeful to get better and wanted to go home. She explained that the resident came to the facility with [redacted] supplies and had a [redacted] to create an [redacted]] from an [redacted] the [redacted]). LPN#1 stated that the [redacted] bags that were sent from the hospital were oval shaped with a round lid on it, and the bag was able to be drained. LPN#1 told the surveyor that she recalled changing the resident's [redacted] bag on [redacted]) and had used the last bag the resident had, which was sent from the hospital. LPN#1 stated that on [redacted], she believed the facility was in the process of ordering supplies for the resident and	F 691		

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F 691	Continued From page 17	F 691		

was hoping that the supplies would be there soon. The surveyor asked LPN#1 if the [redacted] bag ever leaked when she cared for the resident. LPN#1 stated, "Yes. The bag was leaking and that was why I changed it." LPN #1 explained that the bag was leaking because it was a [redacted] f [redacted] that stuck to the resident's skin and the skin needed to remain dry around the bag. LPN#1 stated that on [redacted] when she had changed the resident's bag it had been her second time changing it and both the bags were leaking. LPN#1 told the surveyor that if a resident had a [redacted] bag the expectation would be for the facility to have the appropriate supplies to care for the resident and the supplies should have been readily available.

On 02/13/23 at 11:32 AM, the surveyor conducted a follow up interview with the LPN/UM who stated that prior to the resident being admitted to the facility she reached out to the Nurse Educator because she had concerns related to the resident's care, such as available [redacted] supplies. The LPN/UM stated that the resident was admitted from the hospital with [redacted] bags and that she, "was frustrated" because she was waiting for the supplies to come in. The LPN/UM told the surveyor that upon the resident's admission to the facility, staff made central supply aware that they needed additional supplies for the [redacted] The LPN/UM stated that she also made the Administrator and Director of Nursing (DON) aware that the resident needed [redacted] supplies. The LPN/UM stated that the resident, "definitely" had issues with the [redacted] bag leaking. She further stated that the resident came from the hospital with the [redacted] devices and when she went into the room on [redacted], the resident did not have

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F 691	Continued From page 18	F 691		

supplies left. The LPN/UM stated that when she went into the resident's room that [redacted], she had observed [redacted] on the resident's bed because the resident's [redacted] bag was leaking. She told the surveyor that her and LPN#2 cleaned up the resident and did the best they could to secure the [redacted] bag in place for the resident.

On 02/13/23 at 11:50 AM, the surveyor interviewed the staff member who worked in Central Supply who was responsible for ordering the facility's equipment and supplies. He stated that when a resident was a new admission to the facility, the admissions department and unit mangers would notify him of what supplies he needed to order for the residents. The surveyor asked him he if recalled ordering [redacted] supplies for Resident #159. The central supply staff member stated that he did remember ordering supplies for the resident but could not produce documentation as to when the supplies were ordered by him. The central supply staff member was unsure if he could place an order to receive supplies more quickly to accommodate a resident's needs.

On 02/13/23 at 12:30 PM, the surveyor conducted a telephone interview with the resident's representative who stated that the resident was sent from the hospital to the facility with "maybe" [redacted] bags and the facility ran out of [redacted] supplies. The resident representative told the surveyor that the SW told him/her the [redacted] supplies were special ordered for the resident on [redacted] afternoon and they were waiting for the supplies to be delivered. The resident representative told the surveyor that when he/she came to visit the resident on

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F 691	Continued From page 19	F 691		

[redacted]), the [redacted] bag was leaking everywhere, and towels were soaked in [redacted] The resident representative further stated that the [redacted] bags had not arrived on Monday (02/06/23) or Tuesday (02/07/23) for the resident.

On 02/14/23 at 10:12 AM, the surveyor conducted a follow up interview with the SW who stated that she was not the person who was responsible for ordering [redacted] supplies. The SW told the surveyor that she had spoken to Resident #159's representative on Monday (02/06/23), and told him/her that the order for the supplies was placed that day, and the supplies would be arriving Monday night. This contradicted what the resident representative said to the surveyor. The SW further told the surveyor that she told the resident representative through hearsay (information received from another source) that the [redacted] bags were being delivered Monday night because that was what was communicated to her in the morning meeting by the nursing department.

On 02/14/23 at 10:31 AM, the surveyor conducted a follow up interview with the central supply staff member who showed the surveyor on his cell phone text messages that he had requested [redacted] supplies on 02/03/23 at 10:43 AM and 02/07/23 at 1:15 PM. The central supply staff member stated that the supplies were initially requested Wednesday (02/01/23), but he was unable to show the surveyor evidence to corroborate his statement. The central supply staff member told the surveyor that most supplies were ordered Tuesday and delivered every Thursday. The central supply staff member stated that he was at, "the mercy" of the supply company on when they delivered the supplies to

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F 691	Continued From page 20	F 691		

the facility and only administrative staff had the capability to order supplies for the resident from a different supply company. The central supply staff member did not communicate to the surveyor that the supply company notified him that the resident's [redacted] supplies were on back-order and would not arrive in a timely manner.

On 02/15/23 at 10:07 AM, the surveyor interview LPN#2 who stated that the resident had a new colostomy, came to the facility from the hospital with [redacted] bags, and the [redacted] bag was leaking often. LPN#2 told the surveyor that he did not know why the bag was leaking and made multiple attempts to secure the [redacted] bag to prevent leakage but was unable. LPN#2 explained that he had communicated to management that the resident needed more [redacted] supplies, believed the supplies were ordered by a third-party company, and they came in the morning after the resident was admitted to the hospital.

On 02/16/23 at 11:05 AM, the surveyor interviewed the facility's Administrator in the presence of the Director of Nursing (DON) and survey team who stated that the resident came from the hospital [redacted] bags. The Administrator explained that the [redacted] supplies were ordered for the resident the morning after the resident was admitted to the facility, the colostomy supplies were supposed to be delivered on 02/03/23, they did not arrive, so the central supply staff member reached out to the company that day and the company told him that the [redacted] supplies would be delivered to the facility on 02/07/23. The Administrator further stated that they were notified by the supply company on 02/03/23 that the supplies were on

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F 691	Continued From page 21 back order, so they ordered them from another provider. The Administrator did not speak to why the [redacted] supplies for the resident were not ordered from a different supply on 02/03/23 when the facility was made aware that the [redacted] supplies were on back order and would not be available to the resident. A review of a letter sent to the facility's Administrator from the facility's supply company dated [redacted] reflected a timeline of the resident's [redacted] bag order. The letter indicated that on 02/01/23 the central supply staff member working at the facility ordered [redacted] supplies with the expected delivery date of 02/03/23. The letter further revealed that on 02/03/23 the representative from the supply company spoke with the central supply staff member telling him that the product was on back order and would not arrive till 02/09/23. A review of the facility's [redacted] Care Policy and Procedure revised 06/22 indicated that a clean drainage bag was necessary equipment and supplies required to perform [redacted] care. NJAC 8:39-27.1(a)	F 691		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 693		3/17/23

