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	315521	A. BUILDING _____ B. WING _____	C 01/09/2024

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F 000	INITIAL COMMENTS	F 000		

A Complaint Survey was conducted on behalf of the New Jersey Department of Health.

Complaint #'s: NJ00151851, NJ00152320, NJ00153272, NJ00153799, NJ00156210, NJ00156380, NJ00156580, NJ00156776, NJ00157166, NJ00157215, NJ00157739, NJ00157760, NJ00157827, NJ00158123, NJ00158489, NJ00158677, NJ00158720, NJ00159247, NJ00159319, NJ00159405, NJ00159533, NJ00159679, NJ00159800, NJ00160098, NJ00160123, NJ00161147, NJ00161186, NJ00161524, NJ00161762, NJ00161776, NJ00162177, NJ00162457, NJ00162827, NJ00162977, NJ00165870, NJ00167295, NJ000168256, NJ00168400, NJ00168545, NJ00168603, NJ00169368, and NJ00169776.

On 01/06/24 at 7:46 PM, the facility's Administrator was notified that the failure to ensure residents were free from abuse/neglect and that the facility failed to ensure pharmaceutical services were provided and maintained to meet each residents' needs constituted Immediate Jeopardies at F600-L and F755-L, respectively. Additionally, on 01/08/24 at 6:13 PM, the facility's Administrator was notified that the failure to ensure the facility was administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident constituted Immediate Jeopardy at F835-L. The Immediate Jeopardy at F755 was determined to first exist on 06/04/22, when the facility failed to ensure R33's intravenous (IV) antibiotic

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/14/2024

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

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F 000	Continued From page 1	F 000		

medication was acquired and administered timely. The Immediate Jeopardy at F600 was determined to first exist [redacted] when nursing failed to monitor for head injury after R37 had an unwitnessed fall.

The facility provided an acceptable removal plan on 01/9/24. The removal plan included assessments of all residents with stomas and educating all nursing staff, including agency nurses, on [redacted] management. The removal plan included reviewing all residents receiving [redacted] and any [redacted] to determine if monitoring and educating nursing staff, including agency nurses, on monitoring residents on anticoagulants who [redacted], monitoring residents for changes in condition, timely physician notification, accurate documentation, and sending residents to outside providers per physician orders. The removal plan included assessing all residents with a diagnosis of heart failure and educating nursing staff, including agency nurses, of signs and symptoms of [redacted] and evaluating residents with [redacted] 1/17/2024, the surveyors conducted a revisit and verified that the Removal Plan was fully implemented. The noncompliance remained on 1/17/2024 at a Level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

The Immediate Jeopardy at F600 also constituted Substandard Quality of Care at 42 CFR 483.12 and a partial extended survey was completed.

Survey Dates: 01/03/24-01/09/24

Survey Census: 115

Sample Size: 65

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F 000	Continued From page 2 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 584 SS=E	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; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		2/23/24

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F 584	Continued From page 3 §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: Complaints: NJ00156380, NJ00156776, NJ00157166, NJ00157827, NJ00159247, NJ00159405, NJ00161524, NJ00168545, NJ00168603 Based on observations, interview, and policy review, it was determined the facility failed to ensure a clean comfortable and homelike environment, this was evidenced by the facility failing to have an adequate supply of clean linens (towels, washcloths, flat sheets, fitted sheets, and gowns) available for resident use. Findings include: The facility had 124 beds and a census of 114 at the time of survey entrance. The [redacted] Hallway had 59 residents and the [redacted] Hallway had 55 residents based on facility census. Observation on 01/03/24 at 11:00 AM with the Housekeeping Director (HD) of the storage container located near the back door revealed: 10 dozen (120) towels. 10 dozen (120) washcloths. During an interview at this time the HD stated	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 21, R42, and R57 no longer reside at the facility. R 14, R 44 and R 57: The Nursing Home Administrator met with both residents and interviewed them about availability of towels, washcloths, flat sheets, fitted sheets, and gowns. Both residents stated they had enough of all the items. Repor ted no washcloths or towels for shower. Residents were provided with additional towels, and washcloths to keep in their rooms. Residents were satisfied. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has identified that all residents have the potential to be affected. All occupied rooms were audited for an adequate supply of linens and towels. They all had an adequate supply. A full	

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F 584	Continued From page 4 these supplies were new stock that were not yet in circulation; floor staff did not have access to this supply. Observation on 01/06/24 at 1:00 PM of the clean linen room located on the [redacted] Hallway revealed zero towels and 10 washcloths on the shelves for use. Observation on 01/06/24 at 1:10 PM of the clean linen room located on the [redacted] Hallway revealed zero towels and 12 washcloths on the shelves for use. Observation on 01/06/24 at 1:48 PM of the clean linen cart for rooms 231-[redacted] located in the hallway contained no towels or washcloths. Observation on 01/06/24 at [redacted] PM of the clean linen cart for rooms 215-230 located in the hallway contained no towels or washcloths. Observation on 01/06/24 at [redacted] PM of the clean linen cart for rooms 201-214 located in the hallway contained zero towels and 20 washcloths. Observation on 01/06/24 at 1:57 PM for the clean linen cart for rooms [redacted] could not be located. Observation on 01/06/24 at 2:00 PM of the clean linen cart for rooms [redacted] located next to the nurse's station contained zero towels and five washcloths. During an interview on 01/04/23 at 10:00 AM, Family Member (F) 2 stated when she visited R21 she never saw a towel in the resident's room. F2 stated R21 was not able to take showers because there were no towels for [redacted] to dry off. F2 verified	F 584	house inventory was conducted on towels, washcloths, flat sheets, fitted sheets, and gowns. The center was found to have an adequate supply for all current residents. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Housekeeping, or designee in-serviced housekeeping staff related to all residents on all shifts having an adequate supply of towels, and washcloths for all licensed beds and educated regarding the required par level on each unit based on census. Housekeeping Staff will stock the linen rooms on each unit with an adequate par level of towels and washcloths for the unit census. These rooms will be stocked every shift and as needed. Back up supply of towels and washcloths were brought out of storage and into circulation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Housekeeping, or designee will conduct audits on the facility□s total number of towels, and washcloths. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Housekeeping, or designee will conduct audits on both clean linen storage rooms having an adequate	

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F 584	Continued From page 5 that R21 resided in the facility from NJ EX Order 26461 through NJ EX Order 26461 3. During a group interview held with 13 residents (selected by the facility as being NJ EX Order. 26461) and two family members on 01/05/24 at 2:15 PM, the following complaints related to the availability of linen/towels were made: -R14 stated taking showers depended on the availability of towels and wash cloths. R14 stated the staff brought NJ EX Or gowns or pillowcases to use when showering instead of towels. R14 stated he had gone a couple days at a time without towels. -R42, R57, R14 all verified they did not have washcloths in their rooms. -R44 stated there were typically no washcloth or towels. R44 stated, "We should get towels in the morning." -R57 stated there was a lack of towels. -R42 stated if you wanted a towel, you had to ask in morning. During an interview on 01/06/23 at 4:18 PM, Registered Nurse (RN) 3 stated she had heard reports of residents lacking towels in their rooms and when this happened, NJ EX Or sent the aides to get towels off the linen cart. RN3 stated when the certified nurse aides (CNAs) started their shift, they were responsible for stocking towels on the linen cart. During an interview on 01/03/24 at 11:00 AM, Housekeeping Director (HD) stated, "most of the clean lines are stored in the clean linen rooms on the hallways, with some of it stored in carts in the hallway for easier access for the staff. All of the new linens and extra supplies are stored in a container outback. Normally we receive our orders in seven to ten days. I place a weekly	F 584	supply of towels and washcloths, on each shift. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 584	Continued From page 6	F 584		

supply order to the corporate office for approval and they place the order. The laundry is washed throughout the day and placed back on the floor for use. We try not to store linens in the resident rooms."

During an interview on 01/05/23 at 1:10 PM, the prior Administrator, who continued to be employed by the company, was interviewed. He stated he was the Administrator for most of R21's stay. The prior Administrator stated there were residents who reported concerns of not enough towels and they were placed on a focus list for towels. Staff checked in with them to make sure their needs were met. The prior Administrator stated his expectation had been that there should be towels in the residents' rooms/bathrooms.

During an interview on 01/05/24 at 2:00 PM, the prior Administrator stated, "PAR [periodic automatic replacement] levels should be maintained. [The HD] can pull supplies if needed. If a resident tells a staff member, they need a towel the staff member should go get one."

During an interview on 01/06/24 at 2:05 PM, the HD stated, the normal PAR levels at the start of the day should be 36 washcloths and 36 towels. The laundry is then collected, washed and returned to the floors throughout the day."

During an interview on 01/06/24 at 6:25 PM, RN5 stated, "we are always short of linens on the floor."

A review of the facility policy, "Safe and Homelike Environment," dated April 2023, revealed, Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and

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F 584	Continued From page 7 homelike environment . . . 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. Policy Explanation and Compliance Guidelines: 1. The facility will create and maintain to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting . . . 4. The facility will provide and maintain bed and bath linens that are clean and in good condition . . ." NJAC 8:39.27.2 (j), 21.3 (a), 4.1 (a) 11.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		2/23/24

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of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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F 585	Continued From page 9 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure grievances were addressed for two of 65 sampled residents (Resident (R) 62 and R21). The facility failed to document significant concerns as grievances; failed to address the concerns; failed to communicate resolution; and failed to assess resident/family satisfaction upon the conclusion of the grievance. Findings include:	F 585	F 585 Grievances 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 21 no longer resides in the facility. R 62: The nursing home administrator interviewed R 62 on 2/9/24 about unresolved grievances. R 62 reported no	

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F 585	Continued From page 10 1. Review of the "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R62 was admitted to the facility on [redacted] Review of the "Diagnoses" tab in the EMR under the "Resident" tab revealed R62's admission diagnoses included [redacted] During an interview on 01/05/24 at 4:30 PM, Family Member (F)1 stated [redacted] was dissatisfied because R62 had not received adequate care since [redacted] admission to the facility. F1 stated [redacted] came to the facility on [redacted], the day after R62 was admitted, and [redacted] brought R62's spouse to visit. F1 stated [redacted] had communicated to staff ahead of time to make sure R62 was [redacted] and ready for their planned arrival time. F1 stated, when [redacted] arrived, R62 was lying on the bed with only a [redacted] on with a sheet that was halfway on the bed, and no blanket covering [redacted] had not been [redacted]. F1 stated there was garbage strewn on the floor including [redacted] supplies and the garbage can was full. F1 stated [redacted] went to the nurse's station for assistance and all the nursing staff were on their phones, eating pizza, and they ignored [redacted]. F1 stated [redacted] informed the staff of R62's condition, the condition of the room, and that it was unacceptable. F1 stated the next day [redacted] came into the facility and R62 was in a lot of [redacted] and told [redacted] had not been fed the night before and no one came in to check on [redacted] during night shift. R62 was also wearing the same [redacted] from the day before and he smelled of urine. F1 stated [redacted] had to get water for R62 because there was no water in the room. F1 stated R62 asked for coffee and no one brought [redacted] any. F1 stated [redacted] went to the	F 585	unresolved grievances at that time, all previous grievance conclusions were reviewed with the resident and resident satisfaction. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents filing grievances have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Social Services or designee completed an audit on the last two months of grievances to ensure significant concerns were documented, addressed, resolution communicated and satisfaction assessed. No other residents were found to have been affected. The Director of Social Services or designee in-serviced all facility staff on the grievance process, successfully addressing all grievances, and successfully resolving grievances and communicating those resolutions to the resident/family. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Social Services or designee will audit the grievance log to ensure significant concerns were documented, addressed, resolution communicated and satisfaction assessed. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to	

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nurse's desk and asked to speak to a supervisor and was directed to speak with the Director of Patient Relations. F1 stated [NJ EX Ord] expressed [NJ EX] concerns about the room, R62's condition the day before, and R62's report of not being fed, checked on and being in [NJ EX Ord] to the Director of Patient Relations. F1 stated the Director of Patient Relations took some notes on a piece of paper; however, did not offer her the option of filing a grievance. F1 stated [NJ EX] continued to have concerns about a lack of staff attentiveness and response when R62 needed something.

Review of the "Grievance Log" from [NJ Ex Order 25403] through [NJ Ex Order 25403], provided by the facility, was reviewed. There was no grievance logged regarding R62.

During an interview on 01/06/24 at 2:30 PM, the Administrator stated the Director of Patient Relations was the Manager on Duty (MOD) on [NJ EX Order/Order 25] The Administrator stated F1 approached the Director of Patient Relations about R62 not being ready for a family visit. The Administrator stated F1 grabbed a staff member to take care of R62 at that time. The Administrator stated the Director of Patient Relations had not initiated a grievance but the concerns had been listed on the MOD report that came to [NJ EX Or] The Administrator stated she took the information from the MOD report and initiated a grievance form.

Review of the "Grievance/Concern Form" dated [NJ EX Order 25403] and provided by the facility revealed the concern of, "[R62] not washed up and ready - Staff in to assist and concern form gen [generated]." The summary of the investigation read in full, "Family of resident asked that

the facility QAPI committee until compliance is determined to be sustained.
5. Date of Compliance: February 23rd, 2024

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resident be up and dressed for a visit with [redacted]. Family was upset as they expected [R62] to be up earlier. Around 10 am when the [F1] arrived at the facility patient was not ready. [F1] approached [Director of Patient Relations] upset and yelling. [Director of Patient Relations] immediately informed floor staff and patient was dressed for [redacted] visit." The form indicated the resident or representative was notified of the resolution on [redacted] at approximately 10:00 AM.

During a follow up interview on 01/07/23 at 12:49, F1 stated [redacted] was not aware a grievance had been filed related to the concerns [redacted] had expressed to the Director of Patient Relations on [redacted] F1 stated no one had come back and talked to [redacted] about [redacted] concerns, notified [redacted] of what had been implemented to resolve the problem, or checked with [redacted] to see if [redacted] was satisfied with the resolution. F1 stated [redacted] had not received anything in writing related to the grievance that had been filed. F1 stated [redacted] had also expressed concerns about R62's [redacted] not being removed yet, a request for a different room that was warmer, R62 not receiving [redacted] care, the room being dirty, staff not answering the call light or being attentive to R62's needs with Social Service (SS) 1. F1 stated [redacted] had not heard back from SS1 about [redacted] concerns except for information about a room change/room temperature issue. F1 stated, "That is my whole point. No one reached out to me to follow up."

During an interview on 01/07/24 at 11:41 AM, the Assistant Director of Nursing (ADON) stated she was not familiar with R62. The ADON stated if a concern was raised, staff investigated it. The ADON stated a grievance could be initiated,

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depending on what it was. She stated if it was about poor care or a lack of hygiene, a grievance should be initiated. The ADON stated if there was a nursing grievance, it would go to the manager on that unit for investigation. The ADON stated the results would be reported back to the Administrator or Social Worker. The ADON stated she was not sure who reported back to the resident/family.

During an interview on 01/07/24 at 2:01 PM, SS1 stated F1 expressed a concern to her today about R62's NJ EX Order 264b1. SS1 stated she could not do anything specifically and F1 would have to speak to nursing. SS1 stated F1 expressed concerns in a care conference last week about R62's room being too cold. SS1 stated the facility did not have an open bed at that time to do a room change. SS1 stated F1 had not expressed any additional concerns such as about NJ EX 1 care, or garbage, etc. to her.

During an interview on 01/08/24 at 1:43 PM, the Administrator stated when she started in her position about a month ago, she identified a failure of the facility to address grievances. The Administrator stated staff were not used to following through when concerns were raised. The Administrator stated that was why she took over as the Grievance Official. The Administrator stated she had not contacted F1 after filling out the grievance form because it had been handled by The Director of Patient Relations at the moment. The Administrator stated she had not provided a written copy to the family or contacted F1 herself to determine if F1 was satisfied with the resolution. The Administrator stated she was not fully aware of the facility's specific policy, but stated staff should talk with the

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family/complainant about the resolution.

2. Review of the undated "Admission Record" provided by the facility revealed R21 was admitted to the facility on [redacted]3. R21 was admitted with a diagnoses of a [redacted]. R21 was discharged on [redacted] and [redacted] closed record was reviewed.

Review of the admission "MDS" with an ARD of [redacted] in the EMR under the "MDS" tab, revealed R21 was [redacted] in [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted]

During an interview on 01/04/23 at 10:00 AM, Family Member (F) 2 stated she expressed a number of concerns to the staff during R21's stay. F2 stated, "At first, they did not feed [redacted]. [redacted] [R21] said she was not served any food." F2 stated the guy in admissions (Account Executive/Marketing) told her R21 got fed because it was documented in the computer. F2 stated R21's [redacted] medication ran out and [redacted] was told not to worry about it. F2 stated [redacted] went to the Prior Assistant Administrator and he looked in the medication cart and there was no [redacted] medication but it had been documented as being taken. F2 stated the Director of Patient Relations documented her concerns. F2 stated staff failed to change R21's [redacted] and then failed to implement a toileting program. F2 stated R21 got several [redacted]) in the facility and there were delays in getting a [redacted] completed. F2 stated Registered Nurse (RN) 3 tried to put the [redacted]) up R21 to collect the [redacted] and R21 was

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NJ EX Order 26401 F2 stated NJ EX expressed NJ EX concern over this incident to the Assistant Director of Nursing (ADON) and told NJ EX Order 26 wanted to file a complaint. F2 stated a complaint was not filed. F2 stated NJ EX had also reported RN3 to the Director of Patient Relations because NJ EX was rude and disrespectful towards R21. F2 stated the Director of Patient Relations took down NJ EX concerns and said she would get back to NJ EX but never did. F2 stated NJ EX did not want RN3 working with R21 and the Director of Patient Relations told her RN3 was a good nurse. F2 stated NJ EX had also expressed her concerns about RN3 to the prior Administrator and to the prior Director of Nursing (DON) who were employed during R21's stay. F2 stated NJ EX requested a meeting and in the meeting was told they [facility staff] were "working on it." F2 stated she was told that she would receive a call every week with updates; however, NJ EX received no calls. F2 stated NJ E e also reported a concern with a NJ EX Order 26401. F2 stated none of the staff expressed NJ EX concerns to offered to fill out a grievance or provided a form so NJ EX could complete one.

During an interview on 01/05/24 at 11:23 AM, the Director of Patient Relations stated R21 and F2 had a lot of concerns. The Director of Patient Relations stated R21 did not like the food and complained about an odor. The Director of Patient Relations stated, "I believe there were grievances [filed]." The Director of Patient Relations stated there were issues about a toileting program and administration of a NJ EX Order 2 medication. The Director of Patient Relations stated someone investigated the NJ EX Order 26 medication issue. The Director of Patient Relations stated if a resident/family member expressed concerns to NJ EX Order 264 forwarded the

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concerns to the Administrator. She stated she would document the concerns on a grievance form. The Director of Patient Relations stated she had not initiated a grievance about F2's concern about a lack of a toileting program because there was already a toileting schedule. The Director of Patient Relations stated F2 told her RN3 screamed and was rude to R21 and argued about medicine. The Director of Patient Relations stated she did not fill out a grievance for that, but she informed the DON immediately. The Director of Patient Relations stated RN3 had an [redacted], and it was a [redacted] thing that could be misinterpreted.

During an interview on 01/05/24 at 1:10 PM, the prior Administrator stated F2 came to the prior DON and to him multiple times to discuss concerns including nursing care, an NJ EX Order. 264b1 issue, and a bad smell. The Administrator stated R21 was added to a focus list of residents who were checked on more often. The prior Administrator stated he thought there may have been a grievance completed. The prior Administrator did not mention any concerns related to RN3.

During an interview on 01/05/24 at 3:13 PM, the prior DON stated she had spoken with R21 and F2 about their concerns about [redacted] and a toileting program. She stated she did not remember an issue with the [redacted] medication; however, was aware of the incident with RN3 attempting to NJ EX Order. 264b1 [redacted]) R21 to obtain a [redacted] sample. The prior DON stated the family was upset with the delay in obtaining the [redacted] sample. The prior DON did not mention R21 or F2 being upset about RN3

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specifically.

During an interview on 01/08/24 at 10:43 AM, the Account Executive/Marketing stated he gave his contact number to new families/residents to contact him around time of admission. He stated he did not remember R21 or F2 and did not remember any concerns being voiced to him. The Account Executive/Marketing stated he did not keep documentation of concerns that were relayed to him by residents or families. He stated he passed along any concerns to the appropriate facility staff in real time.

During an interview on 01/08/24 at 12:34 PM, the DON who had been in her position for a [redacted] weeks, stated grievances should be documented, followed up on, the resolution should be documented, and the resolution should be reviewed with the resident.

Review of the "Grievance Log" from [redacted] through [redacted], provided by the facility, was reviewed. There were no grievances logged regarding R21 or by F2 on behalf of R21.

Review of the "Resident and Family Grievances" policy dated January 2023 revealed, "It is the policy of this facility to support each resident's and family member's right to voice grievances . . . Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. b. Written complaint to a staff member or Grievance Official . . . c. Verbal complaint during resident or family council meetings . . . The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to

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F 585	Continued From page 18 complete the form. i. Take any immediate actions needed . . . Forward the grievance form to the Grievance Official as soon as practicable . . . The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form . . . The Grievance Official or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances . . . the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation." NJAC 8:39-4.1 (a) 5, 12 NJAC 8:39-13.2 (c) NJAC 8:39-27.1 (a)	F 585		
F 600 SS=L	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaints: NJ00157215, NJ00161186, NJ00161762, NJ00162457, NJ00162827,	F 600	F 600 Free from Abuse and Neglect 1. Address how corrective action will be	2/23/24

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F 600	Continued From page 19 NJ00167295, NJ00168400, NJ00168545, NJ00168603, NJ00169368 Based on observation, interview, record review, and facility policy review, the facility failed to protect one resident's (Resident (R) 38) right to be free from [redacted] abuse by staff and failed to protect two residents' (R37 and R57) right to be free from neglect out of a total sample of 65 residents. An allegation was reported that R38 was found with [redacted] inside [redacted]. It was reported the [redacted] was in an amount sufficient to [redacted] t R38's [redacted] The facility failed to identify the alleged incident as an allegation of abuse, failed to report the allegation to the state agency, failed to conduct a thorough investigation, and failed to protect residents during the investigation. R37 received [redacted], an [redacted] medication, suffered an [redacted], and the facility neglected to monitor for changes in [redacted] of [redacted]. R37 was sent to the hospital, and it was recorded that [redacted] had a [redacted] R57 had diagnoses including [redacted]) and exhibited signs and symptoms of an [redacted]. The facility neglected to obtain a [redacted] appointment as requested by the resident, neglected to monitor daily weights, neglected to notify the physician when R57 had [redacted], and neglected to intervene when providers did not provide care and services necessary for a resident having an exacerbation [redacted]. R57 was admitted to the hospital and had [redacted] pounds (lbs) of [redacted]	F 600	accomplished for those residents found to have been affected by the deficient practice: R 37 no longer resides at the facility. R 38□s assigned Registered Nurse assessed [redacted] site on the morning of [redacted]. There was no [redacted] on R 38□s [redacted]. An additional Registered Nurse assessed R 38□s [redacted] on [redacted] at approximately 9am. There was no [redacted] on the [redacted] The Director of Nursing assessed R 38□s [redacted] on [redacted] and there was no [redacted] on the [redacted] R 38 has an order to monitor [redacted] site every shift. An additional order was placed for the nurses to monitor [redacted] every four hours. R 38 no longer resides in the facility . All residents in the center with an [redacted] were evaluated. One other resident had an [redacted] y. The Director of Nursing assessed the [redacted] on [redacted] 4 and there was no paste on the [redacted]. R 57 was assessed by the Director of Nursing on [redacted]. He did not exhibit any signs or symptoms of [redacted] The findings were reviewed with the physician. R 57 was evaluated by the Nurse Practitioner on 1/5/2024. The Nurse Practitioner documented that R 57 was in no acute distress. R 57 no longer resides in the facility. All residents in the center with a diagnosis of [redacted] were evaluated by the Registered Nurse on 1/8/2024. None of these residents exhibited any signs or symptoms of a [redacted]. 2. Address how the facility will identify other residents having the potential to be	

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F 600	Continued From page 20 from [redacted] body. The failures to identify allegations of abuse, monitor for changes in NJ EX Order. 264b1, and provide care and services for a resident having an exacerbation [redacted] resulted in an Immediate Jeopardy (IJ) at F600-L; Freedom from Abuse, Neglect, and Exploitation due to the increased likelihood of serious harm or impairment, up to and including death. The facility provided an acceptable removal plan on 01/9/24. The removal plan included assessments of all residents with [redacted] and educating all nursing staff, including agency nurses, on [redacted] management. The removal plan included reviewing all residents receiving NJ EX Order. 264b1 and any [redacted] to determine if monitoring and educating nursing staff, including agency nurses, on monitoring residents on NJ EX Order. 264b1 who fall, monitoring residents for changes in condition, timely physician notification, accurate documentation, and sending residents to outside providers per physician orders. The removal plan included assessing all residents with a diagnosis of [redacted] and educating nursing staff, including agency nurses, of signs and symptoms of [redacted] and evaluating residents with [redacted] On 1/17/2024, the surveyors conducted a revisit and verified that the Removal Plan was fully implemented. The noncompliance remained on 1/17/2024 at a Level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. Review of R38's "Admission Record," provided by the facility, revealed R38 was admitted to the	F 600	affected by the same deficient practice. All residents with [redacted], with [redacted] s and with actual [redacted] have the potential to be affected. The Director of Nursing evaluated all residents in the center with an [redacted]. One other resident had an [redacted]. The Director of Nursing assessed the [redacted] on [redacted] and there was no [redacted] on the [redacted] The Director of Nursing reviewed current residents who [redacted] and were on NJ EX Order. 264b1 s to determine if they were monitored and documented on in the nursing notes [redacted] All residents who met this criteria were documented on appropriately. All residents in the center with a diagnosis of NJ EX Order. 264b1 were evaluated by the Registered Nurse on 1/8/2024. None of these residents exhibited any signs or symptoms of a NJ EX Order. 264b1. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Nursing Home Administrator and Regional Clinical were in-serviced by the Regional Director of Clinical Services on reporting and investigational requirements for allegations of abuse and neglect on 1/6/2024. The Nursing Home Administrator or designee in-serviced all staff on reporting allegations of abuse/neglect immediately, initiating investigations of allegations of abuse/neglect, conducting thorough investigations, and protection of residents	

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F 600	Continued From page 21 facility on [redacted] with diagnoses that included [redacted] aftercare following [redacted] on the [redacted] system, NJ EX Order. 264b1 and [redacted] of the NJ EX Order. 264b1 to the [redacted] where [redacted] is collected in a [redacted] to the NJ EX Order. 264b1) status, and other NJ EX Order. 264b1. Review of R38's "Physician Orders," dated [redacted] and located under the "Orders" tab of the electronic medical record (EMR), revealed R38's [redacted] and [redacted] were to be changed daily on the 11-7 shift. Review of R38's admission "Minimum Data Set (MDS)," located under the "MDS" tab of the EMR and with an Assessment Reference Date (ARD) of [redacted] revealed R38 scored [redacted] on the "Brief Interview for Mental Status (BIMS)," which indicated R38 was [redacted]. Review of R38's undated "Care Plan," provided by the facility, documented a focus problem related to R38's ileostomy. It was recorded to change the [redacted] as ordered and when indicated, to change/empty the [redacted] bag after each [redacted] episode or when full, and to place a proper-fitting [redacted] around the [redacted]. Review of R38's "Progress Notes," dated [redacted] through [redacted], revealed no documentation of any concerns related to R38's [redacted]. On 01/04/24 at 6:00 PM, R38's family member (F) 6 stated that on the morning of [redacted], F7 had started to change R38's [redacted] and when F7 removed the [redacted] F7 found [redacted] inside of R38's [redacted]. F6 showed	F 600	during and after investigations. This began on 1/6/2023. All staff, including agency staff will receive this in-servicing prior to working their next scheduled shift. The Director of Nursing or designee in-serviced nurses, agency and staff, on ostomy management. This began on 1/6/2024. Nurses who have not yet been in-serviced will be in-serviced prior to working their next scheduled shift. The Director of Nursing or designee in-serviced nurses, agency and staff, on monitoring residents on [redacted] who [redacted] monitoring residents for all changes in condition, timely physician notification, accurate documentation, evaluating residents and documenting those evaluations, and sending residents to outside provider□s for treatment and services per the provider□s orders. This began on 1/6/2024. Nurses who have not yet been in-serviced will be in-serviced prior to working their next scheduled shift. The Director of Nursing or designee in-serviced nurses, agency and staff, on signs and symptoms of [redacted] and evaluating residents with [redacted] This began on 1/6/2024. Nurses who have not yet been in-serviced will be in-serviced prior to working their next scheduled shift. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing or designee will review [redacted] documentation, physician notification, and acute change assessment documentation weekly for four weeks, then bi-weekly x 4 weeks, and then monthly x 1 month.	

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F 600	Continued From page 22 the surveyor a photo of what appeared to be a [redacted] with a NJ EX Order. 264b1 substance occluding the opening of the [redacted]. F6 reported that the Director of Patient Relations and two nurses had been informed of the incident. F6 stated she believed the photo had been forwarded to staff members. On 01/04/24 at 6:25 PM, the Administrator and Director of Nursing (DON) were asked if they were aware of the alleged incident. The Administrator stated she had been informed on [redacted], and she had opened a grievance regarding the allegation. The Administrator confirmed a state reportable incident report had not been sent to the state survey agency. The Administrator stated she had seen the photo but had not enlarged it for closer inspection. The DON stated she had not seen the photo. The Administrator identified two staff members, Registered Nurse (RN) 4 and RN2, as working with R38 on the 11-7 shift from 11:00 PM on 01/01/24 through 7:00 AM on 01/02/24. The Administrator stated RN2 had been suspended because she would not return their call and that RN4 was coming to provide a statement before his shift on [redacted]. The Administrator did not identify any nurse aides that had worked with R38 on the shift in question. The Administrator confirmed she had not identified the allegation as an allegation of abuse and had not started an investigation of the alleged incident. On 01/04/24 at 6:58 PM, the Administrator provided documentation concerning the allegation. Included in the documentation were R38's "Admission Record," "Order Summary Report," and a "Grievance/Concern Form," where it was recorded, ". . . 1/3/23 [sic] [F6] stated that	F 600	The regional nurse or regional operator will review all abuse and neglect allegations with the Administrator weekly for four weeks, biweekly for 4 weeks, and then monthly x 1 month. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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that [sic] whomever on the 11-7 shift did not change NJ EX Order. 264b1 for NJ EX Order. 264b1 properly . . ." It was documented that the Director of Public Relations filled out the form. There was no documentation of the allegation that NJ EX Order. NJ EX Order. 264b1 was found in R38's NJ EX Order.

On 01/05/24 at 7:53 AM, the Administrator provided documentation of her investigation of the alleged incident with R38. The documentation included an untitled document, dated NJ EX Order. 264b1 that recorded, ". . . The resident was interviewed by the DON and he stated that there was NJ EX Order. paste on NJ EX Order. 264b1. . ." The investigation documentation included a statement from RN4 where it was noted RN4 did not provide care for R38 on NJ EX Order. NJ EX O a statement from Licensed Practical Nurse Supervisor (LPNS), and a statement from Licensed Practical Nurse (LPN) 5. It was recorded LPN5 was asked what care he provided to R38 on NJ EX Order. 264b1. It was recorded LPN5 stated he did not NJ EX Order. 264b the NJ EX Order. 264b1 EX Or and did not note any concerns with the NJ EX EX Order. bag. There was no documentation LPN5 was asked any questions specific to the allegation of NJ EX Order. 264b1 being inside R38's NJ EX Order. 2

On 01/05/24 at 6:55 PM, the Regional Clinician (RC) stated she had been informed a family member had found NJ EX Order. 264b1 inside R38's NJ EX Order. and she had reported it immediately. The RC stated she had seen the photo and F6 had told staff that the NJ EX Order. 264b1 was NJ EX Order. NJ EX Order. 264b1. The RC stated R38 had a NJ EX Or NJ EX Order. 264b1, and the facility was using different processes to determine what was the best method for NJ EX Order. 264b1 and maintaining R38's NJ EX Order. 264b1. The RC stated staff and family members had been changing R38's NJ EX Order. 264b1

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system two to NJ EX Order. 264b1 per shift because of NJ EX Order. 264b1. The RC reported that RN2 had tested NJ EX Order. 264b1 for NJ EX Order. 264b1 9, and that was why she had not been answering the facility's calls.

On 01/05/24 at 2:00 PM, F7, who was the family member that allegedly found the NJ EX Order. 264b1 NJ EX Order. 264b1 in R38's NJ EX Order. 264b1, reported that on NJ EX Order. 264b1 when he arrived at the facility, R38's NJ EX Order. 264b1 was clean. F7 stated NJ EX found that unusual and began to change R38's NJ EX Order. 264b1. F7 stated when he removed the NJ EX 2, he found what looked to be NJ EX Order. 264b1 inside the NJ EX Order. 2. F7 stated, "It looked like someone squirted it NJ EX Order. 264b1 in there." F7 reported he inserted a "NJ EX Order. 264b1" into the NJ EX Order. 264b1 to NJ EX Order. 264b1 and pulled out approximately NJ EX Order. 264b1 and a NJ EX Order. 264b1. F7 reported he began to clean around NJ EX Order. 264b1, and the NJ EX Order. 264b1 caused three additional pieces of NJ EX Order. 264b1 from the NJ EX Order. F7 reported that after the last piece of NJ EX Order. 264b1 came out, NJ EX Order. 264b1 began coming out.

On 01/06/24 at 10:00 AM, the surveyor observed NJ EX Order. 264b1 supplies, including NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1, were noted on R38's bedside table. The NJ EX Order. 264b1 was noted to be NJ EX Order. 264b1.

On 01/06/24 at 10:36 AM, the Unit Manager (UM) stated nurses changed and emptied NJ EX Order. 264b1 and aides emptied the NJ EX Order. 264b1.

On 01/06/24 at 11:35 AM, the Administrator provided an update to her investigation of the alleged incident with R38. Included a document dated NJ EX Order. 264b1 which recorded Certified Nurse Aide (CNA) 4 had been assigned to R38 on

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F 600	Continued From page 25 NJ EX Order. 264b1. There was no documentation of an interview with CNA4 included in the documents provided to the surveyor. A statement from CNA3, who was the other CNA assigned to R38's unit, was included in the documentation. The Administrator stated RN4 and RN2 had been interviewed and neither worked with R38 on the shift in question. The Administrator reported that LPN5 had been assigned to R38 on the shift in question and that he had been interviewed and denied any concerns. The Administrator provided documentation of interviews with three other residents where the residents were asked "How would you describe your overall care" and "Do you have any concerns at all that you want to express." There was no documentation the residents were asked questions specific to abuse. There was no documentation a statement had been obtained from F7. The Administrator stated the investigation was ongoing and confirmed the incident did occur. The Administrator was asked if all the aides assigned to R38 on that shift had been interviewed. She stated, "No." The Administrator was asked how the facility was protecting residents during the investigation. The Administrator stated residents were being protected with general rounds and observing and monitoring R38's NJ EX Order. 264 The Administrator reported she did not know if there were any other residents with NJ EX Order. 26 in the facility. No further documentation was provided to the surveyor by the end of the survey on 01/09/24 at 12:30 PM. 2. Review of R37's hospital "Active Meds sort by Name," located under the "Misc (Miscellaneous)" tab of the EMR, revealed R37 received NJ E milligrams (mg) of NJ EX Order. 264b1, an NJ EX Order. 264b1) at the hospital on NJ EX Order 264b1 at 9:00 AM.	F 600		

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F 600	Continued From page 26 Review of R37's "Admission Record," provided by the facility, revealed R37 was admitted to the facility on [redacted] with diagnoses including [redacted] NJ EX Order. 264b1). Review of R37's "Physician Orders," located under the "Orders" tab of the EMR, revealed R37 was to receive [redacted] mg twice daily for [redacted]. Review of R37's "Fall Risk Evaluation," dated [redacted] at 3:11 AM, revealed documentation R37 was assessed to have behaviors of an NJ EX Order. 264b1 continuously. The evaluation did not indicate what behaviors R37 exhibited. It was also recorded R37 was ambulatory and [redacted] walking did not occur, and R37's [redacted] was adequate. The Licensed Practical Nurse Supervisor (LPNS) electronically signed the form. Review of R37's "Nurses Notes," dated [redacted] at 3:22 AM and located under the "Progress Notes" tab of the EMR, revealed, ". . . @ 0300 [3:00 AM] [R37] was overheard calling out. Upon entering [redacted] room, [redacted] was noted lying on the floor with only a [redacted] on NJ EX Order. 264b1) and was on [redacted] left side. Full body assessment revealed no bruised [sic], marks, or contusions. She was assisted back intobed [sic] and [family member] and primary physician were notified, and [redacted] [sic] were initiated . . ." Review of R37's "Progress Notes," dated [redacted] and located under the "Progress Notes" tab of the EMR, revealed no documentation to show R37's NJ EX Order. 264b1 was monitored from 3:00 AM through 7:00 AM.	F 600		

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F 600	Continued From page 27 Review of R37's "Nurses Notes," dated [redacted] at 8:30 AM and located under the "Progress Notes" tab of the EMR, revealed, ". . . after reporting on my shift the night nurse said they received a patient [R37] who at the moment was sedated. Patient did not respond at all for entire shift. She had moments of [redacted] about 3.00am [sic] while they were going round the staff found patient on the floor. they [sic] assessed her and picked [redacted] up. They started [redacted] status. around [sic] 8.30 am [sic] i [sic] walked to the room i tried to call the patient but could respond with [redacted] [sic]. on the sheet was [redacted] as if the patient had [redacted] i took [redacted] vital signs bp [blood pressure], [redacted] p [pulse]: [redacted] oxygen [redacted] Temp [temperature]: [redacted], and BS [blood sugar]: [redacted] patient could not [redacted] the [redacted] and while i was there patient [redacted] again. Informed the supervisor, NP [nurse practitioner] and Doctor informed, they decided to evaluate [redacted] for few hrs [hours] and then send [redacted] out . . ." This was five and one-half hours after R37's [redacted]. Review of R37's "Medication Administration Records (MARS)," dated [redacted] and located under the "Orders" tab of the EMR, revealed no documentation R37 had been administered a [redacted] or any medication known to cause [redacted]. It was documented R37 had received [redacted] mg at 9:00 AM on [redacted]. Review of R37's "Assessments," "Progress Notes," and "Misc" tabs of the EMR revealed no documentation of [redacted] or monitoring for R37 after [redacted]. Review of R37's "Nurses Notes," dated [redacted]	F 600		

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at 1:28 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . patient was sent out for evaluation due to NJ EX Order. 264b1 status, NJ EX Order. 264b1, and previous history NJ EX Order . . ."

Review of R37's "Physician/Practitioner Progress Note," dated NJ EX Order. 264b1 at 1:59 PM, revealed, ". . . Nursing states patient had a NJ EX last night. Nursing states patient had NJ EX episodes of NJ EX Order. 264b1 this morning and is NJ EX Order. 264b1 Patient seen in bed with eyes closed with NJ EX Order. 264b1 to NJ EX Order. 26 . Due to NJ EX Order. 264b1, new onset of NJ EX Order. 264b1 and NJ EX Order. 264b1 on NJ EX Order 2 sending patient out for NJ EX O to r/o [rule out] NJ EX Order . . ."

Review of R37's "Nurses Notes," dated NJ EX Order. 264b1 at 6:53 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . [Hospital name withheld] nurse called at 18:30 [6:30 PM] to ask when was the last time [R37] had NJ EX Order 2. NJ EX Order 2 was las [sic] given at 09:00 [9:00 AM], Diagnosis NJ EX Order. 264b1

During an interview on 01/04/24 at 2:35 PM, Registered Nurse (RN) 1 stated NJ EX Order checks were supposed to be documented on paper and then placed in the resident's hard chart. RN1 stated she did not remember anything about R37.

During an interview on 01/04/24 at 4:41 PM, the Administrator and DON provided a copy of R37's incident report for the NJ EX on NJ EX Order. 264b1. Review of the incident report, dated NJ EX Order. 264b1 and prepared by LPNS, revealed, ". . . heard resident call out for help. Staff entered room and observed NJ EX lying on NJ EX O r [right] side on the floor near the bath [unable to read the rest of this sentence] . . . was last seen in bed. Resident ambulated without asking for assistance and lost balance . . ." It was

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recorded R37 was NJ EX Order. 264b1 The Administrator and DON were asked if the incident report recorded any NJ EX Order checks for R37. They stated no.

During an interview on 01/05/24 at 7:58 AM, RN4, who was the nurse responsible for R37 on NJ EX Order. 264b1 stated when R37 was found in the floor, the house supervisor was notified, an assessment was completed, and NJ EX Order checks were started. RN4 stated the physician was notified via the on-call system and no call back from the physician was requested. RN4 stated he did not request a return call because R37 did not have any injuries. RN4 stated he did review R37's medications but did not inform the physician that R37 was receiving NJ EX Order. RN4 stated his call to the physician was just a "notification" of a NJ EX O RN4 stated he documented the NJ EX Order checks, including vital signs, on a NJ EX Order check log sheet. RN4 stated after neuro checks were completed, the log sheet was given to the Unit Manager (UM). RN4 stated he did not note any changes in R37's NJ EX Order. 264b1 status or vital signs. RN4 stated he believed he did notify the physician R37 was receiving NJ EX Order. RN4 was reminded he had previously stated he did not notify the physician of this. RN4 then stated, "I believe I did."

On 01/05/24 at 8:57 AM, the facility provided an investigative summary of R37's NJ EX O. The investigative summary included a NJ EX Order check sheet and statements from RN4, LPNS, and RN1. Review of the investigative summary revealed:

a. Review of R37's "NJ EX Order. 264b1 Check Flowsheet," dated NJ EX Order. 264b1, revealed no documentation that R37's NJ EX Order. 264b1

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had been monitored by RN4 from [redacted] at 3:00 AM through [redacted] at 7:00 AM.

