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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard and Complaint COMPLAINT #: NJ00167074, NJ00164651, NJ00166646, NJ00158043, CENSUS: 37 SAMPLE SIZE: 7 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 235	8:36-2.4(d) Licensure Procedures (d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide the	A 235		

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

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A 235	Continued From page 1	A 235		

surveyor with access to review the electronic medical records (EMRs) for 7 of 7 residents reviewed, Resident #'s: 1, 2, 3, 4, 5, 6, and 7. This deficient practice was evidenced by the following:

On 6/18/2024 at 9:12 a.m., Surveyor #2 requested access to the facility's EMR system. At that time, the facility's Business Office Coordinator (BOC) stated that she would contact the facility's Information Technology Department who would provide the survey team with access to the facility's EMR system.

At 10:20 a.m. the surveyor team received a user ID code and password to the facility's EMR system. Surveyors: 1, 2 and 3 were unable to log into the EMR system.

At 10:26 a.m., the surveyor team notified the facility's BOC that the provided user ID code and password did not grant the team access to the facility's EMR system. The BOC stated that she would investigate why the user ID and password were not working. The surveyor team was not provided EMR access on 6/18/2024.

On 6/19/2024 at 9:45 a.m., during surveyor interview, Surveyor #1 interviewed the facility's Regional Nurse (RN), RN #2, and requested access to the facility's EMR system.

At 10:30 a.m., during surveyor interview, the facility's Regional Executive Director (ED) informed the surveyor team that the EMR system could not be accessed through the surveyors' laptops and must be accessed through a facility's laptop. At that time the Regional ED provided the survey team with a facility laptop to access the facility's EMR.

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A 235	Continued From page 2 At 11:52 a.m., Surveyor #1 attempted to look at Resident #'s: 1, 2, 3, 4, 5, 6, and 7 General Service Plans (GSP) and was unable to locate the documents in the facility's EMR system. At 11:54 a.m., Surveyor #1 interviewed the facility's Regional ED and requested the Regional ED locate the sampled residents' GSPs in the EMR system. At that time the Regional ED stated that the facility's residents' GSPs were kept in a different EMR system, EMR System #2, and the facility would have to provide the survey team with access to EMR System #2. At 12:01 p.m., Surveyor #1 interviewed the facility's RN #2 who stated that she was unable to provide the survey team with access to the EMR System #2. The survey team was not granted full access to all resident records and facility documents located in the facility's EMR systems.	A 235		
A 269	8:36-3.1(a) Administration (a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3.	A 269		

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A 269	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility failed to ensure that an Alternate Executive Director (ED) was designated in writing and available to act in the absence of the Executive Director (ED). This deficient practice was evidenced by the following: On 6/18/2024, 9:15 a.m., the surveyor interviewed the facility's Business Office Coordinator (BOC) and inquired about the facility's ED. The BOC stated that the facility's ED resigned, and her last day was NJ Exec Order 26.4b1. The surveyor then asked the BOC who was appointed to act as an Administrator. The BOC stated that she was the only Director in the building during the survey entrance and would call the regional team to inform that the Department of Health was in the building, and inquire about the facility's ED. At 10:00 a.m., the BOC stated that the Regional Director was covering the facility and the new ED was supposed to start on NJ ex order 26.4b1. The BOC informed the surveyor that the Regional Director would NJ ex order 26.4b1, the date of the survey. The surveyor then asked who was in charge; the BOC replied, "I guess I am." The BOC stated that she did not have anything in writing which designated her to act as the alternate ED. At 1:00 p.m., the surveyor interviewed the facility's Regional Nurse #1 who stated that she was unable to identify who was the facility's alternate ED and there was no alternate ED in writing. At 2:00 p.m., Regional Nurse #2 stated that she	A 269		

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A 269	Continued From page 4 was the acting ED and not the Regional Director, and that she would be the alternate ED until the newly hired ED starts on [NJ ex order 26.4b1].	A 269		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility's Executive Director (ED) failed to ensure the enforcement of the policies and procedures titled, "Shift Report Policy", and "Automated External Defibrillator (AED)." This deficient practice was evidenced by the following: 1. On 6/18/2024 at 1:15 p.m., Surveyor #1 interviewed the facility's Regional Nurse (RN), RN #2, who stated that the facility's Licensed Practical Nurses, caregivers and technicians utilized the facility's document titled, "shift report"	A 310		

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A 310	Continued From page 5	A 310		

to communicate between nursing staff.