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F 693	Continued From page 22 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to: a.) administer [redacted] (nutrition received through a [redacted] per physician's order. This deficient practice was identified for two (2) of 2 resident's, (Resident #99 and Resident #158) reviewed for receiving nutrition via [redacted] and was evidenced by the following: 1.) On 02/07/23 at 11:36 AM, the surveyor entered Resident #158's room and observed the resident sitting upright in his/her bed with his/her resident representative in the room. The surveyor observed that the resident had an undated [redacted] formula hanging on a pole, not attached to a [redacted], and not flowing. The resident was alert, able to mouth words and use gestures, but unable to speak due to a [redacted]	F 693	Concern Tag- F693 – SS=E [redacted] not attached to [redacted] label incomplete on [redacted] formula, order for [redacted] not complete, and malfunctioning pump for resident #158. Resident #99 the [redacted] container was not dated to indicate the time the feeding was started. The nurse failed to clear the [redacted] for the formula consumed. How the corrective action will be accomplished for any resident affected by deficient practice Residents #158 and residents #99 were immediately assessed for significant changes related to Licensed Nurse not clearing the total volume of [redacted] formula administered and [redacted] that was not dated. No adverse affected noted to	

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F 693	Continued From page 23 [redacted]). The resident's representative told the surveyor that the resident was admitted to the facility the [redacted] before. On 02/08/2 at 3 12:14 PM, the surveyor observed the resident in his/her room with his/her resident representative at their bed side. The surveyor further observed a [redacted] formula connected to a [redacted]. The [redacted] formula contained [redacted] milliliters (ml) in the bottle which was full. The bottle was observed to have a label attached to it. Documented on the [redacted] formula label indicated that the [redacted] formula was hung on 02/07/23 at eight (8). The label did not indicate if the [redacted] formula was hung at 8:00 AM or 8:00 PM. The surveyor observed the [redacted] which revealed that the [redacted] formula was flowing at [redacted] ml/hour and [redacted] ml was the Total Volume (TV) that was administered through the [redacted]. The surveyor heard the [redacted] beeping. The words, "feed error - bag empty, - [redacted], [redacted] not loaded" appeared on the [redacted] in front of the surveyor. At that time the resident representative stated that "the lady" had come into the room and told him/her to push a button on the [redacted] because the [redacted] was "messed up" and shouldn't have been beeping like that. The resident representative further told the surveyor that another resident representative had been at the facility into the evening hours the night before and the [redacted] formula was administered to the resident around 7:30 PM. Resident #158 shook his/her head up and down in agreement. The surveyor reviewed the medical record for Resident #158. A review of the resident's Admission Record indicated the resident was admitted to the facility	F 693	either resident. Licensed staff and registered dietician educated to include product name, type of tube, rate of infusion (number of ml per hour), total calories per day, start time and total daily volume to be infused in physician's order. Unit Managers were in-serviced to inspect residents receiving [redacted] for complete orders, complete label and dating on [redacted] label, and properly functioning [redacted] [redacted] competencies completed with nursing staff. No other residents affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. All Licensed Nurses were re in-serviced on facility policy and procedure on [redacted] administration. Registered dietician was re in-serviced on the completion on writing proper orders on [redacted] that will include product name, type of tube, rate of infusion (number of ml per hour), total	

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	315516	A. BUILDING _____ B. WING _____	02/17/2023

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F 693	Continued From page 24 on [redacted] and had diagnoses which included but were not limited to [redacted] A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been admitted to the facility for less than [redacted] days. A review of the resident's [redacted] Order Summary Report (OSR) revealed the following Physician Orders (PO): -PO dated [redacted] for [redacted] Order every night shift. Maintain a closed system. Change feeding administration set with each new bottle; label the formula container, syringe, and administration set with resident's name, date, time, and nurse's initials. -PO dated [redacted] for [redacted] Order [redacted] times a day to meet nutritional needs, document percent administered [redacted] ml per feeding, [redacted] times a day to provide [redacted] calories in a 24-hour period. A complete review of the [redacted]3 OSR did not reveal there was a PO for the type of [redacted] formula, the [redacted] the of the [redacted], the [redacted] of the [redacted] formula, or time the [redacted] was to be administered to the resident prior to [redacted]	F 693	calories per day, start time and total daily volume to be infused in physician's order. Unit managers or designee will review 5 charts weekly x 4 weeks for [redacted] orders to ensure completeness and accuracy. Unit Managers or designee will check residents daily for 90 days for [redacted] documentation accuracy, including the time it was hung and that total volume of the [redacted] is cleared from pump when completed. How the concern will be monitored and title of person responsible for monitoring. Results of Unit manager review and DON observation will be discussed in morning clinical meeting for immediate resolution and will be discussed in monthly QAPI and this will be a part of Quarterly QA. Dates when concern will be completed. March 17, 2023	

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F 693	Continued From page 25	F 693		

A review of the resident's [redacted] Medication Administration Record (MAR) reflected the PO dated [redacted] Order every night shift. Maintain a closed system. Change [redacted] administration set with each new bottle; label the formula container, syringe, and administration set with resident's name, date, time, and nurse's initials. A further review of the MAR indicated the [redacted] formula for the resident had not been administered on [redacted] at night time. The [redacted] MAR revealed that nursing staff signed for the administration of the [redacted] on 02/07/23 and 02/08/23 at night.

A review of the resident's Care Plan dated [redacted] revealed a focus area that the resident required a [redacted] related to [redacted], [redacted], and [redacted] The goal of the resident's Care Plan was for the resident to remain free from side effects or complications related to the [redacted] through the next review date. The interventions in the resident's Care Plan included dietician consult and to monitor caloric intake for the resident.

On 02/09/23 at 12:39 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that the resident was sent form the hospital with physican orders for his/her current [redacted] formula. The LPN/UM further explained that after the resident was admitted to the facility the Registered Dietician (RD) would assess the resident's nutritional needs. The LPN/UM stated that if the [redacted] was not working correctly, it would be nurses' responsibility to fix the [redacted] right away so the resident could receive the adequate nutrition they needed. The LPN/UM told the surveyor that the

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F 693	Continued From page 26 resident's order was discontinued on [redacted] to [redacted] because the resident's [redacted] was not working properly. The LPN/UM stated that the label on the [redacted] formula should accurately document the physician's order which included the rate, total volume to be administered to the resident, date, and time the [redacted] was hung, along with the resident's name and room number. On 02/09/23 at 09:54 AM, the surveyor conducted a follow up interview with the resident's representative who stated that the [redacted] was not working "all day" on [redacted], so around 2:30 PM - 3:00 PM he/she discussed their concerns with facility management who resolved his/her concerns. The resident representative stated that it was inappropriate that the nurse told him/her to press the button on the [redacted] for it to work because it was the nurse's job to make sure the resident received their nutrition. On 02/09/23 at 10:12 AM, the surveyor observed the resident in his/her room. There was no [redacted] in the resident's room. The resident communicated to the surveyor that he/she had received a [redacted] from the nurse that morning. On 02/09/23 at 12:06 PM, the surveyor interviewed the resident's Certified Nursing Aide who stated that it was her second day taking care of the resident and the resident received his/her nutrition by way of [redacted] into an individuals [redacted]). The CNA told the surveyor that her responsibility of care related to the [redacted] was to make sure the resident's head of bed remained elevated. On 02/09/23 at 12:25 PM, the surveyor	F 693		