It was documented by RN1 that R37 was "[redacted]" from 7:00 AM until 11:00 AM on [redacted]. It was documented R37's BP was [redacted] and pulse rate was [redacted] at 8:30 AM. This was inconsistent with the documentation included in the "Nurses Note" dated [redacted] at 8:30 AM where RN1 had documented R37's BP was [redacted] and [redacted] pulse rate was [redacted]

b. Review of RN4's "Accident/Incident Investigation Statement Report," dated [redacted], revealed, ". . . I overheard [R37] yelling [and] went into room. I called [LPNS] into the room [and] we assessed [redacted] r body [and] did [redacted] checks. The assessment showed no injuries, marks, or contusions. I offered [redacted] [and] [patient] refused. [redacted] checks continued to show no change from base line to the last one, between 0630 [6:30 AM] [and] 0645 [6:45 AM]. Pt left in bed in low position [and] encouraged [redacted] to stay in bed [and] she stated [redacted] understood . . ."

c. Review of LPNS's "Accident/Incident Investigation Statement Report," dated [redacted] revealed, ". . . Around 3 am assigned nurse and myself heard a noise from pt's room so we went in to check on [redacted], upon entering room we found pt laying [sic] on the floor. Pt was assessed and helped back to bed. VS [vital signs] was [sic] stable no visible sign swelling around the [redacted] and no injury noted at the time. Pt was talking and was [redacted] denies any pain. Mentation was within normal limits. Monitored throughout night with no change. Before 8am pt was in bed sleeping and no s/s [signs and symptoms] of distress noted . . ." This was inconsistent with R37's [redacted] Risk

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Evaluation," dated [redacted] at 3:11 AM, where it was recorded R37 had an [redacted] of [redacted] present continuously.

d. Review of RN1's typed statement from the facility provided [redacted] investigative summary revealed, ". . . [redacted] I arrived for my 7am shift on [redacted] 3. I received report about [R37] having a [redacted] overnight and that there were no apparent injuries. The nurse gave me the [redacted]-check sheet. I rounded on all my residents. [R37] was in bed sleeping. [redacted] bed was low. [redacted] call bell was in reach. [redacted]-checks were within normal limits. I rounded around 8:30am and observed [redacted] in bed with a small amount of [redacted] on [redacted] sheet. She was [redacted] but [redacted] and mumbling. I took [redacted] vital signs and called the provider. [redacted] vital signs were [redacted] p[redacted], oxygen [redacted], Temp: [redacted] and BS: [redacted]. The provider said to continue monitoring [redacted] We continued to monitor [redacted]. Around 11am, the Director of Nursing spoke with the nurse practitioner and received an order to send [redacted] to the hospital for an evaluation due to a change in mental status . . ." The form contained RN1's signature. The information in the statement was inconsistent with the "Nurses Note," dated [redacted] at 8:30 AM, where it was documented R37 was [redacted] and had [redacted] at all on the previous shift. The statement did not address R37 [redacted] while RN1 was completing her assessment or R37 being [redacted] as was documented in the progress note on [redacted] at 8:30 AM.

On 01/05/24 at 8:59 AM, the surveyor attempted to contact RN1 by telephone. A voice message was left, but no return phone call was received by the end of the survey.

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F 600	Continued From page 32 During an interview on 01/05/24 at 9:06 AM, Nurse Practitioner (NP) 2 stated she was notified of R37's [NJ EX] on [NJ EX Order. 264b1] at approximately 9:30 AM when she arrived at the facility for her morning rounds. NP2 stated she was not notified when R37 fell. NP2 stated she assessed R37 after being told [NJ EX] had suffered a [NJ EX], found the resident [NJ EX Order. 264b1], and immediately sent [NJ EX] to the hospital. NP2 reviewed R37's EMR and stated she would look at her call reports. NP2 stated she was not at the facility at 3:00 AM and did not receive a call from the facility. NP2 opened a Word document on her computer. The document was headed, NJ EX Order. 264b1." Five nursing homes, including Spring Hills Woodbury, were listed on the document. Under each nursing home was a line list containing resident names and specific communication for each resident listed. Under Spring Hills Woodbury, R37's name was listed. The specific communication for R37 was recorded as "new admit." Continuing with the interview on 01/05/24 at 9:11 AM, NP2 stated she assessed R37 at approximately 9:30 AM. This was NJ EX Order. 264b1 hours after R37 [NJ EX Ord]. NP2 stated R37 was [NJ EX Order. 264b1], had [NJ EX Order. 264b1] times, and was on [NJ EX Order. 2], so she had R37 sent to the hospital. NP2 was asked if R37 was sent to the hospital on [NJ EX Order. 264b] at 1:59 PM, the time of her documentation in the progress notes. NP2 stated no. NP2 reviewed documentation in her NP electronic medical records system and stated she had the time of her note detailing R37's assessment and her actions as 10:06 AM. NP2 stated she had recorded the event in the facility's EMR on [NJ EX Order. 264b] at 1:59 PM.	F 600		

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F 600	Continued From page 33 Continuing with the interview on 01/05/24 at 9:11 AM, NP2 stated if she had been notified of R37's fall and the fact R37 was receiving [redacted], she would have probably sent her to the hospital, especially since R37 was [redacted] and was [redacted]. NP2 stated again that she was not notified of R37's fall. NP2 was asked what her expectation of staff was if a resident was receiving an [redacted] and suffered an unwitnessed [redacted]. NP2 stated, "Who did they call if I was on call?" NP2 stated she should have been notified when the [redacted] occurred and should have been notified at 8:30 AM when the resident was found with [redacted] sheet, [redacted] again, and was only [redacted]. NP2 stated, "They should have initiated a 911." During an interview on 01/05/24 at 11:09 AM, the former DON confirmed the facility's policy was to complete an assessment, do [redacted] checks, notify the physician, and monitor a resident for three days following a [redacted] The former DON confirmed that monitoring consisted of writing notes on your shift and checking the resident. The DON confirmed [redacted] should be monitored with [redacted] checks. The former DON confirmed the physician should be notified at least within an hour following a [redacted]. The DON confirmed [redacted] check sheets were part of the clinical documentation and stated at the facility, [redacted] check sheets were pulled and kept with any statements obtained. The former DON confirmed that information in any statements obtained should be consistent with the information in the clinical record. The former DON confirmed the progress notes at 3:30 AM and 8:30 AM recorded the physician was notified and that staff had been ordered at 8:30 AM to	F 600		

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	315521	A. BUILDING _____ B. WING _____	C 01/09/2024

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continue evaluation of R37 for a few hours. The former DON stated the progress note at 8:30 AM was detailing what RN4 had allegedly told RN1, and she did not know where RN1 had received that information. The former DON stated the facility did not always send a resident out if they were receiving NJ EX Order. 26 and had an NJNJ EX Order. 26461 NJ EX Or that it would depend on what the doctor said.

Continuing with the interview on 01/05/24 at 11:09 AM, the former DON stated information on the NJ EX Order 2 check sheets and progress notes should be consistent. The DON confirmed the vital signs listed on the 8:30 AM progress note, RN1's statement, and the NJ EX Order check sheet were inconsistent. The DON stated the nurse could have taken multiple sets of vital signs at that time.

Continuing with the interview on 01/05/24 at 11:09 AM, the former DON was asked where the documentation was of RN1 monitoring R37's NJ EX Order. 26461 from 3:00 AM through 7:00 AM, following the NJ EX Order. 26461. The former DON stated, "He wrote it in his statement that he checked."

Review of the facility's policy titled, NJ EX Order 26 Injury," reviewed October 2023, revealed, ". . . It is the policy of this facility to report potential head injuries to the physician and implement interventions to prevent further injury . . . Assess resident following a known, suspect, or verbalized NJNJ EX O injury. The assessment shall include . . . NJ EX Order. 26461 evaluation for changes in . . . NJ EX Order NJ EX Order. 26461 . . . "

3. Review of R57's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 26461

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Review of R57's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab, revealed the resident was admitted to the facility with diagnoses which included NJ EX Order. 264b1 On the diagnosis of NJ EX Order. 264b1 was added.

Review of R57's quarterly "Minimum Data Set (MDS)," with an ARD of , located in the resident's EMR under the "MDS" tab, revealed the facility assessed R57 to have a "BIMS" score of which indicated the resident was NJ EX Order. 264b1

During an interview on 01/04/24 at 9:40 AM, R57 stated back in , he started having NJ EX Order. 264b1." R57 stated requested an appointment with a because of the however, the facility did not take seriously. R57 also stated the was so bad, touched and the R57 stated he finally got an appointment with the who sent directly to the hospital had about pounds of from

Review of R57's "Physician Note," dated 0, located in the resident's EMR under the "Progress Notes" tab, revealed " ...Chief Complaints NJ EX Order. 264b1 yo [year old] ...pt [patient] evaluated today for monitoring of NJ EX Order. 264b1] ...pt completed [of ...PLAN heart failure seen on ct [.] fu [follow up] with [Name] not available until [.] will monitor pt currently on ...pt counseled on risk of

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F 600	Continued From page 36 NJ EX Order due to NJ EX Order. 264b1 ..." Review of R57's "Progress Note," dated NJ EX Order. 264b1 revealed "Pt complained of r [NJ EX Order. 264b1. MD [Medical Doctor] notified will be evaluated tomorrow." The nursing progress notes lacked assessment information related to R57's NJ EX Order. 2 NJ EX Order. 264b1 Review of R57's Physician/Practitioner "Progress Note," dated NJ EX Order. 264b1 revealed "Note Text: MEDICAL PROGRESS NOTE ...chief complaints ...NJ EX Order. 264b1 ...pt is resting, in bed, noted to have ongoing NJ EX Order. 264b NJ EX Order. 264b and NJN EX, pt being treated with increased dose of NJ EX Order. 264b1 ordered STAT ...Care plan reviewed with pt and nursing [.] vitals reviewed will cont. [continued] to monitor." The note was completed by Nurse Practitioner (NP) 1. NP1's note did not document the extent of the NJ EX Order. 2 or what signs or symptoms nursing was to monitor for the NJ EX Order. 264b1 .. Review R57's NJ EX Order. 264b1 Note," dated NJ EX OX Order. 26 , located in the resident's EMR under the "Progress Notes" tab, revealed "Procedure: ...Findings: There is moderate NJ EX Order. 264b1 There is NJ EX Order. 264b1 in the NJ EX Order. 264b1], NJ EX Order. 264b1 NJ EX Order. 264b1 Review of a nursing progress note, dated NJ EX Order. 26 , revealed "PT [patient] c/o NJ EX Order. 264b1 NJ EX Order. 264b g. NJ EX Order. 264b1 level NJ EX Order . Will continue to monitor." There was no documented evidence that the resident's physician was notified.	F 600		

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Review of R57's "Progress Note," dated [redacted] revealed "[redacted] area to [redacted] measuring about [redacted] applied and covered with [redacted] NP made aware follow up with [redacted] on [redacted] morning." There was no documented evidence of any intervention to address the [redacted] and [redacted] that caused the resident to sustain an [redacted].

Review of R57's "Progress Note," dated [redacted] revealed " ...Pt complained of [redacted] I sat resident up and placed [redacted] throughout the evening until replaced by [redacted]."

Review of the "Progress Notes," dated [redacted] through [redacted] and located in the EMR "Progress Notes" tab, revealed no documentation of monitoring for signs and symptoms of [redacted] for R57.

Review of R57's "Progress Note," dated [redacted] revealed "[resident name] left unit with medical transport [redacted] 1:30 for a [redacted]

Review of R57's "Progress Note," dated 1[redacted] revealed "Patient confirmed to have been sent from [redacted] appt w. [Dr. Name] to [hospital name] and admitted with Dx. [redacted] This was [redacted] days after R57 first complained of [redacted] and [redacted] days after an [redacted] with no consistent monitoring by nursing and no other treatment than an [redacted]

During an interview on 01/04/24 at 2:32 PM, LPN 6 was asked if she remembered back in [redacted] 2[redacted] when R57 had some [redacted] LPN6 started to cry and stated she remembered the resident

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had so much [redacted] she called and told NP1 that it looked like [redacted] was going to [redacted] all over [redacted]. LPN6 stated NP1 came into the facility, assessed the resident, and wanted to send the resident to the hospital for [redacted]; however, the prior Director of Nursing (PDON) told the NP no because of the facility's census numbers. LPN6 stated the NP increased the resident's [redacted] medication; however, it continued to worsen. LPN6 further stated [redacted] got so bad, the resident's NJ EX Order. 264b1 from so much [redacted] LPN6 with tears in her eyes stated she thought the resident was going to die.

During an interview on 01/05/24 at 10:33 AM, NP1 stated when she assessed R57, she recommended the resident to be sent out to the hospital; however, the facility wanted to treat the resident in house. NP1 stated she ordered a [redacted] and increased the resident's [redacted] however, the [redacted] was not able to be completed due to the resident's [redacted] and they had to find a place for [redacted] to be able to have the [redacted] completed which caused a delay in treatment. NP1 stated prior to sending out a resident to the hospital, the former DON would have to approve. NP1 stated she wanted to send R57 out to the emergency room because [redacted] was already on a NJ EX Order. 264b1 by mouth, so she wanted to send NJ EX Order. 264b1. NP1 stated R57 having [redacted] pounds of [redacted] off was a lot and it was concerning the DON not wanting the resident sent out. NP1 stated a possible negative outcome would have been NJ EX Order. 264b1

[redacted] at 11:11 AM, the prior Director of Nursing (PDON) stated she did not remember NP1 wanting to send R57 to the hospital due to [redacted] The PDON

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confirmed the facility's practice was that she would be notified prior to sending any resident to hospital; however, she stated she would not have requested the resident to be treated in the facility and not be sent out. When asked what her expectation was related to the monitoring of R57's [redacted] the PDON stated it meant to monitor and assess the resident; however, she did not expect the nurses to document the monitoring.

During an interview on 01/05/23 at 12:35 PM, the prior Administrator stated the facility's practice was for nurses and providers to notify the PDON prior to sending any residents out of the facility to the hospital. The prior Administrator stated the PDON and provider would have discussions about treating the residents in house by increasing their [redacted] first, redoing [redacted] stat, and other options. The prior Administrator also stated they [the facility] just wanted to do everything here at the facility that they could, but it was ultimately up to the provider.

During an interview on 01/04/24 at 12:50 PM, the Medical Director stated after the provider was notified on [redacted] about R57's [redacted] the provider should have started an intervention at that time. The Medical Director also stated if the provider stated they were going to be in the next day to evaluate the resident, then the provider should have come in. The Medical Director reviewed some of R57's medical record with the surveyor. The Medical Director further stated after the [redacted] results came back, the provider should have completed a follow up with the resident, reassessed the resident, monitored the resident, and ensured the nursing staff was monitoring the resident including daily weights. The Medical

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F 600	Continued From page 40 Director further stated, the provider should not have waited until the resident's NJ EX Order. 264b1 appointment on NJ EX Order. 264b1 for the resident to receive treatment for the NJ EX Order. 264b1. Continued interview revealed the Medical Director stated R57 could have gone into NJ EX Order. 264b1 NJ EX Order. 264b1 Review of the facility's policy titled, "Abuse, Neglect and Exploitation," revised July 2023, revealed, ". . . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . . . Written procedures for investigations include . . . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . . . Reporting of all alleged violations to the . . . state agency, adult protective services and to all other required agencies . . . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . . ." NJAC 8:39- 4.1 (a) 5 NJAC 8:39-5.1 (a) NJAC 8:39-27.1 (a)	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 602		3/11/24

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F 602	Continued From page 41 treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Complaint: NJ000168256 Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents' property was safeguarded from misappropriation for one of two residents (Resident (R) 30) reviewed for misappropriation of property out of a total sample of 65 residents. R30 returned to the facility to retrieve her personal belongings after she was emergently transferred to an acute care hospital; however, the facility could not locate the resident's belongings. Findings include: Review of R30's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [redacted] and discharged to an acute care hospital on [redacted]. Review of R30's nursing "Progress Note," dated [redacted] and located in the resident's electronic medical record (EMR) under "Progress Notes" tab, revealed "eMAR-Administration Note ...Note Text: sent to ER [emergency room] for eval [evaluation]." Review of the EMR revealed no documentation after R30 was discharged to an acute care hospital on [redacted]. During an interview on 01/05/24 at 1:58 PM, R30 stated she was emergently transferred to the hospital on [redacted]. The resident stated on [redacted], [redacted] went to the facility to retrieve [redacted] belongings from the facility while [redacted] was in the hospital; however, [redacted] was unable to locate	F 602	F 602 Free from Misappropriation/Exploitation 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 30 no longer resides in the facility. Facility reported concerns brought to the attention of Administrator to the NJ Department of Health, an investigation was conducted, and misappropriation was not suspected. Resident has been reimbursed for missing items. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Social Services or designee in-serviced all staff on the facility s Resident Personal Belongings policy, misappropriation, storage, and process for resident property inventorying. The Director of Social Services or designee will conduct random resident belongings audits to ensure resident property is not missing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Social Services or designee will conduct 10 random resident	

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F 602	Continued From page 42 NJ EX belongings. Continued interview revealed R30's son spoke with the Director of Patient Relations (DPR) who told NJ EX Order 264 she would look for the items and would be in contact with R30. R30 stated the DPR contacted NJ EX D on NJ EX Order 264b1 and told NJ EX she needed more time to locate the resident's personal belongs. R30 also stated NJ EX D went to the facility "a couple weeks ago" to see if NJ EX D could find her items; however, the DPR told NJ EX Order 264 would have to get a key from the facility's custodian and look for NJ EX belongings in a closet at the facility. The resident also stated NJ EX D spoke with the facility's new Administrator who told NJ EX D she would look into NJ EX missing belongings and would give NJ EX D a call back; however, the resident stated NJ EX had not heard back from the Administrator. The resident stated the following items were missing: NJ EX Order. 264b1 [redacted] and a NJ EX Order. 264b1 . During an interview on 01/05/23 at 12:35 PM, the Prior Administrator stated he did not remember R30 and had no knowledge of R30's missing belongings. The Prior Administrator stated the facility did not inventory residents' belongings. During an interview on 01/05/24 at 2:42 PM, the DPR stated after the resident was discharged to the hospital, the resident's NJ EX D came to the facility to pick up the resident's belongings. The DPR stated the resident's belongings had already been sent to the storage closet and she did not have a key to the storage closet, and she told the resident's son she would look for the belongings and would call the resident. Continued interview with the DPR revealed she looked everywhere for	F 602	belongings audits to ensure the facility has them inventoried and to ensure resident property is not missing. The random audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: March 11, 2024	

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the resident's belongings but was unable to locate them. The DPR stated she reported the resident's missing belongings to the former Administrator as possible misappropriation.

During an interview on 01/09/24 at 11:23 AM, the Administrator stated she became aware of R30's missing property back in [redacted] when the resident came to the facility to check on the status of the missing items. The Administrator stated she could not find any documentation regarding the resident's complaint regarding [redacted] missing belongings. Continued interview revealed she asked the DPR about the resident's belongings being missing, the DPR verified the resident's belongings were missing and that she, the DPR, had reported this to the former Administrator. The Administrator stated she requested R30 to make a list of the missing items and the resident did; however, the resident did not list a monetary amount. The Administrator also stated she had been trying to get in contact with R30 so she can get an amount and get her a check dispersed. The Administrator further stated she had requested this to be approved by the corporation; however, it was a verbal request and there was no type of documented evidence this had occurred. When asked if this had ever been reported to the state survey agency (SSA) when she became aware of the missing items back in [redacted], the Administrator stated it had just been reported today (01/09/24).

Review of the facility's policy titled, "Abuse, Neglect and Exploitation," revised 07/2023, revealed "Policy: It is the policy of this facility to provide protections for health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and

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F 602	Continued From page 44 prevent ...misappropriation of resident property. Definitions: ...'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent ...Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent ...misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations ..." NJAC 8:39-4.1 (a) 15.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		3/11/24

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F 609	Continued From page 45 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to report an allegation of abuse to the required agencies within two hours for one resident (Resident (R) 38) and failed to report timely an allegation of misappropriation of resident property for one resident (R30) out of a total sample of 65 residents. The failure presented a potential for continued abuse and misappropriation of property for R38 and R30, respectively. Findings include: 1. Review of R38's "Admission Record," provided by the facility, revealed R38 was admitted to the facility on [redacted] with diagnoses that included [redacted] aftercare following [redacted] on the [redacted]. Review of R38's "Physician Orders," dated [redacted] and located under the "Orders" tab of the electronic medical record (EMR), revealed staff was to change R38's [redacted] and [redacted] on the 11-7 shift. Review of R38's admission "Minimum Data Set (MDS),"located under the "MDS" tab of the EMR and with an assessment reference date (ARD) of [redacted], revealed R38 scored [redacted] on the "Brief Interview for Mental Status	F 609	F 609 Reporting of Alleged Violations 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 30 and R 38 no longer reside in the facility. R 38 s allegation was reported to the New Jersey Department of Health on [redacted] at 7:07pm, investigation was conducted, and no evidence of abuse was identified. R 38 s assigned Registered Nurse assessed [redacted] site on the morning of [redacted] There was no [redacted] on R 38 s [redacted]. An additional Registered Nurse assessed R 38 s [redacted] on [redacted] at approximately 9am. There was no [redacted] on the [redacted]. The Director of Nursing assessed R 38 [redacted] on [redacted] and there was no [redacted] on the [redacted]. R 38 has an order to monitor [redacted] every shift. An additional order was placed for the nurses to monitor [redacted] every four hours. R 38 no longer resides in the facility. R 30 no longer resides in the facility. Facility reported concerns brought to the attention of Administrator to the NJ Department of Health, an investigation was conducted, and misappropriation was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315521	A. BUILDING _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 46 (BIMS),"which indicated R14 was NJ EX Order. 264b1 NJ EX Order. On 01/04/24 at 6:00 PM, R38's family member (F) 6 reported that on the morning of NJ EX Order. 264b1, F7 had started to change R38's NJ EX Order. 264b1, and when F7 removed the NJ EX Or, F7 found NJ EX Order. 2 NJ EX Order. 264b1 inside of R38's NJ EX Order. 2 F6 showed the surveyor a photo of what appeared to be a NJ EX Order. with a NJ EX Order. 264b1 substance inside the NJ EX Order. 2 The substance appeared to completely NJ EX Order. 264b1 of the NJ EX Order. 2 F6 reported that the Director of Patient Relations and two nurses had been informed of the incident. F6 stated NJ EX Or believed the photo had been forwarded to staff members. On 01/04/24 at 6:25 PM, the Administrator and Director of Nursing (DON) were asked if they were aware of the alleged incident. The Administrator stated she had been informed on NJ EX Order. 264b1, and she had opened a grievance regarding the allegation. The Administrator confirmed a state reportable incident report had not been sent to the state survey agency. The Administrator stated she had seen the photo but had not enlarged it for closer inspection. The DON stated she had not seen the photo. The Administrator confirmed she had not identified the allegation as an allegation of abuse. Cross Reference: F600 Free from Abuse and Neglect. 2. Review of R30's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 264b1 and discharged to an acute care hospital on NJ EX Order. 264b1. Review of R30's nursing "Progress Note," dated NJ EX Order. 264b1 and located in the EMR under "Progress Notes" tab, revealed "eMAR-Administration Note	F 609	not suspected. Resident has been reimbursed for missing items. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Regional Director of Clinical Services in-serviced the Nursing Home Administrator on compliance with reporting allegations of abuse/neglect/exploitation, and misappropriation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Regional Director of Operations or designee will conduct a random audit of 10 residents. The residents will be interviewed to ensure that any allegations are identified, properly investigated and reported to the appropriate agencies. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Regional Director of Clinical Services will review all allegations for compliance with reporting. This will continue weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance	

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F 609	Continued From page 47 ...Note Text: sent to ER [emergency room] for eval [evaluation]." Review of the resident's EMR revealed no documentation after R30 was discharged to the acute care hospital on [redacted] During an interview on 01/05/24 at 1:58 PM, R30 stated she was emergently transferred to the hospital on [redacted] The resident stated on NJ EX Order. 264b1 went to the facility to retrieve [redacted] belongings from the facility while [redacted] was in the hospital; however, [redacted] was unable to locate her belongings. During an interview on 01/05/23 at 12:35 PM, the Prior Administrator stated he did not remember R30 and had no knowledge of R30's missing belongings. During an interview on 01/05/24 at 2:42 PM, the Director of Patient Relations (DPR) stated she reported the resident's missing belongings to the former Administrator as possible misappropriation. During an interview on 01/09/24 at 11:23 AM, the Administrator stated she became aware of R30's missing property back in [redacted] when the resident came to the facility to check on the status of the missing items. When asked if the missing property had been reported to the state survey agency (SSA) after she became aware in [redacted]r, the Administrator stated it had just been reported today (01/09/24). Cross Reference: F602 Free from Misappropriation/exploitation. Review of the facility's policy titled, "Abuse,	F 609	is determined to be sustained. 5. Date of Compliance: March 11, 2024	

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F 609	Continued From page 48 Neglect and Exploitation," revised July 2023, revealed, ". . . Reporting of all alleged violations to the . . . state agency, adult protective services and to all other required agencies . . . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . . . misappropriation of resident property. Definitions: ...'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent ...Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: ...2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations suspected abuse, neglect, or exploitation to the state survey agency ...Identification of Abuse, Neglect, and Exploitation ...B. Possible indicators of abuse include, but are not limited to: ...4. Resident reports of theft of property, or missing property ...Reporting/Response ...A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency ...within specified timeframes ...B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received ..."	F 609		
F 610 SS=D	NJAC 8:39-9.4 (f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		2/23/24

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F 610	Continued From page 49 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to thoroughly investigate an allegation of abuse for one resident (Resident (R) 38) and an allegation of misappropriation of property for one resident (R30) out of a total sample of 65 residents. These failures increased the potential for additional allegations of abuse to go uninvestigated in a timely manner. Findings include: Review of R38's "Admission Record," provided by the facility, revealed R38 was admitted to the facility on [redacted] with diagnoses that included [redacted] following [redacted] on the [redacted]. Review of R38's "Physician Orders," dated [redacted] and located under the "Orders" tab of the electronic medical record (EMR), revealed orders to change R38's [redacted] and [redacted] daily on the 11-7 shift.	F 610	F 610 Investigate/Prevent/Correct Alleged Violation 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 30 and R 38 no longer reside in the facility. R 38's allegation was reported to the New Jersey Department of Health on [redacted] at 7:07pm, investigation was conducted, and no evidence of abuse was identified. R 38's assigned Registered Nurse assessed [redacted] site on the morning of [redacted]. There was no paste on R 38's [redacted]. An additional Registered Nurse assessed R 38's [redacted] on [redacted] at approximately 9am. There was no [redacted] on the [redacted]a. The Director of Nursing assessed R 38's [redacted] on [redacted] and there was no paste on the [redacted] R 38 has an order to	

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F 610	Continued From page 50 Review of R38's admission "Minimum Data Set (MDS),"located under the "MDS" tab of the EMR and with an assessment reference date (ARD) of [redacted] revealed R38 scored 14 out of 15 on the "Brief Interview for Mental Status (BIMS),"which indicated R14 was [redacted] On 01/04/24 at 6:00 PM, R38's family member (F) 6 stated that on the morning of [redacted], F7 had started to change R38's [redacted], and when F7 removed the [redacted] F7 found s[redacted] inside of R38's [redacted] F6 showed the surveyor a photo of what appeared to be a [redacted] with a [redacted] the [redacted] F6 stated that the Director of Patient Relations and two nurses had been informed of the incident. F6 stated she believed the photo had been forwarded to staff members. On 01/04/24 at 6:25 PM, the Administrator and Director of Nursing (DON) were asked if they were aware of the [redacted] had been informed on 01/03/24, and she had opened a grievance regarding the allegation. The Administrator stated she had seen the photo but had not enlarged it for closer inspection. The DON stated she had not seen the photo. The Administrator reported she had identified two staff members, Registered Nurse (RN) 4 and RN2, as working with R38 on the 11-7 shift from 11:00 PM on 01/01/24 through 7:00 AM on [redacted]. The Administrator stated RN2 had been suspended because she would not return their call and that RN4 was coming to provide a statement before his shift on [redacted] The Administrator did not identify any nurse aides that had worked with R38 on the shift in question.	F 610	monitor [redacted] site every shift. An additional order was placed for the nurses to monitor [redacted] every [redacted] hours. R 38 no longer resides in the facility. R 30 no longer resides in the facility. Facility reported concerns brought to the attention of Administrator to the NJ Department of Health, an investigation was conducted, and misappropriation was not suspected. Resident has been reimbursed for missing items. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Nursing Home Administrator was in-serviced by the Regional Director of Clinical Services on reporting and investigational requirements for allegations of abuse/neglect/misappropriation on 1/6/2024. The Nursing Home Administrator or designee in-serviced all staff on initiating investigations for allegations of abuse/neglect/misappropriation and conducting thorough investigations. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Regional Director of Clinical Services will audit allegations to ensure they were thoroughly investigated. The auditing will be conducted weekly x 4 weeks, then	

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F 610	Continued From page 51 The Administrator confirmed she had not started an investigation of the alleged incident. On 01/04/24 at 6:58 PM, the Administrator provided documentation concerning the allegation. Included in the documentation was a "Grievance/Concern Form," where it was recorded, ". . . NJ EX Order 2 [sic] [F1] stated that that [sic] whomever on the 11-7 shift did not change NJ EX Order. 264b1 y properly . . ."It was documented that the Director of Public Relations filled out the form. There was no documentation of the allegation that NJ EX Order. 264b1 was found in R38's NJ EX Order. 264 On 01/05/24 at 7:53 AM, the Administrator provided documentation of her investigation of the alleged incident with R38. The documentation included an untitled document, dated NJ EX Order. 264b1 that recorded, ". . . The resident was interviewed by the DON and he stated that there was NJ EX Order NJ EX Order on NJ EX Order. 264b1 . ."The investigation documentation included a statement from RN4 where it was noted RN4 did not provide care for R38 on NJ EX Order2, a statement from Licensed Practical Nurse Supervisor (LPNS), and a statement from Licensed Practical Nurse (LPN) 5. It was recorded LPN5 was asked what care he provided to R38 on NJ EX Order. 264b1 It was recorded LPN5 stated he did not change the NJ EX Order. 264b1 and did not note any concerns with the NJ EX Order. 264 NJ EX Ord There was no documentation LPN5 was asked any questions specific to the allegation of NJ EX Order. 264b1 being inside R38's NJ EX Order 1. On 01/05/25 at 2:00 PM, F7, who was the family member that allegedly found the NJ EX Order. 264b1 in R38's NJ EX Order. 1 reported that on NJ EX Order. 264b1 when he arrived at the facility, R38's NJ EX Order. 264b1	F 610	every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 610	Continued From page 52	F 610		

was clean. F7 stated [redacted] found that unusual and began to change R38's [redacted]. F7 stated when [redacted] removed the [redacted], [redacted] found what looked to be NJ EX Order. 264b1 inside the [redacted]. F7 stated, "It looked like someone squirted it [redacted] in there."F7 reported he inserted a [redacted] into the NJ EX Order. 264b1 to [redacted] and pulled out approximately [redacted] and a NJ EX Order. 264b1. F7 reported he began to clean around the [redacted] and the pressure caused [redacted] additional NJ EX Order. 264b1 to come from the [redacted]. F7 reported that after the last piece of [redacted] came out, NJ EX Order. 264b1 began coming out.

On 01/06/24 at 10:00 AM, the surveyor observed [redacted] supplies, including two tubes of "[redacted]" NJ EX Order. 264b1, were noted on R38's bedside table. The NJ EX Order. 264b1 was noted to be [redacted].

On 01/06/24 at 11:35 AM, the Administrator provided an update to her investigation of the alleged incident with R38. Included in the documentation was a document dated [redacted] which recorded Certified Nurse Aide (CNA) 4 had been assigned to R38 on [redacted]. There was no documentation of an interview with CNA4 included in the documents provided to the surveyor. The Administrator provided documentation of interviews with three other residents where the residents were asked "How would you describe your overall care" and "Do you have any concerns at all that you want to express." There was no documentation the residents were asked questions specific to abuse. There was no documentation that a statement had been obtained from F6 or F7. The Administrator stated the investigation was

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ongoing and confirmed the incident did occur. The Administrator was asked if all the aides assigned to R38 on that shift had been interviewed. She stated, "No." No further documentation was provided to the surveyor by the end of the survey on [redacted] at 12:30 PM. Cross Reference: F600 Free from Abuse and Neglect.

2. Review of R30's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [redacted] and discharged to an acute care hospital on [redacted].

Review of R30's nursing "Progress Note," dated [redacted] and located in the EMR under "Progress Notes" tab, revealed "eMAR-Administration Note ...Note Text: sent to ER [emergency room] for eval [evaluation]."

Review of the resident's EMR revealed no documentation after R30 was discharged to the acute care hospital on [redacted]

During an interview on 01/05/24 at 1:58 PM, R30 stated she was emergently transferred to the hospital on [redacted] The resident stated on NJ EX Order: 264b1 went to the facility to retrieve [redacted] belongings from the facility while [redacted] was in the hospital; however, [redacted] was unable to locate [redacted] belongings.

During an interview on 01/05/23 at 12:35 PM, the Prior Administrator stated he did not remember R30 and had no knowledge of R30's missing belongings.

During an interview on 01/05/24 at 2:42 PM, the Director of Patient Relations (DPR) stated she reported the resident's missing belongings to the

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F 610	Continued From page 54 former Administrator as possible misappropriation. During an interview on 01/09/24 at 11:23 AM, the Administrator stated she became aware of R30's missing property back in December when the resident came to the facility to check on the status of the missing items. When asked if this had been investigated after she became aware of the missing items back in [redacted]r, the Administrator stated she could not produce any documented evidence it had been investigated. Cross Reference: F602 Free from Misappropriation/exploitation. Review of the facility's policy titled, "Abuse, Neglect and Exploitation," revised July 2023, revealed, ". . . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . . . Written procedures for investigations include . . . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . . ." NJAC 8:39-4.1 (a) 5	F 610		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		2/23/24

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F 684	Continued From page 55 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint: NJ00157215, NJ00157739, NJ00157827, NJ00158677, NJ00161186, NJ00161524, NJ00162977, NJ00167295, NJ00168545 Based on interview and record review, the facility failed to 1. implement physician orders for post-surgical care when staff did not obtain a [redacted], provide [redacted] changes twice daily, and ensure the [redacted] was kept lower than [redacted] degrees for one of one resident (Resident (R) 8) reviewed for [redacted] care; 2. consistently administer [redacted] care as ordered by the physician for resident (R5); and 3. [redacted] and provide oral nutrition supplements as ordered for resident (R16) out of a total sample of 65 residents. These failures caused harm when R8's [redacted] and an additional [redacted] was required for [redacted] Findings include: 1. Review of R8's hospital records, dated [redacted] and located under the "Misc (Miscellaneous)" tab of the electronic medication record (EMR), revealed R8 had a [redacted] that required [redacted] intervention consisting of [redacted]. Review of R8's "Admission Record," provided by the facility, revealed R8 was admitted to the facility on [redacted] with diagnoses that included	F 684	F 684 Quality of Care 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R8, R5, and R16 no longer reside at the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing or designee in-serviced all nursing staff on implementing physician orders, following physician orders, and documenting on the medication, treatment administration records, and reconciliation of hospital medications/order/recommendations. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing or designee will audit 10 resident records to include 2 new admissions, to ensure physician orders are implemented and physician orders are signed on the medication and treatment administration records. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the	

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F 684	Continued From page 56 encounter for NJ EX Order. 264b1 aftercare following NJ EX Order. 264b1 and NJ EX Order. 264b1. Review of R8's hospital discharge orders, dated NJ EX Order. 264b1 and provided by the facility, revealed orders for medications and " ...Continue local NJ EX Order. 264b1 and NJ EX Order. 264b1 per NJ EX Order. 264b1] ..." There were no orders from the NJ EX Order. 264b1 attached to or included in the discharge orders. Review of R8's "Physician's Orders," dated NJ EX Order. 264b1 revealed an order to cleanse R8's NJ EX Order. 264b1 with soap and water and cover with a NJ EX Order. 264b1 daily and to maintain NJ EX Order. 264b1 NJ EX Order. 264b1 degrees elevation. There were no orders related to a specialty bed. Review of R8's "Care Plan," provided by the facility and dated NJ EX Order. 264b1, revealed a focus problem related to the risk NJ EX Order. 264b1 related to NJ EX Order. 264b1 and a history of NJ EX Order. 264b1. Interventions included the use of a NJ EX Order. 264b1. Another focus problem was recorded as NJ EX Order. 264b1 related to a recent NJ EX Order. 264b1. Interventions included the use of a NJ EX NJ EX Order. 264b1 which is a type of specialty bed. Review of R8's "Admission Summary," dated NJ EX Order. 264b1 at 9:32 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . Resident is NJ EX Order. 264b1 but able to move NJ EX [NJ EX Order. 264b1 but claims unable to NJ EX Order. 264b1 NJ EX Order. 264b1 Per hospital report, resident maintained to be on bed rest and maintain on NJ EX degrees NJ EX Order. 264b1 elevation . . ." Review of R8's "Nurses Notes," dated NJ EX Order. 264b1 at 3:26 PM and located under the "Progress Notes"	F 684	audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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tab of the EMR, revealed, ". . . patient has a [redacted] at the [redacted] patient [redacted] is [redacted] well. No signs of infection . . ."

Review of R8's "Progress Notes" and "Assessments" tabs of the EMR revealed no further documentation in regard to the sacral flap incision until [redacted] at 8:47 AM.

Review of R8's "Weekly [redacted] Evaluation," dated [redacted] at 8:47 AM and located under the "Assessments" tab of the EMR, revealed ". . . [redacted] removed. On OR [operating] schedule to [redacted] . . . PATIENT SHOULD BE ON [redacted], CURRENTLY ON [redacted], NURSING AWARE to [redacted] . . ." The form was electronically signed by the Assistant Director of Nursing (ADON) on [redacted]

Review of R8's "Physician Note," dated [redacted] at 9:23 AM and located under the "Progress Notes" tab of the EMR, revealed, ". . . [redacted] . . . pt notes frustration over his [redacted] pt states now he must go back on [redacted] to have [redacted] redone. . . [redacted] ordered . . ."

Review of R8's admission "Minimum Data Set (MDS)," located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of [redacted] revealed R8 scored a [redacted] 15 on the "Brief Interview for Mental Status (BIMS)," which indicated R8 was [redacted]. It was recorded R8 required extensive assistance of two or more people for bed mobility and had a [redacted].

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Review of R8's "Nurses Notes," dated [redacted] at 12:35 PM and located under the "Progress Notes" tab of the EMR, revealed R8 returned to the facility following a [redacted] procedure. It was recorded to NJ EX Order. 264b1 on R8.

Review of R8's "Physician Orders," dated [redacted] and located under the "Orders" tab of the EMR, revealed an order for a NJ EX Order. 264b1 NJ EX Order. 264b1 bed f NJ EX Order. 264b1 NJ EX Order. 264b1 and NJ EX Order. 264b1 air which provides a NJ EX Order. 264b1) bed.

On 01/04/24 at 10:39 AM, a call was placed to R8. R8 declined to be interviewed.

During an interview on 01/05/24 at 12:31 PM, R8's NJ EX Order. 264b1 stated R8 had a [redacted] NJ EX Order. 264b1 with NJ EX Order. 264b1 that had required [redacted] intervention for healing. The [redacted] n stated the intervention involved [redacted], and after the NJ EX Order. 264b1, R38 was sent to the facility for care. The [redacted] stated his specific discharge orders should have been included with the hospital discharge order, and additionally, he had instructed his office to send his orders to the facility prior to R8's arrival to ensure the facility received them and R8 received the proper care and equipment required. The [redacted] stated he had ordered a NJ EX Order. 264b1 " bed and for the NJ EX Order. 264b1 not to be [redacted] degrees. The surgeon stated he came to the facility and noted R8 was not on the correct bed. He stated the nurse on duty argued with him, stating the bed was correct, and he had to show her it was not correct. The [redacted] stated during his visit, he instructed the nurse to ensure the NJ EX Order. 264b1 was not elevated over [redacted]

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degrees. The surgeon stated that while he was in the room with R8, a staff member came into the room and elevated the head of the bed to [redacted] degrees. The surgeon stated he instructed the staff member to immediately [redacted] of the bed, but the staff member stated, "Well, he's got to eat." The surgeon stated during his visit, R8 was [redacted] side, and that is when he identified R8's [redacted] had been [redacted].

On 01/05/24 at 1:18 PM, the [redacted] provided a copy of a fax transmission, dated [redacted], that recorded, ". . . Attention: . . . [ADON's name] Admissions . . . Instructions for New Admission. Pt: [R8] . . . [redacted] [,] No [redacted] [,] [redacted] than [redacted] degrees [,] [redacted] patient [redacted]. Do not use [redacted] with multiple people. Do not [redacted] . . . Wash [redacted] q [every] 12 hours and [redacted] . . ." Attached was a "Transmission Verification Report," dated [redacted] at 3:10 PM, that detailed two pages had been successfully sent to a fax number of [redacted]. During an interview on 01/06/24 at 2:36 PM, the Administrator confirmed the facility's fax number was [redacted].

On 01/05/24 at 2:00 PM, the Administrator was asked to provide all clinical documentation for R8, including any hard chart documentation and hospital discharge orders.

During an interview on 01/06/24 at 3:58 PM, the Administrator reported she had electronically provided all clinical documentation for R8. The Administrator stated she had securely emailed everything in R8's clinical record to the surveyor. Review of the clinical documentation revealed no

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admission orders dated [redacted] from the [redacted] were included.

On 01/07/24 at 12:19 PM, the Administrator provided an email order request, dated [redacted] at 4:45 PM, which recorded, ". . . We need to order an NJ EX Order. 264b1 [redacted] for a new patient coming tonight - [R8] . . ." The response was, ". . . Just want to confirm you are ordering our standard NJ EX Order. 264b1 [redacted])? . . ." The next response was, ". . . Yes, that is correct . . ." confirming that the facility ordered the wrong type of specialty bed for R8.

During an interview on 01/07/24 at 10:10 AM, the ADON stated she had looked through the clinical record and did not find any orders or communication from the surgeon prior to R8's arrival at the facility. The ADON confirmed a '[redacted] was different from a [redacted] mattress and confirmed a [redacted]" bed was a NJ EX Order. 264b1 bed. The ADON confirmed she would expect staff to reach out to a physician for order clarification if there was something they did not understand and would expect staff to implement any orders received from the physician. The ADON confirmed the clinical record contained no information related to R8's suture "malfunction" and stated the expectation was for staff to document any incident occurring with the resident. The ADON confirmed the order for the [redacted] bed was dated [redacted] after R8 was readmitted to the facility after NJ EX Order. 264b1 of the [redacted] The ADON confirmed the care plan should not call for a NJ EX Order. 264b1. The ADON confirmed the faxed orders were for [redacted] changes to be completed twice daily, but the orders in the EMR were for once daily

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NJ EX Order. 264b1 changes. The ADON confirmed the NJ EX Order. 264b1 changes were only completed once daily. The ADON confirmed the orders were for R8's NJ EX Order. to be maintained at NJ EX degrees.

On 01/07/24 at 10:50 AM, the Administrator stated it was her expectation for faxes to either be put into the recipient's mailbox or to be delivered to the person the fax was addressed to. The Administrator stated it was her expectation for staff to follow physician's orders, reach out with any questions, and document as appropriate in the clinical record. The Administrator stated she would have expected documentation and physician notification if a resident's NJ EX Order. 264b1 NJ EX Order. 264b1 or NJ EX Order. 264b1.

On 01/08/24 at 2:28 PM, the NJ EX Order. 264b1 was asked if the failure to use the correct specialty bed, not NJ EX Order. 264b1 daily as ordered, and elevating R8's NJ EX Order. above NJ EX degrees caused the NJ EX Order. of R8's NJ EX Order. 264b1. The NJ EX Order. 264b1 stated, "Yes."