At 1:57 p.m., Surveyor #1 interviewed the facility's Staff Members (SM), SM #1 and SM #2. During surveyor interview, SM #1 and SM #2 stated that they were instructed by management not to utilize the facility's document titled, "Shift Report Policy" to communicate with other members on the nursing team. SM #2 stated that the facility's care givers were instructed to utilize the facility's document titled, "Care Shift Report Log" in March of 2024 but that the use of the care shift report log was no longer utilized.

On 6/19/2024 at 12:30 p.m., Surveyor #1 reviewed the facility's policy and procedure manual provided by the facility's administration and observed a policy titled, "Shift Report Policy", which documented, "... the Shift Report form serves as a means of communication between and among associates and management. Associates should record important resident specific information about health-related matters that occurred during an assigned work period. Associates should also provide detail about any unfinished tasks that require attention by the oncoming shift as well as any issues that require follow-up ... Policy Detail... 1. The Resident Care Associate, Medication Aide, Nurse, or designee, should complete the Shift Report at the end of each shift. 2. The Shift Report forms should be in an area accessible to associates but protected from public view ... 3. The Nurse and Executive Director or designee should review each day's Shift Report and sign each sheet ...".

2. On 6/18/2024 at 10:00 a.m., and 12:30 p.m. Surveyor #2 observed the AED machine mounted onto the wall in the nurses station and observed a red X illuminated on the device. The surveyor

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A 310	Continued From page 6 observed a sign in sheet next to the AED machine. At 2:00 p.m., Surveyor #2 and Regional Nurse #2 (RN #2) observed a red X on the AED machine. The surveyor inquired about the red X and asked RN#2 to perform a check of the device to ensure it is functioning. The surveyor observed RN#2 press the green button and the AED machine prompted to the user to "change batteries." RN #2 stated that the Maintenance Director was responsible for maintaining the AED in working order. The surveyor asked RN #2 for the manufacturer's instruction for the AED machine. On 6/19/2024 at 10:00 a.m., RN #2 informed the surveyor that she could not locate the manufacturer's instructions and that she had changed the battery to the AED machine and now the AED reflected a green check mark and not a red X. The surveyor reviewed the facility's policy titled, "Automated External Defibrillator (AED) revised 2/2021 which revealed, "...The AED is a device that may be used to assist resident in the event that they have no pulse and/or is not breathing...2. The AED(s) equipment is checked and documented on a regular schedule...by the maintenance director..."	A 310		
A 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services	A 355		

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A 355	Continued From page 7 and care in accordance with the resident's individualized general service and/or health service plan; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and implement a resident's General Service Place (GSP) to ensure the resident's care services were implement by staff. The deficient practice was evidenced by the following: On 6/18/2024 at 11:08 a.m., Surveyor #1 interviewed facility Staff Member (SM), SM#1 who stated that the facility did not use the aide assignment sheets to direct the caregivers on the level of care to provide to residents when performing activities of daily living (ADLs). ADLs includes how the resident eats, dresses, bathes, ambulate, and transfer. Further, SM #1 stated that the facility's caregivers previously used the aide assignment sheets but the assignment sheets were incorrect as they included residents that were no longer at the facility, in addition to residents that were still at the facility. In addition, SM #1 stated that the facility's caregivers knew how to care for resident through experience not the facility's Nurse. At 11:37 a.m., Surveyor #1 interviewed SM #2 who stated that the facility's aide assignment sheets were not updated and did not reflect the care residents needed. SM #2 stated that the	A 355		

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facility care givers informed each other how to care for the residents, not the facility's Nurse.