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F 693	Continued From page 27 interviewed the resident's Licensed Practical Nurse (LPN)#1 who stated that he worked the 3:00 PM - 11:00 PM shift the day before (02/08/23) and saw that the resident's [redacted] was changed to [redacted]. LPN#1 further stated that the [redacted] was not working properly yesterday so they had to change the order to [redacted] for the resident. LPN#1 told the surveyor that the label on the [redacted] bottle should always be filled out completely by the nurse administering the [redacted] formula. On 02/10/23 at 10:56 AM, the surveyor interviewed the RD in the presence of the Regional/Registered Dietitian (R/RD) who stated that the resident had a diagnosis of [redacted] and the resident was admitted to the facility from the hospital with physician orders for his/her [redacted] On 02/10/23 at 11:00 AM, the R/RD stated that when a resident came from the hospital, they were usually on a [redacted], so it was "imperative" that the [redacted] was hung right away. The R/RD and the RD reviewed the resident's MAR in the presence of the surveyor and stated that the MAR did not indicate that the resident was administered his/her [redacted] formula on [redacted], the night the resident was admitted to the facility because the nurses had not signed for the administration of it. The R/RD further stated that nursing staff should fill out the label on the [redacted] bottle to make sure the information on it reflected the PO for the resident. The RD explained that she met with the resident and the resident's representative and the resident told her that he/she was on [redacted] prior to his/her recent hospitalization and the resident could administer the [redacted] to himself/herself,	F 693		

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F 693	Continued From page 28 so she changed the order after speaking with the resident. On 02/16/23 at 11:26 AM, the Administrator stated that nursing staff were provided education for proper dating of the [redacted] bottle. 2.) On 02/07/23 at 11:23 AM, the surveyor observed Resident #99 sitting upright in bed with his/her eyes closed. The surveyor observed that the resident had a [redacted] ml/hour and the [redacted] on the [redacted] read [redacted] ml. The [redacted] formula was a [redacted] ml container and there was [redacted] ml left in the [redacted] container. This indicated that [redacted] ml of the [redacted] formula was administered to the resident. The [redacted] documented on the [redacted] container to be administered was [redacted] ml. On 02/08/23 at 12:03 PM, the surveyor observed the resident in bed with his/her eyes closed. The surveyor observed the resident's representative massaging the resident's [redacted] The surveyor further observed the [redacted] flowing at [redacted] ml/hour and [redacted] ml was the [redacted] administered on the [redacted]. The surveyor saw that there was [redacted] ml left in the [redacted] ml [redacted] container. The [redacted] container was not dated or labeled. On 02/09/23 at 10:05 AM, the surveyor observed Resident #99 in bed, with the head of the bed elevated. The [redacted] was flowing at [redacted] ml/hour and the [redacted] through the [redacted] was [redacted] ml. The label on the [redacted] container that was hanging and connected to the [redacted] was not dated, the start time was documented at 0600 (6:00 AM). The surveyor observed approximately [redacted] ml left in the [redacted] ml TF container. This indicated that the resident had received [redacted] ml of their [redacted] formula and nutrition.	F 693		

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F 693	Continued From page 29 On 02/09/23 at 10:12 AM, the surveyor interviewed LPN#2 who stated that she was not sure when the [redacted] formula was hung was because she did not hang the bottle for the resident. LPN#2 stated that it was the nurse's responsibility who hung the [redacted] formula to fill out the label correctly and completely. On 02/09/23 at 10:16 AM, the surveyor interviewed LPN#2 who stated that he was the primary nurse for Resident #99. LPN#2 told the surveyor that he was not the nurse that hung the [redacted] formula for the resident and the label and date on the [redacted] container should have been filled out correctly. LPN#2 stated that he was unsure when the nurse hung the [redacted] formula and assumed that it was hung the day before at 6:00 AM because that was what the label read. The surveyor asked LPN#2 if he knew the [redacted] the resident was to receive. LPN#2 stated he was unsure, but the pump was set for the [redacted] the resident was supposed to receive daily. The surveyor asked LPN#2 to check the [redacted] in the surveyor's presence and let the surveyor know how much [redacted] formula the resident was supposed to receive. LPN#2 checked the [redacted] which indicated on the "dose check" button that [redacted] ml of the [redacted] formula had been administered to the resident. The surveyor asked LPN#2 to explain how the nurses would know to stop the [redacted] formula if the [redacted] was not set into the [redacted], LPN#2 could not explain and stated that they followed the physician's order. On 02/09/23 at 12:10 PM, the surveyor interviewed the resident's CNA who stated that she was familiar with the resident and the resident had some level of cognitive awareness	F 693		

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F 693	Continued From page 30	F 693		

because the resident was able to shake his/her head yes or no. The CNA further stated that the resident did not touch the [redacted]

On 02/09/23 at 12:14 PM, the surveyor conducted a follow up interview with LPN#2 who stated that the resident was not alert or oriented and unable to make needs known. LPN#2 told the surveyor that the resident was Nothing Per Mouth (NPO) and received the [redacted] for all his/her nutritional needs. LPN#2 further stated that the resident's had a PO for his/her [redacted] to run [redacted] for [redacted] hours, and it would be taken down at 1:00 PM and put back up at 3:00 PM. LPN#2 explained that the [redacted] on the [redacted] should be cleared every day and the dose should have been re-set to account for the [redacted] of nutrition the resident was administered per physician order. LPN#2 stated that the [redacted] would beep once the full amount was administered to the resident. LPN#2 further stated that the importance of setting the TV dose to be administered daily would make be to make sure the resident received the accurate amount because if the nurse let the machine keep running, the resident would receive an excess of the [redacted] formula.

On 02/09/23 at 12:56 PM, the surveyor interviewed the LPN/UM who stated that the label should have been accurately filled out on the [redacted] bottle to reflect the amount [redacted] of formula the resident was to receive. The LPN/UM stated that the [redacted] was not appropriately set for Resident #99, and she identified that the nursing staff were not clearing the [redacted] daily. The LPN/UM further stated that she determined that the resident had received an excess of [redacted] formula the day before, so she called the resident's physician to notify and discussed the concern with the RD.