2. Review of R5's undated "Admission Record" located in R5's EMR, under the "Profile" tab, indicated R5 was admitted on NJ EX Order. 264b1 and discharged on NJ EX Order. 264b1 with diagnoses including displaced a NJ EX Order. 264b1 and NJ EX Order. 264b1.

Review of R5's admission "Minimum Data Set (MDS)," located in the EMR under "MDS" tab, with an Assessment Reference Date (ARD) of NJ EX Order. 264b1 revealed R5's "Brief interview of Mental Status (BIMS)" score was NJ EX Order. 264b1 indicating R5 was NJ EX Order. 264b1. R5 required limited assistance of one person for all functional capabilities.

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F 684	Continued From page 62 Review of R5's care plan, located in the EMR under the "Care Plan" tab, dated [redacted] (cancellation date), documented R5 had [redacted], instructing staff to administer [redacted] medication as ordered, and monitor lab results as ordered. There were no documented [redacted] care interventions. Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, "[redacted] Ointment [redacted], apply to NJ EX Order. 264b1 topically every dayshift for [redacted] care, [redacted] with NJ EX Order. 264b1] pat to dry, apply [redacted] then cover with [redacted] daily." The order was dated [redacted] through [redacted] Review of the "Treatment Administration Record (TAR)," located under the EMR "Orders" tab, for NJ EX Order. 264b1, revealed the above treatment order for the [redacted] was not documented as completed on the following dates: 08/12/22, 08/31/22, 09/01/22, 09/03/22, 09/14/22, 09/18/22, 09/19/22, 09/22/22, 09/24/22, 09/29/22, and 10/03/22. Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, "[redacted] Ointment [redacted], apply to NJ EX Order. 264b1 topically every [redacted] hours for [redacted] for [redacted] days." The order was dated [redacted] Review of the "TAR," located under the EMR "Orders" tab for [redacted] and [redacted] revealed the above treatment order for [redacted] had not been documented as completed on the following dates: 08/24/22, 08/26/22, 08/31/22, and 09/01/22.	F 684		

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F 684	Continued From page 63 Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, "[redacted] - apply to NJ EX Order. 264b1 topically every dayshift for NJ EX Order. 264b1 d for [redacted] days, NJ EX Order. 264b1 on NJ EX Order. 264b1 with [redacted] and NJ EX Order. 264b1 gauze (not dressing daily." The order was dated through [redacted]. Review of the "TAR," located under the EMR "Orders" tab for NJ EX Order. 264b1 and [redacted], revealed the above treatment order to the NJ EX Order. 264b1 was not documented as completed on the following dates: 08/31/22 and 09/01/22. Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, [redacted] Apply to NJ EX Order. 264b1 topically one time a day for [redacted] care. Apply to [redacted] topically every day for NJ EX Order. 264b1 [redacted]. Cleanse NJ EX Order. 264b1 [redacted]. Apply [redacted]," dated [redacted] through [redacted]. Review of the "TAR," located under the EMR "Orders" tab for NJ EX Order. 264b1 and [redacted] revealed the above treatment to the [redacted] t had not been documented as completed on the following dates: [redacted] and [redacted]. Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, "[redacted] NJ EX Order. 264b1 apply to [redacted] topically every shift for [redacted] for [redacted] days, NJ EX Order. 264b1 on [redacted]	F 684		

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with and " dated .

Review of the "TAR," located under the EMR "Orders" tab for , revealed the above treatment to the had not been documented as completed on 09/04/22.

Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, Ointment [. Apply topically every hours for for days with , apply and cover with for protection," dated through

Review of the "TAR," located under the EMR "Orders" tab for , revealed the above treatment to the left ear had not been documented as completed on the following dates: , and .

Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, " - apply to topically every day and evening shift for care daily on aspect with , leave dated through

Review of the "TAR," located under the EMR "Orders" tab for , revealed the above treatment to the had not been documented as completed on the following dates: and

During a telephone interview on 01/04/24 at

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12:30PM, R5 stated NJ EX Order. 264b1 care was not consistently done while in the facility and NJ EX Or NJ EX Order. 264b1 has had to assist.

During an interview on 01/05/24 at 4:30PM, the Assistant Director of Nursing (ADON) stated the blanks on R5's "TAR" either meant it was not completed, or not documented as completed.

3. Review of the undated "Admission Record" provided by the facility revealed R16 was admitted to the facility on NJ EX Order. 264b1 with diagnoses including NJ EX Order. 264b1 [redacted]. R16 was discharged on NJ EX Order. 264b1 closed record was reviewed.

Review of the admission "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ EX Order. 264b1 provided by the facility revealed R16's NJ EX Order. 264b1 with a "Brief Interview for Mental Status (BIMS)" score of NJ EX out of NJ EX. R16 was NJ EX Order. 264b1 and weighed NJ EX pounds.

a. Review of the "Order Summary Report" from 08/11/23 through 09/25/23, provided by the facility revealed R16 had an order for dated NJ EX Order. 264b1 for, "NJ EX Order. 264b1 with NJ EX ml [milliliters or one NJ EX Order. 264b1 every NJ hr [hours], every shift." The order remained in effect until R16 was discharged on NJ EX Order. 264b1

During an interview on 01/04/24 at 9:40 AM, R16 stated the nurses did not NJ EX Order. 264b1 every shift like they were supposed to and at times he

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went a couple of days without it being NJ EX Order. 264b1.

Review of the "Care Plan" with a cancellation date of NJ EX Order. 264b1 and provided by the facility revealed a focus area of, "I require a NJ EX Order. 264b1 r/t [related to] NJ EX Order. 264b1." Intervention in pertinent part included, "I require NJ EX Order. 264b1 and NJ EX Order. 264b1. See MD [medical doctor] orders for current t NJ EX Order. 26 orders." The "Care Plan" did not document a problem of R16 refusing care and treatment.

Review of the "Medication Administration Record (MAR)" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed two instances, on NJ EX Order. 264b1 day shift and on NJ EX Order. 264b1 day shift, when the NJ EX Order. 264b1 was not documented. There were blanks on the MAR on these shifts. Review of the nursing "Progress Notes" for NJ EX Order. 264b1 in the EMR under the "Progress Notes" tab revealed no entries related to these missed NJ EX Order. 264b1.

Review of the "Medication Administration Record (MAR)" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed 11 instances: 09/02/23 - NJ EX Order. 264b1 day shift; on NJ EX Order. 264b1 and NJ EX Order. 264b1 afternoon shift; and on NJ EX Order. 26 and NJ EX Order. 264 night shift, when the NJ EX Order. 264b1 was not documented. There were blanks on the MAR on these shifts. Review of the nursing "Progress Notes" for NJ EX Order. 264b1 in the EMR under the "Progress Notes" tab revealed no entries related to these missed NJ EX Order. 264b1.

During an interview on 01/06/24 at 3:31 PM, Registered Nurse (RN) 3 stated R16 was not always cooperative with nursing care. RN3 stated sometimes R16 reported to her he had NJ EX Order. 264 the NJ EX Order. 26 himself. RN3 stated there should be a

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F 684	Continued From page 67	F 684		

code entered into the MAR for the NJ EX Order. 264b1 and there should not be blanks on the MAR. RN3 stated there were codes nurses could enter for refusals, being out of the facility etc.

During an interview on 01/05/24 at 2:50 PM, the Prior Director of Nursing (DON), who continued to be employed by the company and was in place during R16's stay, stated she remembered R16 and talked with him a lot during his stay. The Prior DON stated she was not aware of concerns related to R16's [redacted] not getting [redacted]. The Prior DON stated if there were blanks on the MAR, she could not say that the [redacted] was [redacted] and if it were not documented, it would not count as being done.

During an interview on 01/08/23 at 12:02 PM, the DON stated it was important to flush the G-tube because sometimes it could back up and [redacted] kept the NJ EX Order. 264b1. The DON stated she could not say what a blank on the MAR meant, such as whether something was done or not done.

b. Review of a "Physician's Note" Late Entry for [redacted] in the EMR under the "Progress Notes" tab revealed, "Previously seen outpatient due to significant NJ EX Order. 264b1, and NJ EX Order. 264b1 t . . . NJ EX Order. 264b1 and [redacted] with a [redacted] months NJ EX Order. 264b1 . . . it was determined that PT [patient] had NJ EX Order. 264b1] at NJ EX Order. 264b1 . . ."

During an interview on 01/04/24 at 9:40 AM, R16 stated although [redacted] had a [redacted] during [redacted] stay at the facility [redacted] did not receive [redacted] via the NJ EX Order 264b1 and instead took NJ EX Order. 264b1. R16 stated [redacted] was supposed to get [redacted]

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(NJ EX Order. 264b1 l supplement) due to not being able to eat much related to NJ EX Order. 264b1 NJ EX Order. 264b1). R16 stated he subsisted on NJ EX Order. 264 and should have gotten it NJ EX Order. 264b1 a day. R16 stated NJ EX did not get NJ EX Order. 264 as often as he should have and some days did not get it at all even though he asked the nurses for it.

Review of "Orders" from NJ EX Order. 264b1 through NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed R16 had an order dated NJ EX Order. 264b1 for, NJ EX Order. 264b1 NJ EX Order. times a day for risk for NJ EX Order. 264b1 . . ." The order was discontinued on NJ EX Order. 264b1 when the resident was discharged.

Review of R16 "Care Plan" for ". . .risk for NJ EX Order. 264b1 . ." with a cancellation date of NJ EX Order. 264b1 , provided by the facility, lacked documentation of NJ EX Order. 264b1 or supplement use.

Review of the "Medication Administration Record (MAR)" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed 13 instances in which the NJ EX Order. 264 was not administered: on NJ EX Order. 264b1 at 9:00 AM; NJ EX Order. 264b1 at 1:00 PM; and on NJ EX Order. 264 at 5:00 PM. There were blanks on the MAR on these shifts. Review of the nursing "Progress Notes" for NJ EX Order. 264b1 in the EMR under the "Progress Notes" tab revealed no entries related to NJ EX Order. 264 on these dates/times.

During an interview on 01/06/24 at 3:31 PM, Registered Nurse (RN) 3 stated she remembered R16 having NJ EX Order. 26 in NJ EX room and that NJ EX drank when NJ EX wanted it. RN3 reviewed the Physician's Orders in the EMR and verified NJ EX Order. 264b1 was to be administered NJ EX Order. times a day and that

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F 684	Continued From page 69 there were numerous blanks on the MAR. She stated there were codes nurses could enter for refusals, being out of the facility etc. During an interview on 01/05/24 at 2:50 PM, the prior Director of Nursing (DON) stated she was not aware of concerns related to R16 not being administered [redacted]. The prior DON stated if there were blanks on the MAR, she could not say the [redacted] was administered and if it was not documented, it would not count as being done. During an interview on 01/07/24 at 11:16 AM, the Assistant DON (ADON) stated she did not remember an issue with R16 getting [redacted]. The ADON stated R16 should have gotten something else if the [redacted] was not available; however, [redacted] was typically available on the medication cart. The ADON stated if the facility was out of a supplement, the provider should be updated. Review of the "Admission Orders" policy dated [redacted] and provided by the facility revealed, "A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the residents' immediate care and needs. The licensed nurse will follow such orders." NJAC 8:39-27.1 (a)	F 684		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		2/23/24

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F 692	Continued From page 70 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Complaint: NJ00158720, NJ00159247, NJ00159405, NJ00161186 Based on interview, record review, and policy review, the facility failed to ensure three of 65 sampled residents (Residents (R)15, R3, and R4) reviewed for nutrition received nutritional care and services to maintain adequate parameters of nutritional status. R15 was not [NJ EX Order 2640] and a nutritional assessment was not completed; and for R15, R3, and R4 meal intake was not recorded or monitored. These failures placed residents at risk for undetected [NJ EX Order 2640] and [NJ EX Order 2640]. Findings include: Review of the "Nutritional Management" policy dated August 2023 revealed, "A systematic approach is used to optimize each resident's nutritional status: a. Identifying and assessing	F 692	F 692 Nutrition/Hydration Status Maintenance 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 15 and R 3 no longer reside at the facility. R 4 was evaluated by the dietitian. R 4□s most recent weight was obtained on [NJ EX Order 2] and was stable. R 4 has not experienced [NJ EX Order 2640] for the last six months. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into	

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F 692	Continued From page 71 each resident's nutritional status and risk factors, b. Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary . . . A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission . . ." Review of the "[redacted] Monitoring" policy dated February 2023 revealed, "b. Newly admitted residents - monitor [redacted] weekly for 4 weeks, c. Residents with [redacted] - monitor [redacted] weekly . . . Meal consumption information should be recorded and may be referenced by the interdisciplinary care team as needed." 1. Review of the undated "Admission Record" provided by the facility revealed R15 was originally admitted to the facility on [redacted] was hospitalized, and was then readmitted on [redacted]. R15's diagnoses included [redacted] R15 was hospitalized on [redacted] and did not return to the facility after this date; [redacted] closed record was reviewed. Review of the Prospective Payment System (PPS) "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed R15 was NJ EX Order. 264b1 in cognition with a "Brief Interview for Mental Status (BIMS)" score of [redacted]. R15 required set up assistance and supervision with meals. R15 was NJ EX Order. 264b1 no [redacted] was recorded. Review of "Order Summary Report" from	F 692	place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing or designee in-serviced to the dietitian and nursing staff on the facility□s resident [redacted] policy, nutritional assessment policy, and meal intake documentation policy. The Nursing Home Administrator or designee will conduct audits on the facility□s [redacted], nutritional assessments, and meal intake documentation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Nursing Home Administrator or designee will conduct audits on the facility□s [redacted] nutritional assessments, and meal intake documentation. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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NJ EX Order. 264b1 through NJ EX Order. 264b1, provided by the facility, revealed an order for NJ EX Order. 264b1 on Admission and Weekly x [for] 4 weeks." An order to obtain the resident's NJ EX Order. 264b1 on NJ EX Order. 264b1 was also documented.

Review of the NJ EX Order. 264b1 Summary" for NJ EX Order. 264b1 through NJ EX Order. 264b1 in the electronic medical record (EMR) under the "Vitals" tab revealed no NJ EX Order. 264b1 for R15 were obtained during NJ EX Order. 264b1 stay. R15's NJ EX Order. 264b1) measurement (measurement of the adequacy of NJ EX Order. 264b1 for NJ EX Order. 264b1 was blank and could not be calculated without a NJ EX Order. 264b1.

Review of the EMR revealed a full nutrition assessment had not been completed. A request was made for R15's nutritional assessment and all nutritional progress notes. A NJ EX Order. 264b1 Assessment was not provided. There was one nutrition progress note for R15. The Registered Dietitian's (RD) late entry "Initial NJ EX Order. 264b1 Review" dated NJ EX Order. 264b1 read in full, "Rt [resident] observed at breakfast meal - intake was good, preferences updated. NJ EX Order. 264b1 enjoys variety and cereal, and eggs are fine. NJ EX Order. 264b1 denies any difficulties with NJ EX Order. 264b1. Diet is appropriate at NJ EX Order. 264b1]. Have placed recommendation for NJ EX Order. 264b1 t for further assessment and interventions. Will continue to monitor for change, proceed to plan of care."

A request for R15's meal intake records was made on NJ EX Order. 264b1 and a second request was made on NJ EX Order. 264b1. The provided untitled document showing meal intake from NJ EX Order. 264b1 through NJ EX Order. 264b1 revealed a total of nine entries of meal intake during this period. R15's average intake from NJ EX Order. 264b1 (for the meals in

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which intake was recorded) was 1.8. According to the "POC [point of care] Legend Report" provided by the facility revealed meal intake coding of a 0 indicated 0-25% intake, coding of a 1 indicated 26-50% intake, coding of a 2 indicated 51-75% intake, and coding of a 3 indicated 76 - 100%. No meal intake records were provided for R15's admission from [redacted] through [redacted].

Review of the "Care Plan" with the admission date of [redacted] and provided by the facility revealed a focus area of, "I have a [redacted] Rt [Resident] with recent hospitalization. Rt with [redacted] and may have [redacted] [sic]." The goal was, "Rt will receive appropriate interventions during facility stay to promote optimal outcomes." Interventions in full were, "Diet as ordered. Monitor [redacted] and [redacted] as available."

Review of a "Physician's Note" dated [redacted] in the EMR under the "Orders" tab revealed, "Patient seen and examined this afternoon . . . [redacted] tested NJ EX Order. 264b1 on NJ EX Order. 264b1 after having NJ EX Order. 264b1 and [redacted] . . . [redacted] was transferred onto the [redacted] unit where [redacted] will finish out [redacted] . . . Lying in bed . . . Appetite is fair at best. . ."

Review of a "Physician's Note" dated [redacted] in the EMR under the "Orders" tab revealed, "Patient seen and examined this afternoon for f/u [follow up] [redacted]. Appears NJ EX Order. 264b1 [redacted] compared to last week visit . . [redacted] appetite has been [redacted] . . ."

During an interview on 01/04/24 at 10:45 AM, Family Member (F) 4 stated the staff did not check what R15 was eating and did not monitor

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NJ EX fluid or meal intake while NJ EX was on NJ EX Order: 26401 with NJ EX Order and experiencing a deterioration in condition. F4 stated R15 declined and was not eating or drinking independently. F4 stated NJ EX reported NJ EX concern to a Nurse Practitioner and the nurses on duty during the resident's NJ EX Order: 26401; however, nothing was done. F4 stated the staff removed R15's untouched meal trays from NJ EX room and did not offer NJ EX anything else, such as supplements. F4 stated R15 needed assistance to eat and did not receive it. F4 stated R15 had a history of NJ EX Order: 26401 and when R15 was admitted to the hospital on NJ EX Order: 26401, R15 was diagnosed with NJ EX Order: 26401.

During an interview on 01/06/24 at 2:44 PM, the RD stated a nutritional assessment had not been completed for R15. The RD stated she was waiting for a NJ EX Order: 26 to be obtained, but the resident was not NJ EX Order: 26401. The RD verified no NJ EX Order: 2 was obtained during R15's three week stay. The RD stated NJ EX Order: 2640 were to be obtained weekly for the first four weeks after residents were admitted. The RD stated the department heads reviewed NJ EX Order: 264 in the daily stand-up meetings and she notified nursing of which residents needed to be NJ EX Order: 26401. The RD verified there was no documentation in R15's record of a second request to obtain a NJ EX Order: 26 after her initial nutritional note on NJ EX Order: 26401. The RD stated nursing staff should document meal intake and she reviewed this information when assessing and monitoring a residents' nutritional status.

During an interview on 01/08/24 at 12:16 PM, the Director of Nursing (DON) stated she had been in her position for a NJ EX Order: 26401 and was not sure if documenting meal intake was required.

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The DON verified the policy required weekly [redacted] for the first four weeks. The DON stated either the certified nurse aides (CNAs) or the nurses could obtain the [redacted]. The DON stated the nurses were responsible for making sure [redacted] were obtained.

2. During an interview on 01/04/24 at 2:41PM, R3's Family Member (F) 9, stated R3 had not missed meals while on isolation.

Review of R3's undated "Admission Record" provided by the facility, indicated R3 was admitted to the facility on [redacted], with diagnoses including NJ EX Order. 264b1 and NJ EX Order. 264b1).

Review of R3's admission "MDS" with an ARD of [redacted] provided by the facility, revealed R3 was assessed as not exhibiting behaviors, including rejection of care. R3 required [redacted] of two people for all activities of daily living (ADL); except for eating, [redacted] was independent for this task.

Review of R3's "Order Summary Report" dated [redacted], provided by the facility, documented a diet order for a NJ EX Order. 264b1 consistency.

R3's intake for the months of NJ EX Order. 264b1, NJ EX Order. 264b1, and NJ EX Order. 264b1 were requested from the Administrator on [redacted]. Review of the untitled intake information provided by the facility revealed R3 did not have any intake documented on:
[redacted] for lunch and dinner;
[redacted] for dinner;
[redacted] for dinner;
[redacted] for dinner;

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NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for breakfast, lunch, and dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for breakfast, lunch, and dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for lunch and dinner;
NJ EX Order. 264b1 for lunch and dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for breakfast, lunch, and dinner;
and on NJ EX Order. 264b1 for lunch and dinner.

During an interview on 01/05/24 at 4:30PM, the Assistant DON (ADON) stated there was no way to tell if R3 had received meals during the undocumented entries. ADON stated it was the CNA's responsibility to document the meals, and if meals were refused refusals should be documented.

3. During an interview on 01/04/24 at 12:48 PM, R4's Family Member (F10) recalled R4 receiving food or assistance with NJ EX O food on multiple occasions.

Review of R4's undated "Admission Record" provided by the Facility, indicated R4 was admitted to the facility on NJ EX Order. 264b1 with diagnoses including NJ EX Order. 264b1

Review of R4's "Order Summary Report" provided by the facility, admission date NJ EX Order. 264b1, documented "NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1, NJ EX Order. 264b1 products." Diet order dated NJ EX Order. 264b1 "Regular NJ EX

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NJ EX Order. 264b1 diet."

Review of R4's quarterly "MDS," provided by the facility, with an ARD of [redacted], revealed R4's "BIMS" score was NJ EX Order. 264b1, indicating the resident was cognitively intact. R4 was assessed as not exhibiting any behaviors, such as [redacted]. Further review indicated R4 required the supervision or setup for eating.

Review of R4's "Care Plan," dated [redacted] and provided by the facility, documented, "Resident has NJ EX Order. 264b1 problem or potential NJ EX Order. 264b1 problem r/t [related to] NJ EX Order. 264b1 and NJ EX Order. has a h/o [history of] NJ EX Order. 264b1 d/t [due to] NJ EX Order. 264b1." Interventions included: "assist with meals PRN [as needed], diet as rx'd [prescribed], fluids-NJ EX Order. 264b1), monitor NJ EX Order. 264b1 notify physician with significant changes, Rt will not receive NJ EX Order. 264b1."

R4's intake for NJ EX Order. 264b1 and the last 30 days were requested from the Administrator on 01/05/24. Review of the untitled intake information provided by the facility revealed R3 did not have any intake documented on:
NJ EX Order. 264b1 for lunch and dinner;
NJ EX Order. 264b1 for lunch and dinner;
NJ EX Order. 264b1 for lunch and dinner;
NJ EX IX Order. 264 for lunch and dinner;
NJ EX Order. 264b1 for breakfast, lunch, and dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b1 for breakfast, lunch, and dinner;
NJ EX Order. 264b1 for lunch and dinner;
NJ EX Order. 264b1 for breakfast, lunch, and dinner;
NJ EX Order. 264b1 for dinner;
NJ EX Order. 264b for lunch and dinner;
NJ EX Order. 264b1 for lunch and dinner;
NJ EX Order. 264b1 for dinner;

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F 692	Continued From page 78 NJ EX Order. 264b1 for lunch and dinner; NJ EX Order. 264b1 for lunch and dinner; NJ EX Order. 264b1 for dinner; NJ EX/EX Order. 264b1 for lunch and dinner; NJ EX Order. 264b1 for dinner; NJ EX Order. 264b1 for dinner; NJ EX Order. 264b1 for breakfast, lunch, and dinner; and NJ EX Order. 264b1 for lunch and dinner. During an interview on 01/05/24 at 4:30PM, the ADON stated there was no way to tell if R4 had received meals during the undocumented entries. ADON stated it was the CNA's responsibility to document the meals, and if meals were refused refusals should be documented. NJAC 8:39-17.1 (c), 17.2 (c), (d)	F 692		
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: Complaint : NJ00167295 Based on interview, record review, and policy review, the facility failed to ensure one out of one sampled residents reviewed for NJ EX Order. 264b1 care and services (Resident (R)16) received consistent care and services as prescribed by the	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 16 no longer resides at the center.	2/23/24

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F 695	Continued From page 79 physician to address NJ EX Order. 264b1 and respiratory needs. Findings include: Review of the undated "Admission Record" provided by the facility revealed R16 was admitted to the facility on NJ EX Order. 264b1 with diagnoses including NJ EX Order. 264b1 status. R16 was discharged on NJ EX Order. 264b1; NJ EX closed record was reviewed. Review of the admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ EX Order. 264b1 provided by the facility, revealed R16's NJ EX Order. 264b1 was NJ EX Order. 264b1 with a "Brief Interview for Mental Status (BIMS)" score of NJ EX NJ EX Order. 264b1. Review of the "Care Plan" with a cancellation date of 09/25/23 and provided by the facility revealed a focus area of, "NJ EX Order. 264b1 r/t [related to] (sic)." The goal was, "I will have no s/sx [signs and symptoms] of infection through the review date." Interventions were, "Ensure that NJ EX Order. 264b1 are secured at all times. Monitor/document NJ EX Order. 264b1, NJ EX Order. 2 status, and NJ EX Order. 264b1 PRN [as needed]. NJ EX Order. out procedures: Keep extra NJ EX Order. 264b1 and NJ EX Order. 264b1 [used to insert NJ EX Order. 264b1 at bedside. If the NJ EX Order. is NJ EX Order. 264b1 NJ EX Order. 264b1 with a NJ EX Order. 264b1. If the NJ EX Order. cannot be NJ EX Order. 264b1 monitor/document for signs of NJ EX Order. 264b1. If able to NJ EX Order. 264b1, elevate NJ EX Order. 264b1 degrees and stay with resident. Obtain medical help immediately." Review of the "Order Summary Report" from NJ EX Order. 264b1 through NJ EX Order. 264b1, provided by the facility, revealed R16 had NJ EX Order. 264b1 (for NJ EX	F 695	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with a tracheostomy have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing or designee in-serviced licensed nursing staff on the center□s policy for NJ EX Order. 264b1 care and providing care as ordered by the physician. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing or designee will conduct audits on resident□s with NJ EX Order. 264b1 to ensure they receive consistent care and services as ordered by the physician. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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admission) NJ EX Order. 264b1) physician's orders for:
-'NJ EX Order. 264b1 : change weekly and prn [as needed] for soilage," ordered on NJ EX Order. 264b1
-'NJ EX Order. 264b1 every day and evening shift," ordered on NJ EX IEX Order. 26 .
-'NJ EX Order. 264b1 every shift," ordered on NJ EX Order. 264b1
-'NJ EX Order. 264b1 care every shift," ordered on NJ EX Order. 264b1 and discontinued on NJ EX Order. 264b1

R16's NJ EX Order. 264b1 related care was not provided as follows:
a. Review of the "Treatment Administration Record (TAR)" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed R16's NJ EX Order. 264b1 was not changed weekly in accordance with physician's orders. On NJ EX Order. 264b1 , R16's NJ EX Order. 264b1 was not changed; the "TAR" was blank and there was no entry in nursing progress notes with an explanation.

Review of the "TAR" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed R16's NJ EX Order. 264b1 was not changed on NJ EX Order. 264b1 The "TAR" was blank and there was no entry in nursing progress notes with an explanation.

b. Review of the "TAR" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed R16's NJ EX Order. NJ EX Order. 264b1 was not changed during the day and evening shifts in accordance with physician's orders. The "TAR" was blank and there were no entries in nursing progress notes with an explanation on NJ EX Order. 264b1 for day shift.

c. Review of the "TAR" for NJ EX Order. 264b1 in the EMR under the "Orders" tab revealed NJ EX Order. 264b1

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per shift and [redacted] per shift were not provided to R16 in accordance with physician's orders. The "TAR" was blank and there were no entries in nursing progress notes with an explanation on [redacted] day shift.

Review of the "TAR" for [redacted] in the EMR under the "Orders" tab revealed [redacted] care per shift was not provided to R16 with blanks on the "TAR" and no entries in nursing progress notes with an explanation on [redacted], and [redacted] for evening shift; and [redacted] and [redacted] on the night shift.

Review of the "TAR" for [redacted] in the EMR under the "Orders" tab revealed [redacted] per shift was not provided to R16 with blanks on the TAR and no entries in nursing progress notes with an explanation on [redacted] day shift and on [redacted] evening shift.

During an interview on 01/04/24 at 9:40 AM, R16 stated the nurses did not provide the care [redacted] was supposed to receive for [redacted] R16 stated [redacted] was supposed to be checked and changed [redacted] a day. R16 stated he did not receive [redacted] as often as [redacted] should have. R16 stated he had to clean [redacted] at times because it otherwise did not get done.

During an interview on 01/06/24 at 3:31 PM, Registered Nurse (RN) 3 stated R16 was not always cooperative with nursing care and after an incident on [redacted] she refused to work with R16. RN3 stated she was the day shift nurse responsible for R16's hall; she did not know who provided care after [redacted] to R16 on the days

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when she was scheduled. RN3 stated when R16 refused care from her or was out of the facility at an appointment, she documented on the MAR/TAR with the appropriate code. RN3 verified R16 provided some of [redacted] own t[redacted] care. RN3 stated there should not be blanks on the TAR.

During an interview on 01/05/24 at 2:50 PM, the prior Director of Nursing (DON), who continued to be employed by the company and was in place during R16's stay, stated she remembered R16 but not any concerns related to tracheostomy care and services. The Prior DON stated if there were blanks on the MAR/TAR, she could not say that the care was provided and if it were not documented, it would not count as being done.

During an interview on 01/07/24 at 11:04 AM, the Assistant Director of Nursing (ADON) stated it was important to change R16's [redacted] as ordered weekly to ensure maintenance and care of the [redacted]. The ADON stated it was important to change the [redacted] twice a day as ordered to ensure cleanliness and to make sure it was not [redacted]. The ADON stated trach care and [redacted] every shift was important because the [redacted] underneath could become soiled. The ADON stated if the [redacted] care was not documented, typically that meant it had not been done. She stated there should be a nursing note with an explanation if the care was not provided.

Review of the "[redacted] Care" policy dated 11/28/23 and provided by the facility revealed, "The facility will ensure that residents who need respiratory care, including [redacted] care and [redacted] is provided such care consistent with professional standards of

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F 695	Continued From page 83 practice, the comprehensive person-centered care plan and resident goals and preferences . . . NJ EX Order: 26461 care will be provided according to physician's orders . . . the facility in collaboration with the resident/resident's representative will develop a care plan that include appropriate interventions for NJ EX Order: 26461NJ care . . ." NJAC 8:39-27.1 (a)	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		2/23/24

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F 725	Continued From page 84 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaints: NJ00151851, NJ00153272, NJ00153799, NJ00156210, NJ00157166, NJ00157827, NJ00158123, NJ00158489, NJ00158720, NJ00158677, NJ00159247, NJ00159405, NJ00159679, NJ00159800, NJ00160123, NJ00161147, NJ00161524, NJ00162457, NJ00162827, NJ00162977, NJ00168603, NJ00169368 Based on observation, interview, record review, and policy review, the facility failed to ensure nursing department staffing was adequate in numbers and responsiveness to meet the needs of 17 out 65 sampled residents (Residents (R)59, R34, R35, R36, R14, R16, R18, R21, R20, R15, R62, R57, R42, R40, R44, R41, and R4). Staffing was inadequate to ensure residents' call lights were answered timely, residents were toileted timely, received medications timely, received meals timely, and were gotten up, dressed, and provided hygiene timely. This created the potential for residents' needs not to be met and for residents to decline and be neglected. Findings include: Review of the "Nursing Services and Sufficient Staff" policy dated November 2023 revealed, "It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment . . . The facility must ensure that licensed nurse have the specific	F 725	F 725 Sufficient Nursing Staff 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R59, R34, R35, R36, R16, R18, R21, R20, R15, R 57, and R42 no longer resident at the facility. R14, R62, R40, R44, R41, and R4 were interviewed by The Nursing Home Administrator. They were interviewed on whether call lights were answered timely, were they toileted timely, received their medications timely, received their meals timely, and were they gotten up, dressed, and provided hygiene timely. R14, R62, R40, R44, R41, and R4 said yes to the above interview questions and did not present any additional concerns. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Nursing Home Administrator or designee conducted in-servicing on call lights were answered timely, residents were toileted timely, received medications timely, received meals timely, and were gotten up, dressed, and provided hygiene timely. The Nursing Home Administrator or	

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F 725	Continued From page 85 competencies and sill sets necessary to care for resident's needs . . . Providing care includes but it not limited to, assessing, evaluating, planning, and implementing resident care plans and responding to resident needs . . . The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll Based Journal (PBJ) system." Review of the "Facility Assessment" last reviewed in December 2023 and provided by the facility revealed, the average census was 105 residents and the average range for nurses was; -Director of Nursing (DON) full time on days -Assistant DON (ADON)/Infection Preventionist (IP) full time on days -2 Unit Managers -one 3:00 PM - 11:00 PM Registered Nurse (RN) Supervisor -one 11:00 PM - 7:00 AM Supervisor -two RN Supervisor weekends -48 minutes RN coverage per resident per day (84 hours a day for 105 residents -76 minutes LPN coverage per resident per day (133 hours a day for 105 residents) The average range for Certified Nurse Aides (CNAs) and state of New Jersey requirement was: -1:8 Residents days -1:10 Residents evenings -1:14 Nights 1. During observations throughout the facility on 01/03/24 starting at 6:30 AM. Observations of CNA staffing for night shift showed there were two CNAs assigned and working on the [redacted] hall and two CNAs on the [redacted] hall. This was confirmed by CNA4 who read the staffing	F 725	designee will conduct audits on timely call light response, toileting timely, receiving medications timely, receiving meals timely, and timely assistance with dressing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Nursing Home Administrator or Director of Nursing will conduct audits on 10 residents for timely call light response, toileting timely, receiving medications timely, receiving meals timely, and timely assistance with dressing and hygiene weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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assignment sheet to the surveyor at 6:44 AM. The census for 01/03/24 was 113 residents.

Review of the "Assignment Sheets" for the 11:00 PM - 7:00 AM shift on 01/02/24 provided by the facility revealed there were two CNAs for the [redacted] unit, two CNAs for the [redacted] unit, and one CNA float to go between the [redacted] units for a total of three CNAs for 113 residents. This was a ratio of 1 CNA for 37 residents, more than double the desired ratio per the "Facility Assessment" of 1 CNA for 14 residents.

a.Review of R59's undated "Admission Record" provided by the facility, indicated R59 was admitted to the facility on [redacted], with diagnoses includin [redacted], and [redacted].

Review of R59's admission "Minimum Data Set" (MDS) located in the EMR under the MDS tab, with an "Assessment Reference Date" (ARD) of [redacted], revealed R5's "Brief Interview of Mental Status" (BIMS) score was [redacted] indicating R59 was [redacted].

During the initial tour of the facility on 01/03/24 at 6:00AM, observations were conducted of four hallways on the two nursing units, by four of the five surveyors. During the observations conducted, the call light monitor located on the [redacted]-nursing unit indicated the call light for R59's room had been sounding for 160 minutes. During an interview at this time, R59 stated the call light had been sounding for almost four hours. The bell was ringing both at the room and at the nurse's stations on the [redacted] hallways. Staff were observed responding to the call bell at 7:15 AM.

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The call bell was audible at both nursing stations as well as on both hallways that made up the [redacted] unit. Staff members were observed standing around the nursing station as the bell rang. The call bell system report confirmed the time the call bell was initiated, which was noted to be before 6:10 AM. Continued observation of R59's call light was conducted from 6:00 AM to 7:12 AM, when the Licensed Practical Nurse Supervisor (LPNS) entered R59's room to check on the resident. When asked where the certified nurse aide (CNA) responsible for R59's room was, LPNS stated the CNA must have gone home. LPNS confirmed the call light observation, and stated the CNA should have answered it.

b. Review of R34's "Diagnoses," located under the "Diagnoses" tab of the electronic medical record (EMR), revealed R34 was admitted to the facility on [redacted] with diagnoses that included [redacted].

Review of R34's admission "Minimum Data Set (MDS),"located under the "MDS" tab of the EMR and with an Assessment Reference Date (ARD) of [redacted], revealed R34 scored [redacted] on the "Brief Interview for Mental Status (BIMS),"which indicated R34 was cognitively intact.

During an interview on 01/03/24 at 7:15 AM, R34 stated staff did not respond to call lights in a timely manner. R34 reported [redacted] had to wait for three hours for help one day two weeks ago. R34 stated [redacted] sheets were soiled. R34 stated [redacted] kept "pressing the button, "but no one came. R34 stated, "How do they know you aren't laying [sic] on the floor?"

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c. Review of R35's "Admission Record," provided by the facility, revealed R35 was admitted to the facility on [redacted] with diagnoses that included primary NJ EX Order. 264b1 [redacted].

Review of R35's admission "MDS," provided by the facility and with an ARD of [redacted], revealed R35 scored [redacted] on the "BIMS," which indicated R35 was NJ EX Order. 264b1.

During an interview on 01/03/24 at 7:43 AM, R35 stated [redacted] did not think the facility had enough staff to meet the residents' needs. [redacted] stated evening medications were administered late and it took from 30 minutes to an hour for call lights to be answered.

d. Review of R36's "Diagnoses," located under the "Diagnoses tab of the EMR revealed R36 was admitted to the facility on [redacted] with diagnoses that included aftercare following explantation of NJ EX Order. 264b1.

Review of R36's admission "MDS," with an ARD of [redacted] and located under the "MDS" tab of the EMR, revealed R36 scored [redacted] on the "BIMS," which indicated R36 was [redacted] t.

During an interview on 01/03/24 at 8:11 AM, R36 stated [redacted] had "given up" on staff answering the call light. [redacted] stated it could take an hour or more for staff to answer, so now he just went to find staff when he needed something.

e. Review of R14's "Admission Record," provided by the facility, revealed R14 was admitted to the

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facility on NJ EX Order. 264b1 with diagnoses that included NJ EX Order. 264b1.

Review of R14's annual "MDS," provided by the facility and with an ARD of NJ EX Order. 264b1 revealed R14 scored NJ EX Order. 264b1 on the "BIMS," which indicated R14 was NJ EX Order. 264b1.

During an interview on 01/04/24 at 11:59 AM, R14 stated he had waited as long as two hours for NJ EX call light to be answered. R14 reported NJ EX had NJ EX Order. 264b1 and waited for over an hour for someone to respond to NJ EX call light one time during the previous year. R14 stated during the monthly resident council meetings, residents complained about call lights not being answered and not having enough staff to care for the residents. R14 stated, "Every month it is the same complaints."

2. Resident interviews revealed concerns with staffing:

a. During an interview on 01/04/24 at 3:32 PM, R18 stated NJ EX Or had resided in the facility from NJ EX Order. 264b1 and discharged to the hospital on NJ EX Order. 264b1. R18 stated she was admitted following surgery to her toe. R18 stated NJ EX Or had problems walking and activated the call light to get help to go to the bathroom. R18 stated staff did not answer NJ EX Or call light so NJ EX Or NJ EX Order. 264b1 to the bathroom NJ EX Order. different times to use the toilet.

Review of the Prospective Payment System (PPS) "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ EX OrderNJ EX Or and provided by the facility revealed R18 was NJ EX Order. 264b1 with a "Brief Interview for Mental Status (BIMS)" score of NJ EX Order. 264b1

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b. During an interview on 01/04/24 at 9:40 AM, R16 stated NJ EX Order. 264b1) was not NJ EX Order. 264b1 as often as it should have been; his NJ EX Order. 264b1 supplement was not provided NJ EX Order. 264b1 times a day according to physician's orders; and he did not receiv NJ EX Order. 264b1) care as often as it was ordered by the physician because the nurses were not available. R16 stated he asked the nurse when NJ EX Order. 264b1 needed NJ EX Order. 264b1 and she told NJ EX Order. 264b1 she would come back. R16 stated the nurse either did not come back at all or it took two hours for the nurse to return. R16 stated NJ EX Order. 264b1 did NJ EX Order. 264b1 care and NJ EX Order. 264b1 because the nurses were not doing it. R16 stated it was important that NJ EX Order. 264b1 received NJ EX Order. 264b1 because he could not eat due to having NJ EX Order. 264b1 and NJ EX Order. 264b1 had lost a lot of NJ EX Order. 264b1 prior to coming to the facility. R16 stated he asked for the NJ EX Order. 264b1 but many times the nurses did not bring it or NJ EX Order. 264b1 could not find a nurse to ask.

Review of the admission "MDS" with an ARD of NJ EX Order. 264b1 provided by the facility revealed R16's NJ EX Order. 264b1 with a "BIMS" score of NJ EX Order. 264b1 out of NJ EX Order. 264b1

c. A group interview was held with 13 residents (selected by the facility as being NJ EX Order. 264b1) on NJ EX Order. 264b1 at 2:15 PM. These were primarily long term stay residents and not residents receiving rehabilitation with planned discharges. The following staffing complaints were voiced by six residents (R57, R42, R40, R44, R14, R41):

-R57 stated the agency aides did not always know how to care for NJ EX Order. 264b1
-R42 stated the regular aides were good, but the

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agency staff gave NJ EX a hard time.
-R57 stated NJ EX waited an hour for someone to come in after putting on NJ EX call light. R57 stated the agency aide did know how to clean up NJ EX Order 2 NJ EX Order. 264b1 properly and was in a rush to get the job done and out of the room. R40 agreed with this statement.
-R42 stated staffing was worse during the holidays, and NJ EX waited an hour and a half for assistance. R42 stated the nurse said NJ EX Ord would help, but no one came in.
-R44 stated the nursing staffing levels had been low since NJ EX Ord came to the facility.
-R42 stated NJ EX Ord waited an hour and a half to get her call light answered when NJ EX was waiting for help to get NJ Ex Order. 264b1 so she could go to bed.
-R57 stated the CNAs did not an empty NJ EX Order. 264b1 and NJ EX could not use it because it was full.
-R40 stated the staff came into the room and shut the call light off, went away and did not provide any assistance. R42, R40, R57 all agreed with this statement. R42 stated it was like a game; the staff turned the light off and said they would come back without asking what she needed.
-R40 stated NJ EX Ord needed a NJ EX Order. 264b1 to be transferred, and due to inadequate staffing, she had to NJ EX Ord in NJ Ex Order. 264b1 rather than going on the toilet.
-R42 stated NJ EX Ord would like to get help from the aides to walk as NJ EX Ord had gone as far as NJ EX Ord could with NJ EX Order. 264b1 al therapy. R42 stated nursing staff did not help NJ Ex Order. 264b1 .
-R40 and R57 both reported they stayed in bed some days because there were not enough staff to get them up. R57 stated NJ EX was told the other day, "We are understaffed and we can't get you up."
-R40 stated it happened a lot, approximately NJ EX days out of a month, that NJ EX Ord stayed in bed all

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day because there was no one available to get [NJ EX] up.
-R57 stated he received [NJ EX] medications late due to staffing problems.
-R40 stated [NJ EX] did not get a shower until three months ago. [NJ EX] stated there was one staff that knew how to do it ([NJ EX Order: 264b1] needed). R40 stated when this CNA was on vacation, [NJ EX] did not get showers.
-R41 stated when a substitute nurse was working, getting [NJ EX] medications on time was a problem. R57 and R14 agreed with this statement.
-R42 stated there were instances when [NJ EX] did not get [NJ EX] medications at all.
-R57 stated the nurses should check [NJ EX Order: 264b1] [NJ EX Order: 264b1] before [NJ EX] ate. Due to inadequate staffing, most of the time [NJ EX Order: 264b1] was checked, and [NJ EX Order: 264b1] was given after [NJ EX] ate.
-R14 stated [NJ EX] had observed nursing staff sleeping on the 11:00 PM - 7:00 AM shift. R14 stated he observed nursing staff park residents in front of the television and walk away and sometimes the television was not even on. R14 stated one resident leaned sideways and was not attended to.
-R14 stated the aides ran the facility and the agency aides were "terrible."
-R57 stated if [NJ EX] put [NJ EX] light on at 2:30 PM to get changed, the staff did not come to help and then dinner was delivered. [NJ EX] stated [NJ EX] waited until 5:00 - 6:00 PM for help. R57 stated at 2:00 PM all the aide disappeared from the floor at the same time. R14 and R44 stated they could be gone for an hour and this was the norm.
-R44 stated [NJ EX] needed a [NJ EX Order: 264b1], and it was not provided in time and [NJ EX] was [NJ EX Order: 264b1] as a result. R44 stated [NJ EX Order: 264b1] and was [NJ EX Order: 264b1] and it was a [NJ EX Order: 264b1]." R44 stated when [NJ EX] later addressed the person who was

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supposed to assist [redacted] the aide told [redacted] she had to go to lunch. R44 stated this was very upsetting. -R42 stated, "I should not have to holler for help, after an hour [of waiting for the call light to be answered] I have done that."