At 12:17 p.m., Surveyor #1 observed a red binder in the facility's nursing station that contained aide assignment sheets which listed residents that no longer resided and was not updated with new residents at the time of the survey.

At 12:56 p.m. Surveyor #1 interviewed the facility's Regional Nurse (RN), RN #2, who stated that assignment sheets are updated and placed in the nursing office. At that time, Surveyor #1 requested an updated assignment sheet, to which RN #2 stated that the assignment sheet needed to be printed.

At 1:04 p.m., while at the facility's nursing station, RN #2 was unable to present to the surveyor the location of where the assignment sheets were available to the care givers. At that time RN #1 stated that the updated assignment sheet should have been available in the assignment binder, and both the facility's Regional Nurses stated that the current assignment sheet should have been in the assignment binder.

At 1:14 p.m., Surveyor #1 interviewed the facility's RN #2 who stated that the level of care indicated on assignment sheets were derived from the facility's RN nursing care plans and were placed in the facility's Care Plan Binder located in the nursing office. During continued surveyor interview, RN #2 stated that the facility's care plan binder was up to date and that the care plans were updated as need and every 6 months.

At 1:29 p.m., the surveyor reviewed the facility's care plan binder and observed there were multiple residents that did not have a care plan,

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A 355	Continued From page 9 some of the care plans were not updated, and there were care plans in the binder for residents that no longer resided at the facility.	A 355		
A 515	8:36-5.6(a) General Requirements (a) The facility or program shall maintain and implement written staffing schedules. Actual hours worked by each employee shall be documented. This REQUIREMENT is not met as evidenced by: Based on interview and review of records, it was determined that the facility Administrator failed to ensure that facility's written staffing schedule accurately documented the actual hours worked by each employee in the assisted living. This deficient practice was evidenced by the following: On 6/18/20 at 1:00 p.m., the surveyor reviewed the facility's nursing schedule and observed that on 6/15/2024 during the 11:00 p.m. - 7:00 a.m. shift there was only one Home Health Aide reflected on the schedule for the overnight shift. The surveyor then asked Regional Nurse #1 about the staffing shortage, who stated that she would look into the matter. At 2:30 p.m., Regional Nurse #1 informed the surveyor that the nursing schedule was not updated to accurately reflect the hours worked. Regional Nurse #1 further stated that a Home Health Aide from the second shift (3:00 p.m. - 11:00 p.m.,) worked a double shift, and on 6/15/2024, meaning the second shift and the overnight shift. Regional Nurse #1 acknowledged that the schedule should have been updated.	A 515		

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A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program; 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19.	A 517		

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A 517	Continued From page 11	A 517		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to provide documented evidence that 7 of 7 employees received the required in-service training on Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Dementia Training, and Pain Management. The aforementioned in-services were to be provided upon hire and annually thereafter. This deficient practice was evidenced by the following:

On 6/18/24 at 2:20 p.m., Surveyor #2 requested employee files and training records.

On 6/19/24 at 9:05 a.m., Surveyor #4 interviewed the Business Office Coordinator (BOC) to inquire about the requested employee files and training records. The BOC stated that she would check with upper management.

At 10:50 a.m., the Executive Director (ED) from another facility, who was there to assist during the survey, provided surveyors with the employee files.

At 11:00 a.m., Surveyors #1, #3, and, #4 reviewed the employee files for seven employees, and observed that none of the employees had any records of training/inservices in their file.

At 12:19 p.m., Surveyor #4 interviewed the ED to inquire about the reason why none of the employees had records of training in their