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F 693	Continued From page 31 On 02/10/23 at 11:12 AM, the surveyor interviewed the RD in the presence of the R/RD who stated that the resident was admitted to the facility at the end of [redacted] on the [redacted]. The RD explained that the nursing staff should be documenting on the [redacted] container the date and time that the [redacted] was administered for the resident. The RD further stated that the nurses should have zeroed out the [redacted] on the [redacted] daily and set the dose to reflect the amount administered per physician order, so the resident received an accurate amount of nutrition On 02/10/23 at 11:16 AM, the surveyor interviewed the R/RD in the presence of the RD who stated that after surveyor inquiry the nursing staff identified that there was a discrepancy in the amount of [redacted] formula the resident had received. The surveyor reviewed the medical record for Resident #99. A review of the resident's Admission Record reflected that the resident was admitted to the facility in [redacted] and had diagnoses which included but were not limited to [redacted]. A review of the resident's admission MDS dated	F 693		

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F 693	Continued From page 32 [redacted] reflected that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of [redacted] which indicated the resident had [redacted]. A further review of the resident's MDS, Section [redacted] Swallowing/Nutritional Status revealed that the resident recently had no weight loss or gain and received 51% or more of their caloric needs through [redacted]. A review of the resident's [redacted] OSR reflected a PO dated [redacted] for [redacted] Order via [redacted] ml/hour x [redacted] hours, [redacted] ml; provides [redacted] kcal. A review of the resident's [redacted] MAR revealed that the nursing was signing for [redacted] Order [redacted] at [redacted] ml/hour x [redacted] hours, [redacted] ml; provides [redacted] kcal up at [redacted] (1:00 PM) and down at [redacted] (3:00 PM) from [redacted] through [redacted] A review of the resident's Care Plan reflected a focus area that required [redacted] related to nothing per mouth status. The goal of the resident's Care Plan included that the resident would remain free of side effects or complications related to [redacted] through review date. The interventions in the resident's Care Plan included to maintain the resident's bed at 45 degrees during and thirty minutes after [redacted] and [redacted] as ordered. A review of the facility's [redacted] In-Service reviewed [redacted] and provided to the survey team on 02/13/23 at 8:50 AM indicated that staff were educated that a resident's [redacted] orders, "will be written to ensure consistent volume infusion. The following information will be	F 693		

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F 693	Continued From page 33 included to ensure that the full volume will be infused, regardless of any interrupted [redacted]: a. [redacted]: (1) Product name; (2) Type of tube; (3) Rate of infusion [number of ml per hour]; (4) total calories per day; (5) Start time; and (6) Total daily volume to be infused (number of ml per day). NJAC 8:39-27.1(a)	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to: a.) appropriately follow physician orders for the care of [redacted] equipment and b.) store [redacted] equipment in a manner to prevent infection. This deficient practice was identified for two (2) of 2 residents, (Resident #99 and Resident #158) reviewed for [redacted] care. The deficient practice was evidenced by the following:	F 695	Concern Tag- F695 – SS=D Respiratory/Tracheostomy Care and Suctioning Facility failed to appropriately follow physician orders for the care of respiratory equipment and store equipment in a manner to prevent infection. Resident # 158 [redacted] and [redacted] in the resident's room was not dated. Resident #99 the [redacted]	3/17/23

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ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 695	Continued From page 34 1.) On 02/07/23 at 11:39 AM, the surveyor observed Resident #158 sitting upright in bed, with a [redacted]. The resident's representative was in the room with the resident. The surveyor further observed that all the respiratory and [redacted] in the resident's room was not dated or labeled. The surveyor saw that the [redacted] connected to the resident's [redacted] was connected to the [redacted] machine on the resident's nightstand. The surveyor observed an [redacted] (a machine that plugs into the wall and administers [redacted]) in the resident's room, not in use. The resident was [redacted] and able to communicate to the surveyor by [redacted], shaking his/her up and down and by using his/her hands. The resident representative told the surveyor that the resident had been admitted to the facility on the [redacted] shift the [redacted] before. The surveyor visually assessed that the resident was not in [redacted] distress. On 02/08/23 at 12:14 PM, the surveyor observed the resident in his/her room sitting upright in bed. At that time, the surveyor observed that the resident's [redacted] was not labeled or dated. The surveyor saw that the resident's [redacted] was connected to the [redacted] machine, not the [redacted]. The surveyor further observed that the resident was not in [redacted] distress. On 02/09/23 at 10:31 AM, the surveyor observed that all the resident's [redacted] was labeled with a piece of tape and dated [redacted]h). The surveyor further observed [redacted] connected to the [redacted]r. The [redacted] was flowing at a rate of [redacted]	F 695	equipment in the resident's room was not dated and labeled. The [redacted] canister was placed in the top drawer of the resident's night stand, undated and not stored in a plastic bag. How the corrective action will be accomplished for any resident affected by deficient practice The [redacted] for Resident #158 and resident #99 was discarded and changed. [redacted] was dated and bagged appropriately. Resident #99 [redacted] canister was immediately discarded and changed. [redacted] canister was dated and bagged accordingly. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Measures to ensure were/will be put into place to assist this area of concern. Nursing staff in-serviced to obtain and follow physician order for the [redacted] and route of administration of [redacted]. Nursing staff in-serviced to date, label, and store [redacted] equipment properly.	

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	315516	A. BUILDING _____ B. WING _____	02/17/2023

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ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 695	Continued From page 35 The surveyor reviewed the medical record for Resident #158. A review of the resident's Admission Record reflected that the resident was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been admitted to the facility for less than [redacted] days. A review of the resident's [redacted] Order Summary Report (OSR) revealed the following Physician Orders (PO): - PO dated [redacted] to change [redacted], [redacted] weekly. Label with date, time, and nurse's initials every night shift on Sunday for preventative care. - PO dated [redacted] to check [redacted] saturation as needed for [redacted] - PO dated [redacted] to check [redacted] saturation every shift. - PO dated [redacted] for [redacted] care, [redacted] at [redacted] LPM every shift. A review of the [redacted] Medication Administration Record (MAR) indicated a PO dated [redacted] to change [redacted], [redacted] weekly. Label with date, time, and	F 695	Nursing staff in-serviced on policy and procedure to administer [redacted], including [redacted] care. Unit Managers educated to reflect the amount of [redacted], the route the [redacted] is to be delivered, and care of [redacted] equipment in resident's care plan. Nurses assigned resident completed tracheostomy care competency. Unit managers or designee will audit five (5) residents on [redacted] weekly X 4 weeks to ensure [redacted] and administration is correct and all equipment properly functioning. DON or designee will check (5) residents ordered [redacted] weekly for 4 weeks for proper dating and storage. DON or designee will review (5) residents weekly X 4 weeks for accuracy of Care plans for inclusion of amount of [redacted], route of [redacted], and care of [redacted] equipment. How the concern will be monitored and title of person responsible for monitoring. Results of this audit and observation will be discuss in morning clinical meeting for immediate resolution and this will be discussed in monthly QAPI and this will be a part of quarterly QA. Dates when concern will be completed. March 17, 2023	

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F 695	Continued From page 36 nurse's initials every night shift on Sunday for preventative care. There was no nursing signature on the MAR indicting the resident's [redacted] had been dated and labeled. A further review of the resident's [redacted] MAR revealed a PO dated [redacted] to administer [redacted] at [redacted] every shift. The [redacted] MAR reflected that the nurses had signed the MAR on 02/07/23 through 02/08/23 on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift that the resident was receiving [redacted] at [redacted]. Additionally, the nurses had signed the MAR on 02/09/23 during the 7:00 AM - 3:00 PM shift that the resident was receiving oxygen at [redacted]. The MAR further reflected that the nurses were documenting the resident's [redacted] saturation every shift which was within normal range. A review of the resident's Care Plan reflected a focus area that the resident had an [redacted] and [redacted] related to [redacted]. The goal of the resident's Care Plan was that the resident would have no signs and symptoms of poor [redacted] absorption through the next review date. The interventions in the residents Care Plan included to administer medications as ordered and position the resident with proper body alignment for an optimal [redacted] pattern. The resident's Care Plan did not reflect the amount of [redacted] the resident was to receive, the route the [redacted] was to be administered, or the care of [redacted] equipment. On 02/09/23 at 12:06 PM, the surveyor interviewed the resident's Certified Nursing Aide	F 695		