3. Family interviews revealed concerns with staffing:

a. During an interview on 01/05/24 at 10:29 AM, Family Member (F) 3 stated R20 had resided in the facility from NJ EX Order. 264b1 23. F3 stated, "It was a horror place. There was no staff on weekends." F3 stated staff called out on weekends. F3 stated R20 went, "forever without food or being NJ EX Order. 264b1]." F3 stated R20 was dependent on staff and at their mercy. F3 stated, "I had to beg someone to come and change her [R20]. Staffing is horrible . . . They never had enough help." F3 stated, when the call light was not answered, she went to find staff to help change R20's NJ EX Order. 264b1. The nurse said she was a nurse and would not [redacted]; the aides said they were not [redacted] aide and would not [redacted]. F3 stated, "One day I broke down in tears; [R20] wanted to get in bed due to [redacted]. They [staff] said [redacted] was supposed to sit up." F3 stated [redacted] had to beg the staff to put R20 in bed. F3 stated [redacted] had talked to about 10 people when this instance occurred and, "They all said 'I am not [redacted] nurse or aide'." F3 stated [redacted] arrived at the facility between 1:00 and 2:00 PM once and R20 had not been washed or cleaned up yet for that day.

b. During an interview on 01/04/23 at 10:00 AM, F2 stated when [redacted] visited R21 it was, "a long time before they [nursing staff] came" after the call light was activated. F2 stated R21 waited too

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long to get assistance to use the bathroom so she (F2) went into the halls looking for staff to assist. F2 stated when [redacted] went into the hallways, many of the other residents' rooms also had their call lights on. F2 stated R21 waited too long to get assistance.

c. During an interview on 01/05/24 at 4:30 PM, F1 stated the day after R62 was admitted, when she arrived at approximately 10:00 AM on [redacted] R62 was lying on the bed with only a [redacted]" on with a sheet that was halfway on the bed, and no blanket covering [redacted]. F1 stated, R62 had not been [redacted] F1 stated she had communicated to staff ahead of time to make sure R62 was shaved and ready for their planned arrival time. F1 stated she went to the nurse's station for assistance and all the nursing staff were on their phones, eating pizza, and they ignored [redacted]r. F1 stated the next day [redacted] came into the facility and R62 told [redacted] had not been fed the night before and no one came in to check on [redacted] during night shift. R62 was also wearing the same "dirty" clothing from the day before and [redacted]. F1 stated [redacted] had to get water for R62 because there was no water in the room. F1 relayed an instance where a request was made for R62's [redacted] to be [redacted] and there was a delay for that to be done even though the nurse was in the room administering medications and could have done it at the time. F1 stated the staff did, "not answer the buzzer." F1 stated [redacted] continued to have concerns about a lack of staff attentiveness and response when R62 needed something.

d. During an interview on 01/04/24 at 10:45 AM, F4 stated staffing was inadequate to care for R15. F4 stated, "They don't check or respond to

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the [call] button. They are never seen again. Every day we went [to see R15]." F4 stated R15 got covid while residing in the facility and [redacted] was put into [redacted] and once on [redacted], staff did not monitor R15 adequately. F4 stated staff did not check what R15 was [redacted] and [redacted] trays were removed untouched. As R15's condition declined, F4 stated the staff did not assist R15 with [redacted] F4 stated F15 requested Tylenol and the nursing staff never brought it. F4 stated [redacted] called 911 due to R15's decline in condition and when R15 was hospitalized, [redacted] was diagnosed with [redacted].

e. During a group interview on 01/05/24 at 2:15 PM, F5 stated she was a family member of R4 and was in the facility "all the time." F5 stated there was no accountability for the CNAs. F5 stated there should be shift change update, but there was not. F5 stated the CNAs did not know who the residents were or how to take care of them. F5 stated R4 did not get [redacted] and had lots of [redacted]." F5 stated if a resident needed to have an [redacted] changed by staff, "they [nursing staff] can't even get it done once a shift." F5 stated she went to the floor nurse because R4 had not been changed for an entire shift and the nurse came with an attitude. F5 stated, the nurse was aggravated but R4's [redacted] had not been changed for the whole shift. F5 stated this occurred [redacted] days ago.

4. Review of the "Assignment Sheets" for the 100 unit and [redacted] unit from [redacted] revealed CNA staffing was not in accordance with the parameters laid forth in the Facility Assessment. The census ranged between 113 - 116 and called for 14 CNAs total for day shift; 11

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CNAs total for evening shift; and eight CNAs total for night shift. The assignment sheets reflected shortages as follows:

a. On 01/01/24, there were 10 CNAs on day shift, ten CNAs on evening shift, and six CNAs on night shift.

b. On 01/02/24, there were 11 CNAs on day shift, 10 CNAs on evening shift, and five CNAs on night shift.

c. On 01/03/24, there were 10 CNAs on day shift and five CNAs on night shift.

e. On 01/04/24, there were nine CNAs on day shift and seven CNAs on night shift.

f. On 01/05/24, there were 11 CNAS on day shift and seven CNAs on night shift.

g. On 01/06/24, there were 11 CNAs on day shift and five CNAs on night shift.

h. On 01/07/24, there were 11 CNAs on day shift and five CNAs on night shift.

5. During an interview on 01/05/24 at 11:21 AM, the Director of Patient Relations stated she greeted residents when they were admitted and did a quick orientation with them and then did rounding during the day, primarily with newer residents. The Director of Patient Relations stated she received concerns about call lights and staffing and when she did, she passed these concerns to the DON or Unit Manger. The Director of Patient Relations stated that some of the residents/families voiced concerns that nursing staff were overworked and the facility

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needed more staff.

During an interview on 01/05/24 at 1:37 PM, the prior Administrator, who continued to work for the company, stated he left his position as Administrator about a month ago. The prior Administrator stated nursing staffing was a struggle and he had used agency staff routinely to ensure enough staff were on hand. He stated he had enlisted department heads to pass meal trays. He stated therapy staff helped to get people up and cleaned in the morning. He stated the facility had utilized retention bonuses to keep staff from leaving and recruitment had been ongoing. The Prior Administrator stated they had also used shift differentials and referral bonuses. He stated the facility had paid for two CNA classes that were offered in another building. He stated two of the concierges and a unit clerk were CNAs and they could be pulled to help with care. He stated nurses had their own on call rotation and in an emergency, the DON, ADON, etc. came to cover shifts. He stated they had raised base rates, shift differentials, and had offered bonuses for nurses to work on the weekends. The prior Administrator verified the required staffing levels were one CNA to eight residents on day shift, one CNA to 10 residents on evening shift, and one CNA to 14 residents on night shift. He states there were days when they did not have staffing to meet those requirements.

During an interview on 01/06/24 at 4:18 PM, RN3 stated it was sometimes difficult to get all her work done when she had intravenous fluids (IVs) to administer, several treatments, and numerous medications to pass. RN3 stated she could not take a break during her shift. RN3 stated it was a busy facility and normally there were 21 rooms

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per nurse. RN3 stated there were generally enough staff scheduled but not all of them showed up. RN3 stated there were a lot of call offs and no shows. RN3 stated there was an incident with R21 when she had tried to obtain a urine sample. R21 became upset and she went to notify the aide that R21 needed to have her [redacted] changed because she was wet and smelly. RN3 stated she went back a couple hours later when she had a break and found out the aide had not provided [redacted] care timely and the family was upset. RN3 stated the aide did not get in there timely because he was busy and she (RN3) had been passing medications.

During an interview on 01/07/24 at 9:30 AM, the ADON stated the census varied and that determined how many CNAs worked on each unit. The ADON stated she assisted Human Resources and the DON with scheduling. The ADON stated the average number of CNAs was between five to seven on each side (10 - 14 total) for day shift; three nurses on day shift and evening shift on each side (six total); five to six CNAs on each side for evening shift (10 - 12 total); and three to four CNAs on each side for night shift (six to eight total); and two nurses on each side for night shift (four total). The ADON stated at times they did not have the desired number of staff due to agency staff being spread too thin and a lack of availability. The ADON stated, for the most part, there was adequate RN coverage and ideally there were three working per day.

During an interview on 01/07/24 at 2:28 PM, CNA2 stated there were not enough CNAs all the time. He stated if there were not enough, he might not have time to give showers or to shave

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F 725	Continued From page 99 residents. CNA2 stated weekends and nights were, "pretty bad." CNA2 stated sometimes there were incentives to work extra, but not always. CNA2 stated, when there were call offs, it could be difficult to answer call lights timely. During an interview on 01/08/24 at 12:16 PM, the DON, who had been in her position approximately [redacted] weeks, stated she had not been directly involved in the scheduling yet. The DON stated the Human Resource staff had been primarily in charge and she was currently out of the building and not available for interview. 6. The facility was cited with deficiencies in five areas in part due to insufficient staffing to meet residents' needs: F695 for a failure to provide [redacted] care and service for a resident with a [redacted]; F684 for a failure to provide adequate nursing care and services to prevent a [redacted] procedure from requiring a [redacted] and not providing [redacted]s for a [redacted] and providing nutritional supplements for a [redacted] resident; F692 for a failure to obtain [redacted] and document meal intake; and F755 for a failure to obtain and administer medications timely. Cross refer to these citations. NJAC 8:39-4.1 (a) 11, 12 NJAC 8:39-27.1 (a)	F 725		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		2/23/24

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F 726	Continued From page 100 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Complaints: NJ00151851, NJ00153272, NJ00153799, NJ00156210, NJ00157166, NJ00157827 Based on interview and record review, the facility failed to ensure agency staff were competent in their duties before allowing them to work with residents. This had the potential to affect 115 of 115 residents who resided at the facility. Findings include: During an interview on 01/04/24 at 12:00 PM,	F 726	F 726 Competent Nursing Staff 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified in the 2567. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	

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	315521	A. BUILDING _____ B. WING _____	C 01/09/2024

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F 726	Continued From page 101 Registered Nurse (RN) 1 stated "sometimes" the agency nurses working at the facility did not order medications as needed. RN1 reported that during [redacted] a resident had to be sent to the hospital for NJ EX Order. 26461 because the agency staff had not ordered a refill of their [redacted] treatment medication. During an interview on 01/04/24 at 8:37 AM, Licensed Practical Nurse (LPN) 7, who was an agency nurse, stated she did not receive any orientation to the facility prior to working there other than how to log into PCC (Point Click Care, the facility's electronic medical records system). LPN7 reported that [redacted] was her first day working at the facility. During an interview on 01/04/24 at 12:28 PM, LPN 9, who was an agency nurse, stated she was not sure how long it took for medications to arrive at the facility after being ordered. LPN9 stated she did not receive any orientation to the facility prior to working. During an interview on 01/04/24 at 1:00 PM, LPN11 stated residents did run out of medications because agency staff did not reorder the medications. LPN11 stated agency nurses also neglected to pass issues, such as medication refills, along in report. On 01/06/24 at 10:36 AM, Unit Manager (UM) 1 was asked how the competency of agency nurses was ensured. UM1 stated all nurses were required to complete continuing education for their licenses. UM1 stated everything the agency nurses needed to care for the residents was located in PCC.	F 726	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Human Resource Director or designee will ensure all licensed agency nurses, and agency certified nurses aides receive a facility orientation prior to being assigned to a resident. The Human Resource Director or designee will audit all licensed agency nursing staff files to ensure they received the facility orientation prior to being assigned to a resident. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Human Resource Director or designee will audit 5 licensed agency nurses and 5 agency certified nurse aide files to ensure they received the facility orientation prior to being assigned to a resident. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 726	Continued From page 102 On 01/09/24 at 8:50 AM, UM2 stated there was an orientation form that agency nurses had to review prior to working on the floor. UM2 stated the supervisors usually gave the form to the agency nurses to review. UM2 confirmed the only orientation agency nurses received was reviewing the orientation form. On 01/09/24 at 9:39 AM, the Administrator provided a copy of the "Agency Licensed Nurse Orientation Checklist," revised January 2023. Included on the list was "Unavailable Medications & Refusal of Medications" and "Falsification of Records." Cross-Reference F755: Pharmaceutical Services and F842: Resident Records. NJAC 8:39-27.1 (a), (d)	F 726		
F 755 SS=L	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		2/28/24

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F 755	Continued From page 103 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaints: NJ00158123, NJ00158489, NJ00158677, NJ00159247, NJ00159800, NJ00167295, NJ00168400, NJ00168603, NJ00169368, NJ00169776 Based on observations, interviews, record reviews, and review of the facility's policies, the facility systemically failed to provide and maintain pharmaceutical services to acquire, receive, dispense, administer, and reconcile medications for 10 residents reviewed for medications (Resident R 60, R14, R33, R64, R31, R32, R63, R13, R11, and R9) out of a total sample of 65 residents. This systemic failure affected and/or had the likelihood to affect all residents of the facility, and any future admissions to the facility. The facility's systemic failure to ensure pharmaceutical services were provided to meet the needs of each resident had caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [redacted] and was determined to	F 755	F 755 Pharmacy F755 Srvcs/Procedures/Pharmacist/Records 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R33, R64, R31, R32, R63, R13, and R11 no longer reside at the facility. R 60 was assessed by the Director of Nursing on [redacted] did not exhibit any signs of [redacted]. The findings were reviewed with [redacted]. R 60 was seen by the physician on [redacted] No adverse effects noted. Per R 60's hospital record, he received [redacted] in the hospital on 1/5/2024 at 5:14am and 2:16pm. [redacted] arrived at Woodbury at 11:30pm on [redacted] received his [redacted] on [redacted] at 3:36pm and 11:33 pm. The physician was made aware of the times these medications were administered at Woodbury. R 60 had a [redacted] level	

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F 755	Continued From page 104 exist on [redacted], in the area of §483.45 Pharmacy Services F755 at a scope and severity (S/S) of L. The Administrator was notified of the Immediate Jeopardy on [redacted] at 7:46 PM. The facility was notified that an acceptable plan of removal had been accepted on [redacted] On [redacted], the surveyors conducted a revisit and verified that the Removal Plan was fully implemented. The noncompliance remained on 1/17/2024 at a Level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. Review of R60's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [redacted] at 11:30 PM [redacted]. Review of R60's hospital discharge summary dated [redacted] at 5:40 PM, located in the resident's electronic medical record (EMR) under the "Misc (Miscellaneous)" tab, revealed the resident was recipient of a [redacted] on [redacted] Continued review of R60's hospital discharge documentation revealed the resident's discharge medications included [redacted] (a medication used to [redacted] mg [milligram] [redacted] capsule, every [redacted] hours. Review of R60's hospital medication administration record (MAR) revealed the last dose of [redacted] mg administered at the hospital was at 2:16 PM on [redacted] Review of R60's "Physician's Orders," dated [redacted] at 1:36 Am located in the resident's EMR revealed the resident was ordered [redacted] mg capsule every [redacted] hours for [redacted]	F 755	drawn . R 60 no longer resides at the facility. R 14 was assessed by the Director of Nursing on [redacted]. He did not exhibit any signs of [redacted]. The findings were reviewed with the physician. R 9 was assessed by the Director of Nursing on [redacted]. R 9 did not have any [redacted] issues or ill effects noted. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected . 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing or designee will review the missed medication audit daily for 1 week, then weekly x 3 weeks, then bi-weekly x 4 weeks, and then monthly x 1 month to identify if residents missed scheduled medications. This will be documented on a log. The Director of Nursing or designee will review the facility□s back up medication supply daily to ensure the supply is stocked. This will be documented on a log. The Director of Nursing or designee of Nursing will review the medications eligible for refill report daily to ensure medications are reordered timely. This will be documented on a log. Audits will be completed by running the report in Point Click Care. The Director of Nursing or designee will	

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F 755	Continued From page 105 During an interview on 01/06/24 at 9:38 AM, Registered Nurse (RN) 3 stated R60's NJ EX Order: 264D1 medication had not been received from the pharmacy and she was unable to administer the medication to R60. RN3 also stated R60 was admitted to the facility on NJ EX Order: 264D1 at approximately 10:00 PM. Review of R60's order audit report for the medication of NJ EX Order: 264D1 revealed the facility ordered the medication from the pharmacy on NJ EX Order: 264D1 at 1:36 AM. Review of R60's nursing "Progress Note," dated NJ EX Order: 264D1 at 9:40 AM, completed by Regional Nurse (RGN) 1 and located in the resident's EMR under the "Progress Notes" tab revealed, "[Medical Director's name] made aware that [R60's Name] NJ EX Order: 264D1 due at 9am today has not arrived. The pharmacy was contacted and confirmed that the NJ EX Order: 264D1 is being delivered on the first pharmacy delivery today. [Medical Director's Name] was also made aware of this. He ordered toplace [sic] a one-time order when the medication arrives and to hold this mornings dose." The progress note, notification, and order to hold the resident's medication doses were all made after R60's physician ordered scheduled administration time for the NJ EX Order: 264D1 medication. A subsequent interview with RN3 on 01/06/24 at 11:00 AM revealed she called the pharmacy, and the medication would be leaving the pharmacy at 2:00 PM. RN3 stated it should be at the facility by 3:00 PM. Review of R60's nursing "Progress Note," dated NJ EX Order: 264D1 at 3:25 PM, completed by the Director of	F 755	review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered from the pharmacy right away. This will be documented on a log. The Director of Nursing or designee will in-service all licensed nurses, including agency nurses on: a. Administering medications consistent with physician□s orders to ensure there is not a break in the provision of the needed medications to treat residents. This includes the process for notifying the provider of medications that are unavailable. If the physician is not available, the providers in each practice always have someone on call. b. Medications that have been reordered and haven□t arrived c. Reordering medications for all residents d. Timely reconciliation and entry of new admission medications In-servicing began on 1/6/2023. All licensed nurses, including agency, will be in-serviced prior to their first scheduled shift. The Director of Nursing or designee will ensure that all nurses including agency nurses working in the center have access to the backup medication supply. The safety of the backup medication supply will be ensured through the backup supply being counted daily. 4. Indicate how the facility plans to monitor its performance to make sure that	

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F 755	Continued From page 106 Nursing (DON) and located in the resident's EMR under the "Progress Notes" tab, revealed "[Medical Director's Name] called made aware of arrival time of NJ EX Order. 264b1 and received orders to give now and administer next dose as ordered at 9pm." Review of R60's "Medication Administration Record (MAR)," dated NJ EX Order. 264b1 and located in the resident's EMR under the "Orders" tab, revealed "NJ EX Order. 264b1 Oral Capsule NJ EX Or MG ...Give NJ capsule by mouth every NJ EX hours for NJ EX Order. 264b1. Start Date NJ EX Order. 264b1 0900 [9:00 AM]. Hold Date from NJ EX Order. 264b1 0946 [9:46 AM] to NJ EX Order. 264b1 2100 [9:00 PM]." For the scheduled administration date and time of NJ EX Order. 264b1 4 at 9:00 AM, the administration block was blank, which indicated the medication was not administered. For the administration date and time 01/06/24 at 9:00 PM, the administration block was documented with "H" indicating the medication was held. Continued review of the "MAR" revealed on NJ EX Order. 264b1 at 3:36 PM, it was documented R60 was administered his tacrolimus transplant medication. It had been over 25 hours since R60 received NJ EX Order. 264b1 medication that was ordered to be administered every NJ EX hours. Further review of the "MAR" revealed that the 9:00 PM dose ordered by the physician on NJ EX Order. 264b1 was not administered. During an interview with the Consultant Pharmacist (CP) on NJ EX Order. 264b1 at 11:27 AM revealed post-transplant medication was very important, and the resident should be receiving the medication twice a day and they never want a	F 755	solutions are lasting: The Director of Nursing or designee will conduct the missed medication audit daily for 1 week, then weekly x 3 weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. The Administrator will ensure that the Director of Nursing or designee reviews the facility□s back up medication supply daily and that the Director of Nursing or designee reviews new admission discharge medication lists prior to residents arriving to the center. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review the missed medication audit daily for 4 week, then weekly x 3 weeks, then bi-weekly x 4 weeks, and then monthly x 4 month to identify if residents missed scheduled medications. This will be documented on a log. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review the facility□s back up medication supply daily to ensure the supply is stocked. This will be documented on a piece of paper. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained.	

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F 755	Continued From page 107 resident to miss a dose of NJ EX Order. 264b1 medication. The CP stated if the resident received NJ EX O last dose at 2:00 PM on NJ EX Order. 264b1, it would be optimum he received his next dose within NJ EX hours. During an interview on 01/08/24 at 3:10 PM, the Medical Director stated R60 was admitted after 10:00 PM on NJ EX Order. 264b1, so there was no way to get the resident's medications to the facility for NJ EX O to be administered NJ EX O morning medications. The Medical Director stated the NJ EX Order. 264b1 medication was a specialty medication. The Medical Director stated that other than the family bringing in the medication from home, there was no way of getting the medication to the facility any sooner. 2. Review of R14's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 264b1 with diagnoses which included NJ EX Order. 264b1, and NJ EX Order. 264b1 NJ NJ EX Order. 264b1 Review of the "National Library of Medicine [Department of Health and Human Services, National Institutes of Health]" updated on 01/04/24 revealed " .. NJ EX Order. 264b1 tablet ...Boxed Warning [the strongest warning that the Food and Drug Administration (FDA) requires, signifies that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects] ... The continued use of NJ EX Order. 264b1, including NJ EX Order. 264b1 tablets, may lead to clinically significant physical dependence. The risks of NJ EX Order. 264b1 and NJ EX Order. 264b1 increase with longer treatment duration and higher daily dose. NJ EX Order t	F 755	The Director of Nursing or designee will review the medications eligible for refill report daily to ensure medications are reordered timely. This will be documented on a log. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review the medications re-ordered report to ensure they were delivered timely. This will be documented on a log. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered from the pharmacy right away. This will be documented on a log. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained.	

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F 755	Continued From page 108 NJ EX Order. 264b1 or NJ EX Order. 264b1 of NJ EX Order. 264b1 tablets after continued use may precipitate NJ EX Order. 264b1 reactions, which can be life-threatening ... NJ EX Order. 264b1 Signs and Symptoms. NJ EX Order. 264b1 signs and symptoms associated with NJ EX Order. 264b1 have included abnormal involuntary movements .. NJ EX Order. 264b1 ...Medication Guide ... NJ EX Order. 264b1 and NJ EX Order. 264b1 reactions. NJ EX Order. 264b1 tablets can cause NJ EX Order. 264b1 and NJ EX Order. 264b1 reactions. Do not suddenly stop taking NJ EX Order. 264b1 tablets. Stopping NJ EX Order. 264b1 tablets suddenly can cause serious and life-threatening side effects, including, NJ EX Order. 264b1 Call your healthcare provider or go to the nearest hospital emergency room right away if you get any of these symptoms ..." NJ EX Order. 264b1 Review of R14's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed R14 was originally ordered NJ EX Order. 264b1 (a NJ EX Order. 264b1 medication used NJ EX Order. 26 1 NJ EX Order. 264 and discontinued on NJ EX Order. 264b1. The orders also revealed on NJ EX Order. 264b1 R14 was ordered	F 755	5. Date of Compliance: February 28th, 2024	

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NJ EX Order: 26401 tablet NJ mg two times a day. The physician orders also indicated on NJ EX Order: 26401 R14's NJ EX Order: 26401 was reduced to NJ EX O mg every NJ EX hours as needed. On NJ EX Order: 26401 the resident was ordered NJ EX Order: 26401 tablet NJ mg two times a day for NJ EX Order: 264 The resident had continuously received the medication at varying dosages since NJ EX was admitted which would be considered long term use of the NJ EX Order: 26401.

Review of R14's "MAR" dated NJ EX Order: 26401, located in the resident's EMR under the orders tab, revealed the resident was scheduled to be administered NJ EX Order: 26401 mg by mouth at 5:00 PM and 10:00 PM every day. Continued review of the MAR revealed R14's routine NJ EX Order: 26401 was not documented as administered for NJNJ EX Order: 264- both doses, NJ EX Order: 26401-both doses, NJ EX Order: 26401-both doses, NJ EX Order: 26401-both doses, and NJ EX Order: 26401-both doses. The administration dates and times were documented with a NJ EX which indicated "Other."

Review of R14's nursing "Progress Notes," dated NJNJ EX Order: 264 at 6:11 PM and NJ EX Order: 26401 at 10:08 PM, located in the resident's EMR under the "Progress Notes" tab revealed "Administration Note. Note Text: awaiting pharmacy."

Review of R14's nursing "Progress Notes," dated NJ EX Order: 26401 at 6:35 PM and NJNJ EX Order: 264 at 9:33 PM, located in the resident's EMR under the "Progress Notes" tab revealed "Administration Note. Note Text: on order."

Review of R14's nursing "Progress Notes," dated NJ EX Order: 26401 at 4:36 PM, located in the resident's EMR under the "Progress Notes" tab revealed "Administration Note. Note Text: med [medication] not available at this time." Continued review of

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F 755	Continued From page 110	F 755		

the progress notes dated NJ EX Order. 264b1 revealed a note completed at 9:00 PM revealed "Administration Note. Note Text: on order."

Review of R14's nursing "Progress Note," dated NJ EX Order. 264b1 at 4:39 PM, located in the resident's EMR under "Progress Notes" tab revealed "Administration Note. Note Text: Medication on order, awaiting from pharmacy."

Review of R14's nursing "Progress Note," dated NJ EX Order. 264b1 at 9:28 PM, located in the resident's EMR under the "Progress Notes," tab revealed "Administration Note. Note Text: On order, awaiting from pharmacy."

Review of R14's "Individual Patient Controlled Substance Administration Record-30 dose" for NJ EX Order. 264b1 tablet revealed on 10/25/23 at 10:00 PM, the resident's last dose of NJ EX Order. 264b1 was signed out for administration.

Review of the facility's untitled emergency medication backup (cubex) transaction reports dated NJ EX Order. 264b1, and NJ EX Order. 264b1 provided by the facility, revealed no documented evidence NJ EX Order. 264b1 was retrieved to be administered to R14.

During an interview on 01/06/24 at 1:00 PM, R14 stated at the end of NJ EX Order. 264b1 regular nurse went on vacation and that was the last time NJ EX received NJ EX Order. 264b1 until she returned from vacation. R14 stated the nurses would tell NJ EX Or every day that the pharmacy said it would be on the night delivery. R14 stated he reported to the nurses NJ EX had NJ EX Order. 264b1, NJ EX Order. 264b1 inside NJ EX Order. 264b1 and on the outside of NJ EX Order. 264b1 and

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NJ EX Order. 264b1. R14 stated NJ EX had never had this feeling before.

Review of R14's EMR revealed no documented evidence that the nursing staff documented any NJ EX Order. 264b1 other than the resident complaining of a NJ EX Order. 264b1 on NJ EX NJ EX Order 1.

During an interview on 01/06/24 at 11:27 AM, the CP stated if the facility was out of R14's NJ EX Order. 264b1 for multiple days, that was a problem. The CP stated nursing should have notified the physician to see if they could have ordered a different medication that was the same class of drug that was in stock in the cubex. The CP also stated R14 could experience withdrawal due to going without the medication.

Review of an untitled and undated facility document, provided by the facility on NJ EX Order. 264b1 revealed " ...the center [facility] had an adequate supply of NJ EX Order. 264b1] in the cubex on these dates [NJ EX Order. 264b1, NJ EX Order. 264b1 and 1 NJ EX Order. 264b1. So, while his medication administration record [MAR] documents that the medication wasn't administered on the dates in question, the medication was in the center ..." The medication being available at the facility but not administered further indicated the facility's systemic failure to provide pharmaceutical services which included accurate acquiring, receiving, dispensing, and administering of all drugs.

3. Review of R33's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 264b1 and discharged on NJ EX Order. 264b1 with diagnoses which included NJ EX Order. 264b1 infection in the

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NJ EX Order 264

Review of R33's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ EX Order 26461 located in the resident's EMR under the "MDS" tab, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of NJ EX Order 26461 which indicated the resident was NJ EX Order 26461 NJ EX Order

Review of R33's hospital "Summary of Care," dated NJ EX Order 26461, located in the resident's EMR under the "Misc" tab, revealed "Follow-Up After Discharge ...Additional instructions: NJ EX Order 26461 grams every NJ hours until NJ EX Order 26461 or as otherwise directed by NJ EX Order 26461 disease ..." Continued review revealed the last time R33 was administered NJ EX Order 26461 at the hospital prior to discharging was on NJ EX Order 26461 at 5:56 AM.

Review of R33's admission "Progress Note," located in the resident's EMR under the "Progress Notes" tab, revealed the resident was admitted to the facility on NJ EX Order 26461 at 4:03 PM.

Review of R33's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed an order dated NJ EX Order 26461 for 'NJ EX Order 26461 GM [grams]."

Review of R33's "Order Audit Report," located in the resident's EMR under the "Orders" tab, revealed for the medication of NJ EX Order 26461 every NJ hours for NJ EX Order 26461, the medication was ordered on NJ EX Order 26461 at 4:05 PM.

Review of R33's nursing "Progress Note," dated NJ EX Order 26461 at 12:51 AM, located in the resident's

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EMR under the "Progress Notes" tab, revealed "This nurse called [Pharmacy's Name] to make sure that the patients NJ EX Order. 264b1 would be delivered in the am. The pharmacy stated that the NJ EX pharmacy won't open until 8 am and will be processed then ..."

Review of R33's nursing "Progress Note," dated NJ EX Order. 264b1 at 10:31 AM, located in the resident's EMR under the "Progress Notes" tab revealed "Orders-Administration Note. Note Text: d NJ EX Order. 264 NJ EX Order. 264b1 GM. Use NJ E gram NJ EX Order. 264b1 every NJ E hours for bacteremia. Awaiting medication from pharmacy."

Review of R33's "MAR," dated NJ EX Order. 264b1 located in the resident's closed EMR under the "Reports" tab, revealed "NJ EX Order. 264b1 GM ...Use N gram NJ EX Order. 264b1 every NJ E hours for NJ EX Order. 264b1 a with a start date of NJ EX Order. 264b1. Continued review of the "MAR" revealed for the date of NJ EX Order. 264b1 was documented for the 12:00 AM and 8:00 AM administration times. The "MAR" showed the NJ EX Order. 264b1 medication was administered on NJ EX Order. 264b1 at the 4:00 PM, NJ EX hours and NJ EX minutes after the last dose was administered in the hospital prior to admission to the facility. There was no documented evidence provided when the medication was delivered or that the medication was retrieved from the facility's cubex.

During an interview on 01/05/24 at 1:43 PM, R33 stated he missed a total of NJ EX doses of the NJ EX Order. 264b1 medication. R33 stated NJ EX was admitted to the facility on NJ EX Order. 264b1 around 4:00 PM and was told by the nurse that the facility did not have NJ EX Order. 264b1 medications yet. The resident stated NJ EX expected to get an NJ EX Order. 264b as soon as NJ EX Order. 264

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admitted to the facility; however, the facility was not prepared nor equipped to receive [redacted] as an admission. R33 stated [redacted] to take the rest of [redacted] medications the first day hoping that would expedite the facility getting [redacted]. Continued interview revealed the nurses kept telling [redacted] that they called the pharmacy, and the medication would be on its way. R33 also stated the [redacted] was for a [redacted] that about [redacted], so [redacted] was afraid the [redacted] was going to come back and that [redacted] would die if it did return.

During an interview on 01/06/24 at 11:27 AM, the CP stated it was important R33 would have received [redacted]s as ordered. The CP stated the nurses should have notified the physician if the [redacted] was not at the facility. The CP also stated with resident not getting the continued [redacted] as ordered after leaving the hospital placed the resident at risk for the [redacted] not clearing up completely and the resident could have built up a [redacted] to the [redacted]

There was no documented evidence that the resident's physician was notified of the missed administration of the [redacted]tic after the [redacted] notification.

Review of an untitled and undated facility document, provided by the facility on [redacted] revealed " ...the center [facility] had an adequate supply of [redacted] in the [redacted] box on these dates [redacted] and [redacted]. So, while the medication administration record [MAR] documents that the medication wasn't administered on the dates in question, the medication was in the center ..." The medication

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being available at the facility but not administered further indicated the facility's failure to provide pharmaceutical services which included accurate acquiring, receiving, dispensing, and administering of all drugs.

4. Review of R64's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [redacted] with diagnoses which included NJ EX Order. 264b1) of NJ EX Order. 264b1 , and [redacted] NJ EX Order. 264b1

Review of R64's "Admission Note," dated [redacted] at 11:23 PM, located in the resident's EMR under the "Progress Notes" tab, revealed the resident was admitted to the facility on [redacted] at 4:00 PM.

Review of R64's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed an order dated [redacted] at 9:00 PM for [redacted] Capsule [redacted] MG" give [redacted] capsule by mouth [redacted] a day.

During an interview on 01/05/24 at 5:35 PM, Licensed Practical Nurse (LPN) 2 stated the facility had not received R64's NJ EX Order. 264b1 [redacted] rom the pharmacy 24 hours after the resident was admitted and the resident was in [redacted]. LPN2 stated he was not assigned to the resident during the interview.

During an observation and interview on 01/05/24 at 5:40 PM, LPN9 revealed the medication cart lacked R64's [redacted] medication. LPN9 confirmed the resident's medication had not arrived from the pharmacy yet. When asked if the medication

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could be retrieved from the facility's backup medications in the cubex, LPN9 stated she was an agency nurse and agency nurses did not have access to the cubex.

During an observation and interview on 01/05/24 at 6:11 PM, R64 was tearful and stated she arrived at the facility on [redacted] and [redacted] was not fully controlled. The resident stated [redacted] was experiencing [redacted] and [redacted] level was [redacted]

Review of R64's [redacted] Summary," dated [redacted] at 6:24 PM, located in the resident's EMR under the "Vitals" tab revealed the resident's [redacted] was assessed by LPN9 and the resident rated the [redacted] an [redacted]

Review of R64's "MAR" dated [redacted], located in the resident's EMR under the "Orders" tab, revealed it was documented the [redacted] medication was administered to R64 on [redacted] at 9:00 PM, on [redacted] at 9:00 AM, and on [redacted] at 9:00 PM, even though the pharmacy had not delivered the resident's medication to the facility.

Review of R64's pharmacy "Packing Slip Proof of Delivery," dated [redacted]4, provided by the facility revealed the resident's [redacted]) was not delivered to the facility until [redacted] at 6:47 AM.

Review of the facility's cubex "Transactions By Patient, C14," with the date range of [redacted] provided by the facility revealed the medication of [redacted] was not dispensed from the cubex for R64.

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During an interview on [NJ EX Order 2640] at 11:27 AM, the CP stated [NJ EX Order 2] was a [NJ EX Ord] medication that worked differently for [NJ EX Ord] than other [NJ EX Ord] medications, so the facility may have fewer options to replace the medication with a medication from the cubex. The CP stated the nurse should have notified the resident's physician if the medication was not at the facility when it was scheduled to be administered to ensure the resident's [NJ EX Ord] was being managed.

During an interview on 01/08/24 at 2:13 PM, the Director of Nursing (DON) stated per R64's MAR, the facility's nurses administered the resident's [NJ EX Order] to [NJ EX Or] on [NJ EX Order 2640] at 9:00 PM, on [NJ EX Order 2640] at 9:00 AM, and on [NJ EX NJ EX Order] at 9:00 PM. The DON confirmed for these administration times and dates, R64's medication had not been delivered to the facility yet and she also confirmed the medication had not been dispensed from the facility's cubex. When asked how the nurses would have administered the medication if the medication were not in the facility and if the "MAR" was inaccurate, the DON stated she was not sure where the nurses would have obtained the medication from, but the "MAR" documented that [NJ EX Order 2] was administered.

5. Review of R31's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [NJ EX Order 2640].

Review of R31's "Medical Diagnoses" located in the resident's EMR under the "Med Diag" tab, revealed the resident was admitted to the facility with diagnoses which included [NJ EX Order 2640]

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Review of R31's nursing "Admission/Readmission Note," located in the resident's EMR under the "Progress Notes" tab, revealed the resident was admitted to the facility on [redacted] at 10:00 PM.

Review of R31's "Physician Orders," located in the resident's EMR under the "Orders" tab revealed the resident was ordered the following medications on [redacted] the day after the resident was admitted: "[redacted] Oral Tablet (an [redacted] medication used to help [redacted] MG give 1 tablet by mouth in the evening for [redacted] medication used for [redacted] MG tablet give [redacted] tablet every [redacted] hours as needed for [redacted], [redacted] e Oral Tablet (a [redacted] used to [redacted]) [redacted] MG give [redacted] tablet [redacted] times a day for [redacted], [redacted] MG give [redacted] tablet by mouth [redacted] times a day for [redacted], and [redacted] Oral Tablet (a [redacted] used to reduce [redacted] MG Give [redacted] tablet my by mouth one time a day for [redacted]

Review of R31's "Order Audit Report," located in the resident's EMR under the "Orders" tab, revealed the resident's [redacted] MG and [redacted] MG tablets were ordered from the pharmacy on [redacted] at 12:15 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility, [redacted] MG tablets were ordered from the pharmacy on [redacted] at 2:29 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility, [redacted] MG tablets were ordered from the pharmacy on [redacted] at 12:15 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility, and [redacted] MG tablets was ordered on

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NJ EX Order: 26461 at 12:15 PM which indicated there medication was ordered NJ EX hours after the resident was admitted to the facility.

Review of R31's "MAR," dated NJ EX Order: 26461 located in the resident's EMR under the "Orders" tab revealed the resident was not administered any medications during NJ EX brief admission to the facility.

Review of R31's nursing "Progress Notes," dated NJ EX Order: 26461, located in the resident's EMR under the "Progress Notes" tab, revealed a note at 9:51 PM of " ...21:40 [9:40 PM] pt left NJ EX Order: 26461 NJ EX Order: 26461] with NJ EX Order: 26461. Refused to sign NJ EX Order paperwork. Family very upset, felt staff was not attentive to their NJ EX Order: 26461 needs." Continued review revealed a note at 10:18 PM of " ...Pt's family unhappy with care client receiving at facility. Family spoke with nursing supervisor regarding concerns and family adamant about taking client home."

During an interview on 01/05/24 at 1:52 PM, Family Member (F) 31 stated R31 was admitted to the facility from the hospital at approximately 11:00 PM on NJ EX Order: 26461 F31 stated came back to the facility the next morning on NJ EX Order: 26461 to visit R31. Continued interview with F31 revealed R31 had not received NJ EX medications since being admitted to the facility so NJ EX found R31's nurse who informed her that R31's medications had not been ordered yet. F31 stated the whole day had passed and the facility never obtained medications to administer to R31. F31 also stated at approximately 9:00 PM on NJ EX Order: 26461 decided it was not safe for NJ EX Order: 26461 to stay at the facility and NJ EX took the resident home. F31 stated it was important for NJ EX Order: 26461 to receive

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medications to prevent NJ EX Order. 264b1 as NJ EX [redacted] was admitted to the facility from the hospital after sustaining a NJ EX Order. 264b1.

6. Review of R32's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 264b1.

Revive of R32's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab, revealed the resident was admitted with diagnoses which included NJ EX Order. 264b1 [redacted] NJ EX Order. 264

Review of R32's nursing "Admission/Readmission Note," dated NJ EX Order. 264b1 at 12:30 AM, located in the resident's EMR under the "Progress Notes" tab, revealed "[Resident's name] arrived at the facility on NJ EX Order. 264b1 [at] 3:02 PM ..."

Review of R32's "New Jersey Universal Transfer Form," dated NJ EX Order. 264b1 located in the resident's EMR under the "Misc" tab, revealed the resident was being transferred from the hospital to the facility for reasons of NJ EX Order. 264b1 and NJ EX OrdOrder. 264b1 NJ EX Order. 264b1"

Review of R32's hospital discharge instructions titled, "My Discharge Instructions," dated NJ EX Order. 264b1 revealed " ...Other Instructions: You came to the hospital because your NJ EX Order. 264b1 r was NJ EX Order. 264b1. You had your NJ EX Order. 264b1 removed on NJ EX Order. 264b1 You were experiencing NJ EX Order. as well as an increased NJ EX Order. 264b1. NJ EX Order. 264b1 disease was consulted. You were started on NJ EX Order. 264b1 Your NJ EX Order. 264b1 was still

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going up. NJ EX Order. 264b1 was consulted as NJ EX Order. 264b1 showed a [redacted]. Interventional [redacted] felt this collection was not something that could be [redacted]. They felt it would be better managed with [redacted] per infectious disease. Infectious disease switched your [redacted] to meropenem. Your NJ EX Order. 264b1 started to [redacted]e. [redacted] disease wants you to complete a [redacted] total course of NJ EX Order. 264b1. Unfortunately, [redacted] is only able to be given with [redacted] so you had [redacted] placed to be able to receive your [redacted] at rehab. You are able to be discharged to rehab. You are to finish [redacted] more days [redacted], including today. Today, you received 1 dose so far. You will have [redacted] more doses of [redacted] today, Afterwards, you will have [redacted] every [redacted] hours for [redacted] more days. You will receive you last dose of [redacted] on [redacted]" Continued review of the discharge instructions revealed R32 received [redacted] last dose of NJ EX Order. 264b1 at the hospital on [redacted] at 12:13 PM.

Review of R32's "Order Audit Report," located in the resident's EMR under the "Orders" tab, revealed the resident's NJ EX Order. 264b1 [redacted] MG was ordered from the pharmacy on 1[redacted] at 9:15 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility. Continued review of R32's order audit report revealed on [redacted] at 12:19 AM, the resident's [redacted] was again ordered from the pharmacy as "NJ EX Order. 264b1 [redacted] GM ...Use [redacted] gram [redacted] one time only for NJ EX Order. 264b1 [redacted] NJ EX Order. 264b1 until [redacted]..."