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A 517	Continued From page 12 employee files. The ED stated that the education/trainings were done online through a program called "Relias." The ED stated that he would provide a printout of trainings for each employee. At 1:08 p.m., the ED provided the surveyors with the online Relias training for five of the seven employees requested, and the results were as follows: 1. Employee #1 was hired for a Home Health Aide position, had no documentation of trainings received. Date of hire was not documented in the employee's file. 2. Employee #2 was hired for a Cook position, had no training documentation. The date of hire was not documented in the employee's file. 3. Employee #3 was hired for a Certified Nursing Aide position, did not have a training on Assisted Living Concepts. Date of hire was not documented in the employee's file. 4. Employee #4 was hired for a Receptionist position, did not have training on Assisted Living Concepts, Resident Rights, or Pain Management. Date of hire was not documented in the employee file. 5. Employee #5 was hired for a Licensed Practical Nurse position, did not have training on Assisted Living Concepts, Resident Rights, or Pain Management. Date of hire was not documented in employee file. 6. Employee #6 was hired for a Cook position on [NJ ex order 26.4b] did not receive the annual re-training for Assisted Living Concepts.	A 517		

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A 517	Continued From page 13 7. Employee #7 was hired for a Resident Program Coordinator (RPC) position on [NJ ex order 26.4]. The RPC did not receive the annual inservices required for Assisted Living Concepts or for Alzheimer Dementia. The facility was unable to provide the surveyor with above wih thre required inservice information for the aboveee-mentioned staff members missing at the time of the survey.	A 517		
A 571	8:36-5.10(a)(6) General Requirements (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following: 6. Termination of employment of the administrator, and the name and qualifications of his or her replacement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure that the Department of Health (DOH) was notified after the termination of employment of the Executive Director (ED) with the name and qualifications of the replacement. This deficient practice was evidenced by the following: On 6/18/2024 at 9:20 a.m., during the entrance	A 571		

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A 571	Continued From page 14 conference the Business Office Coordinator (BOC) stated that the previous ED's last day worked was NJ ex order 26.4b1. At that time the surveyor asked who was in charge. The BOC stated that she would call the regional team to inform them that the Department of Health was in the building. The BOC further stated that she was in charge in the absence of the ED. The surveyor observed the previous ED, Certified Assisted Living Administrators License hung on the wall where other notices were posted. Later that day Regional Nurse #2, (RN#2), informed the surveyor that she was the covering ED until the newly hired ED was supposed to start on NJ ex order 26.4b1 At that time the surveyor inquired if the DOH was notified of the change in administration. RN #2 stated that she was not sure but would inquire. On 6/19/2024 RN#2 presented to the surveyor with a letter to the DOH dated NJ ex order 26.4b1, which informed the DOH of the previous ED's NJ ex order 26.4b1 and who would replace the ED, along with their qualifications. The surveyor noted the email was dated NJ ex order 26.4b1, and after the surveyor inquired.	A 571		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

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	10a001	A. BUILDING: _____ B. WING _____	C 06/19/2024

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A 891	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents it was determined that the facility failed to prepare, store and label food in accordance with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines" which placed the highly susceptible population/residents' health and safety at risk for foodborne illnesses. This deficient practice was evidenced by the following: Reference: Chapter 24, N.J.A.C. 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines" read: Reference: Chapter 24, N.J.A.C 8:24- 4.2 (r) "Equipment compartments that are subject to accumulation of moisture due to conditions such as condensation, food or beverage drip, or water from melting ice shall be sloped to an outlet that allows complete draining." Reference: Chapter 24, N.J.A.C 8:24-4.1(i), "Multiuse kitchenware, such as frying pans, griddles, saucepans, cookie sheets, and waffle bakers that have a perfluorocarbon resin coating, shall be used with nonscoring or nonscratching utensils and cleaning aids." Reference: Chapter 24, N.J.A.C 8:24-4.6(c), "Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food, residue, and other debris ..." Reference: Chapter 24, N.J.A.C 8:24-3.3(c)(1)(viii), "Storing the food in packages, covered	A 891		

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A 891	Continued From page 16	A 891		

containers, or wrappings except:
1. Whole, uncut, raw fruits and vegetables and nuts in the shell, that require peeling or hulling before consumption.
2. Primal cuts, quarters, or sides of raw meat or slab bacon that are hung on clean, sanitized hooks or placed on clean, sanitized racks.
3. Whole, uncut, processed meats such as country hams, and smoked or cured sausages that are placed on clean, sanitized racks.
4. Food being cooled; or
5. Shellstock ..."