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F 695	Continued From page 37 (CNA) who stated that the resident was [redacted] and [redacted] and [redacted] with staff by writing with a [redacted]. The CNA told the surveyor that the nurses were responsible for the care of the resident's [redacted] equipment On 02/09/23 at 12:33 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident had a [redacted], and the nurse's performed [redacted] care every shift. The LPN stated that the [redacted] should have been dated for infection control reasons, the resident was currently receiving [redacted] and should have always been receiving the [redacted] at that flow rate. On 02/09/23 at 12:50 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that the resident had a [redacted] and the [redacted] in the resident's room was supposed to be labeled, dated, and changed weekly to prevent risk for infection. The LPN/UM further stated that the resident was supposed to be receiving [redacted] at [redacted] LPM and she noticed that yesterday the [redacted] was not hooked up to the [redacted], so she fixed it. On 02/16/23 at 11:26 AM, the Director of Nursing (DON) in the presence of the facility's Administrator and survey team stated that the nurses should have followed the physician's order for the administration of [redacted] 2.) On 02/07/23 at 11:23 AM, the surveyor observed Resident #99 in his/her room sitting upright in bed. The resident had a tracheostomy and was receiving [redacted] at [redacted] LPM. The	F 695		

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F 695	Continued From page 38 surveyor observed that the [redacted] and [redacted] equipment in the resident's room was not labeled or dated. The surveyor further observed additional [redacted] in the top drawer of the resident's nightstand in direct contact with the drawer of the nightstand. The resident's eyes were closed at the time of observation. On 02/08/23 at 12:03 PM, the surveyor observed the resident in bed, with his/her eyes closed on [redacted] at [redacted] LPM [redacted]. The surveyor further observed that none of the [redacted] in the resident's room was labeled or dated. The [redacted] was connected to the [redacted] and observed placed in the top drawer of the resident's nightstand in direct contact with the drawer of the nightstand, undated and not stored in a plastic bag. On 02/09/23 at 10:05 AM, the surveyor observed Resident #99's [redacted] and canister dated [redacted]). The surveyor further observed that the [redacted] connected to the [redacted] canister was placed in the top drawer of the resident's nightstand in direct contact with the drawer of the nightstand, undated and not stored in a plastic bag. The surveyor reviewed the medical record for Resident #99. A review of the resident's Admission Record reflected that the resident was admitted to the facility in [redacted] and had diagnoses which included but were not limited to [redacted],	F 695		

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F 695	Continued From page 39	F 695		

[redacted]

A review of the resident's admission MDS dated [redacted] reflected that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of [redacted] which indicated the resident had [redacted]. A further review of the resident's MDS, Section [redacted] Special Treatments, Procedures, and Programs revealed that the resident required [redacted] care.

A review of the resident's [redacted] OSR indicated a PO dated [redacted] to change [redacted] supplies weekly every night shift every Tuesday for routine care.

A review of the [redacted] Treatment Administration Record (TAR) reflected that the nurse had signed on 02/07/23 during the 11:00 PM - 7:00 AM shift that the resident's [redacted], [redacted] and supplies were changed.

A review of the resident's Care Plan revealed a focus area that the resident had altered [redacted] status and [redacted] related to [redacted] with [redacted]. The goal of the resident's Care Plan was the resident would not have signs or symptoms of poor [redacted] through the next review date. The interventions in the resident's Care Plan included to administer medications as ordered, monitor for effectiveness and [redacted]

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F 695	Continued From page 40 [redacted]	F 695		

On 02/09/23 at 12:10 PM, the surveyor interviewed the resident's CNA who stated that she was familiar with the resident and the resident had some [redacted] awareness because he/she would [redacted] with her by shaking his/her head yes and no. The CNA stated that she did not touch the [redacted] equipment in the resident's room because that was the nurse's job.

On 02/09/23 at 12:22, the surveyor interviewed the resident's LPN who stated that the resident was admitted to the facility with a [redacted] and nursing performed [redacted] care on the resident every shift. The LPN further stated that that all the [redacted] and [redacted] equipment should be dated and labeled for infection control purposes. The LPN explained to the surveyor that if the [redacted] was not in use, it should be stored in a plastic bag for infection control purposes

On 02/09/23 at 01:01 PM, the surveyor interviewed the LPN/UM who stated that the [redacted] should have been dated and labeled for infection control purposes and if the [redacted] was not in use, it should have been stored in a plastic bag.

On 02/16/23 at 11:26 AM, the DON in the presence of the facility's Administrator and survey team stated that staff was educated on dating and labeling [redacted] equipment and the importance of dating and labeling [redacted] equipment was for infection control purposes.

A review of the facility's, "[redacted] Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	02/17/2023

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F 695	Continued From page 41 Policy and Procedure" reviewed 06/22 indicated that the nurses were to obtain a physician's order for the [redacted] and route of administration of [redacted], assemble the [redacted] and [redacted], making sure it's secure, change [redacted] bottle, and [redacted] tubing weekly and label and date with initials. NJAC 8:39-27.1(a)	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne	F 812	Concern Tag- F812 – SS=E Food Procurement, Store/Prepare/Serve-Sanitary	3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 42 illness. This deficient practice was evidenced by the following: 1.) On 2/07/23 from 9:27 AM to 10:04 AM, the surveyor accompanied by the Director of Dining Services (DODS), completed the Initial Tour of the Kitchen, observed and reviewed the refrigerator and freezer temperature logs with the following missing entries: Kitchen Reach in Refrigerator Temperature Log. Location: Milk Fridge; Month/Year: Feb 2023. Days1 through 5 not completed. Kitchen Reach in Refrigerator Temperature Log. Location: Trayline Fridge; Month/Year: Feb 2023. Days 1 through 5 not completed. Kitchen Reach in Refrigerator Temperature Log. Location: Health Shakes; Month/Year: Feb 2023. Days 1 through 5 not completed. Kitchen Walk-in Refrigerator/Freezer Temperature Log. Location Back of Kitchen; Month/Year: Feb 2023. Days 1 through 5 not completed. Kitchen Reach in Refrigerator Temperature Log. Location: White Chest Freezer ; Month/Year: Feb 2023. Days 1 through 5 not completed. Kitchen Reach in Refrigerator Temperature Log. Location: Prep Fridge; Month/Year: Feb 2023. Days 1 through 5 not completed. When asked who is responsible for completing the temperature logs for the refrigerator and the freezer, the DODS responded, "The cooks should be doing them and I should be checking them". 2.) The surveyor observed and reviewed that the "Three Compartment Sink Parts Per Million	F 812	Kitchen temperature for the Refrigerator and the Freezer logs were incomplete, from February 1, 2023 to February 5, 2023. Three Compartment Sink Parts per million (PPM) Chlorine Month /Year January 2023 was not posted and completed. The slicer was uncovered with debris noted How the corrective action will be accomplished for any resident affected by deficient practice The Temperature log of the Refrigerator, Freezer, and the Three Compartment Sink were immediately checked and recorded. The Slicer was cleaned and covered appropriately. Food service director and kitchen staff who utilize equipment in-serviced to ensure all equipment remains sanitary. No residents were affected with this deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Measures to ensure were/will be put into place to assist this area of concern.	