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Review of R32's nursing "Alert Note," dated [redacted] at 12:22 AM, located in the resident's EMR under the "Progress Notes" tab, revealed "Note Text: Resident med [medication] no delivery on time. MD [medical doctor] call and new order given [redacted] time dose [redacted] for [redacted]. Order will be resume upon pharmacy delivery tomorrow ..."

Review of R32's "MAR," dated [redacted] located in the resident's EMR under the "Orders" tab, revealed for [redacted] for elevated [redacted] it was documented the medication was administered on [redacted] at 1:41 AM which indicated it had been over [redacted] hours since the resident received [redacted] last dose at the hospital on [redacted] at 12:13 PM for an [redacted] that was physician ordered every [redacted] hours.

7. Review of R63's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [redacted].

Review of R63's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab revealed the resident was admitted to the facility with diagnoses which included [redacted]

Review of R63's "Physician Orders," located in the resident's EMR under the "Orders" tab revealed an ordered dated [redacted] of '[redacted] time a day for [redacted]

Review of R63's pharmacy "Packing Slip Proof of Delivery," dated [redacted], provided by the facility

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F 755	Continued From page 123 revealed the facility received NJ EX Order 2 doses of "NJ EX Order. 264b1 ..." from the pharmacy. Review of the facility's pharmacy "Packing Slip," dated NJ EX Order. 264b1 provided by the facility revealed R63 had NJ EX Order 2 doses of NJ EX Order. 264b1 GM ..." delivered to the facility. During an interview on 01/08/24 at 3:34 PM, the DON confirmed the facility had received two deliveries of R63's NJ EX Order. 264b1 medication of NJ EX Order. 264b1 of NJ EX Order doses each delivery which totaled 1 doses. Review of R63's "MAR," dated NJ EX Order. 264b1, located in the resident's EMR under the "Orders" tab revealed it was documented the resident had been administered one dose of the NJ EX Order. 264b1 NJ EX Order. 264b1 Review of R63's "MAR," dated NJ EX Order. 264b1, located in the resident's EMR under the "Orders" tab revealed it was documented the resident had been administered NJ EX Order doses of the NJ EX Order. 264b1 NJ EX Order. 264b1 Review of the "MAR"s revealed the resident had been administered at total of NJ EX Order doses of the resident's NJ EX doses received from the pharmacy by the facility. During the continued interview on 01/08/24 at 3:34 PM, the DON stated she counted the number of R63's NJ EX Order. 264b1 doses the facility had on hand as NJ EX Order. 264b1, and the resident only had NJ EX Order doses left when NJ EX Order should have had NJ EX Order doses left which indicated a deficit of one dose. When asked if she could explain why there was one dose of the resident's NJ EX Order. 264b1 missing, the DON stated she did not know as there was nothing documented in the resident's EMR to	F 755		

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account for the missing dose. When asked if the missing dose of the resident's [redacted] should be reported as misappropriation and if the facility should investigate what happened to the resident's medication, the DON stated "No."

8. Review of R13's "Diagnoses," located in the EMR under the "Diagnoses" tab, revealed R13 was admitted to the facility on [redacted] with diagnoses that included [redacted].

Review of R13's "Physician Orders," located in the EMR under the "Orders" tab, revealed:
a. an order, dated [redacted], for R13 to receive [redacted] milligrams (mg) give [redacted] tablet every [redacted] hours (9:00 AM and 9:00 PM) for [redacted], and
b. an order, dated [redacted] for R13 to receive [redacted] medication) 500 mg 2.5 tablets to [redacted] mg daily at 9:00 AM and give [redacted] tablets to equal [redacted] mg by mouth at bedtime for s[redacted].

Review of R13's "Medication Administration Sheets (MARS),"dated [redacted] revealed:
a. no documentation to show R13 received the 9:00 AM dose of [redacted] on [redacted] or the 9:00 PM dose of [redacted] and
b. no documentation to show R13 received the 9:00 AM dose of [redacted] on [redacted] the 9:00 PM dose of [redacted] on [redacted].

During an interview on 01/08/24 at 1:17 PM, the Director of Nursing (DON) confirmed there was no documentation to show R13 had been provided the above referenced medications. The

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DON confirmed there was no documentation to show why R13 had not received the medications.

9. Review of R11's "Admission Record," provided by the facility, revealed R11 was admitted to the facility on [redacted] with diagnoses that included [redacted].

Review of R11's "Physician Orders," provided by the facility, revealed:
a. an order, dated [redacted] mg ([redacted] 12 hours (9:00 AM and 9:00 PM) for [redacted]
b. an order, dated [redacted], for [redacted] (used to treat [redacted] milliliters (ml) every [redacted] hours (9:00 AM and 9:00 PM) for [redacted]; and
c. an order, dated [redacted], for [redacted] (used to treat [redacted] mg every [redacted] hours (9:00 AM and 9:00 PM) for [redacted].

Review of R11's "MARS," dated [redacted], revealed:
a. no documentation to show R11 received [redacted] 9:00 PM dose [redacted] on [redacted] or either dose on [redacted]
b. no documentation to show R11 received her 9:00 PM dose of Perforomist on [redacted]; and
c. no documentation to show R11 received [redacted] 9:00 PM dose of [redacted] on [redacted].

Review of R11's "Progress Notes," dated [redacted] and located under the "Progress Notes" tab of the EMR revealed:
a. [redacted] at 11:18 PM - ". . . [redacted] . . . new admission awaiting for arrival from pharmacy . . ."

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F 755	Continued From page 126 b. [redacted] at 11:21 PM - ". [redacted] . . . new admission awaiting arrival from pharmacy . . ." c. [redacted] at 9:59 AM - ". . [redacted] . . . med [medication] not available at this time . . ."and d. 11/22/22 at 11:45 PM and two entries at 11:46 PM - ". . . Pharmacy action required . . ." During an interview on 01/08/24 at 2:21 PM, the DON confirmed there was no documentation to show R11 had been provided the above referenced medications. The DON confirmed there was no documentation to show why R11 had not received the medications or why the medications would not be available. The DON confirmed her expectation was for staff to call the physician to get an alternate medication if a medication was not available and to call the pharmacy to identify the problem and correct it. 10. Review of R9's "Admission Record," provided by the facility, revealed R9 was admitted to the facility on [redacted] with diagnoses that included [redacted]). Review of R9's "Physician Orders," provided by the facility, revealed: a. an order, dated [redacted], for [redacted] (an [redacted] inhaled every [redacted] hours (9:00 AM and 9:00 PM); and b. an order, dated 1[redacted], for [redacted] (used to treat [redacted] one dose [redacted] every [redacted] hours (12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM). Review of R9's "MARS," dated [redacted], revealed: a. no documentation to show R9 received [redacted]	F 755		

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F 755	Continued From page 127 9:00 PM dose of [redacted] on [redacted], either dose on [redacted] and the 9:00 AM dose on [redacted]; and b. no documentation to show R9 received her [redacted] on [redacted] at 6:00 PM. Review of R9's "Progress Notes," dated [redacted] through [redacted] revealed no documentation why the above referenced medications were not provided. During an interview on 01/08/24 at 12:53 PM, the DON confirmed there was no documentation to show R9 received [redacted] medications as ordered. The DON confirmed [redacted] expectation was for staff to follow physician orders, check the facility's emergency medication for supply for any missing medications, notify the physician if medications were not available, and document accordingly. During an interview on 01/04/24 at 12:50 PM, the Medical Director stated that if a resident was admitted to the facility during the day, it should only take a few hours for the pharmacy to deliver the resident's medications. The Medical Director stated it was his expectation if a resident does not receive a medication because it has not been delivered from the pharmacy, then the nurse should see if the medication is in the cubex and then call the provider to get an order for the medication or a substitute for the medication needed. Continued interview with the Medical Director revealed he had not been made aware of any issues of the facility acquiring resident medications timely. The Medical Director also stated the cubex should never be used more than 24 hours to obtain the same medication for a resident.	F 755		

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During an interview on 01/05/24 at 10:33 AM, Nurse Practitioner (NP) 1 stated she was not aware of residents being out of narcotic medications and the facility's cubex not having the medications either. NP1 stated anytime a resident does not receive a medication because of the facility not having the medication on hand, the nurse should contact her or another provider so an order could be obtained for an equivalent medication the facility has on hand. The NP stated when residents do not receive their NJ EX Order: 2640U t medication after being admitted from the hospital, it places the resident at an increased risk of NJ EX Order: 2640U. Continued interview with the NP revealed anytime a resident goes without narcotic NJ EX Order: 2640U medications and/or NJ EX Order: 2640U NJ EX Order: 2640U medications, residents could experience NJ EX Order: 2640U from the medications and if the resident is at the facility for therapy and their NJ EX Or is not managed, it could delay their rehabilitation.

During an interview on 01/05/24 at 11:11 AM, the prior DON (PDON) stated the majority of the residents admitted to the facility were post-acute and the most common medications residents were ordered were blood pressure medications, pain medications, and some antianxiety medications. The PDON stated she was not aware of any concerns related to consistent problems of resident medications being acquired. The PDON stated if a resident were admitted late in the day but prior to 10:00 PM, the pharmacy would deliver the resident's medication at midnight. Continued interview revealed it was the PDON's expectation that no resident would ever go without any of their medications and if the medication is not in the facility she would expect for the nurse to notify the physician and get an

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order for a medication that the facility did have on hand.

During an interview on 01/05/24 at 12:35 PM, the prior Administrator stated the facility could not order a resident's medications until after the resident was physically in the facility. Continued interview revealed generally, if the medication has not been received from the pharmacy, the nursing staff could obtain the medication from the facility's cubex. The Prior Administrator stated agency nurses did not have access to the cubex and was not sure they should have access to the cubex. The prior Administrator also stated while he was the Administrator he had not been made aware of any issues where residents did not receive their medication because of the medication not being delivered and this would have been something he would have wanted to be made aware of. The prior Administrator stated it was important the facility would have residents' medications on hand to avoid any delays in treatment and to prevent a negative outcome.

During an interview on 01/08/24 at 1:31 PM, the DON stated since she had been the DON at the facility (approximately two weeks) she had not been made aware of any issues related to acquiring residents' medications from the pharmacy. The DON stated if a resident's medication is not in the medication cart, it was her expectation the nurse would look at what medications were in the cubex, call the pharmacy and inquire about when the medication will arrive at the facility, and then notify the medical provider and receive directions form the provider.

During an interview on 01/08/24 at 4:00 PM, the Regional Director of Operations (RDO) stated he

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had not been made aware of any issues related to pharmacy services.

Review of the facility's policy titled "Pharmacy Services," revealed "It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice ...Pharmaceutical services refers to: The process (including documentation, as applicable) of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling ...dispensing ...administering ...of all medications ..."

Review of the facility's policy titled, "6.0 Automated Dispensing Devices Medication Dispensing System," revised 02/16/22, revealed "Policy. Automated Dispensing Devices may be installed in appropriate facilities as permitted by the state pharmacy law. Procedure ...B. Stocked Automated Dispensing Device Medications: 1. The contents of this supply are determined by Specialty Rx, Inc. in collaboration with the facility staff and medical director and in accordance with state regulations. 2. Pharmacy manager and facility's medical director or designee must approve any changes to the content of this supply. The consultant pharmacist and director of nursing are consulted on and notified of all and any changes. C. Only licensed facility personnel, who have the approval of the director of nursing and appropriate training on the Automated Dispensing Device, have access to medications in the Automated Dispensing Device. D. REMOVAL of Medications: 1. Medications may be removed from the Automated Dispensing Device

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F 755	Continued From page 131 following the device's instructions: a. Upon receiving a new medication order, to obtain the number of doses needed to cover the period of time from the administration of the first dose until receipt of the medication from the pharmacy ..." NJAC 8:39-29.2 (d) NJAC 8:39-29.3 (a) 5, 6 NJAC 8:39-27.1 (a) NJAC 8:39-13.1 (d)	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Complaints: NJ00158123, NJ00158489, NJ00158677, NJ00159247, NJ00159800 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate of less than 5%. Fifteen errors were made with a total of 47 opportunities for error, resulting in a 31.9% error rate. The errors involved two residents of five residents (Resident (R) R58 and R65) reviewed for medication administration out of a total sample of 65 residents. Fourteen medications, including [redacted] were not administered to R58 within one hour of the scheduled time. [redacted], a NJ EX Order. 264b1 , was not administered to R65 due to the medication not being available.	F 759	F 759 Free of Medication Error Rats 5 Percent or More 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R58 and R65 no longer reside at the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The pharmacy consultant in-serviced	2/23/24

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F 759	Continued From page 132 1. Review of R58's electronic medical record (EMR), under the "Profile" tab, documented R58 was admitted on [redacted], with diagnoses including [redacted] Review of R58's admission "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD), located in the EMR under the "MDS" tab, documented R58's "Brief Interview for Mental Status (BIMS)" score was [redacted], indicating R58 was [redacted] tact. Review of R58's "Physician Orders" located in the EMR under the "Orders" tab, documented the following medications were ordered: a. [redacted] times a day for [redacted] with a meal, ordered [redacted] b. [redacted] supplement) [redacted] milligrams (mg) [redacted] times a day, ordered [redacted] c. [redacted] medication) [redacted] mg [redacted] time a daily, ordered [redacted]. d. [redacted] time a day, for [redacted], ordered on [redacted] e. [redacted] time a day for [redacted], ordered [redacted] f. [redacted] for [redacted] ordered [redacted] g. [redacted] mg [redacted] time a day for [redacted] h. [redacted] (mcg) [redacted], [redacted] for [redacted] ordered [redacted].	F 759	nurses on preventing medication errors. Facility was unable to educate LPN4, and LPN7 as survey team share their identity with the facility. The pharmacy consultant will conduct medication pass audits. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The pharmacy consultant will conduct medication pass audits on 3 nurses weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 759	Continued From page 133 i. NJ EX Order. 264b1 mg, NJ EX Or time a day, for NJ EX Order. 264b1, ordered NJ EX Order. 264b1. j. NJ EX Order. 264b1 mg one time a day for NJ EX Order. 264b1), ordered NJ EX Order. 264b1 k. NJ EX Order. 264b1 mg, NJ EX Or times a day for NJ EX Order. 264b1 infection. k. NJ EX Order. 264b1 mg NJ EX O times a day for NJ EX Order. 26, ordered NJ Ex Order. 264b1; and l. NJ EX Order. 264b1 times a day for NJ EX Orde NJ EX Order. 264b1 ordered NJ Ex Order. 264b1 During observation and interview on 01/05/24 at 12:05 PM, while Licensed Practical Nurse (LPN) 4 administered R58's oral morning medications at R58's bedside, LPN4 stated these were R58's "morning medications," they were ordered to be given from 8 AM to 9AM. When asked why LPN4 did not give them at those times, LPN4 responded that she had gotten "busy." LPN4 did not administer R58's NJ EX Order. 264b1 or NJ EX Order. at this time. At 12:09 PM, LPN4 stated she would have to call the nurse practitioner to decide if R58's NJ EX Order. 26 should be administered late. During the secondary medication administration observation conducted on 01/05/24 at 12:25 PM, LPN4 proceeded to administer R58's 8:00 AM NJ EX Order. 264b1. During an observation and concurrent interview conducted on 01/05/24 at 12:36 PM, the Unit Manager (UM)1 and Assistant Director of Nursing (ADON) entered R58's room to speak with the resident and surveyor. UM1 stated R58 was supposed to receive NJ EX morning medications at 8:00 AM. UM1 stated she had been made aware of the issue with LPN4 not administering the medications and NJ EX Order. this morning. The ADON	F 759		

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F 759	Continued From page 134	F 759		

stated her expectation was for medications to be given within the compliance window, one hour before or one hour after they were due. UM1 and ADON confirmed LPN4 had documented she had administered R58's medications at 9:00 AM, although LPN4 had not administered the medication until 12:05 PM. When asked about the potential outcome of late medications, the ADON stated it depended on the medications. The ADON was asked specifically about the outcome for R58's [redacted] not being given. The ADON stated the resident could become [redacted]

During an interview conducted on 01/05/24 at 1:15 PM, the Director of Nursing (DON) stated she expected medications to be administered on time.

2. Review of R65's "Diagnoses" tab of the EMR revealed R65 was admitted to the facility on [redacted] with diagnoses of orthopedic aftercare and [redacted]

Review of R65's "Physician Orders," dated [redacted] and located under the "Orders" tab of the EMR, revealed R65 was to receive [redacted] once daily related to [redacted]

Review of R65's "Medication Administration Records (MARS)," dated [redacted] through [redacted] revealed documentation the [redacted] had been administered as ordered.

During an observation of the medication pass on 01/04/24 at 9:36 AM, Licensed Practical Nurse (LPN) 7 was observed administering medications

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ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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F 759	Continued From page 135 to R65. LPN7 reviewed R65's medications, looked in the medication cart, and stated the NJ EX Order: 2640[illegible]r was not available for R65. LPN7 stated it was documented in Point Click Care (PCC, the facility's electronic charting system) that the medication had been ordered on NJ EX Order: 2640[illegible]. LPN7 showed the PCC screen to the surveyor, and it was observed the documentation was the medication had been ordered on NJ EX Order: 2640[illegible] LPN7 administered R65 NJ EX[illegible] other medications and stated R65's medication pass was complete. Review of R65's "MARS," dated NJ EX Order: 2640[illegible] and located under the "Orders" tab of the EMR, revealed a NJ EX[illegible] was coded in the box to document the administration of the NJ EX Order: 2[illegible] During an interview on 01/08/24 at 1:25 PM, the Director of Nursing (DON) confirmed that the code "9" meant a medication was not available. The DON was informed of the facility's medication error rate. The DON confirmed she expected medications to be administered within one hour before and one after their scheduled times and for staff to check the emergency medication supply and call the pharmacy if a medication was unavailable. Review of the facility's policy titled, "Medication Administration," revised 05/30/23, revealed, ". . . Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician . . . Sign MAR after administered . . ." NJAC 8:39-29.2 (a), (d) NJAC 8:39-11.2 (b) NJAC 8:39-27.1 (a)	F 759		

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F 800	Continued From page 136	F 800		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Complaints: NJ00157166, NJ00162457 Based on observation, interview, and record review, the facility failed to ensure 15 residents, including seven sampled residents (Resident (R)18, R53, R47, R55, R49, R50, R51) and eight of 13 residents attending the group interview (R6, R42, R43, R40, R44, R57, R4, R41), were served a well-balanced diet taking into consideration the preferences of each resident. Residents' preferences were not served in accordance with their meal tickets. When residents contacted the dietary department for alternate selections staff did not consistently answer the phone, the selections were not consistently available, or the selections were not served. This created the potential for resident dissatisfaction and weight loss. Findings include: 1. During an interview on 01/03/23 at 10:19 AM, the Dietary Manager (DM) stated new residents were given a copy of the weekly menu in effect and the "Always Available Menu" at the time of admission. The DM stated residents were asked about their food preferences within 48 hours of admission by a patient relations staff and this information was provided to the dietary department via a text message, a diet slip, or it	F 800	F 800 Provided Diet Meets Needs of Each Resident 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R18, R49, R50, R51, R6, R42, R44, and R57 no longer reside at the facility. R53, R47, R55, R43, R40, R4, R41 were interviewed by the Dietitian on 1/9/2024, They were interviewed on whether they were served a diet taking into consideration their preferences and what they received for meals. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Dietitian or designee will in-service the dietary department staff on providing well balanced meals that meet resident preferences and timely response to kitchen calls and requests.	2/23/24

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F 800	Continued From page 137 was communicated verbally. The DM stated the "Always Available Menu" provided alternate entree selections for lunch and dinner. The DM stated there were no standard alternates prepared at meals such as an alternate entrée, vegetable or starch; residents had the "Always Available Menu" to choose from. The DM verified there were no alternate selections for vegetables or starches on the "Always Available Menu." The DM stated there was no formal system for residents to select from the "Always Available Menu." Typically, residents called the kitchen on the phone and their orders were taken at that time by dietary staff and their selections were recorded. There was no specific time frame in which they were supposed to call down or times when dietary staff should be available to answer the phone. Review of the undated "Always Available Menu" provided by the facility revealed the options were: chef salad, grilled hot dog, flame broiled burger, deli sandwich, grilled cheese sandwich, and cheese pizza. 2. Review of the undated "Admission Record" provided by the facility revealed R18 was admitted to the facility on NJ EX Order. 264b1 with diagnoses includin NJ EX Order. 264b1 R18 was discharged on NJ EX Order. 264b1 and NJ EX O closed record was reviewed. Review of the PPS (Prospective Payment System) "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ EX Order. 264b1 revealed R18 was NJ EX Order. 264b1 with a Brief Interview for Mental Status (BIMS) score of NJ EX Order. 264b1	F 800	The Dietitian or designee will audit meal trays to ensure the prescribed diet is followed and served, and that the food served meets the resident□s preferences. The Dietitian or designee will interview residents to ensure they receive the correct diet and that their preferences are met. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: R53, R47, R55, R43, R40, R4, R41 will be interviewed on whether they are served a well-balanced diet taking into consideration their preferences and what they receive for meals weekly x 4 weeks, then every other week for 4 weeks to ensure ongoing compliance. The Dietitian or designee will audit 10 meal trays to ensure the prescribed diet is followed and served, and that the food served meets the resident□s preferences. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Dietitian or designee will interview ten residents to ensure they receive the correct diet and that their preferences are met. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained.	

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F 800	Continued From page 138 During an interview on 01/04/24 at 3:32 PM, R18 stated the facility did not serve [redacted] food [redacted] could eat; [redacted] subsisted on white bread and water, and had no choices about the food during her stay. R18 stated [redacted] had been on a [redacted], and [redacted] diet prior to being admitted to the facility and while at the facility, was served numerous foods [redacted] could not eat such as chili on top of rice, corn, and broccoli. R18 stated [redacted] asked for decaf coffee and was told there was none and they also did not have nondairy creamer. R18 stated [redacted] was not supposed to get milk and was served milk. R18 stated [redacted] could not have chocolate and was served a brownie and chocolate pudding. R18 stated [redacted] had reported these food requirements/preferences when [redacted] was interviewed by a patient liaison shortly after being admitted. Review of the undated "Resident Preferences" form provided by the facility revealed special instructions of non-dairy creamer for breakfast, lunch, and dinner; white toast for breakfast and no green vegetables. No additional food preferences were documented and the only food disliked was applesauce. R18 was prescribed a [redacted] without any [redacted]. 3. During a group interview held with 13 residents (selected by the facility as being [redacted]) and two family members on 01/05/24 at 2:15 PM, the following food complaints related to not receiving food preferences or foods selected from the "Always Available Menu" were voiced: R6 stated if he wanted something different than what the menu called for, [redacted] called down to the kitchen (on the phone) the night before to order from the "Always Available" menu; however, [redacted]	F 800	5. Date of Compliance: February 23rd, 2024	

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F 800	Continued From page 139	F 800		

did not receive the foods he requested.

R42 stated it was hard to get through to notify the kitchen of selections from the "Always Available Menu" because the dietary staff did not answer the phone. This resulted in being served foods that were disliked. R43, R40, R44, R43, and R57 confirmed this statement.

R40, R6, R44, R43, and R57 all stated there were no alternate choices for vegetables or starches. The "Always Available Menu" only included alternate entrees.

F5 stated that she went to the kitchen to get alternate foods for R4 but did not receive the foods R4 wanted. F5 stated there used to be two full meal choices to pick from; however, that had been eliminated. F5 stated when calling down to the kitchen for something from the "Always Available Menu," the dietary staff did not always answer the phone.

R41 stated he preferred to have meat for breakfast but he did not always receive it.

R44 also stated no meat was served for breakfast even though staff had recorded this preference.

R42 stated [redacted] meal ticket indicated she should not be served seafood due to an [redacted]; however, she was not [redacted] to [redacted]. R42 stated [redacted] asked a few times for a hamburger (from the "Always Available Menu") and was told they were out.

R57 stated [redacted] asked for a bagel for breakfast and staff told [redacted] they would check into it. R57 stated [redacted] also called the front desk to request it, but he

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F 800	Continued From page 140	F 800		

did not receive the bagel for breakfast.

The following residents indicated the facility ran out of the food they wanted to eat and they did not consistently receive a balanced diet: R44, F5 for R4, R41, and R57. R57 stated, "They ran out of ham yesterday."

Review of "Resident Council Minutes" dated [redacted] and provided by the facility revealed the following concern under Old Business, "Phone in dietary better but still not being answered when needing to change order." Under Dining Department and Dietitian, the minutes read, "Calling down the answering machine in the kitchen is not being answered all the time . . . soup on the menu but not on tray."

During an interview on 01/05/24 at 5:01 PM, the Registered Dietitian (RD) stated she was aware of the complaints about the availability of dietary staff to answer the phone to take residents' meal requests. She stated phone availability had improved but there were still issues with the phone being answered.

4. Kitchen and dining observations revealed residents were not served preferred foods or were served foods identified as being disliked:

a. During lunch tray line meal service in the kitchen on 01/03/24 from 11:45 AM to 12:09 PM observations revealed:
R53's meal ticket documented pudding and soup were to be served. Neither pudding nor soup were served.

R47's meal ticket documented tuna and egg salad were to be served. Neither tuna nor egg

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F 800	Continued From page 141	F 800		

salad were served.

R55's tray card documented a preference for fresh fruit. R55 was served canned pears.

R49's, R50's, and R51's tray cards documented they were to be served whole milk. Each resident's cup of milk was covered with plastic wrap with an "S" written on it. Dietary Aide (DA)1 stated the "S" stood for skim milk and indicated all the remaining cups of milk that had been poured were all skim. DA1 stated R49, R50, and R51 were receiving skim milk because all the pre-poured whole milk had been served. After serving these three residents skim milk, staff poured more whole milk for the tray line.

b. During an interview on 01/05/24 at 12:20 PM while R47 was eating lunch, R47 stated he used to be served tuna and egg salad but he was not receiving it anymore and he had not received it for this meal. He stated he liked and wanted to be served tuna and egg salad.

5. During an interview of 01/05/24 at 4:50 PM, the RD stated residents' food preferences were obtained on admission by the Patient Liaison and also by herself. She stated residents should be served preferred foods and served foods as directed on the meal tickets.

The prior Administrator, who continued to work for the company and had been gone from this facility for approximately [redacted] month was interviewed on 01/05/24 at 2:30 PM. The Prior Administrator stated food complaints had been a problem and the new Dietary Manager and Assistant Dietary Manager had been hired in [redacted] in part to address this concern. The

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F 800	Continued From page 142 prior Administrator stated there had been problems with food preferences, the accuracy of the residents' trays and receiving meal substitutes. A policy regarding food preferences/choices was requested on 01/03/24 and on 01/06/24. No policy was provided as of the survey exit on 01/09/24. Review of the "Menus and Adequate Nutrition" policy dated March 2023 revealed, "Standard meal planning guides used for menu planning and food purchasing will be adjusted to consider individual needs . . . Menus shall reflect input from residents and resident groups. a. Alternatives shall be immediately available if the primary menu or selections for a particular meal are not to a resident's liking . . ." NJAC 8:39-17.4 (a) 1, (c), (e)	F 800		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		2/23/24

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F 803	Continued From page 143 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Complaints: NJ00153272, NJ00160123, NJ00161147, NJ00169368 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the menus were followed for five residents (Resident (R) 46, R47, R51, R52, R54). Foods were not served in accordance with the menu for residents on NJ EX Order. 264b1 and NJ EX Order. 2 diets. Findings include: 1. Review of the undated "Diet Master" report provided by the facility on 01/03/24 and review of each resident's meal ticket dated 01/03/24 revealed: a. R46 was prescribed a NJ EX Order. 264b1 (NJ EX Order. 264b1 diet with NJ EX Order. 264b1. b. R47 was prescribed a NJ EX Order. 264 diet. c. R51 was prescribed a NJ EX Order. diet. d. R52 was prescribed a NJ EX Order. 264b1, NJ EX Order. 264b1) diet. e. R54 was prescribed a NJ EX Order. 264b1 diet. 2. Kitchen and dining observations revealed R46, R47, R51, R52, and R54 were not served the	F 803	F803 Menu Meets Resident Needs 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R46, R51, R52 no longer reside at the facility. R 47 and R 54 were interviewed by the Dietitian on 2/9/2024, both residents reported receiving meals according to the menu. The Dietitian completed tray line observation, she identified that all food was prepared and served according to menus. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with NJ EX Order. 264b1 diets have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 803	Continued From page 144 correct foods in accordance with the menu: a. Review of the undated "Week 1 Menu" for lunch on 01/03/24 called for peppers and onions, two chicken tacos (with tortillas), salsa, sour cream, and rosy pears for dessert. Review of the undated "Week 1 Menu" for lunch on 01/03/24 for residents on [redacted] diets called for peppers and onions, grilled chicken on a bun, sour cream, and rosy pears. Review of the undated "Week 1 Menu" for lunch on 01/03/24 for residents on [redacted] diets called for ground peppers and onions, two ground chicken tacos, salsa, sour cream and rosy pears. Review of the undated "Week 1 Menu" for lunch on 01/03/24 for residents on [redacted] diets called for pureed peppers and onions, two [redacted] chicken tacos, pureed salsa, sour cream, and pureed pears. During tray line observations on 01/03/24 between 11:02 AM through 12:10 PM revealed R46, R47, R51, R52, and R54 were not served the correct foods as directed on the menu: -R46 and R52 were served two tortillas, a mixture of peppers, onions, and chicken in a brown sauce with cheese sprinkled on top, and pears for lunch. R46 and R54 were not served a chicken patty on a bun as directed on the menu for the [redacted] diet. -R47 was served a ground combination of peppers, onions, and chicken in a brown sauce, sour cream, salsa, and rosy pears. R47 was not served two tortillas as directed on the menu and was instead served plain mashed potatoes.	F 803	The Dietitian/Designee in-serviced all dietary department staff on serving residents in accordance with the menu for residents on NJ EX Order. 264b1 [redacted] diets. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Dietitian/Designee will audit ten meal trays to ensure meals are served in accordance with the menu for residents on NJ EX Order. 264b1 [redacted] diets. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Dietitian/Designee will complete 2 tray line observations per week to ensure meals are served in accordance with the menu for residents on NJ EX Order. 264b1 [redacted]. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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-R51 and R54 were served [NJ EX Order: 264] combination of peppers, onions, and chicken in a brown sauce, sour cream, and plain mashed potatoes. R51 and R54 were not served [NJ EX Order: 26] tortillas with the chicken, pepper, and onion mixture in sauce as directed on the [NJ EX Order: 2] menu.

During an interview on 01/03/24 at 12:34 PM, the Dietary Manager (DM) and Assistant (DM) were interviewed together and verified tortillas were not served to residents on NJ EX Order: 264b1 diets or to residents on pureed diets. Residents on these diets ([NJ EX Order: 264b1] | [NJ EX Order: 264b1]) received mashed potatoes instead. After reviewing the menu, the DM and Assistant DM stated the menu called for the tortillas to be pureed and not mashed potatoes.

During an interview on 01/05/24 at 5:01 PM, the Registered Dietitian (RD) verified residents on [NJ EX Order] diets on [NJ EX Order: 264b1] for lunch received the chicken, peppers, and onions in sauce and were not served a chicken patty on a bun in accordance with the menu.

b. Review of the undated "Week 1 Menu" for dinner on 01/05/24 called for soup of the day, cheeseburger (with bun), coleslaw, and ice cream. Additional foods were observed on the tray line including French fries, onion rings, and Brussel sprouts.

Review of the undated "Week 1 Menu" for dinner on 01/05/24 for residents on [NJ EX Order: 264] diets called for pureed soup, pureed cheeseburger, pureed French fries, [NJ EX Order: 2] Brussel sprouts, and ice cream.

During tray line observations on 01/05/24 from

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F 803	Continued From page 146 5:01 PM to 5:23 PM, R51 and R54 were served [redacted] hamburger, bun, Brussel sprouts, and mashed potatoes. Neither resident received the [redacted] soup in accordance with the menu. Tray line observations with the RD at 5:23 PM verified no pureed soup was available. The DM who was present stated at 5:23 PM that the soup should have been [redacted] but had not been. Review of the "Menus and Adequate Nutrition" policy dated March 2023 revealed, "Menus shall be followed." NJAC 8:39-17.4 (a)	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaints: NJ00157166, NJ00160123, NJ00162177, NJ00162457, NJ00162977 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure food was palatable for ten residents including two sampled residents (Resident (R) 20 and R18) and eight of 13 residents attending the group interview (R44, R43, R41, R42, R57, R14, R40, R4) out of a total sample of 65 residents.	F 804	F 804 Nutritive Value/Appear, Palatable/Prefer Temp 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R44, R43, R42, R57, R20, and R18 no longer reside at the facility. R41, R14, R40, and R4 were interviewed by the Dietitian on 1/9/24. They were	2/23/24

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F 804	Continued From page 147 Specifically, the food did not taste good, was not appetizing in appearance, and was not at a palatable temperature when residents received their meals. This created the potential for dissatisfaction and weight loss. Findings include: 1. During an interview on 01/05/24 at 10:29 AM, Family Member (F) 3 stated R20 did not like the food. F3 stated the food was, "inedible . . . like dog food." F3 further stated the food was, "awful" and R20 would not eat it. Review of the undated "Admission Record" provided by the facility revealed R20 was admitted to the facility on [redacted] with diagnoses including [redacted]. R20 was discharged on [redacted]. Review of the discharge "Minimum Data Set (MDS)" assessment provided by the facility, with an assessment reference date (ARD) of [redacted], revealed R20 had [redacted] There was no "Brief Interview for Mental Status (BIMS)" score. 2. During an interview on 01/04/24 at 3:32 PM, R18 stated she was served a cheese steak that was "nasty" because it was undercooked and added, "I don't eat red or pink meat." Review of the undated "Admission Record" provided by the facility revealed R18 was admitted to the facility on [redacted]. R18 was discharged on [redacted]. Review of the PPS (Prospective Payment System) "MDS" with an ARD of [redacted] revealed R18 was [redacted] with a "BIMS" score of [redacted].	F 804	interviewed on the palatability, taste, and appearance. They reported satisfaction in all areas. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Dietitian or designee will in-service the dietary department staff on palatability, taste, temperature, and appearance of food. The Dietitian or designee will audit meal trays to ensure the food is palatable, has taste, is the correct temperature, and appears appetizing. The Dietitian or designee will interview residents to ensure their food is palatable, has taste, is the correct temperature, and appears appetizing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The dietitian or designee will audit 10 meal trays to ensure the food is palatable, has taste, is the correct temperature, and appears appetizing. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The dietitian or designee will interview 10	

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F 804	Continued From page 148 3. During a group interview held with 13 residents (selected by the facility as being NJ EX Order: 264b1 and two family members on 01/05/24 at 2:15 PM, the following food complaints related to unpalatable food were voiced: R44 stated that frequently when she was served her meal, she sent it back and asked for a peanut butter and jelly sandwich because it was poor quality and because the food was not hot. R44 stated, "The food is horrible . . . It is so unfair." R43 stated the food looked bad and the mashed potatoes lay flat. R43 stated staff put water in the mashed potatoes and they had no taste. R43 added that the best part of the meal was the water. R41 stated, "The food tastes bad." R41 stated the food was cold and the syrup tasted like it was watered down. R41 further stated he saved the condiments when he received them because meals did not consistently come with condiments. R42 and R57 stated the food had no seasoning. R42 stated the food was 98% bad. R14, R41, R43, and R42 agreed with the statement. R42, R40, R57, and R41 stated it was hard to identify what the food was. Family member (F)5 stated R4's food was cold at times and did not look appealing. F5 stated, "The food looks like it should go to the dogs." F5 stated R4 had lost weight due to the poor food quality.	F 804	residents to ensure their food is palatable, has taste, is the correct temperature, and appears appetizing. These interviews will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 804	Continued From page 149	F 804		

R57 stated the food temperature was not usually hot.

R14 stated the food had been poor for a long time.

5. Kitchen and dining observations revealed residents were not served palatable food:

a. Review of the undated "Week 1 Menu" for lunch on 01/03/24 called for peppers and onions, two chicken tacos (with tortillas), salsa, sour cream, and rosy pears for dessert.

Observations of meal preparation and food temperatures prior to meal service were conducted on 01/03/24 from 11:02 AM to 12:10 PM. A mixture of peppers, onions, and chicken pieces in a brown colored sauce was observed on the steam table along with tortillas. For residents on pureed and mechanical soft diets, mashed potatoes were prepared to be served instead of tortillas. Diced pears in pink liquid were observed to be dished up and in soufflé cups. Individual servings of sour cream and salsa were also available.

On 01/03/24 at 11:02 AM, cold air was blowing down from above the ovens and steamtable area and continued to blow throughout the observation. Tray line hot food temperatures were taken by the Cook1 and met minimum requirements of 135 degrees Fahrenheit (F). However, the canned pears which were to be served cold were 68 degrees F, above the cold food requirement of less than 41 degrees. Dietary Aide (DA)1 stated on 01/03/24 at 11:10 AM that the pears had just been opened and had not been refrigerated. DA1 then proceeded to

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F 804	Continued From page 150	F 804		

prepare pureed pears and when finished with pureeing the pears, she measured the temperature of the pears and they were 76 degrees F.

A test tray of a regular diet meal on the last cart for the 100 unit was evaluated by the surveyor, Dietary Manager (DM), and Assistant DM on 01/03/24 at 12:34 PM. The pears were 56 degrees F and were not cold. The DM stated the pears should be 41 degrees F or colder. The chicken, pepper, onion sauce was served on the plate with two tortillas on the side. The mixture was semi liquid which did not meet the standard appearance of "tacos" but the flavor and temperature were acceptable.

A test tray of a pureed diet on the last cart for the 200 unit was evaluated by the surveyor, DM, and Assistant DM on 01/03/24 at 12:56 PM. The pureed chicken and vegetables mixture was sufficiently hot and was acceptable in flavor; however, the mashed potatoes were unpalatable without any milk, fat (margarine/butter), or seasoning evident. The Assistant DM verified the potatoes did not taste good, were not flavorful, and lacked any milk, margarine/butter, or seasoning which he indicated should have been added. The pureed pears were not cold at 73 degrees and the DM stated the pears should have been refrigerated ahead of time.

b. Review of the undated "Week 1 Menu" for dinner on 01/05/24 called for soup of the day, cheeseburger (with bun), coleslaw, and ice cream. Additional foods were observed on the tray line including French fries, onion rings, and Brussel sprouts.

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F 804	Continued From page 151	F 804		

Observations of the tray line meal service on 01/05/24 from 4:50 PM to 5:44 PM were made with the Registered Dietitian (RD). At 5:35 PM, the RD measured the temperatures of the foods on the tray line; there were two carts (out of eight total) remaining to be served. The temperatures of the French fries were 126 degrees F and the onion rings were 84 degrees F. The RD verified these temperatures were below the minimum required hot holding temperature of 135 degrees F. The lids of all the steam table pans had been removed with all food completely uncovered during meal service and cold air was blowing down above the steam table area verified by the RD.

6. During an interview on 01/03/24 at 10:19 AM, the DM stated she had received food complaints after starting in her role in October 2023 and primarily the complaints involved cold food. The DM stated staff had been educated about ensuring the plates were heated at the correct time and not too far ahead and making sure the steam table was sufficiently hot. The DM stated she was not aware of current complaints about food palatability. The DM stated hot food holding temperatures on the tray line should be a minimum of 140 degrees Fahrenheit.