Reference: Chapter 24, N.J.A.C 8:24-3.3 (k) (1, 2), "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: In the food with their handles above the top of the food and the container..., in a food that is not potentially hazardous, with their handles above the top of the food within containers of equipment that can be closed, such as bins of sugar, flour, or cinnamon."

Reference: Chapter 24, N.J.A.C 8:24-4.6(b), "The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations."

Reference: Chapter 24, N.J.A.C 8:24-6.3(c)(2) "Dressing area and locker requirements include the following: ... Lockers or other suitable facilities shall be provided for the orderly storage of employees' clothing and other possessions."

Reference: Chapter 24, N.J.A.C 8:24-6.3(d)(2) "Designated area requirements include the following: ... Lockers or other suitable facilities shall be located in a designated room or area where contamination of food, equipment, utensils, linens, and single-service and single-use articles cannot occur."

1. On 6/19/2024 at 9:44 a.m., the surveyor

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A 891	Continued From page 17 conducted a tour of the facility's kitchen. The surveyor observed an ice scoop mounted to the wall above the ice machine without drainage. 2. At 10:01 a.m., the surveyor observed a mounted can opener on the side of the main kitchen prep area which had a large amount of dark brown in color matter build up around the joints and in the corners. The surveyor also observed three co-polymer cutting boards with scoring and scratching to the surfaces. 3. At 10:04 a.m., the surveyor observed the refrigerator had the following food items stored inside that were not labeled or dated: Turkey burgers (per kitchen staff), string beans and kidney beans, cheese slices, peach slices, garlic, beets, butter balls, iced tea, and juices in serving containers. 4. At 10:05 a.m., the surveyor observed the freezer had the following food items stored inside that were removed from their original containers/boxes, and sealed without a label or date: - 1 Package of chicken tenders - 11 packages of waffles with 8 waffles in each pack - 2 clear bags of mashed potatoes (per facility staff) - 1 package of frozen deli meat, turkey (per facility staff) 5. At 10:10 a.m., the surveyor observed the freezer had the following food items stored inside that were opened without a label or date: - 1 bag of precooked pretzels - 1 package of chicken tenders - Cornbread muffins - 5 waffles	A 891		

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A 891	Continued From page 18 - Beef patties (open to air) - 4 chicken patties in a wrap (per facility staff) - eggplant in a blue bag (open to air) - 1 bag of mixed vegetables (open to air) 6. At 10:20 a.m., the surveyor observed the freezer had the following food items stored inside that were without an expiration date or shipment date: - Fresh crumb breaded cod, open to air - Flounder fillets, open to air - Chocolate brownies, open to air - Lemon Lovers bar, open to air - Feta crumbles, open to air - 5 key lime pies - 4 lime pies - 1 Sara Lee Chocolate Cake - 4 Chef Pierre desserts - 1 fruit pie - 1 pecan pie - 2 peach cobblers - 1 fruit of the forest pie - 1 Hershey's Ice Cream Cake - 1 Banana Cream Pie - 3 bags containing 5 pie shells each - 1 Lemon Meringue Pie - 1 package of Fancy Shredded Mild Cheddar Cheese 7. At 10:23 a.m., the surveyor toured the dry storage area of the facility's kitchen and found the following: - Tortilla chips- opened, without a label and opened date. - Tortilla chips- opened, without a label, dated 4/6/2024. - Coconut flakes- without a label and opened date, a facility staff member verified the food item.	A 891		