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	315516	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 812	Continued From page 43 (PPM) Chlorine Month/Year January 2023" log displayed with following missing entries: Day 16 through 22 Breakfast, Lunch, and Dinner Day 24 Lunch and Dinner Day 25 Breakfast, Lunch, and Dinner Day 26-27 Dinner Day 29 Breakfast and Lunch Day 30 Lunch -Water Temp of 3rd Sink and Initials and entire Dinner Day 31 Lunch and Dinner February Log was not posted and not completed. Upon reviewing the "Three Compartment Sink Parts Per Million (PPM) Chlorine Month/Year January 2023" log, the DODS stated, "I realized that the wrong log was up. This [sink] is a [redacted] and this is the log for Chlorine and it for January". When asked who was responsible for completing the logs, the DODS responded, "Dietary Aides are responsible and I should be checking". 3.) The surveyor observed in Prep Area, under the sink on the bottom shelf was an uncovered slicer unit with its corresponding pusher holder exposed to the environment with debris noted. Located on the table across from the prep area sink was an uncovered slicer unit exposed to the environment with debris noted. When asked how unused kitchen equipment is to be stored the DODS responded, "They are to be cleaned and covered." During an interview with the surveyor on 2/16/23 at 11:31 AM, the Administrator stated that the expectation for the Refrigerator/Freezer and 3 Sink Compartment logs were for them to be completed on a daily basis and the "Dietary	F 812	Food Service Director or designee to check refrigerator, Freezer, Three Compartment Sink logs daily X 90 days and thereafter. Regional Food Service Director or designee will check Kitchen equipment weekly X 90 days to ensure they are cleaned and stored properly. Food service director and kitchen staff in-serviced regarding maintaining daily logs for all refrigerators and freezers. How the concern will be monitored and title of person responsible for monitoring. Results of findings will be discussed with the administrator for resolution and will be discussed in monthly QAPI and this will be a part of quarterly QA. Dates when concern will be completed. March 17, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 812	Continued From page 44	F 812		

Director" was responsible for ensuring completeness. When asked how the kitchen equipment is to be stored in the kitchen, the Administrator responded "cleaned and covered". When asked who is responsible for the overall cleanliness and storage of kitchen equipment the Administrator responded "anyone is responsible". When asked who is responsible for ensuring that everything is stored correctly the LNHA stated "the Dietary Director".

The surveyor reviewed the facility policy titled, "Food Storage" that was Reviewed/Revised 6/2022. The following was revealed under the heading Policy Interpretation and Implementation:
12. The Food Service Director, or his/her designee, will check refrigerators and freezers in all units daily for proper temperatures. The Food Service Director will maintain records of such information.

The surveyor reviewed the facility policy titled, "Preventing Foodborne Illness-Food Handling" that was Revised April 2010. The following was revealed under the heading Policy Interpretation and Implementation:
5. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state-specific requirements.

The surveyor reviewed the facility policy titled, "Daily Temperatures Log of Refrigeration and Freezer" with the Effective Date 2023. The following was revealed under the heading Procedure:
Log will be maintained for all refrigerators and freezers (both walk-in and reach-in units) in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

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F 812	Continued From page 45 A designated food service employee will log the date, temperatures and their initials each day. Temperature must be log at least twice per day, once in the morning and once in the evening. The surveyor reviewed the facility policy titled, "Three Compartment Sink" that was Revised on 7/1/22. The review of the policy does not reflect the requirement of completion and maintenance of the Three Compartment Sink PPM Log. The surveyor reviewed an undated facility policy titled, "Cleaning and Sanitation of Equipment". The following was revealed under the heading Policy, "Cleaning and sanitation of equipment is to remove food debris that bacteria need to grow, and to kill those bacteria that are present. It is important that the cleaned and sanitized equipment are stored dry so as to prevent bacteria growth". The following is identified under the heading, Procedure: MEAT SLICER-Frequency: after each use 10. Cover slicer after it has air-dried and is not in use. N.J.A.C 18:39-17.2(g)	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. 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: a.) mechanical lifts with scales in accurate	F 908	Concern Tag- F908 – SS=D ESSENTIAL EQUIPMENT, SAFE	3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

(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 908	Continued From page 46 operating condition and b.) a [redacted], an essential piece of equipment that administered nutrition to a resident. This deficient practice was identified for two (2) of 21 resident's reviewed, (Resident #81 & Resident #158). This deficient practice was evidenced by the following: 1.) On 02/07/23 at 10:11 AM, during the initial tour on the [redacted] unit, Surveyor #1 observed Resident #81 supine in bed, [redacted]. On 02/08/23 at 11:48 AM, Surveyor #1 reviewed the resident's electronic medical record (EMR.) The resident was admitted with diagnoses which included [redacted]. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated the resident had [redacted] deficits. The MDS also revealed the resident required extensive assistance from two people for physical assistance for bed mobility and transfers. A complete review of the resident's EMR revealed deviations in weights that were assessed and addressed by the Registered Dietician (RD). On 02/13/23 at 11:15 AM, Surveyor #1 interviewed the Certified Nursing Assistant (CNA#1) who was assigned to Resident #81. CNA#1 stated that the Mechanical Lift (ML) with the scale (an electrical piece of equipment that's	F 908	OPERATING CONDITION Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to maintain: a.) mechanical lifts with scales in accurate operating condition and b.) a functional [redacted] an essential piece of equipment that administered nutrition to a resident. This deficient practice was identified for two (2) of 21 residents reviewed, (Resident #81 & Resident #158). Facility failed to maintain [redacted] with scales in accurate operating condition. Facility failed to provide functional [redacted] How the corrective action will be accomplished for any resident affected by deficient practice. Maintenance Director immediately checked the [redacted] lift for proper functioning. Battery was changed. Hoyer lift is in good working condition. Residents #81 and resident #158 were immediately assessed. There was no evidence of any significant changes. [redacted] was ordered and was replaced. No other residents were affected with this	

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	315516	A. BUILDING _____ B. WING _____	02/17/2023