The prior Administrator, who continued to work for the company and had been gone from this facility for approximately one month was interviewed on 01/05/24 at 2:30 PM. The prior Administrator stated he had received food complaints about the quality of the food and the current Dietary Manager and Assistant Dietary Manager had been hired in October 2023 in part to address the concerns. The prior Administrator stated there were concerns with food not being

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F 804	Continued From page 152 plated correctly and with the flavor and quality. A request was made for a food palatability policy on 01/03/24 and on 01/06/24. As of the survey exit on 01/09/24, a food palatability policy was not provided. Review of the "Record of Food Temperature" policy dated March 2023 revealed, "It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled . . . 1. Food temperatures will be checked on all items prepared in the dietary department. 2. Hot foods will be held at 135 degrees Fahrenheit or greater . . . 4. Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit. 5. Food containers will be kept covered to retain heat." NJAC 8:39-17.4 (a) 2	F 804		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility Administrator's Job Description, the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each	F 835	F 835 Administration 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 38□s assigned Registered Nurse	2/23/24

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F 835	Continued From page 153 resident. This failure had the likelihood to affect all 115 residents of the facility. 1. The facility's administration failed to ensure residents remained free from neglect and abuse when R37 and R57 sustained actual harm from being deprived of treatment; and R38's family reported that NJ EX Order. 264b1 was found directly in the center of R38's NJ EX Order. 264b1 the NJ EX Order. 264b1 into NJ EX Order. 264b1. Even after being informed of the potential abuse, the Administrator failed to identify the event as an allegation of abuse, report the event as an allegation of abuse to the state survey agency, and failed to complete a thorough investigation. Cross Reference: F600-L 2. The facility's administration failed to ensure pharmaceutical services were maintained to meet residents' needs. During the abbreviated survey, the facility consistently had issues with the procurement of residents' admission medications and re-ordering of medications dating back to [redacted]. The facility's administration stated they were not aware of any concerns related to procurement of medications even though residents' medical records verified a longstanding and ongoing issue. Cross Reference: F755-L Immediate Jeopardy at F600-L Freedom from Abuse, Neglect, and Exploitation was identified and the Administrator was notified on [redacted] at 7:46 PM and was determined to start on [redacted]. Immediate Jeopardy at F755-L Pharmacy Services was identified and the Administrator was notified on [redacted] at 7:47 PM and was determined to start on [redacted] Acceptable Immediate Jeopardy Removal Plans were received on [redacted], which alleged	F 835	assessed [redacted] site on the morning of [redacted]. There was [redacted] on R 38□s [redacted]. An additional Registered Nurse assessed R 38□s [redacted] on [redacted] at approximately 9am. There was [redacted] on the [redacted]. The Director of Nursing assessed R 38□s [redacted] on [redacted] and there was [redacted] on the [redacted]. R 38 has an order to monitor [redacted] every shift. An additional order was placed for the nurses to monitor [redacted] every four hours. The Nursing Home Administrator reported the allegation on [redacted]. R 38 no longer resides in the center. R 57 was assessed by the Director of Nursing on [redacted]. He did not exhibit any signs or symptoms of [redacted] The findings were reviewed with the physician. R 57 was evaluated by the Nurse Practitioner on [redacted]. The Nurse Practitioner documented that R 57 was in NJ EX Order. 264b1. R 57 no longer resides in the facility. R 37 no longer resides in the center. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with an ostomy, with [redacted], and [redacted] while receiving an NJ EX Order. 264b1 have the potential to be affected. All residents in the center with [redacted] were evaluated. One other resident has an [redacted]. The Director of Nursing assessed the [redacted] on [redacted] and there was NJ EX Order. 264b1. The Director of Nursing reviewed current residents who [redacted] and were on [redacted] to determine if they were	

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F 835	Continued From page 154 removal of the Immediate Jeopardies at F600 and F755. 3. In addition, Substandard Quality of Care (SCQ) was identified at §483.12 Freedom from Abuse, Neglect, and Exploitation F600. During the survey, actual harm of a resident was identified at F684 Quality of Care. 4. Additionally, the facility's administration failed to ensure through a position description or contract with the Medical Director, how the Medical Director would fulfill their responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility; the facility failed to ensure residents received care from competent nursing staff; the facility failed to ensure residents' clinical medical records were complete and accurate; and failed to have an effective Quality Assurance/Performance Improvement (QAPI) program. Cross References: F726 Competent Nursing Staff; F841 Responsibilities of Medical Director; F842 Resident Records; and F867 Quality Assurance and Performance Improvement. These failures resulted in an Immediate Jeopardy at F835-L being identified and the Administrator notified on 01/08/24 at 6:13 PM. The facility provided an acceptable Removal Plan on [redacted]. On 1/17/2024, the surveyors conducted a revisit and verified that the Removal Plan was fully implemented. The noncompliance remained on 1/17/2024 at a Level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. Findings include:	F 835	monitored and documented on in the nursing notes [redacted]. No residents on anticoagulants had a [redacted] recently. All residents in the center with a diagnosis of [redacted] were evaluated by the Registered Nurse on [redacted]. None of these residents exhibited any signs or symptoms of a [redacted]. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Administrator was educated by the Regional Director of Clinical Services 01/04/24 regarding all staff on reporting allegations of abuse/neglect immediately, initiating investigations of allegations of abuse/neglect, conducting thorough investigations, and protection of residents during and after investigations. The Administrator was educated by the Regional Director of Clinical Services on 1/6/2024 on: a. Monitoring residents for all changes in condition, physician notification which includes timely notification, and accurate documentation. b. Assessing residents and documenting the assessments c. Sending residents to outside providers for treatment and services per the provider□s orders The Administrator was educated by the Regional Director of Clinical Services on 01/06/24 regarding Pharmaceutical Services, Procurement of Medications upon Admission, and Reordering Medications, Back Up Medication Supply. The Administrator was educated by the	

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F 835	Continued From page 155 Review of the Administrator's "Job Description," signed and dated 12/06/23, revealed " ...Position Purpose ...Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents ...Major Duties and Responsibilities...Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations ...Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility ...Leads and coordinates daily, weekly, bi-monthly or monthly management team meetings to discuss priorities and develop solutions with facility leaders such as census, collections, clinical health, survey readiness, customer service satisfaction ...Ensures delivery of compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover ...optimal resident functioning-physically and psychosocially. Identifies and collaborates with members of the interdisciplinary team, physicians, consultants, and community agencies to identify opportunities for enhanced services to the residents and/or resolve issues ...Performs rounds to observe residents and ensure overall needs are being met. Knows residents by name and sight ...Makes written and oral reports/recommendations to the	F 835	Regional Director of Clinical Services on NJ EX Order 20/21 a. Administering medications consistent with physician□s orders to ensure there is not a break in the provision of the needed medications to treat residents. This includes the process for notifying the provider of medications that are unavailable. b. Medications that have been reordered and haven□t arrived. c. Reordering medications for all residents d. Reconciliation and timely order entry for admission medications The Director of Nursing or designee will review the missed medication audit daily for one week, then weekly x three weeks, then bi-weekly x four weeks, and then monthly x one month to identify if residents missed scheduled medications. This will be documented on a log. The Director of Nursing or designee will review the facility□s back up medication supply daily to ensure the supply is stocked. This will be documented on a log. The Director of Nursing or designee will review the medications eligible for refill report daily to ensure medications are reordered timely. This will be documented on a log. Audits will be complete by running the report in Point Click Care. The Director of Nursing or designee will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered	

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F 835	Continued From page 156 governing board concerning the operation of the facility ...Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etc. are reported to the correct entity within the stated regulatory requirement ...Additional Tasks ...Reports any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of resident to appropriate regulatory entities. Protects residents from abuse, and cooperates with all investigations ..." The Director of Nursing's (DON's) job description was requested but not provided prior to exit. During an interview on 01/08/24 at 4:00 PM, the Regional Director of Operations (RDO) stated the facility's administration should have been aware of the pharmacy services issues identified by the survey team. Review of an email from the Administrator to the surveyor dated 01/08/24 revealed the facility did not have a position description for the Medical Director. Review of a statement on the facility's letterhead, signed by the Administrator on 01/07/24 revealed the facility did not have a contract with the Medical Director. NJAC 8:39-9.2 (a) NJAC 8:39-9.3 (a) NJAC 8:39-29.2 (d) NJAC 8:39-29.3 (a) 5, 6 NJAC 8:39-27.1 (a)	F 835	from the pharmacy right away. This will be documented on a log. The Director of Nursing or designee will in-service all licensed nurses, including agency nurses on: a. Administering medications consistent with physician□s orders to ensure there is not a break in the provision of the needed medications to treat residents. This includes the process for notifying the provider of medications that are unavailable. If the physician is not available, the providers in each practice always have someone on call. b. Medications that have been reordered and haven□t arrived c. Reordering medications for all residents d. Timely reconciliation and entry of new admission medications In-servicing began on 1/6/2023. All licensed nurses, including agency, will be in-serviced prior to their first scheduled shift. Fourteen nurses have been in serviced thus far. 14 divided by 20 equals 70 percent. 5 agency nurses have been in-serviced thus far. The Director of Nursing or designee will ensure that all nurses including agency nurses working in the center have access to the backup medication supply. The safety of the backup medication supply will be ensured through the backup supply being counted daily. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Regional Director of Operation or Regional Director of Clinical Services will review [redacted] documentation, physician	

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F 835	Continued From page 157	F 835	notification, and acute change assessment documentation weekly for four weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Regional Director of Operation or Regional Director of Clinical Services will review all abuse and neglect allegations with the Administrator weekly for 4 weeks, biweekly for 4 weeks, and then monthly x 1 month. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or Assistant Director of Nursing will review the following daily for 1 week, then weekly x 3 weeks, then bi-weekly for 4 weeks, and then monthly x 1 month. It will be documented on a log. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained: " Missed medication audit " Will review the facility□s back up medication supply daily to ensure the supply is stocked. " Will review the medications eligible for refill report. " Will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered from the pharmacy right away.	

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F 835	Continued From page 158	F 835	This will be documented on a log. 5. Date of Compliance: February 23rd, 2024	
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's Medical Director's Responsibilities policy, the facility failed to ensure the Medical Director was aware of serious occurrences in Freedom from Abuse, Neglect, and Exploitation, Quality of Care, and Pharmacy Services that resulted in actual harm and/or the likelihood for serious harm or death. The facility's failure had the potential to affect all 115 residents who resided at the facility. Findings include: During an interview on 01/04/24 at 12:50 PM, the Medical Director stated he was not aware of any issues with the facility procuring medications for residents as nothing had been brought up in QAPI or the facility's monthly meetings. The Medical Director stated it was his expectation if a resident was admitted during the day, the resident's medications would only take a few hours to arrive at the facility as the pharmacy was "just a couple miles down the road." Cross Reference: F755-L	F 841	F 841 Responsibilities of Medical Director 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified as having been affected in the 2567. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected . 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Regional Director of Operations in-serviced the Nursing home Administrator on notifying the Medical Director regarding all allegations of abuse, quality of care, and pharmacy services issues timely.	2/23/24

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F 841	Continued From page 159 The Medical Director stated related to R57's edema, the provider who was initially notified of the resident's concern should have started and intervention at that time and they did not. The Medical Director stated when the provider told the nurse they were coming in the next day to evaluate the resident, the provider should have. When asked was he aware the resident did not receive any other treatment, aware that no documented evidence of nursing monitoring the resident's NJ EX Order: 264[illegible] and aware that there were no provider intervention from NJNJ EX Order: 264[illegible] until NJ EX Order: 26401 when the resident was sent directly to the emergency room from a cardiologist appointment where NJ EX has NJ EX Order: 26401 of NJ EX drawn from NJ EX the Medical Director stated he was not aware of this. Cross Reference: F600-L During a subsequent interview on 01/08/23 at 3:10 PM, the Medical Director stated he had not been made aware of R37 sustaining a NJ EX Order: 26401 NJ EX Order: 26401) from a NJ EX. Cross Reference: F600-L. The Medical Director stated he had not seen a position description for his position of Medical Director and he did not know what the facility's expectations were of him related to his responsibilities; however, he has been a Medical Director for over NJ EX Order: 2640[illegible]. During an interview on 01/08/24 at 4:00 PM, the Regional Director of Operations (RDO) stated the Medical Director should have been aware of the concerns identified by the surveyors. Review of the facility's undated policy titled, "Medical Director Responsibilities," provided by the Administrator revealed "Policy: The facility retains a physician designated as Medical	F 841	The Regional Director of Operations will meet with the Medical Director to determine if all allegations of abuse, quality of care, and pharmacy services issues were reported timely. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Regional Director of Operations will meet with the Medical Director to determine if all allegations of abuse, quality of care, and pharmacy services issues were reported timely. These interviews will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x three months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 841	Continued From page 160 Director, to coordinate the medical care provided by attending physicians, and to assist with development and implementation of resident care policies. Policy Explanation and Compliance Guidelines: ...2. Medical Director will have his own caseload of residents as well as being available to oversee the medical care of all residents within the facility when other Attending Physicians are not available ...4. The Medical Director's responsibilities include participation in: a. Administrative decisions including recommending, developing and approving facility policies related to resident care of physical, mental and psychosocial well-being; b. Issues related to the coordination of medical care identified through the facility's QA committee and other activities related to the coordination of care; c. Organizing and coordinating physician services and services provided by other professionals as they relate to resident care; d. Participate in the Q.A. Committee ...8. Medical Director will assist in the development of systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring other licensed practitioners (e.g., nurse practitioners) who may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law." NJAC 8:39-23.1 (a)	F 841		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		2/23/24

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 162 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaints: NJ00158123, NJ00158489, NJ00159800 Based on observations, interviews, record reviews, and review of the facility's policy, the facility failed to ensure resident records were complete and accurate for six residents (Resident (R) 64, R14, R63, R57, R58, and R15) of a total sample of 65 residents. The facility's failure to ensure nursing staff completely and accurately documented each residents clinical status placed all 115 residents of the facility at risk for serious unmet care needs. Findings include: 1. Review of R64's undated "Admission Record,"	F 842	F 842 Resident Records - Identifiable Information 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R64, R63, R57, R58, and R15 no longer reside at the facility. R 14 was assessed by the Director of Nursing on [redacted]. did not exhibit any signs of [redacted]. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be	

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F 842	Continued From page 163 provided by the facility, revealed the resident was admitted to the facility on [redacted] with diagnoses which included NJ EX Order. 264b1 [redacted] NJ EX Order. 264b1 [redacted] Review of R64's "Physician Orders," located in the resident's electronic medical record (EMR) under the "Orders" tab, revealed an order dated [redacted] at 9:00 PM for [redacted] medication] Capsule [redacted] MG [milligram]" give [redacted] capsule by mouth [redacted] a day. During an observation and interview on 01/05/24 at 5:40 PM, Licensed Practical Nurse (LPN) 9 was asked if R64's [redacted] was available in the medication cart. LPN9 was observed to unlock the medication cart and then unlock the narcotic medication box which revealed R64's [redacted] medication was not available to be given to the resident. LPN9 confirmed the resident's medication had not arrived from the pharmacy yet. Review of R64's "Medication Administration Record (MAR)," dated [redacted] and located in the resident's EMR under the "Orders" tab, revealed it was documented the [redacted] medication was administered to R64 on [redacted] at 9:00 PM, on [redacted] at 9:00 AM, and on [redacted] at 9:00 PM, even though the resident's medication had not been delivered to the facility. Review of R64's pharmacy "Packing Slip Proof of Delivery," dated [redacted] and provided by the facility, revealed the resident's NJ EX Order. 264b1) was not delivered to the facility until [redacted] at 6:47 AM even though facility nurses had documented on R64's MAR that the medication	F 842	affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing or designee will in-service staff on accurately documenting medications, treatments, and resident status in the resident□s record. The Director of Nursing or designee will audit resident records for accurate documentation of medications, treatments, and resident status in the resident□s record. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: R 14□s medication administration record will be reviewed by the Director of Nursing or Assistant Director of Nursing weekly x 4 weeks, then every other week for 4 weeks to ensure ongoing compliance. All findings will be reviewed at the quality assurance meetings. The Director of Nursing or designee will audit 10 resident records for accurate documentation of medications, treatments, and resident status in the resident□s record. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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had been administered to the resident prior to its delivery.

Review of the facility's cubex (the facility's backup medication system) "Transactions By Patient, C14," with the date range of NJ EX Order. 264b1 provided by the facility, revealed the medication of NJ EX Order 2 was not dispensed from the cubex for R64.

During an interview on 01/08/24 at 2:13 PM, the Director of Nursing (DON) stated per R64's "MAR" the facility's nurses had administered the resident's NJ EX Order 2 to NJ EX Or on NJ EX Order. 264b1 at 9:00 PM, on 01/05/24 at 9:00 AM, and on NJ EX Order. 264b1 at 9:00 PM. The DON confirmed for these administration times and dates, R64's medication had not been delivered to the facility yet and she also confirmed the medication had not been dispensed from the facility's cubex. When asked if the "MAR" was inaccurate, the DON stated she was not sure where the nurses would have obtained the medication from, but the "MAR" says it was administered.

2. Review of R14's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 264b1 with diagnoses which included NJ EX Order. 264b1 .

Review of R14's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed R14 was ordered on NJ EX Order. 264b1 NJ EX Order. 264b1 medication used to treat NJ EX Order. 264b1 mg tablet NJ EX O times a day for anxiety.

Review of R14's "MAR" dated NJ EX Order. 264b1 located in the resident's EMR under the orders

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tab, revealed the resident was scheduled to be administered NJ EX Order. 264b1 mg by mouth at 5:00 PM and 10:00 PM every day. Continued review of the "MAR" revealed R14's routine c NJ EX Order. 264b1 m was not documented as administered for NJ EX Order. 264b1 - both doses, NJ EX Order. 264b1 -both doses, NJ EX Order. 264b1 -both doses, NJ EX Order. 264b1 -both doses, and NJ EX Order. 264b1 -both doses. Further review of R14's "MAR" revealed 'NJ EX Order. 264b1 monitoring: Monitor for the following symptoms: NJ EX Order. 264b1 [redacted] or NJ EX Order. 264b1 every shift for Monitoring If symptoms identified, enter "Y [yes]" document in progress note and call MD, if no symptoms identifed [sic] enter "N [no]." For NJ EX Order. 264b1 "N" was documented for the day, evening, and night shifts even though a nursing note for NJ EX Order. 264b1 had documented the resident complained of a NJ EX Order. 264b1 which contradicted the nursing documentation on the "MAR."

Review of R14's annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ EX Order. 264b1, located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of NJ EX Order. 264b1 which indicated the resident was NJ EX Order. 264b1 NJ EX Order.

During an interview on 01/04/24 at 2:30 PM, LPN6 stated she had took leave the last week of NJ EX Order. 264b1. LPN6 stated when she returned to the facility the first week of November, an agency nurse told her that R14 had been out of his NJ EX Order. 264b1 the prior week and had experienced NJ EX Order. 264b1 and NJ EX Order. 264b1.

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Continued interview revealed LPN6 confirmed in the resident's EMR that the medication was not on hand and the resident had missed several doses. LPN6 stated she contacted the pharmacy and ordered the resident's medication and then went to see R14. LPN6 stated R14 was upset and told her he needed NJ EX Order. 264b1 and that NJ EX had experienced NJ EX Order. 264b1 from not having the medication. LPN6 was asked as a nurse, what did she think the symptoms NJ EX was experiencing was from, LPN6 stated NJ EX Order. 264b1 from going without the NJ EX Order. 264b1.

During an interview on 01/06/24 at 1:00 PM, R14 stated at the end of NJ EX Order. 264b1 regular nurse (LPN6) went on vacation and that was the last time NJ EX received NJ EX Order. 264b1 until she returned from vacation on NJ EX Order. 264b1 when she ordered his medication. R14 stated he reported to the nurses NJ EX had NJ EX Order. 264b1, NJ EX Order. 264b1 R14 stated NJ EX had never had this feeling before. R14 also stated that NJ EX was very thankful for when LPN6 returned. R14 stated NJ EX told LPN6 what NJ EX experienced, and she ensured the pharmacy sent NJ EX medication.

During an interview on 01/06/24 at 11:27 AM, the Consultant Pharmacist (CP) stated R14 could experience NJ EX Order. 264b1 due to going without the medication.

Review of R14's EMR revealed no documented evidence that the nursing staff documented any NJ EX Order. 264b1 other than the resident complaining of a NJ EX Order. 264b1 on NJ EX Order. 264b1

3. Review of R63's undated "Admission Record,"

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F 842	Continued From page 167 provided by the facility, revealed the resident was admitted to the facility on 1[redacted]. Review of R63's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab revealed the resident was admitted to the facility with diagnoses which included [redacted]. Review of R63's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed an ordered dated [redacted] of '[redacted] GM Use[redacted] gram [redacted] time a day for [redacted]] During an interview on 01/07/24 at 10:07 AM, R63 stated on 01/06/24 at 11:45 AM a nurse started [redacted] medication. R63 stated at 4:00 PM she noticed that the [redacted] may not have been administering the medication correctly. The resident stated she touched the [redacted] and [redacted] and [redacted] hand. R63 stated a different nurse determined the nurse had [redacted] too much. R63 stated the nurse readministered the [redacted] at 4:30 PM. Review of R63's untitled documentation dated [redacted], provided by R63, revealed the resident documented on [redacted] at 11:45 AM [redacted] m [sic]," which indicated the resident was administered the [redacted]. Continued review of the resident's documentation revealed on [redacted] at 4:00 PM [redacted] not working proper [sic]." Further review of R63's documentation revealed on [redacted] at 4:30 PM [redacted] which indicated a nurse was readministering the resident's [redacted].	F 842		

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During an interview on 01/08/24 at 10:15 AM, LPN8 stated she administered R63's NJ EX Order. 264b1 medication on NJ EX Order. 264b1 at approximately 12:00 PM. LPN8 stated normally, with it being set at NJ EX O NJ EX Order. 264b1 is completed withing an hour. LPN8 stated she returned to R63's room at approximately 2:00 PM to administer the resident's NJ EX Order. 264b medication and the NJ EX Order. 26 was still NJ EX Order. 264 and was NJ EX Order. 264b administered. LPN8 stated since it was NJ EX Order. 264b1, she did not have any reason to believe it was not functioning properly. LPN8 also stated if the 3pm-11pm shift nurse noticed it was not administered properly and he had to rehang a NJ EX Order. 264b1 to readminister the medication, the nurse should have documented this in the resident's record that there was a problem with the first administration and notified the physician to get directions before administering the NJ EX Order. 264b1 a second time.

During an interview on 01/08/24 at 3:34 PM, the DON confirmed the facility had received two deliveries of R63's NJ EX Order. 264b1 medication of NJ EX Order. 264b1, of NJ EX Order. 2 doses each delivery which totaled NJ EX doses.

Review of R63's "MAR," dated NJ EX Order. 264b1, located in the resident's EMR under the "Orders" tab revealed it was documented the resident had been administered one dose of the NJ EX Order. 264b1 NJ EX Order. 264b1

Review of R63's "MAR," dated NJ EX Order. 264b1, located in the resident's EMR under the "Orders" tab revealed it was documented the resident had been administered eight doses of the NJ EX Order. 264b1 NJ EX Order. 264b1 Review of the "MARs" revealed the

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resident had been administered at total of [redacted] doses of the resident's 14 doses received from the pharmacy by the facility.

During a continued interview on 01/08/24 at 3:34 PM, the DON stated she counted the number of R63's [redacted] doses the facility had on hand as of [redacted], and the resident only had [redacted] doses left when she should have had [redacted] doses left which indicated a deficit of one dose. When asked if she could explain why there was one dose of the resident's [redacted] missing, the DON stated she did not know as there was nothing documented in the resident's EMR to account for the missing dose.

Review of R63's EMR revealed neither nurse (LPN8 nor the 3-11 shift nurse) documented in the resident's medical record related to the administrations of the medication [redacted]

4. Review of R57's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [redacted]

Review of R57's "Progress Notes," dated [redacted] at 6:02 PM, located in the resident's EMR under the "Progress Notes" tab, revealed "eMAR-Administration Note ...Note Text: PRN [as needed] Administration was: Effective Follow-up [redacted] Scale was: [redacted]

Review of R57's "MAR," dated [redacted], located in the resident's EMR under the "Orders" tab revealed for [redacted], R57 was not administered any PRN [redacted] medication even though the resident's progress note indicated a follow-up from [redacted] medication being

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F 842	Continued From page 170 administered. During an interview on 01/07/24 at 5:20 PM, when reviewing R57's progress notes and "MAR," the DON stated she could not say for sure if R57 received any PRN [NJ EX Ord] medication or not because the nursing progress note for [NJ EX Order: 2640] and the "MAR" didn't match, and they should match each other. Review of R57's "Progress Note," dated [NJ EX Order: 2640] at 5:57 PM revealed "eMAR-Administration Note Text: PRN Administration was: Effective Follow-up [NJ EX Ord] Scale was [NJ EX] Review of R57's "MAR" dated November 2023 revealed there was no documented evidence the resident was administered any PRN [NJ EX Ord] medication by the 3:00 PM-11:00 PM nurse for the nurse's documented note of the effectiveness of a PRN [NJ EX Ord] medication. During an interview on 01/07/24 at 5:20 PM, while reviewing R57's progress notes and "MAR" for [NJ EX Order: 2640] the DON stated the nurse on the 3:00 PM-11:00 PM shift assessed the effectiveness of the 7:00 AM-3:00 PM nurse's administration of the resident's PRN [NJ EX Ord] medication o[NJ EX Order: 2640] at 9:51 AM. When asked if the 3:00 PM-11:00 PM shift nurse could have accurately documented the effectiveness of a [NJ EX Ord] medication that was administered [NJ EX Ord] t hours earlier, the DON stated the 3:00 PM-11:00 PM nurse could not have accurately assessed the effectiveness of the 7:00 AM-3:00 PM nurse's administration of R57's PRN [NJ EX Ord] medication. Review of R57's "Progress Note," dated 11/10/23 at 8:53 PM revealed "eMAR-Administration Note	F 842		

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F 842	Continued From page 171 Text: PRN Administration was: Effective Follow-up [redacted] Scale was [redacted] Review of R57's "MAR" dated NJ EX Order: 264b1 revealed there was no documented evidence the resident was administered any PRN [redacted] medication on [redacted] by the 3:00 PM-11:00 PM nurse for the nurse's documented note of the effectiveness of a PRN [redacted] medication. During an interview on 01/07/24 at 5:20 PM, the DON stated the nurse who documented the progress note on [redacted] at 8:53 PM documented the effectiveness of the PRN NJ EX Order: 264b1 medication that was administered at 9:40 AM. The DON also stated the reason the nurse may have answered the effectiveness was because the 7:00 AM-3:00 PM shift did not go back and document the effectiveness and it would not allow the 3:00 PM-11:00 PM administer medication until it was answered. Review of R57's "Progress Note," dated [redacted] at 5:30 PM revealed "eMAR-Administration Note Text: PRN Administration was: Effective Follow-up [redacted] Scale was [redacted] Review of R57's "MAR" dated NJ EX Order: 264b1 revealed there was no documented evidence the resident was administered any PRN [redacted] medication on [redacted] by the 3:00 PM-11:00 PM nurse for the nurse's documented note of the effectiveness of a PRN pain medication that reflected [redacted] at 5:30 PM progress note. During an interview on 01/07/23 at 5:20 PM, the DON stated the nurse who documented the progress note on [redacted] at 5:30 PM,	F 842		

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documented the effectiveness of the PRN NJ EX Order. 264b1 medication that was administered by the nurse on the 7:00 AM-3:00 PM shift at 10:47 AM. When asked about the progress notes and "MARs" she reviewed with the surveyor, if she could say if R57's medical record was accurate, the DON stated she could not say it was accurate. When asked if the resident's medical record painted an accurate picture of R57's clinical status, the DON stated "no."

5. Review of R58's undated "Admission Record," provided by the facility revealed the resident was admitted on NJ EX Order. 264b1 with diagnoses which included NJ EX Order. 264b1.

Review of R58's "Physician Orders," located in the resident's EMR under the "Orders" tab revealed an order dated NJ EX Order. 264b1 for NJ EX Order. 264b1 NJ EX Order. 264b1 daily with meals.

Review of R58's "MAR," dated NJ EX Order. 264b1 located in the resident's EMR under the "Orders" tab revealed the NJ EX Order. 264b1 was scheduled to be administered at 8:00 AM and it was documented as being administered at 8:00 AM on NJ EX Order. 264b1

Continued review of the "MAR" revealed the following medications were ordered to be administered at 9:00AM and were documented as being administered NJ EX Order. 264b1 at 9:00 AM: NJ EX Order. 264b1 supplement) to be given with breakfast, NJ EX Order. 264b1 for NJ EX Order. 264b1 NJ EX Order. 264b1 for Alzheimer , NJ EX Order. 264b1 NJ EX Order. 264b1 for

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NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1 for NJ EX Order. 264b1

During an interview on 01/05/24 at 12:02 PM, LPN4 was questioned if R58 had received his morning medications. LPN4 stated she had administered NJ EX Order. 264b1, and she was getting ready to administer the rest of NJ EX morning medications. This interview contradicted the documented "MAR."

During an observation on 01/05/24 at 12:05 PM at R58's bedside, LPN4 was administering R58's medications. R58 asked LPN4 where NJ EX Order. 264b1 was. LPN4 stated, "I checked your NJ EX Order. 264b1 this morning and gave you your NJ EX Order. 2" R58 asked the LPN4 how did you check my NJ EX Order. NJ EX Order. LPN4 stated, "I NJ EX Order. 264b1" R58 told LPN4, "No, you did not. Because I have an NJ EX Order. 26 that checks NJ EX Order. 264b1, and no you did not give me NJ EX Order. 264b1" After LPN4 left the room, R58 checked NJ EX Order. 264b1, the results were NJ EX Or.

Observation on 01/05/24 at 12:09 PM, LPN4 returned to R58's room. LPN4 apologized to R58, and stated "No, I did not check your NJ EX Order. 264b1, or give you NJ EX Order. 264b1. I will have to call the nurse practitioner and let her know and find out what she wants me to do."

During an observation and interview on 01/05/24 at 12:36 PM, Unit Manager (UM) 1 and the Assistant Director of Nursing (ADON) entered R58's room. UM1 stated to the surveyor she was

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made aware of LPN4 not administering R58's [redacted] this morning even though the LPN documented it had been administered. UM1 and ADON both confirmed that LPN4 had documented that she had administered R58's medications at 9:00AM, although LPN4 had not administered the medication until 12:05 PM.

6. Review of the undated "Admission Record" provided by the facility revealed R15 was originally admitted to the facility on [redacted] was hospitalized, and then was readmitted on [redacted]. R15's diagnoses included metabolic [redacted] R15 was hospitalized on [redacted] and she did not return to the facility after this date; [redacted] closed record was reviewed.

Review of the Prospective Payment System (PPS) "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed R15 was [redacted] with a "Brief Interview for Mental Status (BIMS)" score of [redacted]

During an interview on 01/04/24 at 10:45 AM, Family Member (F) 4 stated when R15 got [redacted] on [redacted] was placed on [redacted] and remained there until she went to the hospital on [redacted]. F4 stated R15 had a history of [redacted] F4 stated R15's condition deteriorated starting on [redacted] and on [redacted], R15 became [redacted]. F4 stated she asked the nurses about obtaining [redacted] for R15 on [redacted]. F4 stated R15 later reported to [redacted] felt like [redacted] was [redacted]. F4 stated on

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NJ EX Order. 264b1 stat labs, a NJ EX Order. 264b1 were ordered by the Nurse Practitioner. F4 stated NJ EX O was with R15 all day on NJ EX Order. 264b1 and in the afternoon the NJ EX Order. 264b1 had not been completed and R15 continued to decline so F4 called 911 and R15 was transported to the hospital. F4 stated R15 was admitted to the hospital on NJ EX Order. 264b1 with NJ EX Order. 264b1 and a NJ EX Order. 264b1 64b1.

Review of a "Physician's Note" dated NJ EX Order. 264b1 the EMR under the "Orders" tab revealed, "Patient seen and examined this afternoon . . . NJ EX Order. 264b1 for NJ EX Order. 264b1 on NJ EX Order. 264b1 after having NJ EX Order. 264b1 . . . NJ EX O was transferred onto the NJ EX Order unit where NJ EX Or will finish out NJ EX Order. 264b1 . . Lying in bed . . . NJ EX Or Order. 2 is fair at best . . ."

Review of a "Physician's Note" dated NJ EX Order. 264b1 at 3:44 PM in the EMR under the "Orders" tab revealed, "Patient seen and examined this afternoon for f/u [follow up] NJ EX Order. 264b1. Appears NJ EX Order. 264b1 increasingly NJ EX O compared to last week visit. NJ EX Order. 264b1 is visiting and concerned NJ EX O may need to go to the hospital. Stat [immediate] NJ EX Order. 264b1 has already been ordered and waiting for lab to come. Nurse reports patient has been refusing NJ EX Order. 264b1 supplement. Will tend to only take if family is present. NJ EX O has been NJ EX Order. 264b1 according to NJ EX Order. 264b1. NJ EX Order. 264b1 has been trying to NJ EX Order. 264b1 NJ EX Order. 264b1) as much as possible when NJ EX O is here. Discussed with patient and NJ EX Order. 264b1 that NJ EX Order. 264b1] can be started, NJ EX Order. 264b1 pending and NJ EX Order. 264b1] to be collected . . ."

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Review of a "Nurse's Note" dated [redacted] at 4:10 PM in the EMR under the "Progress Notes Tab" revealed, "Note Text: Family called 911 to have resident sent out. Family member [redacted]) stated that the resident is 'declining' and [redacted] do not feel at this time resident is a fit for this facility."

Except for "eMAR [electronic Medication Administration Record] Administration Notes," there were no nursing "Progress Notes" in the EMR documenting R15's condition from [redacted] until [redacted] at 4:10 PM at which time the nurse documented F4 calling 911 to have R15 sent to the hospital (see note above). There was no documentation of nursing staff monitoring R15's condition, that labs that had been ordered earlier that day and the status of getting them completed, and no documentation of the order for [redacted] and status of that.

Attempts were made to find nurses who had worked with R15 during her stay and during [redacted] change in condition; however, there were no nurses who remembered or were familiar with R15 available to interview during the survey.

During an interview with the prior Director of Nursing (DON) who was employed when R15 resided at the facility until [redacted] month before the survey, stated she did not remember R15.

During an interview on 01/10/24 at 12:28 PM, the DON who had been hired approximately [redacted] earlier, stated when a resident was experiencing a change in condition, the nurses should monitor and document the resident's condition a minimum of every shift (eight-hour shifts utilized at the facility) in the progress notes.

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F 842	Continued From page 177 Review of the facility' policy titled, "Maintenance of Clinical Records," revised 11/29/23, revealed "Policy: This facility will maintain clinical records for each resident in accordance with acceptable standards of practice that reflects the current plan of care and services provided as well as in a manageable size for use by the care providers ...2. In accordance with accepted professional standards of practices, the facility must maintain medical records on each resident that are: a. Complete b. Accurately documented ...3. The clinical record will contain at least, but not limited to: ...b. A record of the resident's assessments ...d. Physician, nurse, and other licensed professionals progress notes ...h. Interdisciplinary documentation that reflects the plan developed and the progress of such plan to meet the needs of the resident. i. Sufficient information for staff to respond to the changing status and needs of the resident ..."	F 842		
F 867 SS=F	NJAC 8:39-35.2 (d) 6 QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input	F 867		2/23/24

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from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

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(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or

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	315521	A. BUILDING _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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F 867	Continued From page 180 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) program that identified quality concerns, developed corrective actions, and monitored for adverse events related to pharmacy services, documentation, and call light response times. This had the potential to affect 115 of 115 residents who resided at the facility. Findings include: During an interview on 01/09/24 at 9:31 AM, the Regional Clinician (RC) confirmed she was speaking on behalf of the facility regarding the facility's QAPI program. The RC was asked how the QAPI program addressed the facility's pharmacy system. The RC stated if concerns	F 867	F 867 QAPI/QAA Improvement Activities 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified as having been affected in the 2567. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Regional Director of Operations or	

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F 867	Continued From page 181 were brought up, most likely the nursing department would be put in charge of putting a plan of improvement in place. The RC was asked what monitoring systems were in place for the pharmacy system. The RC stated the facility had clinical meetings Monday through Friday where they discussed notes from nursing, patient relations, lab results, and assessments to determine what to address. The RC stated concerns related to pharmacy services were also discussed in the clinical meetings. The RC was asked what kind of auditing systems were in place for pharmacy services. The RC stated she pulled weekly reports and medication and treatment administration records, and during the clinical meetings, the nursing department was supposed to review the documents for medication pass compliance. The RC stated compliance was measured by if medications were given one hour before or after their scheduled administration time. Continuing with the interview on 01/09/24 at 9:40 AM, the RC was asked if prior to the survey, had any concerns related to pharmacy services been identified. The RC stated, "I personally did not." The RC stated that when she was in the building, she was not working the floor. The RC confirmed she had heard complaints, but not to the extent she was hearing now. The RC was asked if she had heard concerns related to medications being missed, administered late, and inaccurate documentation of medications. The RC stated, "Only if there is an issue." Continuing with the interview on 01/09/24 at 9:43 AM, the RC was asked how the QAPI program addressed the facility's system of documentation. The RC stated the clinical team was supposed to	F 867	Regional Director of Clinical Services in-serviced the Nursing Home Administrator and facility staff on having an effective Quality Assurance Performance Improvement program that identifies quality concerns, developing corrective actions, and monitoring for adverse events. The Regional Director of Operations or Regional Director of Clinical Services will review the information presented and discussed at the Quality Assurance Performance Improvement program to ensure quality concerns are reviewed, corrective actions are developed, and there is monitoring for adverse events. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Regional Director of Operations or Regional Director of Clinical Services will review the information presented and discussed at the Quality Assurance Performance Improvement program to ensure quality concerns are reviewed, corrective actions are developed, and there is monitoring for adverse events. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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F 867	Continued From page 182	F 867		

monitor documentation daily and address any questionable documentation. The RC was asked if the facility completed any type of charting audits. She stated the 11-7 supervisors were supposed to pull reports for new orders, an order listing report, and complete chart checks for new admissions. The RC was asked what caused the documentation discrepancies found by the survey team. The RC stated it was due to communication. The RC stated if the reports were not pulled or the residents did not complain, then the management staff would not know about the concerns. The RC stated that the volume of residents might be part of the problem. The RC stated there were only about 15 long-term care residents, and staff might not even get the opportunity to monitor charts for those residents who were here for only a few days. The RC was asked how the facility's QAPI program could function, or nurses take care of residents without accurate information. The RC stated, "QAPI wouldn't be accurate."

Continuing with the interview on 01/09/24 at 9:55 AM, the RC was asked if the facility had a system in place to monitor and audit call light response times. She stated she was unsure if there was a standard policy, but call lights should be answered as quickly as possible.

Continuing with the interview on 01/09/24 at 10:00 AM, the RC was asked how the breakdown occurred in the facility's pharmacy and documentation systems. She stated she was not sure and would have to investigate. The RC was asked who monitored the staff responsible for monitoring the facility's systems. The RC confirmed that was the responsibility of the regional nurses.

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F 867	Continued From page 183 Review of the facility's policy titled, "Quality Assessment and Assurance Committee," revised July 2023, revealed, ". . . This facility will maintain a Quality Assessment and Assurance (QAA) Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies . . . The committee will . . . Provide oversight of the QAPI program . . ." Cross-Reference F-725: Sufficient Nurse Staffing; F-755: Pharmacy Services; and F-842: Resident Records NJAC 8:39-33.2 (a), (b) (c), (d). 33.1	F 867		

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S 000	Initial Comments	S 000		

Complaint #'s: NJ00151851, NJ00152320, NJ00153272, NJ00153799, NJ00156210, NJ00156380, NJ00156580, NJ00156776, NJ00157166, NJ00157215, NJ00157739, NJ00157760, NJ00157827, NJ00158123, NJ00158489, NJ00158677, NJ00158720, NJ00159247, NJ00159319, NJ00159405, NJ00159533, NJ00159679, NJ00159800, NJ00160098, NJ00160123, NJ00161147, NJ00161186, NJ00161524, NJ00161762, NJ00161776, NJ00162177, NJ00162457, NJ00162827, NJ00162977, NJ00165870, NJ00167295, NJ000168256, NJ00168400, NJ00168545, NJ00168603, NJ00169368, and NJ00169776.

Survey Dates: 01/03/24-01/09/24
Survey Census: 115
Sample Size: 65

The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.