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A 891	Continued From page 19 8. The following items were opened, without a date: - Egg noodles, rice, pancake mix, Craisins Ocean Spray, spaghetti, croutons, soy sauce. 9. At 10:29 a.m., the surveyor toured the dry storage room with the Food Service Director (FSD). Upon tour of the dry storage room, the surveyor observed that a container of flour contained a scoop that was stored in the flour. Additionally, there was a container with a label which indicated that the content was flour, with an open date of 2/1/2024, and a use-by date of 6/1/2024, on the side of the container handwritten was "Italian seasoning". The FSD was unable to identify the contents of the container, a kitchen staff member identified the contents as quinoa. Additionally, the surveyor observed a purse-like item in dry storage on the second rack from the bottom. 10. At 10:30 a.m., the surveyor observed that the pans and baking sheets were encrusted with appeared to be grease deposits and food debris accumulations. The surveyor interviewed the FSD who stated that the pans and baking sheets should not have grease deposits and accumulated debris them. Continued interview with the FSD confirmed that all opened items should have been labeled and dated, not open to air, scoops should not be in the dry storage, and facility staff should keep their personal belongings, as well as personal food and drinks in the designated employee space. Additionally, the surveyor observed facility staff members' personal food and drink items throughout the facility's refrigerator and freezer spaces throughout the tour of the kitchen.	A 891		

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A 973	Continued From page 20	A 973		
A 973	8:36-11.6(a)(5) Pharmaceutical Services (a) The facility or program shall designate a pharmacist who shall direct pharmaceutical services and provide consultation to the physician, facility, or program staff, and residents, as needed. The pharmacist shall assist the facility or program with, at a minimum, the following: 5. At least quarterly, inspecting all common areas of the facility or program where medications are stored or administered, documenting any problems and proposing solutions to these problems, and maintaining records of such inspections. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure that the Consultant Pharmacist inspected the medication storage areas of the unit on a quarterly basis. This deficient practice was evidenced by the following: On 6/19/2024, at 11:20 a.m., the surveyor requested the most recent pharmacy consultant report from Regional Nurse #3 (RN), RN #3. The surveyor reviewed the pharmacy consultant report dated NJ ex order 26.4b1, through NJ ex order 26.4b1 and there was no documentation that the medication storage areas were reviewed. On 6/19/2024 at 11:26 a.m., the surveyor inspected the medication cart and observed	A 973		

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A 973	Continued From page 21 creams, ointments, and powders were stored together and not sealed in individual packages. The surveyor also observed eye drops, ear drops, and inhalers without the date the medication was opened to indicate when the medication needed to be used by per manufacturers orders. At 12:32 p.m., the surveyor interviewed RN #3 who stated that medication storage areas were not reviewed by the pharmacy consultant.	A 973		
A 981	8:36-11.7(a)(4) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 4. Each resident's medications shall be kept separated within the storage area, with the exception of large volume medications which may be labeled and stored together in the storage area. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility nursing staff failed to store ointments and creams separately for each resident within the medication cart. This deficient practice was evidenced by the following: On 6/19/2024 at 11:26 a.m., in the presence of a Regional Nurse # #4 (RN #4), the surveyor	A 981		

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A 981	Continued From page 22 inspected the medication cart and observed that creams, ointments, and powders were stored together without a sealed package to prevent the prescribed medication from one resident encountering another resident's medication while inside the medication cart. The surveyor interviewed the agency Licensed Practical Nurse (LPN), who was assigned to the medication cart at the time of the survey. The LPN stated that the medications should be in individual packages to prevent cross-contamination in the treatment cart. The surveyor reviewed the facility policy titled, "Medication & Treatment- Storage Policy", revised 10/2018 which indicated: " ... The designated area should be clean and orderly ... 6. Medications and treatments should be stored by route of administration and separated by resident. Ointments and creams should be stored separately in individual bags labeled appropriately."	A 981		
A 983	8:36-11.7(a)(5) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 5. Medications shall be stored in accordance with manufacturer's instructions, and/or extemporaneously applied pharmacy labels and/or directions, and/or United States Pharmacopoeia Drug Information (USP DI)	A 983		