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F 908	Continued From page 47 used to weigh and to transfer residents) was used to weigh Resident #81. CNA#1 explained that normally a nurse and an aide would use the equipment together to weigh the resident and the resident was weighed at the beginning of the month unless physician orders specified otherwise. CNA#1 stated that once the weight was obtained, the nurse was told the weight verbally, would document the weight and that if there was a significant change, "like 10 pounds gained or lost," the resident would have been reweighed for accuracy. CNA#1 explained to the surveyor that a re-weight was conducted for accuracy, to ensure that staff did not make an error and to ensure the scale was calibrated correctly. CNA#1 stated that there were two MLs on the unit but only one had a scale and that was the most accurate way to weigh the resident. CNA#1 further stated that to ensure the scale was not malfunctioning, it should be zeroed out before the weight was obtained so there was not information left from the last weight. CNA#1 then stated that it was important to have an accurate weight to ensure that the resident was getting the right nutrition and that they didn't gain or lose too much weight. On 02/13/23 at 11:24 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN#1) who stated the CNA and the nurse do the ML weights together, the lift should have been hooked up and the scale was on zero before the resident was lifted. LPN#1 stated she would confirm an accurate weight was done by reweighing the resident and that she would know that the scale was malfunctioning because the weights would not have been accurate. On 02/13/23 at 11:54 AM, Surveyor #1	F 908	deficient practice. How we identified other residents/areas that could potentially be affected. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future.) Measures to ensure were/will be put into place to assist this area of concern. Maintenance Director or designee will inspect monthly x 90 days and thereafter to ensure accurate operating condition of scales. Scales are inspected twice a year by vendor. Next scheduled inspection 3/23/23. Malfunctioning equipment to be discussed daily in morning meeting for immediate action. Nursing staff in-serviced to inform administration, physician, and Registered Dietician immediately if [redacted] is malfunctioning. DON or designee will review and check residents on [redacted] daily x 4 weeks for operating condition. How the concern will be monitored and title of person responsible for monitoring. Findings will be discussed in daily morning meeting with the administrator for	

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F 908	Continued From page 48 interviewed the [redacted] Unit Manager (UM) who stated that Resident #81's weights were done with the ML with the scale and that the CNAs weighed all the residents weekly. The UM stated that the weights were documented in the EMR under weights/vitals and that a reweight would be done if there was a gain or loss of two pounds. The UM stated that to confirm the accuracy of the weight that she would need to observe the scale while the resident was being weighed and that she would know if the scale was malfunctioning if it did not zero out or did not turn on. On 02/13/23 at 12:48 PM, in the presence of the other surveyors and the Regional RD, Surveyor #1 interviewed the RD who stated the nurses and CNAs weighed the residents and reported the weight to the UM who entered the information into the EMR under the weights/vitals tab and that the residents were weighed monthly. The RD stated that if there was a gain or loss that a weekly weight would be done to check the accuracy and that if there was a deviation of weights, she would ask the UM for a reweight and that both weights would be documented into the EMR to assess any weight changes in the future. The RD further stated that she would confirm it was an accurate weight by the reweight and then she monitored and trended the residents weights. On 02/14/23 at 10:34 AM, Surveyor #1 observed LPN#1 enter the shower room on the [redacted] unit and obtain a ML with a scale. The surveyor observed LPN#1 press the on/off buttons on the scale which made the scale display blink on, then turn off. LPN#1 stated, "I am not sure it works, I don't prefer that one." LPN#1 further stated that she knew it did not	F 908	immediate resolution and will be discussed in monthly QAPI and this will be a part of Center QA program. Dates when concern will be completed. March 17, 2023.	

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F 908	Continued From page 49	F 908		

work because the scale turned on then off. LPN#1 then reported to the UM that she needed a ML with a scale and that the one on the unit was not working right. LPN#1 went to the [redacted] unit to obtain a ML with a scale but there was none. LPN#1 then went to the [redacted] unit to obtain a ML scale. LPN#1 obtained the ML with the scale, pressed the scale on/off button and the display stayed on. LPN#1 stated, "that's how you know it's working," and brought the ML scale to the [redacted] unit to weigh Resident #81.

On 02/14/23 at 10:46 AM, Surveyor #1 observed LPN#2 press the on/off button on the ML scale from the [redacted] unit and [redacted] appeared on the scale display. LPN#2 pressed the zero button, 0.00 appeared on the display and LPN#2 stated you had to press the zero button to zero out the scale before use. LPN#1, LPN#2 and Surveyor #1 then entered Resident #81's room with the ML scale. Surveyor #1 observed both LPNs perform handwashing, raised the resident's bed, placed the ML pad under the resident, hooked the pad to the ML, then LPN#1 turned on and zeroed out the scale. LPN#1 then lowered the resident's bed and pressed the up button on the ML scale control to raise the lift arm which made a clicking sound but did not raise. LPN#2 stated he would get a new battery for the ML and left the room. LPN#1 pressed the down button on the ML control and the lift arm was observed to lower however, when LPN#1 pressed the up button on the ML scale control the arm did not move and audible clicks were heard. LPN#1 stated they would normally get a new battery if the ML scale did not work.

On 02/14/23 at 10:55 AM, LPN#2 returned to the resident's room and stated he got another battery

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F 908	Continued From page 50	F 908		

that was on the charger and stored in the medication room then proceeded to change the battery on the ML. LPN#1 pressed the up button on the ML control and the arm did not raise, audible clicks were heard.

On 02/14/23 at 10:56 AM, LPN#1 left the resident's room, then returned and stated that the battery charger in the medication room was dead and she had to go to another unit to obtain a battery.

On 02/14/23 at 11:01 AM, LPN#1 returned to Resident #81's room and again replaced the battery on the ML. LPN#1 pressed the up button on the ML control and the arm did not raise, audible clicks were heard. At this time LPN#1 stated they would get another ML, test another battery then write in the maintenance log on the unit for the maintenance staff to check the ML. LPN#1 stated it was important to have a functioning ML and scale to monitor weights accurately as the resident could have [redacted]) and we would have needed to know if they gained or lost weight. In the medication room, the LPN#1 showed Surveyor #1 where the ML batteries were stored and charged. LPN#1 stated that the charger was unplugged and pointed to the unlit light on the charger which indicated the unit was not on.

On 02/14/23 at 11:05 AM, Surveyor #1 informed the UM that the ML and scale were not functioning. The UM stated that the process if the ML or scale were not working was that she would call or e-mail maintenance to have them come to the unit to look at the ML.

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F 908	Continued From page 51 On 02/14/23 at 12:04 PM, Surveyor #1 interviewed the Maintenance Director (MD) who stated that if there was an issue with equipment that each unit had a logbook that was reviewed by maintenance daily. The MD further stated that the staff would write down minor problems that they would fix and if they were unable to fix them that they would have called an outside vendor to take care of the issue. Surveyor #1 inquired as to whether there were ever any problems with the ML and the MD stated, "Not until today, about 15 minutes ago." The MD further stated the an outside vendor was responsible for the ML and that he did not have a log of their visits. This indicated that there was no accountability for the ML and scale functioning. The MD did not speak to how frequently the batteries for the ML's and scales were checked for proper functioning. On 02/14/23 at 01:01 PM, the surveyors met with the Administrator and Director of Nursing (DON) who were made aware of concerns with the ML and malfunctioning scales. On 02/14/23 at 01:19 PM, in the presence of the surveyors and the Administrator, Surveyor #1 interviewed the DON who stated that the CNAs were responsible for weighing the residents. The DON further stated that she would confirm the accuracy of the weight by reweighing the resident and that if the weight was "off" that she would have done it again. The DON further stated that the staff would let her or the Administrator know of a malfunctioning scale and that they would have maintenance or an outside service involved. The DON did not speak to how frequently the batteries for the ML's with scales were checked for proper functioning.	F 908		