On 01/06/24 at 7:46 PM, the facility's Administrator was notified that the failure to ensure residents were free from abuse/neglect and that the facility failed to ensure pharmaceutical services were provided and maintained to meet each residents' needs constituted Immediate Jeopardies, S395 and

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

Electronically Signed | 02/14/24

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S 000	Continued From page 1 S1935 respectively. Additionally, on 01/08/24 at 6:13 PM, the facility's Administrator was notified that the failure to ensure the facility was administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident constituted Immediate Jeopardy, S765. The Immediate Jeopardy at S1935 was determined to first exist on 06/04/22, when the facility failed to ensure R33's intravenous (IV) antibiotic medication was acquired and administered timely. The Immediate Jeopardy at S395 was determined to first exist on 06/15/23 when nursing failed to monitor for head injury after R37 had an unwitnessed fall. The facility provided an acceptable removal plan on 01/9/24. The removal plan included assessments of all residents with stomas and educating all nursing staff, including agency nurses, on ostomy management. The removal plan included reviewing all residents receiving anticoagulants and any falls to determine if monitoring and educating nursing staff, including agency nurses, on monitoring residents on anticoagulants who fall, monitoring residents for changes in condition, timely physician notification, accurate documentation, and sending residents to outside providers per physician orders. The removal plan included assessing all residents with a diagnosis of heart failure and educating nursing staff, including agency nurses, of signs and symptoms of CHF and evaluating residents with CHF. On 1/17/2024, the surveyors conducted a revisit and verified that the Removal Plan was fully implemented. The noncompliance remained on 1/17/2024 at a Level F for no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.	S 000		

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S 000	Continued From page 2 The Immediate Jeopardy of S395 also constituted Substandard Quality of Care at 42 CFR 483.12 and a partial extended survey was completed.	S 000		
S 395	8:39-4.1(a)(5) Mandatory Resident Rights (a) Each resident shall be entitled to the following rights: 5. To be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaints: NJ00157215, NJ00161186, NJ00161762, NJ00162457, NJ00162827, NJ00167295, NJ00168400, NJ00168545, NJ00168603, NJ00169368 Based on observation, interview, record review, and facility policy review, the facility failed to protect one resident's (Resident (R) 38) right to be free from physical abuse by staff and failed to protect two residents' (R37 and R57) right to be free from neglect out of a total sample of 65 residents. An allegation was reported that R38 was found with adhesive paste inside NJ EX Order. 264b1. It was reported the NJ EX Order. 264b1 was in an amount sufficient to obstruct R38's [redacted] The facility failed to identify the alleged incident as an allegation of abuse, failed to report the allegation to the state agency, failed to conduct a thorough	S 395	S 395 Mandatory Resident Rights 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 37 no longer resides at the facility. R 38□s assigned Registered Nurse assessed [redacted] site on the morning of [redacted]. There was no paste on R 38□s [redacted] An additional Registered Nurse assessed R 38□s [redacted] on [redacted] at approximately 9am. There was no [redacted] on the [redacted]. The Director of Nursing assessed R 38□s [redacted] on [redacted] and there was no [redacted] on the [redacted] R 38 has an order to monitor his [redacted] site every shift. An additional order was placed for the nurses to monitor his ostomy every four hours. R 38 no longer resides in the facility.	2/23/24

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S 395	Continued From page 3 investigation, and failed to protect residents during the investigation. R37 received NJ EX Order. 264b1 an NJ EX Order. 264b1 medication, suffered an unwitnessed fall, and the facility neglected to monitor for changes in NJ EX Order. R37 was sent to the hospital, and it was recorded that NJ EX Or had a NJ EX Order. 264b1 NJ EX Order. 264b1 R57 had diagnoses including NJ EX Order. 264b1 NJ EX Order. 264b1 and exhibited signs and symptoms of an NJ EX Order. 264b1. The facility neglected to obtain a cardiologist appointment as requested by the resident, neglected to monitor daily weights, neglected to notify the physician when R57 had NJ EX Order. 264b1 and neglected to intervene when providers did not provide care and services necessary for a resident having an exacerbation NJ EX Order. 2. R57 was admitted to the hospital and had NJ EX pounds (lbs) of NJ EX Order. 264b1 from NJ EX Order. 264b. The failures to identify allegations of abuse, monitor for changes i NJ EX Order. 264b1, and provide care and services for a resident having an exacerbation of NJ EX Order resulted in an Immediate Jeopardy (IJ) being called on NJ EX Order. 264b3. The facility provided an acceptable removal plan on NJ EX Order. 264b3 abuse and neglect. On 1/17/2024, the surveyors conducted a revisit and verified that the IJ removal plan was fully implemented. Findings include: 1. Review of R38's "Admission Record," provided by the facility, revealed R38 was admitted to the facility on NJ EX Order. 264b3 with diagnoses that included surgical aftercare following NJ EX Order. 264b1 and	S 395	All residents in the center with an NJ EX Order. 264 were evaluated. One other resident had an NJ EX Order. 264b3 The Director of Nursing assessed the NJ EX Order. 26 on NJ EX Order. 264b3 and there was no NJ EX Order on the NJ EX Order. 264 R 57 was assessed by the Director of Nursing on 1/6/2024. He did not exhibit any signs or symptoms of NJ EX Order. 264b1 NJ EX Order. 264b1 The findings were reviewed with the physician. R 57 was evaluated by the Nurse Practitioner on 1/5/2024. The Nurse Practitioner documented that R 57 was in no acute distress. R 57 no longer resides in the facility. All residents in the center with a diagnosis of heart failure were evaluated by the Registered Nurse on 1/8/2024. None of these residents exhibited any signs or symptoms of a NJ EX Order. 264b1. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with NJ EX Orde with NJ EX Order. 26 □s and with actual falls have the potential to be affected. The Director of Nursing evaluated all residents in the center with an NJ EJ EX Order. One other resident had an NJ EX Order. 264 . The Director of Nursing assessed the NJ EX Order. 26 on NJ EX Order. 264b3 and there was no NJ EX Order on the NJ EX Order. 2 The Director of Nursing reviewed current residents who NJ EX O and were on NJ EX Order. 264b1 to determine if they were monitored and documented on in the nursing notes post NJ EX O All residents who met this criteria were documented on appropriately. All residents in the center with a diagnosis	

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S 395	Continued From page 4 attachment of the NJ EX Order. 264b1 to the NJ EX Order. 264b1 where NJ EX Order. 264b1 to the outside NJ EX Order. 264b1 status, and other NJ EX Order. 264b1 Review of R38's "Physician Orders," dated NJ EX Order. 264b1 and located under the "Orders" tab of the electronic medical record (EMR), revealed R38's NJ EX Order. 264b1 were to be changed daily on the 11-7 shift. Review of R38's admission "Minimum Data Set (MDS)," located under the "MDS" tab of the EMR and with an Assessment Reference Date (ARD) of NJ EX Order. 264b1, revealed R38 scored NJ EX Order. 264b1 on the "Brief Interview for Mental Status (BIMS)," which indicated R38 was NJ EX Order. 264b1. Review of R38's undated "Care Plan," provided by the facility, documented a focus problem related to R38's NJ EX Order. 264b1. It was recorded to NJ EX Order. 264b1 as ordered and when indicated, to change/empty the NJ EX Order. 264b1 after each NJ EX Order. episode or when full, and to place a NJ EX Order. 264b1 around the NJ EX Order. site. Review of R38's "Progress Notes," dated NJ EX Order. 264b1 through NJ EX Order. 264b1, revealed no documentation of any concerns related to R38's NJ EX Order. 264b1. On 01/04/24 at 6:00 PM, R38's family member (F) 6 stated that on the morning of NJ EX Order. 264b1, F7 had started to change R38's NJ EX Order. 264b1, and when F7 removed NJ EX Order. 264b1 F7 found NJ EX Order. NJ EX Order. 264b1 inside of R38's NJ EX Order. F6 showed the surveyor a photo of what appeared to be a NJ EX Order. with a NJ EX Order. 264b1 the NJ EX Order. 264b1. F6 reported that the Director of Patient Relations and two nurses had	S 395	of NJ EX Order. 264b1 were evaluated by the Registered Nurse on 1/8/2024. None of these residents exhibited any signs or symptoms of a NJ EX Order. exacerbation. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Nursing Home Administrator and Regional Clinical were in-serviced by the Regional Director of Clinical Services on reporting and investigational requirements for allegations of abuse and neglect on 1/6/2024. The Nursing Home Administrator or designee in-serviced all staff on reporting allegations of abuse/neglect immediately, initiating investigations of allegations of abuse/neglect, conducting thorough investigations, and protection of residents during and after investigations. This began on 1/6/2023. All staff, including agency staff will receive this in-servicing prior to working their next scheduled shift. The Director of Nursing or designee in-serviced nurses, agency and staff, on NJ EX Order. management. This began on 1/6/2024. Nurses who have not yet been in-serviced will be in-serviced prior to working their next scheduled shift. The Director of Nursing or designee in-serviced nurses, agency and staff, on monitoring residents on NJ EX Order. 264b1 who NJ EX, monitoring residents for all changes in condition, timely physician notification, accurate documentation, evaluating residents and documenting those evaluations, and sending residents to outside provider□s for treatment and services per the provider□s orders. This	

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S 395	Continued From page 5 been informed of the incident. F6 stated she believed the photo had been forwarded to staff members. On 01/04/24 at 6:25 PM, the Administrator and Director of Nursing (DON) were asked if they were aware of the alleged incident. The Administrator stated she had been informed on [redacted] and she had opened a grievance regarding the allegation. The Administrator confirmed a state reportable incident report had not been sent to the state survey agency. The Administrator stated she had seen the photo but had not enlarged it for closer inspection. The DON stated she had not seen the photo. The Administrator identified two staff members, Registered Nurse (RN) 4 and RN2, as working with R38 on the 11-7 shift from 11:00 PM on [redacted] through 7:00 AM on [redacted] The Administrator stated RN2 had been suspended because she would not return their call and that RN4 was coming to provide a statement before his shift on [redacted] The Administrator did not identify any nurse aides that had worked with R38 on the shift in question. The Administrator confirmed she had not identified the allegation as an allegation of abuse and had not started an investigation of the alleged incident. On 01/04/24 at 6:58 PM, the Administrator provided documentation concerning the allegation. Included in the documentation were R38's "Admission Record," "Order Summary Report," and a "Grievance/Concern Form," where it was recorded, ". . . [redacted] [sic] [F6] stated that that [sic] whomever on the 11-7 shift did not change [redacted]/care for [redacted] properly . . ." It was documented that the Director of Public Relations filled out the form. There was no documentation of the allegation that [redacted]	S 395	began on 1/6/2024. Nurses who have not yet been in-serviced will be in-serviced prior to working their next scheduled shift. The Director of Nursing or designee in-serviced nurses, agency and staff, on signs and symptoms of [redacted] and evaluating residents with [redacted]. This began on 1/6/2024. Nurses who have not yet been in-serviced will be in-serviced prior to working their next scheduled shift. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing or designee will review post [redacted] documentation, physician notification, and acute change assessment documentation weekly for four weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. The regional nurse or regional operator will review all abuse and neglect allegations with the Administrator weekly for four weeks, biweekly for 4 weeks, and then monthly x 1 month. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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S 395	Continued From page 6 NJ EX Order. 264b1 was found in R38's NJ EX Order. 26 On 01/05/24 at 7:53 AM, the Administrator provided documentation of her investigation of the alleged incident with R38. The documentation included an untitled document, dated NJ EX Order. 264b1, that recorded, ". . . The resident was interviewed by the DON and he stated that there was NJ EX Order. NJ EX Order on NJ EX Order. 264b1 . ." The investigation documentation included a statement from RN4 where it was noted RN4 did not provide care for R38 on NJ EX Order. 264b1, a statement from Licensed Practical Nurse Supervisor (LPNS), and a statement from Licensed Practical Nurse (LPN) 5. It was recorded LPN5 was asked what care he provided to R38 on NJ EX Order. 264b1. It was recorded LPN5 stated he did not change the NJ EX Order. 264b1 and did not note any concerns with the NJ EX Order. 26 NJ EX Orde There was no documentation LPN5 was asked any questions specific to the allegation of stoma NJ EX Order. 264b1 being inside R38's NJ EX Order. On 01/05/24 at 6:55 PM, the Regional Clinician (RC) stated she had been informed a family member had found NJ EX Order. 264b1 inside R38's NJ EX Order and she had reported it immediately. The RC stated she had seen the photo and F6 had told staff that the substance was NJ EX Order NJ EX Order. 264b1. The RC stated R38 had a NJ EX Or NJ EX Order. 264b1, and the facility was using different processes to determine what was the best method for changing and maintaining R38's NJ EX Order. 264b1. The RC stated staff and family members had been changing R38's NJ EX Order. 264b1 NJ EX Order. 26 NJ EX Order. 264b1 times per shift because of leakage. The RC reported that RN2 had tested NJ EX Order. 264b1, and that was why she had not been answering the facility's calls. On 01/05/24 at 2:00 PM, F7, who was the family	S 395		

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member that allegedly found the NJ EX Order. 264b1 NJ EX Order in R38's NJ EX Order, reported that on NJ EX Order. 264b1 when he arrived at the facility, R38's NJ EX Order. 264b1 was clean. F7 stated he found that unusual and began to change R38's NJ EX Order. 264b1. F7 stated when he removed the NJ EX Order he found what looked to be NJ EX Order. 264b1 inside the NJ EX Order. F7 stated, "It looked like someone squirted it NJ EX Order. 264b1 there." F7 reported he inserted a NJ EX Order" into the NJ EX Order. 264b1 to NJ EX Order. 264b1 and pulled out approximately NJ EX Order. 264b1 and a NJ EX Order. 264b1. F7 reported he began to clean around the NJ EX Order. 1 and the pressure caused NJ EX Order additional pieces of NJ EX Order. 264b1 to come from the NJ EX Order. 2. F7 reported that after the last piece of NJ EX Order. 264b1 came out, NJ EX Order. 264b1 began coming out.

On 01/06/24 at 10:00 AM, the surveyor observed NJ EX Order. 26 supplies, including NJ EX Order. 264b1 of NJ EX Order. 264 , were noted on R38's bedside table. The NJ EX Order. 264b1 was noted to be NJ EX Order. 264b1.

On 01/06/24 at 10:36 AM, the Unit Manager (UM) stated nurses changed and emptied NJ EX Order. 264b1 and aides emptied the NJ EX Order. 264b1.

On 01/06/24 at 11:35 AM, the Administrator provided an update to her investigation of the alleged incident with R38. Included a document dated NJ EX Order. 264b1 which recorded Certified Nurse Aide (CNA) 4 had been assigned to R38 on NJ EX Order. 264b1. There was no documentation of an interview with CNA4 included in the documents provided to the surveyor. A statement from CNA3, who was the other CNA assigned to R38's unit, was included in the documentation. The Administrator stated RN4 and RN2 had been interviewed and neither worked with R38 on the

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shift in question. The Administrator reported that LPN5 had been assigned to R38 on the shift in question and that he had been interviewed and denied any concerns. The Administrator provided documentation of interviews with three other residents where the residents were asked "How would you describe your overall care" and "Do you have any concerns at all that you want to express." There was no documentation the residents were asked questions specific to abuse. There was no documentation a statement had been obtained from F7. The Administrator stated the investigation was ongoing and confirmed the incident did occur. The Administrator was asked if all the aides assigned to R38 on that shift had been interviewed. She stated, "No." The Administrator was asked how the facility was protecting residents during the investigation. The Administrator stated residents were being protected with general rounds and observing and monitoring R38's [redacted] The Administrator reported she did not know if there were any other residents with [redacted] in the facility. No further documentation was provided to the surveyor by the end of the survey on 01/09/24 at 12:30 PM.

2. Review of R37's hospital "Active Meds sort by Name," located under the "Misc (Miscellaneous)" tab of the EMR, revealed R37 received [redacted] milligrams (mg) of [redacted], an [redacted] at the hospital on 06/14/23 at 9:00 AM.

Review of R37's "Admission Record," provided by the facility, revealed R37 was admitted to the facility on [redacted] with diagnoses including [redacted]).

Review of R37's "Physician Orders," located under the "Orders" tab of the EMR, revealed R37

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S 395	Continued From page 9 was to receive NJ EX Order. 264b1 mg twice daily for NJ EX Order. 264b1 Review of R37's NJ EX Order. 264b1 Risk Evaluation," dated NJ EX Order. 264b1 at 3:11 AM, revealed documentation R37 was assessed to have behaviors of an NJ EX Order. 264b1. The evaluation did not indicate what behaviors R37 exhibited. It was also recorded R37 was NJ EX Order. 264b1, walking did not occur, and R37's vision was adequate. The Licensed Practical Nurse Supervisor (LPNS) electronically signed the form. Review of R37's "Nurses Notes," dated 0 NJ EX Order. 264b1 at 3:22 AM and located under the "Progress Notes" tab of the EMR, revealed, ". . . @ 0300 [3:00 AM] [R37] was overheard calling out. Upon entering her room, she was noted lying on the floor with only a NJ EX Order. 264b1 and was on NJ EX Order. 264b1. Full body assessment revealed no bruised [sic], marks, or contusions. She was assisted back intobed [sic] and [family member] and primary physician were notified, and NJ EX Order. 264b1 [sic] were initiated . . ." Review of R37's "Progress Notes," dated NJ EX Order. 264b1 and located under the "Progress Notes" tab of the EMR, revealed no documentation to show R37's NJ EX Order. 264b1 was monitored from 3:00 AM through 7:00 AM. Review of R37's "Nurses Notes," dated NJ EX Order. 264b1 at 8:30 AM and located under the "Progress Notes" tab of the EMR, revealed, ". . . after reporting on my shift the night nurse said they received a patient [R37] who at the moment was NJ EX Order. 264b1 Patient did not respond at all for entire shift. She had moments of NJ EX Order. 264b1 about 3.00am [sic] while they were going round the staff	S 395		

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found patient on the floor. they [sic] assessed [NJ EX] and picked her up. They started [NJ EX Order] status. around [sic] 8.30 am [sic] i [sic] walked to the room i tried to call the patient but could respond with [NJ EX Order: 264b1] sic]. on the sheet was [NJ EX Order: 264b1] as if the patient had [NJ EX Order: 264b1] i took [NJ EX] vital signs bp [blood pressure], [NJ EX Order: 264] p [pulse]: [NJ EX], oxygen [NJ EX], Temp [temperature]: 9[NJ EX], and BS [blood sugar]: [NJ EX], patient could [NJ EX Order: 264b1] and while i was there patient [NJ EX Order: 264b1] again. Informed the supervisor, NP [nurse practitioner] and Doctor informed, they decided to evaluate [NJ EX] for few hrs [hours] and then send [NJ EX] out . . ." This was [NJ EX Order: 264b1] hours after R37's [NJ EX]

Review of R37's "Medication Administration Records (MARS)," dated [NJ EX Order: 264b] and located under the "Orders" tab of the EMR, revealed no documentation R37 had been administered a [NJ EX Order: 264b] or any medication known to cause [NJ EX Order: 264b] [NJ EX Order: 264b] It was documented R37 had received [NJ EX Order: 264b] mg at 9:00 AM on [NJ EX Order: 264b].

Review of R37's "Assessments," "Progress Notes," and "Misc" tabs of the EMR revealed no documentation of [NJ EX Order:] checks or monitoring for R37 after [NJ EX Order: 9].

Review of R37's "Nurses Notes," dated [NJ EX Order: 264b] at 1:28 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . patient was sent out for evaluation due to [NJ EX Order: 264b1] [NJ EX Order: 264b1], and previous history [NJ EX Order] . . ."

Review of R37's "Physician/Practitioner Progress Note," dated [NJ EX Order: 264b] at 1:59 PM, revealed, ". . . Nursing states patient had a [NJ EX] last night. Nursing states patient had [N] episodes of [NJ EX Order: 264b] this morning and is l[NJ EX Order: 264]. Patient seen in bed

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with eyes closed with NJ EX Order. 264b1 . Due to mental status change, new onset of , and unwitnessed NJ EX Order. 264b1 sending patient out for NJ EX Order. 264b1 . . ."

Review of R37's "Nurses Notes," dated at 6:53 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . [Hospital name withheld] nurse called at 18:30 [6:30 PM] to ask when was the last time [R37] had was las [sic] given at 09:00 [9:00 AM], Diagnosis NJ EX Order. 264b1 ."

During an interview on 01/04/24 at 2:35 PM, Registered Nurse (RN) 1 stated were supposed to be documented on paper and then placed in the resident's hard chart. RN1 stated she did not remember anything about R37.

During an interview on 01/04/24 at 4:41 PM, the Administrator and DON provided a copy of R37's incident report for the on . Review of the incident report, dated and prepared by LPNS, revealed, ". . . heard resident call out for help. Staff entered room and observed her lying on NJ EX Order. 264b1 on the floor near the bath [unable to read the rest of this sentence] . . . was last seen in bed. Resident ambulated without asking for assistance and . . ." It was recorded R37 was NJ EX Order. 264b1 and . The Administrator and DON were asked if the incident report recorded any checks for R37. They stated no.

During an interview on 01/05/24 at 7:58 AM, RN4, who was the nurse responsible for R37 on stated when R37 was found in the floor, the house supervisor was notified, an assessment was completed, and checks were started. RN4 stated the physician was

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notified via the on-call system and no call back from the physician was requested. RN4 stated he did not request a return call because R37 did not have any injuries. RN4 stated he did review R37's medications but did not inform the physician that R37 was receiving [redacted] RN4 stated his call to the physician was just a "notification" of a [redacted] RN4 stated he documented the [redacted] checks, including vital signs, on a [redacted] check log sheet. RN4 stated after neuro checks were completed, the log sheet was given to the Unit Manager (UM). RN4 stated he did not note any changes in R37's [redacted] status or vital signs. RN4 stated he believed he did notify the physician R37 was receiving [redacted] RN4 was reminded he had previously stated he did not notify the physician of this. RN4 then stated, "I believe I did."

On 01/05/24 at 8:57 AM, the facility provided an investigative summary of R37's [redacted] The investigative summary included a [redacted] sheet and statements from RN4, LPNS, and RN1. Review of the investigative summary revealed:

a. Review of R37's [redacted] Check Flowsheet," dated [redacted], revealed no documentation that R37's [redacted] had been monitored by RN4 from 06/15/23 at 3:00 AM through [redacted] at 7:00 AM.

It was documented by RN1 that R37 was "alert" from 7:00 AM until 11:00 AM on [redacted] It was documented R37's BP was [redacted] and pulse rate was [redacted] at 8:30 AM. This was inconsistent with the documentation included in the "Nurses Note" dated [redacted] at 8:30 AM where RN1 had documented R37's BP was [redacted] and [redacted] pulse rate was [redacted]

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b. Review of RN4's "Accident/Incident Investigation Statement Report," dated [redacted] revealed, ". . . I overheard [R37] yelling [and] went into room. I called [LPNS] into the room [and] we assessed [redacted] [and] did [redacted] checks. The assessment showed no injuries, marks, or contusions. I offered [redacted] [and] [patient] refused. [redacted] checks continued to show no change from base line to the last one, between 0630 [6:30 AM] [and] 0645 [6:45 AM]. Pt left in bed in low position [and] encouraged her to stay in bed [and] [redacted] stated [redacted] understood . . ."

c. Review of LPNS's "Accident/Incident Investigation Statement Report," dated [redacted] revealed, ". . . Around 3 am assigned nurse and myself heard a noise from pt's room so we went in to check on [redacted], upon entering room we found pt laying [sic] on the floor. Pt was assessed and helped back to bed. VS [vital signs] [redacted] no visible sign swelling around the head and no injury noted at the time. Pt was talking and was alert, denies any [redacted] Mentation was within normal limits. Monitored throughout night with no change. Before 8am pt was in bed sleeping and no s/s [signs and symptoms] of distress noted . . ." This was inconsistent with R37's "Fall Risk Evaluation," dated [redacted] at 3:11 AM, where it was recorded R37 had an [redacted].

d. Review of RN1's typed statement from the facility provided fall investigative summary revealed, ". . . [redacted] I arrived for my 7am shift on [redacted]. I received report about [R37] having a [redacted] overnight and that there were no apparent injuries. The nurse gave me the [redacted] k sheet. I rounded on all my residents. [R37] was in bed sleeping. [redacted] bed was low. [redacted] call bell was in reach. [redacted]-checks were

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within normal limits. I rounded around 8:30am and observed her in bed with a small amount of [NJ EX Order: 264b1] on [NJ EX] sheet. [NJ EX Or] was [NJ EX Orde] but NJ EX Order. 264b1 I took her vital signs and called the provider. [NJ EX Or] vital signs were [NJ EX Order: 264] p:[NJ EX] oxygen [NJ EX Or], Temp: [NJ EX Orde] and BS: [NJ EX Orde] The provider said to continue monitoring [NJ EX Or] We continued to monitor [NJ EX]. Around 11am, the Director of Nursing spoke with the nurse practitioner and received an order to send [NJ EX Or] to the hospital for an evaluation due to a [NJ EX Order: 264b1] . . ." The form contained RN1's signature. The information in the statement was inconsistent with the "Nurses Note," dated [NJ EX Order: 264b1] at 8:30 AM, where it was documented R37 was sedated and had not responded at all on the previous shift. The statement did not address R37 [NJ EX Order: 264b] while RN1 was completing her assessment or R37 being unable to [NJ EX Orde] as was documented in the progress note on [NJ EX Order: 264b1] at 8:30 AM.

On 01/05/24 at 8:59 AM, the surveyor attempted to contact RN1 by telephone. A voice message was left, but no return phone call was received by the end of the survey.

During an interview on 01/05/24 at 9:06 AM, Nurse Practitioner (NP) 2 stated she was notified of R37's fall on 06/15/23 at approximately 9:30 AM when she arrived at the facility for her morning rounds. NP2 stated she was not notified when R37 [NJ EX] NP2 stated she assessed R37 after being told she had suffered a [NJ EX], found the resident [NJ EX Order: 264b1] and immediately sent [NJ EX] to the hospital. NP2 reviewed R37's EMR and stated she would look at her call reports. NP2 stated she was not at the facility at 3:00 AM and did not receive a call from the facility. NP2 opened a Word document on her computer. The

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document was headed, "Wednesday NJ EX Order. 264b1 " Five nursing homes, including Spring Hills Woodbury, were listed on the document. Under each nursing home was a line list containing resident names and specific communication for each resident listed. Under Spring Hills Woodbury, R37's name was listed. The specific communication for R37 was recorded as "new admit."

Continuing with the interview on 01/05/24 at 9:11 AM, NP2 stated she assessed R37 at approximately 9:30 AM. This was NJ EX Order. 264b1 hours after R37's fall. NP2 stated R37 was unresponsive, had NJ EX Order. 264b1, and was on NJ EX Order. 2, so she had R37 sent to the hospital. NP2 was asked if R37 was sent to the hospital on NJ EX Order. 264b1 at 1:59 PM, the time of her documentation in the progress notes. NP2 stated no. NP2 reviewed documentation in her NP electronic medical records system and stated she had the time of her note detailing R37's assessment and her actions as 10:06 AM. NP2 stated she had recorded the event in the facility's EMR on NJ EX Order. 264b1 at 1:59 PM.

Continuing with the interview on 01/05/24 at 9:11 AM, NP2 stated if she had been notified of R37's fall and the fact R37 was receiving NJ EX Order. 26 she would have probably sent her to the hospital, especially since R37 was NJ EX Order. 264b and was NJ EX Order. 264b1. NP2 stated again that she was not notified of R37's NJ EX l. NP2 was asked what her expectation of staff was if a resident was receiving an NJ EX Order. 264b1 and suffered an unwitnessed NJ EX Or NP2 stated, "Who did they call if I was on call?" NP2 stated she should have been notified when the NJ EX occurred and should have been notified at 8:30 AM when the resident was found with NJ EX Order on NJ EX Order. 264b1 again, and

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was only NJ EX Order. 264b1 NP2 stated, "They should have initiated a 911."

During an interview on 01/05/24 at 11:09 AM, the former DON confirmed the facility's policy was to complete an assessment, do NJ EX Order 2 checks, notify the physician, and monitor a resident for three days following a NJ EX 1 The former DON confirmed that monitoring consisted of writing notes on your shift and checking the resident. The DON confirmed NJ EX Order. 264b1 should be monitored with NJ EX Order 2 checks. The former DON confirmed the physician should be notified at least within an hour following a NJ EX 1 The DON confirmed NJ EX Order check sheets were part of the clinical documentation and stated at the facility, NJ EX Order 2 check sheets were pulled and kept with any statements obtained. The former DON confirmed that information in any statements obtained should be consistent with the information in the clinical record. The former DON confirmed the progress notes at 3:30 AM and 8:30 AM recorded the physician was notified and that staff had been ordered at 8:30 AM to continue evaluation of R37 for a few hours. The former DON stated the progress note at 8:30 AM was detailing what RN4 had allegedly told RN1, and she did not know where RN1 had received that information. The former DON stated the facility did not always send a resident out if they were receiving NJ EX Order 2 and had an unwitnessed NJ EX 1 that it would depend on what the doctor said.

Continuing with the interview on 01/05/24 at 11:09 AM, the former DON stated information on the NJ EX Order 2 check sheets and progress notes should be consistent. The DON confirmed the vital signs listed on the 8:30 AM progress note, RN1's statement, and the NJ EX Order check sheet were inconsistent. The DON stated the nurse could

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have taken multiple sets of vital signs at that time.

Continuing with the interview on 01/05/24 at 11:09 AM, the former DON was asked where the documentation was of RN1 monitoring R37's NJ EX Order. 264b1 from 3:00 AM through 7:00 AM, following the unwitnessed fall. The former DON stated, "He wrote it in his statement that he checked."

Review of the facility's policy titled, NJ EX Order. 26 Injury," reviewed October 2023, revealed, ". . . It is the policy of this facility to report potential head injuries to the physician and implement interventions to prevent further injury . . . Assess resident following a known, suspect, or verbalized NJ EX Order injury. The assessment shall include . . . NJ EX Order. 264b1 evaluation for changes in . . . NJ EX Order of NJ EX Order. 264b1 . . "

3. Review of R57's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on NJ EX Order. 264b1

Review of R57's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab, revealed the resident was admitted to the facility with diagnoses which include NJ EX Order. 264b1 On NJ EX Order. 26 the diagnosis of NJ EX Order. 264b1 NJ EX Order. 264b1 was added.

Review of R57's quarterly "Minimum Data Set (MDS)," with an ARD of NJ EX Order. 264b1, located in the resident's EMR under the "MDS" tab, revealed the facility assessed R57 to have a "BIMS" score of NJ EX Order. 264b1 which indicated the resident was NJ EX Order. 264b1

During an interview on 01/04/24 at 9:40 AM, R57

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stated back in October 2023, [redacted] started having [redacted]." R57 stated he requested an appointment with a [redacted]t because of the [redacted] however, the facility did not take [redacted] seriously. R57 also stated the [redacted] was so bad, [redacted] touched [redacted] and the [redacted] R57 stated he finally got an appointment with the [redacted] who sent [redacted] directly to the [redacted] where he had about [redacted] of [redacted] from [redacted]

Review of R57's "Physician Note," dated [redacted], located in the resident's EMR under the "Progress Notes" tab, revealed " ...Chief Complaints [redacted] [redacted] yo [year old] [redacted] ...pt [patient] evaluated today for monitoring of [redacted] [redacted]] ...pt completed [redacted] ...PLAN [redacted] seen on ct [.] fu [follow up] with [redacted] Name] not available until august [.] will monitor pt currently on [redacted] ...pt counseled on [redacted] k of [redacted] due to [redacted] ..."

Review of R57's "Progress Note," dated [redacted], revealed "Pt complained of [redacted] ing. MD [Medical Doctor] notified will be evaluated tomorrow." The nursing progress notes lacked assessment information related to R57's [redacted]

Review of R57's Physician/Practitioner "Progress Note," dated [redacted], revealed "Note Text: MEDICAL PROGRESS NOTE ...chief complaints ...[redacted]], [redacted] ...pt is resting, in bed, noted to have ongoing [redacted] and [redacted] pt being treated with increased dose of [redacted] ordered STAT ...Care plan reviewed with pt and nursing [.] vitals reviewed will cont. [continued] to monitor."

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S 395	Continued From page 19 The note was completed by Nurse Practitioner (NP) 1. NP1's note did not document the extent of the NJ EX Order. 2 or what signs or symptoms nursing was to monitor for the NJ EX Order. 264b1 .. Review R57's NJ EX Order. 264b1 Note," dated 10/04/23, located in the resident's EMR under the "Progress Notes" tab, revealed "Procedure: ...Findings: There is NJ EX Order. 264b1 There is NJ EX Order. 264b1 in the NJ EX Order. 264b1 of the NJ EX Order. NJ EX Order. 264b1 , and NJ EX Order. 264b1 [sic] ..." Review of a nursing progress note, dated NJ EX Order. 264b1 revealed "PT [patient] c/o having NJ EX Order. 2 . NJ EX Order. NJ EX Order. 264b1 Will continue to monitor." There was no documented evidence that the resident's physician was notified. Review of R57's "Progress Note," dated NJ EX Order. 264b1 revealed "small open area to NJ EX Order. 264b1 NJ EX Order. 264b1 measuring about NJ EX Order. 264b1 NJ EX Order. 2 applied and covered with NJ EX Order. 264b1] NP made aware follow up with NJ EX Order. 264b1 on NJ EX Order. 2 morning." There was no documented evidence of any intervention to address the NJ EX Ord and NJ EX Order. 2 that caused the resident to sustain an NJ EX Order. 264b1 . Review of R57's "Progress Note," dated NJ EX Order. 264b1 revealed " ...Pt complained of NJ EX Order. 264b1 NJ EX Order. 264b1 I sat resident up and placed NJ EX Order. 264 NJ EX Order. hroughout the evening until replaced by NJ EX Order. 2 for NJ EX Order. 264 Review of the "Progress Notes," dated 1 NJ EX Order. 264 through NJ EX Order. 264b1 and located in the EMR "Progress Notes" tab, revealed no documentation	S 395		

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of monitoring for signs and symptoms of [redacted] for R57.

Review of R57's "Progress Note," dated [redacted] revealed "[resident name] left unit with medical transport [redacted] 1:30 for a [redacted]

Review of R57's "Progress Note," dated [redacted] revealed "Patient confirmed to have been sent from [redacted] appt w. [Dr. Name] to [hospital name] and admitted with Dx.[redacted]." This was [redacted] days after R57 first complained of [redacted] and [redacted] days after an NJ EX Order. 264b1 with no consistent monitoring by nursing and no other treatment than an [redacted].

During an interview on [redacted] at 2:32 PM, LPN 6 was asked if she remembered back in [redacted] when R57 had some swelling. LPN6 started to cry and stated she remembered the resident had so much [redacted] she called and told NP1 that it looked like [redacted] was going to [redacted] all [redacted]. LPN6 stated NP1 came into the facility, assessed the resident, and wanted to send the resident to the hospital for [redacted] however, the Prior Director of Nursing (PDON) told the NP no because of the facility's census numbers. LPN6 stated the NP increased the resident's [redacted] medication; however, it continued to worsen. LPN6 further stated [redacted] got so bad, the resident's [redacted] pen from so much [redacted]. LPN6 with tears in her eyes stated she thought the resident was going to die.

During an interview on 01/05/24 at 10:33 AM, NP1 stated when she assessed R57, she recommended the resident to be sent out to the hospital; however, the facility wanted to treat the resident in house. NP1 stated she ordered a [redacted] and increased the resident's [redacted];

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however, the CT was not able to be completed due to the resident's NJ EX Order. 26 and they had to find a place for him to be able to have the NJ EX completed which caused a delay in treatment. NP1 stated prior to sending out a resident to the hospital, the former DON would have to approve. NP1 stated she wanted to send R57 out to the emergency room because NJ EX was already on a NJ EX Order. 264b1 mouth, so she wanted to send NJ EX Order. 264b1. NP1 stated R57 having NJ EX pounds of NJ EX Order. 264b1 off was a lot and it was concerning the DON not wanting the resident sent out. NP1 stated a possible NJ EX Order. 264b outcome would have been NJ EX Order. 264b1

During an interview on 01/05/24 at 11:11 AM, the prior Director of Nursing (PDON) stated she did not remember NP1 wanting to send R57 to the hospital due to NJ EX Order. 264b1. The PDON confirmed the facility's practice was that she would be notified prior to sending any resident to hospital; however, she stated she would not have requested the resident to be treated in the facility and not be sent out. When asked what her expectation was related to the monitoring of R57's NJ EX Order. 2, the PDON stated it meant to monitor and assess the resident; however, she did not expect the nurses to document the monitoring.

During an interview on 01/05/23 at 12:35 PM, the prior Administrator stated the facility's practice was for nurses and providers to notify the PDON prior to sending any residents out of the facility to the hospital. The prior Administrator stated the PDON and provider would have discussions about treating the residents in house by increasing their NJ EX Orde first, redoing labs stat, and other options. The prior Administrator also stated they [the facility] just wanted to do everything here

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at the facility that they could, but it was ultimately up to the provider.

During an interview on 01/04/24 at 12:50 PM, the Medical Director stated after the provider was notified on [redacted]3 about R57's edema, the provider should have started an intervention at that time. The Medical Director also stated if the provider stated they were going to be in the next day to evaluate the resident, then the provider should have come in. The Medical Director reviewed some of R57's medical record with the surveyor. The Medical Director further stated after the [redacted] results came back, the provider should have completed a follow up with the resident, reassessed the resident, monitored the resident, and ensured the nursing staff was monitoring the resident including [redacted]. The Medical Director further stated, the provider should not have waited until the resident's [redacted] appointment on [redacted] for the resident to receive treatment for the [redacted] Continued interviewed revealed the Medical Director stated R57 could have gone into [redacted].

Review of the facility's policy titled, "Abuse, Neglect and Exploitation," revised July 2023, revealed, ". . . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . . . Written procedures for investigations include . . . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . . . Reporting of all alleged violations to the . . . state agency, adult protective services and to all other required agencies . . . Immediately, but not later than 2 hours after the

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S 395	Continued From page 23 allegation is made, if the events that cause the allegation involve abuse . . ."	S 395		
S 765	8:39-9.2(a) Mandatory Administration (a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator. The administrator shall be administratively responsible for all aspects of the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility Administrator's Job Description, the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This failure had the likelihood to affect all 115 residents of the facility. The facility's systemic failure to ensure residents were free from abuse and neglect, pharmaceutical services were maintained and administrative oversight of the day to day duties and responsibilities to meet the needs of each resident identified an Immediate Jeopardy. An IJ was called on [redacted] for abuse and neglect and pharmaceutical services. On [redacted], an IJ was called for Administration. The facility provided acceptable removal plans for the Immediate Jeopardies. On 1/17/2024, a revisit was done to ensure that the IJ removal plans were implemented.	S 765	S765 Mandatory Administration 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: R 38's assigned Registered Nurse assessed [redacted] site on the morning of [redacted]. There was no paste on R 38's [redacted]. An additional Registered Nurse assessed R 38's [redacted] on [redacted] at approximately 9am. There was no [redacted] on the [redacted] The Director of Nursing assessed R 38's [redacted] on [redacted] and there was no paste on the [redacted] R 38 has an order to monitor [redacted] site every shift. An additional order was placed for the nurses to monitor his [redacted] every [redacted] hours. The Nursing Home Administrator reported the allegation on [redacted] R 38 no longer resides in the center. R 57 was assessed by the Director of Nursing on [redacted] did not exhibit	2/28/24

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S 765	Continued From page 24 In addition, Substandard Quality of Care (SCQ) was identified at Freedom from Abuse, Neglect, and Exploitation. Findings include: Review of the Administrator's "Job Description," signed and dated 12/06/23, revealed " ...Position Purpose ...Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents ...Major Duties and Responsibilities...Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations ...Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility ...Leads and coordinates daily, weekly, bi-monthly or monthly management team meetings to discuss priorities and develop solutions with facility leaders such as census, collections, clinical health, survey readiness, customer service satisfaction ...Ensures delivery of compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover ...optimal resident functioning-physically and psychosocially. Identifies and collaborates with members of the interdisciplinary team, physicians, consultants, and community agencies to identify opportunities for enhanced services to the residents and/or resolve issues ...Performs rounds to observe	S 765	any signs or symptoms of NJ EX Order. 264b1 [redacted]. The findings were reviewed with the physician. R 57 was evaluated by the Nurse Practitioner on [redacted] The Nurse Practitioner documented that R 57 was in no NJ EX Order. 264b1. R 57 no longer resides in the facility. R 37 no longer resides in the center. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with an NJ EX Order. 264b1, and [redacted] while receiving an NJ EX Order. 264b1 have the potential to be affected. All residents in the center with an [redacted] were evaluated. One other resident has an [redacted] The Director of Nursing assessed the [redacted] on [redacted] and there was no [redacted] on the [redacted] The Director of Nursing reviewed current residents who fell and were on anticoagulants to determine if they were monitored and documented on in the nursing notes post fall. No residents on NJ EX Order. 264b1 had a [redacted] recently. All residents in the center with a diagnosis of [redacted] were evaluated by the Registered Nurse on [redacted]. None of these residents exhibited any signs or symptoms of a NJ EX Order. 264b1. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Administrator was educated by the Regional Director of Clinical Services 01/04/24 regarding all staff on reporting allegations of abuse/neglect immediately, initiating investigations of allegations of abuse/neglect, conducting thorough	

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S 765	Continued From page 25 residents and ensure overall needs are being met. Knows residents by name and sight ...Makes written and oral reports/recommendations to the governing board concerning the operation of the facility ...Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etc. are reported to the correct entity within the stated regulatory requirement ...Additional Tasks ...Reports any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of resident to appropriate regulatory entities. Protects residents from abuse, and cooperates with all investigations ..." The Director of Nursing's (DON's) job description was requested but not provided prior to exit. During an interview on 01/08/24 at 4:00 PM, the Regional Director of Operations (RDO) stated the facility's administration should have been aware of the pharmacy services issues identified by the survey team. Review of an email from the Administrator to the surveyor dated [redacted] revealed the facility did not have a position description for the Medical Director. Review of a statement on the facility's letterhead, signed by the Administrator on [redacted] revealed the facility did not have a contract with the Medical Director. Additionally, the facility's administration failed to ensure through a position description or contract with the Medical Director, how the Medical Director would fulfill their responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility; the facility failed to ensure residents received care from competent nursing staff; the	S 765	investigations, and protection of residents during and after investigations. The Administrator was educated by the Regional Director of Clinical Services on 1/6/2024 on: d. Monitoring residents for all changes in condition, physician notification which includes timely notification, and accurate documentation. e. Assessing residents and documenting the assessments f. Sending residents to outside providers for treatment and services per the provider□s orders The Administrator was educated by the Regional Director of Clinical Services on 01/06/24 regarding Pharmaceutical Services, Procurement of Medications upon Admission, and Reordering Medications, Back Up Medication Supply. The Administrator was educated by the Regional Director of Clinical Services on 1/6/2024: e. Administering medications consistent with physician□s orders to ensure there is not a break in the provision of the needed medications to treat residents. This includes the process for notifying the provider of medications that are unavailable. f. Medications that have been reordered and haven□t arrived. g. Reordering medications for all residents h. Reconciliation and timely order entry for admission medications The Director of Nursing or designee will review the missed medication audit daily for one week, then weekly x three weeks, then bi-weekly x four weeks, and then	

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S 765	Continued From page 26 facility failed to ensure residents' clinical medical records were complete and accurate; and failed to have an effective Quality Assurance/Performance Improvement (QAPI) program The facility's administration failed to ensure residents remained free from neglect and abuse when R37 and R57 sustained actual harm from being deprived of treatment; and R38's family reported that NJ EX Order. 264b1 was found directly in the center of R38's NJ EX Order. 264b1 the NJ EX Order. from emptying into NJ EX Order. 264b1 Even after being informed of the potential abuse, the Administrator failed to identify the event as an allegation of abuse, report the event as an allegation of abuse to the state survey agency, and failed to complete a thorough investigation. The facility's administration failed to ensure pharmaceutical services were maintained to meet residents' needs. During the abbreviated survey, the facility consistently had issues with the procurement of residents' admission medications and re-ordering of medications dating back to NJ EX Order. 264b1. The facility's administration stated they were not aware of any concerns related to procurement of medications even though residents' medical records verified a longstanding and ongoing issue. .	S 765	monthly x one month to identify if residents missed scheduled medications. This will be documented on a log. The Director of Nursing or designee will review the facility□s back up medication supply daily to ensure the supply is stocked. This will be documented on a log. The Director of Nursing or designee will review the medications eligible for refill report daily to ensure medications are reordered timely. This will be documented on a log. Audits will be complete by running the report in Point Click Care. The Director of Nursing or designee will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered from the pharmacy right away. This will be documented on a log. The Director of Nursing or designee will in-service all licensed nurses, including agency nurses on: a. Administering medications consistent with physician□s orders to ensure there is not a break in the provision of the needed medications to treat residents. This includes the process for notifying the provider of medications that are unavailable. If the physician is not available, the providers in each practice always have someone on call. b. Medications that have been reordered and haven□t arrived c. Reordering medications for all residents d. Timely reconciliation and entry of new admission medications In-servicing began on 1/6/2023. All licensed nurses, including agency, will be	

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S 765	Continued From page 27	S 765	in-serviced prior to their first scheduled shift. Fourteen nurses have been in serviced thus far. 14 divided by 20 equals 70 percent. 5 agency nurses have been in-serviced thus far. The Director of Nursing or designee will ensure that all nurses including agency nurses working in the center have access to the backup medication supply. The safety of the backup medication supply will be ensured through the backup supply being counted daily. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Regional Director of Operation or Regional Director of Clinical Services will review [redacted] documentation, physician notification, and acute change assessment documentation weekly for four weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Regional Director of Operation or Regional Director of Clinical Services will review all abuse and neglect allegations with the Administrator weekly for 4 weeks, biweekly for 4 weeks, and then monthly x 1 month. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or Assistant Director of Nursing will review the following daily for 1 week, then weekly x 3 weeks, then bi-weekly for 4 weeks, and	

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S 765	Continued From page 28	S 765	then monthly x 1 month. It will be documented on a log. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained: " Missed medication audit " Will review the facility□s back up medication supply daily to ensure the supply is stocked. " Will review the medications eligible for refill report. " Will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered from the pharmacy right away. This will be documented on a log. 5. Date of Compliance: February 28th, 2024	
S1935	8:39-29.2(d) Mandatory Pharmacy (d) Medications shall be accurately administered and documented by properly authorized individuals, as per prescribed orders and stop order policies. This REQUIREMENT is not met as evidenced by: Complaints: NJ00158123, NJ00158489, NJ00158677, NJ00159247, NJ00159800, NJ00167295, NJ00168400, NJ00168603, NJ00169368, NJ00169776	S1935	S1935 Mandatory Pharmacy 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	2/23/24

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S1935	Continued From page 29 Based on observations, interviews, record reviews, and review of the facility's policies, the facility systemically failed to provide and maintain pharmaceutical services to acquire, receive, dispense, administer, and reconcile medications for 10 residents reviewed for medications (Resident R 60, R14, R33, R64, R31, R32, R63, R13, R11, and R9) out of a total sample of 65 residents. This systemic failure affected and/or had the likelihood to affect all residents of the facility, and any future admissions to the facility. The facility's systemic failure to ensure pharmaceutical services were provided to meet the needs of each resident identified an Immediate Jeopardy. An IJ was called on NJ EX Order. 264b1 and an acceptable removal plan was provided by the facility. On NJ EX Order. 264b1, a revisit was done to ensure that the IJ removal plan was implemented. Findings include: 1. Review of R60's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on NJ EX Order. 264b1 at 11:30 PM post back surgery. Review of R60's hospital discharge summary dated 01/05/24 at 5:40 PM, located in the resident's electronic medical record (EMR) under the "Misc (Miscellaneous)" tab, revealed the resident was recipient of a NJ EX Order. 264b1 on NJ EX Order. 264b1 Continued review of R60's hospital discharge documentation revealed the resident's discharge medications included NJ EX Order. 264b1) 0.50 mg [milligram] NJ EX Or capsule, every NJ EX hours. Review	S1935	R33, R64, R31, R32, R63, R13, and R11 no longer reside at the facility. R 60 was assessed by the Director of Nursing on NJ EX Order. 264b1. NJ EX did not exhibit any signs of organ rejection. The findings were reviewed with NJ EX Order. 264b1 R 60 was seen by the physician on 1/6/2024. No adverse effects noted. Per R 60's hospital record, he received NJ EX NJ EX Order. 264b1 in the hospital on NJ EX Order. 264b1 at 5:14am and 2:16pm. NJ EX arrived at Woodbury at 11:30pm on NJ EX Order. 264b1 received NJ EX Order. 264b1 on NJ EX Order. 264b1 at 3:36pm and 11:33 pm. The physician was made aware of the times these medications were administered at Woodbury. R 60 had a NJ EX Order. 264b1 level drawn. R 60 no longer resides at the facility. R 14 was assessed by the Director of Nursing on NJ EX Order. 264b1. He did not exhibit any signs of NJ EX Order. 264b1 The findings were reviewed with the physician. R 9 was assessed by the Director of Nursing on NJ EX Order. 264b1. R 9 did not have any respiratory issues or ill effects noted. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing or designee will review the missed medication audit daily for 1 week, then weekly x 3 weeks, then bi-weekly x 4 weeks, and then monthly x 1	

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S1935	Continued From page 30 of R60's hospital medication administration record (MAR) revealed the last dose of NJ EX Order: 264b1 NJ EX mg administered at the hospital was at 2:16 PM on NJ EX Order: 264b1 Review of R60's "Physician's Orders," dated NJ EX Order: 264b1 at 1:36 Am located in the resident's EMR revealed the resident was ordered NJ EX Order: 264b1 mg capsule every NJEX hours for NJ EX Order: 264b1 During an interview on 01/06/24 at 9:38 AM, Registered Nurse (RN) 3 stated R60's transplant medication had not been received from the pharmacy and she was unable to administer the medication to R60. RN3 also stated R60 was admitted to the facility on 01/05/24 at approximately 10:00 PM. Review of R60's order audit report for the medication of NJ EX Order: 264b1 revealed the facility ordered the medication from the pharmacy on NJ EX Order: 264b1 at 1:36 AM. Review of R60's nursing "Progress Note," dated NJ EX Order: 264b1 at 9:40 AM, completed by Regional Nurse (RGN) 1 and located in the resident's EMR under the "Progress Notes" tab revealed, "[Medical Director's name] made aware that [R60's Name] NJ EX Order: 264b1 due at 9am today has not arrived. The pharmacy was contacted and confirmed that the NJ EX Order: 264b1 being delivered on the first pharmacy delivery today. [Medical Director's Name] was also made aware of this. He ordered toplace [sic] a one-time order when the medication arrives and to hold this mornings dose." The progress note, notification, and order to hold the resident's medication doses were all made after R60's physician ordered scheduled administration time for the NJ EX Order: 264b1 medication.	S1935	month to identify if residents missed scheduled medications. This will be documented on a log. The Director of Nursing or designee will review the facility□s back up medication supply daily to ensure the supply is stocked. This will be documented on a log. The Director of Nursing or designee of Nursing will review the medications eligible for refill report daily to ensure medications are reordered timely. This will be documented on a log. Audits will be completed by running the report in Point Click Care. The Director of Nursing or designee will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the facility□s back up supply, it will be ordered from the pharmacy right away. This will be documented on a log. The Director of Nursing or designee will in-service all licensed nurses, including agency nurses on: a. Administering medications consistent with physician□s orders to ensure there is not a break in the provision of the needed medications to treat residents. This includes the process for notifying the provider of medications that are unavailable. If the physician is not available, the providers in each practice always have someone on call. b. Medications that have been reordered and haven□t arrived c. Reordering medications for all residents d. Timely reconciliation and entry of new	

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S1935	Continued From page 31 A subsequent interview with RN3 on 01/06/24 at 11:00 AM revealed she called the pharmacy, and the medication would be leaving the pharmacy at 2:00 PM. RN3 stated it should be at the facility by 3:00 PM. Review of R60's nursing "Progress Note," dated NJ EX Order: 264b1 at 3:25 PM, completed by the Director of Nursing (DON) and located in the resident's EMR under the "Progress Notes" tab, revealed "[Medical Director's Name] called made aware of arrival time of NJ EX Order: 264b1 and received orders to give now and administer next dose as ordered at 9pm." Review of R60's "Medication Administration Record (MAR)," dated NJ EX Order: 264b1 and located in the resident's EMR under the "Orders" tab, revealed NJ EX Order: 264b1 Oral Capsule NJ EX Or MG ...Give 1 capsule by mouth every NJ EX hours for NJ EX Order: 264b1. Start Date NJ EX Order: 264b1 0900 [9:00 AM]. Hold Date from NJ EX Order: 264b1 0946 [9:46 AM] to NJ EX Order: 264b1 2100 [9:00 PM]." For the scheduled administration date and time of NJ EX Order: 264b1 at 9:00 AM, the administration block was blank, which indicated the medication was not administered. For the administration date and time NJ EX Order: 264b1 at 9:00 PM, the administration block was documented with "H" indicating the medication was held. Continued review of the "MAR" revealed on NJ EX Order: 264b1 at 3:36 PM, it was documented R60 was administered NJ EX Order: 264b1 NJ EX Order: 264b1 medication. It had been over 25 hours since R60 received NJ EX Order: 264b1 medication that was ordered to be administered every NJ EX hours. Further review of the "MAR" revealed that the	S1935	admission medications In-servicing began on 1/6/2023. All licensed nurses, including agency, will be in-serviced prior to their first scheduled shift. The Director of Nursing or designee will ensure that all nurses including agency nurses working in the center have access to the backup medication supply. The safety of the backup medication supply will be ensured through the backup supply being counted daily. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting: The Director of Nursing or designee will conduct the missed medication audit daily for 1 week, then weekly x 3 weeks, then bi-weekly x 4 weeks, and then monthly x 1 month. The Administrator will ensure that the Director of Nursing or designee reviews the facility□s back up medication supply daily and that the Director of Nursing or designee reviews new admission discharge medication lists prior to residents arriving to the center. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review the missed medication audit daily for 4 week, then weekly x 3 weeks, then bi-weekly x 4 weeks, and then monthly x 4 month to identify if residents missed scheduled medications. This will be documented on a log. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained.	