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F 908	Continued From page 52 On 02/15/23 at 11:12 AM, Surveyor #1 observed LPN#3 enter the shower room on the [redacted] unit and obtain a ML with a scale. LPN#3 stated that before a resident was lifted by the ML that the scale would need to be zeroed out. Surveyor #1 observed LPN#3 turn on the scale and pressed the zero button which caused the display to read 0.00. On 02/15/23 at 11:20 AM, Surveyor #1 observed LPN#3 and CNA#1 enter Resident #81's room with the ML. CNA#1 pressed the on/off button on the scale then pressed the up button on the ML control. The ML arm did not raise, audible clicks were heard and CNA#1 stated that the battery was dead. LPN#3 removed the battery from the ML and left the room. This was the third time the surveyor observed a malfunctioning scale on the ML prior to weighing the resident. On 02/15/23 at 11:24 AM, LPN#3 returned to the resident's room, replaced the battery, and pressed the up button on the ML control which caused the ML arm to raise. LPN#3 and CNA#1 placed the ML pad under the resident, positioned the ML, attached the pad loops to the arm of the ML, zeroed out the scale, and raised the resident off the bed to obtain a weight of [redacted] pounds. On 02/16/23 at 11:54 AM, Surveyor #1 interviewed the DON in the presence of the Administrator who stated that the scale on the ML needed to be zeroed out before weighing a resident for accuracy and the batteries to the ML with the scales should be charged daily to maintain proper functioning and accuracy of resident weights. The DON further stated that all staff were responsible for changing the batteries	F 908		

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F 908	Continued From page 53 on the scale. The DON was unsure of how frequently the batteries on the ML needed to be changed. At that time the survey team asked the Administrator how frequently the scales were calibrated for accuracy. The Administrator stated that he was unsure and would have to check with the MD. The Administrator was unable to provide the survey team with an accountability record for charging the batteries on the ML and scales. 2.) On 02/07/23 at 11:36 AM, the surveyor entered Resident #158's room and observed the resident sitting upright in his/her bed with his/her resident representative in the room. The surveyor observed that the resident had a [redacted] formula hanging on a pole, not attached to a [redacted], and not flowing. The resident was [redacted], but [redacted] due to a [redacted] The resident's representative told the surveyor that the resident was admitted to the facility the [redacted] before. On 02/08/2 at 3 12:14 PM, the surveyor observed the resident in his/her room with his/her resident representative at their bed side. The surveyor further observed a [redacted] formula connected to a [redacted]. The [redacted] formula contained [redacted] milliliters (ml) in the bottle which was full. The bottle was observed to have a label attached to it. Documented on the [redacted] formula label indicated that the [redacted] formula was hung on [redacted] at eight (8). The label did not indicate if the [redacted] formula was hung at 8:00 AM or 8:00 PM. The surveyor observed the [redacted] which revealed that the [redacted] formula was flowing at [redacted] ml/hour and [redacted] ml was the [redacted] that was	F 908		

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F 908	Continued From page 54 administered through the [redacted]. The surveyor heard the [redacted] beeping. The words, [redacted] appeared on the [redacted] in front of the surveyor. At that time the resident representative stated that "the lady" had come into the resident's room and told him/her to push a button on the [redacted] because the [redacted] was "messed up" and shouldn't have been beeping like that. The resident representative further told the surveyor that another resident representative had been at the facility into the evening hours the [redacted] before and the [redacted] formula was administered to the resident around 7:30 PM. Resident #158 shook his/her head up and down in agreement. The surveyor reviewed the medical record for Resident #158. A review of the resident's Admission Record indicated the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted]. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been admitted to the facility for less than [redacted] days. A review of the resident's [redacted] Order	F 908		

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F 908	Continued From page 55 Summary Report (OSR) revealed the following Physician Orders (PO): -PO dated [redacted] for [redacted] Order every night shift. Maintain a closed system. Change feeding administration set with each new bottle; label the formula container, syringe, and administration set with resident's name, date, time, and nurse's initials. -PO dated [redacted] for [redacted] Order [redacted] day to meet nutritional needs, document percent administered [redacted] ml per [redacted] times a day to provide [redacted] calories in a 24-hour period. A review of the resident's [redacted] Medication Administration Record (MAR) reflected the PO dated [redacted] for [redacted] Order every night shift. Maintain a closed system. Change [redacted] administration set with each new bottle; label the formula container, syringe, and administration set with resident's name, date, time, and nurse's initials. A further review of the MAR indicated that the [redacted] formula for the resident had not been administered on [redacted] at [redacted] On 02/09/23 at 12:39 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that the resident was sent form the hospital with PO for his/her current [redacted] formula. The LPN/UM further explained that after the resident was admitted to the facility the Registered Dietician (RD) would assess the resident's nutritional needs. The LPN/UM further stated that if the [redacted] was not working correctly, it would be nurses' responsibility to fix the [redacted] right away so the	F 908		

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F 908	Continued From page 56	F 908		

resident could receive the adequate nutrition they needed. The LPN/UM told the surveyor that the resident's order was discontinued on [redacted] to [redacted]) because the resident's [redacted] was not working properly. The LPN/UM stated that as soon as she found out that the [redacted] wasn't working, she went looking for a replacement [redacted] and could not find one, so she notified the facility's RD who changed the resident's nutritional intake to [redacted]

On 02/09/23 at 09:54 AM, the surveyor conducted a follow up interview with the resident's representative who stated that the [redacted] was not working "all day" on [redacted], so around 2:30 PM - 3:00 PM he/she discussed their concerns with facility management who resolved his/her concerns. The resident representative stated that it was inappropriate that the nurse told him/her to press the button on the [redacted] for it to work because it was the nurse's job to make sure the resident received their nutrition. The resident representative stated that the RD had told him/her that Resident #158 had not received his/her [redacted] as he/she was supposed to.

On 02/09/23 at 10:12 AM, the surveyor observed the resident in his/her room. There was no [redacted] in the resident's room. The resident communicated to the surveyor that he/she had received a [redacted] from the nurse that morning

On 02/09/23 at 12:06 PM, the surveyor interviewed the resident's Certified Nursing Aide who stated that it was her second day taking care of the resident and the resident received his/her nutrition by way of [redacted]

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F 908	Continued From page 57 On 02/09/23 at 12:25 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that he worked the 3:00 PM - 11:00 PM shift the day before [redacted] and saw that the resident's [redacted] was changed to [redacted]. The LPN further stated that the [redacted] was not working properly [redacted] so they had to change the order to [redacted] for the resident. On 02/14/23 at 11:38 AM, the RD stated that she did not know the [redacted] in the resident's room was not working. On 02/17/23 at 10:39 AM, the surveyor interviewed the Administrator in the presence of the facility's DON and survey team who stated that if staff was given medical equipment that did not work properly then they should have notified management. The Administrator further stated that the facility had contracts with outside companies that inspected the medical equipment to make sure it was functional, and he or the Maintenance Director would also try and fix the equipment if it was broken. NJAC 8:39-31.2(c)(e)	F 908		