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S1935	Continued From page 32 9:00 PM dose ordered by the physician on [redacted] was not administered. During an interview with the Consultant Pharmacist (CP) on 01/06/24 at 11:27 AM revealed post-transplant medication was very important, and the resident should be receiving the medication [redacted] a day and they never want a resident to miss a dose of [redacted] medication. The CP stated if the resident received [redacted] last dose at 2:00 PM on 01/05/24, it would be optimum he received [redacted] next dose within [redacted] hours. During an interview on 01/08/24 at 3:10 PM, the Medical Director stated R60 was admitted after 10:00 PM on [redacted], so there was no way to get the resident's medications to the facility for him to be administered [redacted] morning medications. The Medical Director stated the [redacted] medication was a specialty medication. The Medical Director stated that other than the family bringing in the medication from home, there was no way of getting the medication to the facility any sooner. 2. Review of R14's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] Review of the "National Library of Medicine [Department of Health and Human Services, National Institutes of Health]" updated on [redacted] revealed " .. [redacted] tablet ...Boxed Warning [the strongest warning that the Food and Drug Administration (FDA) requires, signifies that medical studies indicate that the drug carries a	S1935	The Director of Nursing or designee will review the facility□s back up medication supply daily to ensure the supply is stocked. This will be documented on a piece of paper. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review the medications eligible for refill report daily to ensure medications are reordered timely. This will be documented on a log. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review the medications re-ordered report to ensure they were delivered timely. This will be documented on a log. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. The Director of Nursing or designee will review new admission discharge medication lists prior to the resident arriving to the center. If there is medication listed that is not in the	

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S1935	Continued From page 33 significant risk of serious or even life-threatening adverse effects] ... The continued use of NJ EX Order. 264b1, including NJ EX Order. 264b1 tablets, may lead to clinically significant NJ EX Order. 264b1. The risks of dependence and NJ EX Order. 264b1 e with longer treatment duration and higher daily dose. Abrupt discontinuation or rapid dosage reduction of NJ EX Order. 264b1 tablets after continued use may precipitate NJ EX Order. 264b1 reactions, which can be life-threatening ... NJ EX Order. 264b1 Signs and Symptoms. NJ EX Order. 264b1 signs and symptoms associated with NJ EX Order. 264b1 have included abnormal NJ EX Order. 264b1 ...Medication Guide ... Physical dependence and withdrawal reactions. NJ EX Order. 264b1 tablets can cause physical dependence and withdrawal reactions. Do not suddenly stop taking NJ EX Order. 264b1 tablets. Stopping NJ EX Order. 264b1 tablets suddenly can cause serious and life-threatening side effects, including, unusual movements, responses, or NJ EX Order. 264b1 Call your healthcare provider or go to the nearest hospital emergency room right away if you get any of these symptoms ..." NJ EX Order. 264b1 Review of R14's "Physician Orders," located in	S1935	facility□s back up supply, it will be ordered from the pharmacy right away. This will be documented on a log. These audits will be conducted weekly x 4 weeks, then every other week for 4 weeks, and then monthly x 3 months. The results of the audit will be reported to the facility QAPI committee until compliance is determined to be sustained. 5. Date of Compliance: February 23rd, 2024	

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the resident's EMR under the "Orders" tab, revealed R14 was originally ordered NJ EX Order: 26401 medication used to treat NJ EX Order: 26401 mg, NJ EX times a day on NJ EX Order: 26 and discontinued on NJ EX Order: 26401. The orders also revealed on NJ EX Order: 26401 R14 was ordered NJ EX Order: 26401 tablet NJ mg NJ EX Or times a day. The physician orders also indicated on NJ EX Order: 26401 R14's NJ EX Order: 26401 was reduced to NJ EX mg every NJ EX hours as needed. On NJ EX Order: 26401 the resident was ordered NJ EX Order: 26401 tablet NJ mg NJ EX times a day for NJ EX Order: 264. The resident had continuously received the medication at varying dosages since he was admitted which would be considered long term use of the NJ EX Order: 26401

Review of R14's "MAR" dated NJ EX Order: 26401, located in the resident's EMR under the orders tab, revealed the resident was scheduled to be administered NJ EX Order: 26401 mg by mouth at 5:00 PM and 10:00 PM every day. Continued review of the MAR revealed R14's routine NJ EX Order: 26401 was not documented as administered for 10/26/23-both doses, 10/27/23-both doses, 10/28/23-both doses, 10/30/23-both doses, and 10/31/23-both doses. The administration dates and times were documented with a "9" which indicated "Other."

Review of R14's nursing "Progress Notes," dated 10/26/23 at 6:11 PM and 10/26/23 at 10:08 PM, located in the resident's EMR under the "Progress Notes" tab revealed "Administration Note. Note Text: awaiting pharmacy."

Review of R14's nursing "Progress Notes," dated 10/27/23 at 6:35 PM and 10/27/23 at 9:33 PM, located in the resident's EMR under the "Progress Notes" tab revealed "Administration Note. Note Text: on order."

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S1935	Continued From page 35 Review of R14's nursing "Progress Notes," dated 10/28/23 at 4:36 PM, located in the resident's EMR under the "Progress Notes" tab revealed "Administration Note. Note Text: med [medication] not available at this time." Continued review of the progress notes dated 10/28/23 revealed a note completed at 9:00 PM revealed "Administration Note. Note Text: on order." Review of R14's nursing "Progress Note," dated 10/31/24 at 4:39 PM, located in the resident's EMR under "Progress Notes" tab revealed "Administration Note. Note Text: Medication on order, awaiting from pharmacy." Review of R14's nursing "Progress Note," dated 10/31/23 at 9:28 PM, located in the resident's EMR under the "Progress Notes," tab revealed "Administration Note. Note Text: On order, awaiting from pharmacy." Review of R14's "Individual Patient Controlled Substance Administration Record-30 dose" for NJ EX Order. 264b1 tablet revealed on [redacted] at 10:00 PM, the resident's last dose of [redacted] was signed out for administration. Review of the facility's untitled emergency medication backup (cubex) transaction reports dated 10/26/23, 10/27/23, 10/28/23, 10/30/23, and 10/31/23, provided by the facility, revealed no documented evidence NJ EX Order. 264b1 was retrieved to be administered to R14. During an interview on 01/06/24 at 1:00 PM, R14 stated at the end of NJ EX Order. 264b1 regular nurse went on vacation and that was the last time [redacted] received NJ EX Order. 264b1 until she returned from vacation. R14 stated the nurses would tell [redacted] every day that the pharmacy said it would be	S1935		

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on the night delivery. R14 stated he reported to the nurses he had NJ EX Order. 264b1, NJ EX Order. 264b1 inside NJ EX Order. 264b1 and on the outside of NJ EX Order. 264b1 and NJ EX Order. 264b1 R14 stated he had never had this feeling before.

Review of R14's EMR revealed no documented evidence that the nursing staff documented any NJ EX Order. 264b1 symptoms other than the resident complaining of a NJ EX Order. 264b1 on NJ EX Order. 264b1

During an interview on 01/06/24 at 11:27 AM, the CP stated if the facility was out of R14's NJ EX Order. 264b1 for multiple days, that was a problem. The CP stated nursing should have notified the physician to see if they could have ordered a different medication that was the same class of drug that was in stock in the cubex. The CP also stated R14 could experience NJ EX Order. 264b1 due to going without the medication.

Review of an untitled and undated facility document, provided by the facility on 01/09/24 revealed " ...the center [facility] had an adequate supply NJ EX Order. 264b1] in the cubex on these dates [10/26/23, 10/27/23, 10/28/23, 10/30/23, and 10/31/23]. So, while his medication administration record [MAR] documents that the medication wasn't administered on the dates in question, the medication was in the center ..." The medication being available at the facility but not administered further indicated the facility's systemic failure to provide pharmaceutical services which included accurate acquiring, receiving, dispensing, and administering of all drugs.

3. Review of R33's undated "Admission Record," provided by the facility, revealed the resident was

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S1935	Continued From page 37 admitted to the facility on 06/04/22 and discharged on 06/28/22 with diagnoses which included NJ EX Order. 264b1 Review of R33's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ EX Order. 264b1, located in the resident's EMR under the "MDS" tab, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of NJ EX Order. 264b1 which indicated the resident was NJ EX Order. 264b1 Review of R33's hospital "Summary of Care," dated NJ EX Order. 264b1, located in the resident's EMR under the "Misc" tab, revealed "Follow-Up After Discharge ...Additional instructions: NJ EX Order. 264b1 [antibiotic] NJ EX Order. 264b1 every NJ E hours until NJ EX Order. 264b1 or as otherwise directed by infectious disease ..." Continued review revealed the last time R33 was administered NJ EX Order. 264b1 at the hospital prior to discharging was on NJ EX Order. 264b1 at 5:56 AM. Review of R33's admission "Progress Note," located in the resident's EMR under the "Progress Notes" tab, revealed the resident was admitted to the facility on NJ EX Order. 264b1 at 4:03 PM. Review of R33's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed an order dated NJ EX Order. 264b1 for " NJ EX Order. 264b1 NJ EX Order. 26 solution reconstituted NJ E GM [grams]." Review of R33's "Order Audit Report," located in the resident's EMR under the "Orders" tab, revealed for the medication of NJ EX Order. 264b1 NJ EX Order. 264b1 every NJ E hours for NJ EX Order. 264b1, the medication was ordered on 06/04/22 at 4:05 PM.	S1935		

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Review of R33's nursing "Progress Note," dated NJ EX Order. 264b1 at 12:51 AM, located in the resident's EMR under the "Progress Notes" tab, revealed "This nurse called [Pharmacy's Name] to make sure that the patients NJ EX Order. 264b1] would be delivered in the am. The pharmacy stated that the NJ EX pharmacy won't open until 8 am and will be processed then ..."

Review of R33's nursing "Progress Note," dated NJ EX Order. 264b1 at 10:31 AM, located in the resident's EMR under the "Progress Notes" tab revealed "Orders-Administration Note. Note Text: NJ EX Order. 264b1 NJ EX Order. 264b1 GM. Use NJ gram NJ EX Order. 264b1 every NJ hours for NJ EX Order. 264b1. Awaiting medication from pharmacy."

Review of R33's "MAR," dated NJ EX Order. 264b1, located in the resident's closed EMR under the "Reports" tab, revealed "NJ EX Order. 264b1 Solution NJ EX Order. 264b1 GM ...Use NJ gram NJ EX Order. 264b1 every NJ hours for bacteremia with a start date of NJ EX Order. 264b1 Continued review of the "MAR" revealed for the date of NJ EX Order. 264b1, "9" was documented for the 12:00 AM and 8:00 AM administration times. The "MAR" showed the NJ EX Order. 264b1 medication was administered on 06/05/22 at the 4:00 PM, NJ EX hours and NJ EX minutes after the last dose was administered in the hospital prior to admission to the facility. There was no documented evidence provided when the medication was delivered or that the medication was retrieved from the facility's cubex.

During an interview on 01/05/24 at 1:43 PM, R33 stated he missed a total of five doses of the NJ EX Order. 264b1 medication. R33 stated NJ EX was admitted to the facility on NJ EX Order. 264 around 4:00 PM and was told by the nurse that the facility did not have NJ EX Order. 264b1 medications yet. The resident stated

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he expected to get an NJ EX Order. 264b1 as soon as he was admitted to the facility; however, the facility was not prepared nor equipped to receive NJ EX Or as an admission. R33 stated NJ EX refused to take the rest of NJ EX medications the first day hoping that would expedite the facility getting NJ EX Order. 264b1. Continued interview revealed the nurses kept telling NJ EX O that they called the pharmacy, and the medication would be on its way. R33 also stated the NJ EX Order. 264b1 was for a NJ EX Order. 264b1 that about NJ EX Order. 264b1, so NJ EX was afraid the NJ EX Order. 264b1 was going to come back and that NJ EX would die if it did return.

During an interview on 01/06/24 at 11:27 AM, the CP stated it was important R33 would have received NJ EX Order. 264b1 as ordered. The CP stated the nurses should have notified the physician if the NJ EX Order. 264b1 was not at the facility. The CP also stated with resident not getting the continued NJ EX Order. 264b1 as ordered after leaving the hospital placed the resident at risk for the NJ EX Order. 264b not clearing up completely and the resident could have built up a resistance to the NJ EX Order. 264b1

There was no documented evidence that the resident's physician was notified of the missed administration of the NJ EX Order. 264b1 after the NJ EX Order. 264b1 notification.

Review of an untitled and undated facility document, provided by the facility on 01/09/24 revealed " ...the center [facility] had an adequate supply of NJ EX Order. 264b1 in the NJ EX Order. 264b1 box on these dates [10/04/22 and 10/05/22]. So, while the medication administration record [MAR] documents that the medication wasn't administered on the dates in question, the medication was in the center ..." The medication

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S1935	Continued From page 40 being available at the facility but not administered further indicated the facility's failure to provide pharmaceutical services which included accurate acquiring, receiving, dispensing, and administering of all drugs. 4. Review of R64's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on [redacted] with diagnoses which included NJ EX Order. 264b1 [redacted] Review of R64's "Admission Note," dated [redacted] at 11:23 PM, located in the resident's EMR under the "Progress Notes" tab, revealed the resident was admitted to the facility on [redacted] at 4:00 PM. Review of R64's "Physician Orders," located in the resident's EMR under the "Orders" tab, revealed an order dated [redacted] at 9:00 PM for [redacted] Capsule [redacted] MG" give [redacted] capsule by mouth [redacted] a day. During an interview on 01/05/24 at 5:35 PM, Licensed Practical Nurse (LPN) 2 stated the facility had not received R64's [redacted] (used to treat [redacted] caused by NJ EX Order. 264b1) from the pharmacy [redacted] hours after the resident was admitted and the resident was in [redacted]. LPN2 stated [redacted] was not assigned to the resident during the interview. During an observation and interview on 01/05/24 at 5:40 PM, LPN9 revealed the medication cart lacked R64's [redacted] medication. LPN9 confirmed the resident's medication had not arrived from the pharmacy yet. When asked if the medication could be retrieved from the facility's backup	S1935		

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medications in the cubex, LPN9 stated she was an agency nurse and agency nurses did not have access to the cubex.

During an observation and interview on 01/05/24 at 6:11 PM, R64 was tearful and stated she arrived at the facility on NJ EX Order. 26401 and NJ EX Order. 264 was not fully NJ EX Order. 26401. The resident stated she was experiencing NJ EX Order. 26401, and NJ EX Order. 264 level was NJ EX Order. 26401

Review of R64's NJ EX Order Level Summary," dated NJ EX Order. 26401 at 6:24 PM, located in the resident's EMR under the "Vitals" tab revealed the resident's NJ EX Or was assessed by LPN9 and the resident rated the NJ EX Order. 26401 out of NJ EX

Review of R64's "MAR" dated NJ EX Order. 26401, located in the resident's EMR under the "Orders" tab, revealed it was documented the NJ EX Order medication was administered to R64 on 01/04/24 at 9:00 PM, on 01/05/24 at 9:00 AM, and on 01/05/24 at 9:00 PM, even though the pharmacy had not delivered the resident's medication to the facility.

Review of R64's pharmacy "Packing Slip Proof of Delivery," dated NJ EX Order. 26401, provided by the facility revealed the resident's NJ EX Order. 26401) was not delivered to the facility unti NJ EX IEX Order. 264 at 6:47 AM.

Review of the facility's cubex "Transactions By Patient, C14," with the date range of NJ EX Order. 26401, provided by the facility revealed the medication of NJ EX Order. 2 was not dispensed from the cubex for R64.

During an interview on 01/06/24 at 11:27 AM, the CP stated NJ EX Order. 2 was a NJ EX Orde medication that

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worked differently for [NJ EX Or] than other [NJ EX Or] medications, so the facility may have fewer options to replace the medication with a medication from the cubex. The CP stated the nurse should have notified the resident's physician if the medication was not at the facility when it was scheduled to be administered to ensure the resident's [NJ EX Or] was being managed.

During an interview on 01/08/24 at 2:13 PM, the Director of Nursing (DON) stated per R64's MAR, the facility's nurses administered the resident's [NJ EX Order 2640] on 01/04/24 at 9:00 PM, on 01/05/24 at 9:00 AM, and on 01/05/24 at 9:00 PM. The DON confirmed for these administration times and dates, R64's medication had not been delivered to the facility yet and she also confirmed the medication had not been dispensed from the facility's cubex. When asked how the nurses would have administered the medication if the medication were not in the facility and if the "MAR" was inaccurate, the DON stated she was not sure where the nurses would have obtained the medication from, but the "MAR" documented that [NJ EX Order 2] was administered.

5. Review of R31's undated "Admission Record," provided by the facility, revealed the resident was admitted to the facility on [NJ EX Order 2640]

Review of R31's "Medical Diagnoses" located in the resident's EMR under the "Med Diag" tab, revealed the resident was admitted to the facility with diagnoses which included [NJ EX Order 2640]

Review of R31's nursing "Admission/Readmission Note," located in the resident's EMR under the "Progress Notes" tab, revealed the resident was

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admitted to the facility on [redacted] at 10:00 PM.

Review of R31's "Physician Orders," located in the resident's EMR under the "Orders" tab revealed the resident was ordered the following medications on [redacted], the day after the resident was admitted: "[redacted] Oral Tablet (an [redacted] medication used to help prevent [redacted] MG give [redacted] tablet by mouth in the evening for prophylactic, [redacted] medication used for [redacted] MG tablet give [redacted] tablet every [redacted] hours as needed for [redacted], [redacted] Oral Tablet (a [redacted] used to reduce [redacted] MG give [redacted] tablet [redacted] times a day for [redacted] MG give [redacted] tablet by mouth [redacted] times a day for [redacted], and [redacted] Oral Tablet (a [redacted] used to reduce [redacted] MG Give [redacted] tablet my by mouth [redacted] time a day for [redacted] ..."

Review of R31's "Order Audit Report," located in the resident's EMR under the "Orders" tab, revealed the resident's [redacted] MG and [redacted] MG tablets were ordered from the pharmacy on [redacted] at 12:15 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility, [redacted] MG tablets were ordered from the pharmacy on [redacted] at 2:29 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility, [redacted] MG tablets were ordered from the pharmacy on [redacted] at 12:15 PM which indicated the medication was ordered [redacted] hours after the resident was admitted to the facility, and [redacted] MG tablets was ordered on [redacted] at 12:15 PM which indicated there medication was ordered [redacted] hours after the resident was admitted to the facility.

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Review of R31's "MAR," dated NJ EX Order: 264b1, located in the resident's EMR under the "Orders" tab revealed the resident was not administered any medications during her brief admission to the facility.

Review of R31's nursing "Progress Notes," dated NJ EX Order: 264b1, located in the resident's EMR under the "Progress Notes" tab, revealed a note at 9:51 PM of " ...21:40 [9:40 PM] pt left NJ EX Order: 264b1 NJ EX Order: 264b1 NJ EX Order: 264b1 ice] with NJ EX Order: 264b1. Refused to sign NJ EX CA U paperwork. Family very upset, felt staff was not attentive to their NJ EX Order: 264b1 needs." Continued review revealed a note at 10:18 PM of " ...Pt's family unhappy with care client receiving at facility. Family spoke with nursing supervisor regarding concerns and family adamant about taking client home."

During an interview on 01/05/24 at 1:52 PM, Family Member (F) 31 stated R31 was admitted to the facility from the hospital at approximately 11:00 PM on NJ EX Order: 264b1. F31 stated came back to the facility the next morning on NJ EX Order: 264b1 to visit R31. Continued interview with F31 revealed R31 had not received her medications since being admitted to the facility so NJ EX D found R31's nurse who informed her that R31's medications had not been ordered yet. F31 stated the whole day had passed and the facility never obtained medications to administer to R31. F31 also stated at approximately 9:00 PM on 02/04/23, NJ EX Dis decided it was not safe for NJ EX Order: 264b1 to stay at the facility and NJ EX D took the resident home. F31 stated it was important for NJ EX Order: 264b1 to receive medications to prevent NJ EX Order: 264b1 as NJ EX D NJ EX Order: 264b1 was admitted to the facility from the hospital after sustaining a NJ EX Order: 264b1.

6. Review of R32's undated "Admission Record,"

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S1935	Continued From page 45 provided by the facility, revealed the resident was admitted to the facility on [redacted]. Revive of R32's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab, revealed the resident was admitted with diagnoses which included NJ EX Order. 264b1 [redacted] and encounter for [redacted] following [redacted] on the [redacted]. Review of R32's nursing "Admission/Readmission Note," dated [redacted] at 12:30 AM, located in the resident's EMR under the "Progress Notes" tab, revealed "[Resident's name] arrived at the facility on [redacted] [at] 3:02 PM ..." Review of R32's "New Jersey Universal Transfer Form," dated [redacted], located in the resident's EMR under the "Misc" tab, revealed the resident was being transferred from the hospital to the facility for reasons of [redacted] and NJ EX Order. 264b1 [redacted]." Review of R32's hospital discharge instructions titled, "My Discharge Instructions," dated [redacted] revealed " ...Other Instructions: You came to the hospital because your NJ EX Order. 264b1 You had your [redacted] removed on [redacted] You were NJ EX Order. 264b1 as well as an NJ EX Order. 264b1 [redacted]. Infectious disease was consulted. You were started on [redacted] ...Your NJ EX Order. 264b1 was still going up. Interventional [redacted] was consulted as [redacted] and NJ EX Order. 264b1 [redacted] Interventional [redacted] felt this collection was not something that could be [redacted] They felt it would be better managed with [redacted] per infectious disease. Infectious	S1935		

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disease switched your NJ EX Order. 264b1. Your NJ EX Order. 264b1 started to decrease. Infectious disease wants you to complete a NJ EX Order. 26 total course of NJ EX Order. 264b1. Unfortunately, NJ EX Order. 264b1 is only able to be given with NJ EX so you had a NJ EX Order. 26 placed to be able to receive your NJ EX Order. 264b1 You are able to be discharged to rehab. You are to finish NJ more NJ EX Order. 264b1, including today. Today, you received NJ E dose so far. You will have NJ more doses of NJ EX Order. 264b1 today, Afterwards, you will have NJ EX Order. 264b1 every NJ E hours for NJ more days. You will receive you last dose of NJ EX Order. 264b1 on NJ EX Order. 264b1 ..." Continued review of the discharge instructions revealed R32 received NJ EX O last dose of NJ EX Order. 264b NJ EX Order. 264b1 at the hospital on NJ EX Order. 264b1 at 12:13 PM.

Review of R32's "Order Audit Report," located in the resident's EMR under the "Orders" tab, revealed the resident's NJ EX Order. 264b1 NJ EX Order. 264b1 MG was ordered from the pharmacy on NJ EX Order. 26 3 at 9:15 PM which indicated the medication was ordered NJ EX hours after the resident was admitted to the facility. Continued review of R32's order audit report revealed on NJ EX Order. 264b1 at 12:19 AM, the resident's NJ EX Order. 264b1 was again ordered from the pharmacy as NJ EX Order. 264b1 NJ EX Order. 264b1 GM ...Use NJ gram NJ EX Order. 264b1 one time only for NJ EX Order. 264b1 NJ EX Order. 264b1 removal until NJ EX Order. 264b1 ..."

Review of R32's nursing "Alert Note," dated NJ EX Order. 264b1 at 12:22 AM, located in the resident's EMR under the "Progress Notes" tab, revealed "Note Text: Resident med [medication] no delivery on time. MD [medical doctor] call and new order given NJ time dose NJ EX Order. 264b1 for NJ EX Order. 264b1 NJ EX Order. 264b1 Order will be resume upon

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pharmacy delivery tomorrow ..."

Review of R32's "MAR," dated NJ EX Order. 264b1, located in the resident's EMR under the "Orders" tab, revealed for NJ EX Order. 264b1 for NJ EX Order. 264b1 removal, it was documented the medication was administered on NJ EX Order. 264b1 at 1:41 AM which indicated it had been over NJ EX hours since the resident received NJ EX last dose at the hospital on NJ EX Order. 264b1 at 12:13 PM for an NJ EX Order. 264b1 that was physician ordered every NJ E hours.

7. Review of R63's undated "Admission Record," provided by the facility revealed the resident was admitted to the facility on NJ EX Order. 264b1

Review of R63's "Medical Diagnoses," located in the resident's EMR under the "Med Diag" tab revealed the resident was admitted to the facility with diagnoses which included NJ EX Order. 264b1

Review of R63's "Physician Orders," located in the resident's EMR under the "Orders" tab revealed an ordered dated NJ EX Order. 264b1 of "NJ EX Order. 264b1 [an NJ EX Order. 264b1] NJ EX Order. 264b NJ E GM Use NJ gram NJ EX Order. 264b1 one time a day for NJ EX Order. 264b1 NJ EX Order. 264b1

Review of R63's pharmacy "Packing Slip Proof of Delivery," dated NJ EX Order. 264b1 provided by the facility revealed the facility received seven doses of NJ EX Order. 264b1 GM ..." from the pharmacy.

Review of the facility's pharmacy "Packing Slip," NJ EX Order. 264b1 provided by the facility revealed R63 had NJ EX Order. 2 doses of NJ EX Order. 264b1 ..." delivered to the facility.

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S1935	Continued From page 48 During an interview on NJ EX Order. 264b1 at 3:34 PM, the DON confirmed the facility had received two deliveries of R63's NJ EX Order. 264b1 medication of NJ EX Order. 264b1, of NJ EX Order. doses each delivery which totaled NJ EX doses. Review of R63's "MAR," dated NJ EX Order. 264b1 located in the resident's EMR under the "Orders" tab revealed it was documented the resident had been administered one dose of the NJ EX Order. 264b1 NJ EX Order. 264b1 Review of R63's "MAR," dated NJ EX Order. 264b1, located in the resident's EMR under the "Orders" tab revealed it was documented the resident had been administered NJ EX Order doses of the NJ EX Order. 264b1 NJ EX Order. 264b1. Review of the "MAR"s revealed the resident had been administered at total of NJ EX Or doses of the resident's NJ EX doses received from the pharmacy by the facility. During the continued interview on 01/08/24 at 3:34 PM, the DON stated she counted the number of R63's NJ EX Order. 264b1 doses the facility had on hand as of NJ EX Order. 264b1 and the resident only had NJ EX Or doses left when NJ EX O should have had NJ EX Or doses left which indicated a deficit of NJ EX O dose. When asked if NJ EX C could explain why there was one dose of the resident's NJ EX Order. 264b1 missing, the DON stated NJ EX D did not know as there was nothing documented in the resident's EMR to account for the missing dose. When asked if the missing dose of the resident's NJ EX Order. 264b1 should be reported as misappropriation and if the facility should investigate what happened to the resident's medication, the DON stated "No." 8. Review of R13's "Diagnoses," located in the EMR under the "Diagnoses" tab, revealed R13 was admitted to the facility on NJ EX Order. 264b1 with	S1935		

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Review of R13's "Physician Orders," located in the EMR under the "Orders" tab, revealed:
a. an order, dated [redacted] for R13 to receive [redacted] (an NJ EX Order. 264b1 milligrams (mg) give [redacted] tablet every [redacted] hours (9:00 AM and 9:00 PM) for s[redacted], and
b. an order, dated [redacted], for R13 to receive [redacted] (an [redacted] medication) [redacted] mg [redacted] tablets to equal [redacted] mg daily at 9:00 AM and give [redacted] tablets to equal [redacted] mg by mouth at NJ EX Order. 264b1.

Review of R13's "Medication Administration Sheets (MARS),"dated NJ EX Order. 264b1 revealed:
a. no documentation to show R13 received the 9:00 AM dose of NJ EX Order. 264b1 or the 9:00 PM dose of NJ EX Order. 264b1 and
b. no documentation to show R13 received the 9:00 AM dose of [redacted] on 09/14/22 or the 9:00 PM dose of [redacted] on 09/26/22.

During an interview on 01/08/24 at 1:17 PM, the Director of Nursing (DON) confirmed there was no documentation to show R13 had been provided the above referenced medications. The DON confirmed there was no documentation to show why R13 had not received the medications.

9. Review of R11's "Admission Record," provided by the facility, revealed R11 was admitted to the facility on [redacted] with diagnoses that included NJ EX Order. 264b1 [redacted].

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUI	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1935	Continued From page 50	S1935		

Review of R11's "Physician Orders," provided by the facility, revealed:
a. an order, dated [redacted], for [redacted] mg ([redacted], a [redacted] medication) every [redacted] hours (9:00 AM and 9:00 PM) for pain;
b. an order, dated [redacted] for [redacted] (used to treat [redacted] milliliters (ml) every [redacted] hours (9:00 AM and 9:00 PM) for [redacted] and
c. an order, dated [redacted], for [redacted] (used to treat [redacted] mg every [redacted] hours (9:00 AM and 9:00 PM) for [redacted].

Review of R11's "MARS," dated [redacted], revealed:
a. no documentation to show R11 received her 9:00 PM dose [redacted] on 11/21/22 or either dose on 11/22/22;
b. no documentation to show R11 received [redacted] 9:00 PM dose of [redacted] on 11/21/22; and
c. no documentation to show R11 received [redacted] 9:00 PM dose of [redacted] on 11/22/22.

Review of R11's "Progress Notes," dated [redacted] and located under the "Progress Notes" tab of the EMR revealed:
a. 11/21/22 at 11:18 PM - ". . . [redacted]. . . new admission awaiting for arrival from pharmacy . . ."
b. 11/21/22 at 11:21 PM - ". . . [redacted] . . . new admission awaiting arrival from pharmacy . . ."
c. 11/22/22 at 9:59 AM - ". . [redacted] . . . med [medication] not available at this time . . ."and
d. 11/22/22 at 11:45 PM and two entries at 11:46 PM - ". . . Pharmacy action required . . ."

During an interview on 01/08/24 at 2:21 PM, the DON confirmed there was no documentation to show R11 had been provided the above

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	08008	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUI	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1935	Continued From page 51	S1935		

referenced medications. The DON confirmed there was no documentation to show why R11 had not received the medications or why the medications would not be available. The DON confirmed her expectation was for staff to call the physician to get an alternate medication if a medication was not available and to call the pharmacy to identify the problem and correct it.

10. Review of R9's "Admission Record," provided by the facility, revealed R9 was admitted to the facility on NJ EX Order. 264b1 with diagnoses that included NJ EX Order. 264b1 of the NJ EX Order. 264b1 NJ EX Order

Review of R9's "Physician Orders," provided by the facility, revealed:
a. an order, dated NJ EX Order. 264b1, for NJ EX Order. 264b1 (an NJ EX Order. 26 used to treat NJ EX Order. 264b1 every NJ EX hours (9:00 AM and 9:00 PM); and
b. an order, dated NJ EX Order. 264b1 for NJ EX Order. 264b1 (used to treat NJ EX Order. 264b1 mg NJ E ml one dose NJ EX Order. 264b1 every six hours (12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM).

Review of R9's "MARS," dated NJ EX Order. 264b1, revealed:
a. no documentation to show R9 received NJ EX 9:000 PM dose of NJ EX Order. 264b1 on 12/02/23, either dose on 12/03/23, and the 9:00 AM dose on 12/04/23; and
b. no documentation to show R9 received her Albuterol on 12/02/23 at 6:00 PM.

Review of R9's "Progress Notes," dated NJ EX Order. 264b1 through NJ EX Order. 264b1, revealed no documentation why the above referenced medications were not provided.

During an interview on 01/08/24 at 12:53 PM, the

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	08008	A. BUILDING: _____ B. WING _____	C 01/09/2024

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ATLAS POST ACUTE AT WOODBURY COUNTRY CLUI	467 COOPER STREET WOODBURY, NJ 08096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1935	Continued From page 52 DON confirmed there was no documentation to show R9 received her medications as ordered. The DON confirmed her expectation was for staff to follow physician orders, check the facility's emergency medication for supply for any missing medications, notify the physician if medications were not available, and document accordingly. During an interview on 01/04/24 at 12:50 PM, the Medical Director stated that if a resident was admitted to the facility during the day, it should only take a few hours for the pharmacy to deliver the resident's medications. The Medical Director stated it was his expectation if a resident does not receive a medication because it has not been delivered from the pharmacy, then the nurse should see if the medication is in the cubex and then call the provider to get an order for the medication or a substitute for the medication needed. Continued interview with the Medical Director revealed he had not been made aware of any issues of the facility acquiring resident medications timely. The Medical Director also stated the cubex should never be used more than 24 hours to obtain the same medication for a resident. During an interview on 01/05/24 at 10:33 AM, Nurse Practitioner (NP) 1 stated she was not aware of residents being out of NJ EX Order 264D medications and the facility's cubex not having the medications either. NP1 stated anytime a resident does not receive a medication because of the facility not having the medication on hand, the nurse should contact her or another provider so an order could be obtained for an equivalent medication the facility has on hand. The NP stated when residents do not receive their NJ EX Order: 264D medication after being admitted from the hospital, it places the resident at an	S1935		

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	08008	A. BUILDING: _____ B. WING _____	C 01/09/2024

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S1935	Continued From page 53 increased risk of blood clots. Continued interview with the NP revealed anytime a resident goes without [redacted] medications and/or [redacted] medications, residents could experience [redacted] from the medications and if the resident is at the facility for therapy and their [redacted] is not managed, it could delay their rehabilitation. During an interview on 01/05/24 at 11:11 AM, the Prior DON (PDON) stated the majority of the residents admitted to the facility were post-acute and the most common medications residents were ordered were blood pressure medications, pain medications, and some antianxiety medications. The PDON stated she was not aware of any concerns related to consistent problems of resident medications being acquired. The PDON stated if a resident were admitted late in the day but prior to 10:00 PM, the pharmacy would deliver the resident's medication at midnight. Continued interview revealed it was the PDON's expectation that no resident would ever go without any of their medications and if the medication is not in the facility she would expect for the nurse to notify the physician and get an order for a medication that the facility did have on hand. During an interview on 01/05/24 at 12:35 PM, the Prior Administrator stated the facility could not order a resident's medications until after the resident was physically in the facility. Continued interview revealed generally, if the medication has not been received from the pharmacy, the nursing staff could obtain the medication from the facility's cubex. The Prior Administrator stated agency nurses did not have access to the cubex and not sure they should have access to the cubex. The Prior Administrator also stated while he was the	S1935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1935	Continued From page 54	S1935		

Administrator he had not been made aware of any issues where residents did not receive their medication because of the medication not being delivered and this would have been something he would have wanted to be made aware of. The Prior Administrator stated it was important the facility would have residents' medications on hand to avoid any delays in treatment and to prevent a negative outcome.

During an interview on 01/08/24 at 1:31 PM, the DON stated since she had been the DON at the facility (approximately two weeks) she had not been made aware of any issues related to acquiring residents' medications from the pharmacy. The DON stated if a resident's medication is not in the medication cart, it was her expectation the nurse would look at what medications were in the cubex, call the pharmacy and inquire about when the medication will arrive at the facility, and then notify the medical provider and receive directions form the provider.

During an interview on 01/08/24 at 4:00 PM, the Regional Director of Operations (RDO) stated he had not been made aware of any issues related to pharmacy services.

Review of the facility's policy titled "Pharmacy Services," revealed "It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice ...Pharmaceutical services refers to: The process (including documentation, as applicable) of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling ...dispensing ...administering ...of all

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S1935	Continued From page 55 medications ..." Review of the facility's policy titled, "6.0 Automated Dispensing Devices Medication Dispensing System," revised 02/16/22, revealed "Policy. Automated Dispensing Devices may be installed in appropriate facilities as permitted by the state pharmacy law. Procedure ...B. Stocked Automated Dispensing Device Medications: 1. The contents of this supply are determined by Specialty Rx, Inc. in collaboration with the facility staff and medical director and in accordance with state regulations. 2. Pharmacy manager and facility's medical director or designee must approve any changes to the content of this supply. The consultant pharmacist and director of nursing are consulted on and notified of all and any changes. C. Only licensed facility personnel, who have the approval of the director of nursing and appropriate training on the Automated Dispensing Device, have access to medications in the Automated Dispensing Device. D. REMOVAL of Medications: 1. Medications may be removed from the Automated Dispensing Device following the device's instructions: a. Upon receiving a new medication order, to obtain the number of doses needed to cover the period of time from the administration of the first dose until receipt of the medication from the pharmacy ..."	S1935		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
08008 Y1	A. Building B. Wing Y2	3/25/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0395	Correction	ID Prefix S0765	Correction	ID Prefix S1935	Correction
Reg. # 8:39-4.1(a)(5)	Completed	Reg. # 8:39-9.2(a)	Completed	Reg. # 8:39-29.2(d)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315521 Y1	A. Building B. Wing Y2	3/25/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0585	Correction	ID Prefix F0600	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.12(a)(1)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix F0602	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.12	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix F0684	Correction	ID Prefix F0692	Correction	ID Prefix F0695	Correction
Reg. # 483.25	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix F0725	Correction	ID Prefix F0726	Correction	ID Prefix F0755	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.35(a)(3)(4)(c)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix F0759	Correction	ID Prefix F0800	Correction	ID Prefix F0803	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60	Completed	Reg. # 483.60(c)(1)-(7)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315521 Y1	A. Building B. Wing Y2	3/25/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS POST ACUTE AT WOODBURY COUNTRY CLUB	467 COOPER STREET WOODBURY, NJ 08096

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ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0804	Correction	ID Prefix	F0835	Correction	ID Prefix	F0841	Correction
Reg. #	483.60(d)(1)(2)	Completed	Reg. #	483.70	Completed	Reg. #	483.70(h)(1)(2)	Completed
LSC		03/25/2024	LSC		03/25/2024	LSC		03/25/2024
ID Prefix	F0842	Correction	ID Prefix	F0867	Correction			
Reg. #	483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	483.75(c)(d)(e)(g)(2)(i)(ii)	Completed			
LSC		03/25/2024	LSC		03/25/2024			

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/9/2024	☐ YES ☐ NO