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A 983	Continued From page 23 Volume I, Drug Information for the Health Care Professional, 2005, incorporated herein by reference, as amended and supplemented and USP DI Volume II: Advice for the Patient, incorporated herein by reference, as amended and supplemented. USP DI Volume I: Drug Information for the Health Care Professional and USP DI Volume II: Advice for the Patient can be obtained by contacting Thomson-Micromedex, 6200 S. Syracuse Way, Suite 300, Greenwood Village, CO 80111, (303) 486-6400. This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined that the Executive Director (ED) failed to ensure medications were consistently stored according to the manufacturer's specifications for 3 of 6 residents reviewed, Resident #'s 4, 5, and 6. This deficient practice was evidenced by the following: The surveyor observed that the following prescribed eye drops, ear drops, nasal spray, and inhaler containers were opened but did not include the date when opened on each individual container. The manufacturer of each provides instructions as to how many days after the product is opened that it should be discarded and not used, however, if the facility failed to indicate the date the products were opened and therefore were not aware of the date the products should have been no longer used on residents. The surveyor observed the following:	A 983		

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A 983	Continued From page 24 1. On 6/19/2024 at 11:26 a.m., the surveyor entered the medication room and observed Registered Nurse (RN) #4 with a black marker and an [NJ Exec Order 26.4b] box in his hands. Upon surveyor review of the medication cart, the surveyor observed that RN #4 had written an opened date on the eye drop box. The surveyor reviewed Medication Cart #1 and identified medications that included but were not limited to, [NJ Exec Order 26.4b1], ear drops, and inhalers. 2. The surveyor observed the following medication for Resident #4, who had a move-in date of [NJ ex order 26.], with diagnoses which included [NJ ex order 26.4b1] 3. The surveyor observed the following medication for Resident #5, who had a move-in date of [NJ ex order 26.], with diagnoses which included [NJ ex order 26.4b1] 4. The surveyor observed the following medications for Resident #6, who had a move-in date of [NJ ex order 26.4b], with diagnoses that include [NJ ex order 26.4b1]	A 983		

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A 983	Continued From page 25 At 11:45 a.m. the surveyor interviewed an agency Licensed Practical Nurse, who was at the facility at the time of the survey, and stated that it was her practice to add the date when she opened medications such as eye drops, ear drops, inhales, or nasal sprays. At 1:03 p.m., the surveyor entered the medication room and noted RN #4 with a black marker writing on medication boxes. Upon surveyor observation, it was noted that some medications that did not previously have open dates now had handwritten dates in black marker.	A 983		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to maintain the building and grounds free from fire hazards and other hazards to residents' health and safety. Specifically, the facility failed to maintain a clean kitchen and failed to ensure overhangs exceeding	A1249		

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A1249	Continued From page 26 4 feet were protected by sprinklers according to National Fire Protection Association (NFPA) 13, Standard for the Installation of Sprinkler Systems. The deficiencies had the potential to affect all 34 residents who currently resided in the facility. Findings included: 1. A "Cleaning Schedule" for the week of 06/10/2024 revealed no evidence of documentation of cleaning of the stove cooktop as part of the weekly or monthly cleaning tasks. During a concurrent interview and observation of the kitchen on 06/18/2024 at 11:05 AM, the stove cook top in the main cook line had a heavy accumulation of dirt, grease, and debris. The Maintenance Manager stated that the kitchen staff supervised the cleaning of the kitchen. During an interview on 06/18/2024 at 11:10 AM, the Food Coordinator stated there was a checklist that staff followed to clean the kitchen weekly that was posted in the kitchen. He stated that staff initialed the checklist when the tasks were completed. During an interview on 06/18/2024 at 11:25 AM, the Maintenance Manager stated that the facility did not have a written policy or procedure for the completion of environmental cleaning rounds. 2. During a concurrent interview and observation on 06/18/2024 at 11:45 AM, the combustible exterior overhang, directly outside of the main lobby that faced the center courtyard, measured 6 feet 10 inches off the main building. The overhang lacked fire sprinkler protection, which did not comply with the standards set forth by NFPA 13. The Maintenance Manager stated he	A1249		

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A1249	Continued From page 27 was not aware of the requirements for sprinkler protection.	A1249		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
10a001 Y1	A. Building B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 A0235	Correction	ID Prefix A0310	Correction	ID Prefix A0355	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(1)	Completed
LSC	06/30/2024	LSC	06/20/2024	LSC	06/20/2024
ID Prefix A0517	Correction	ID Prefix A0891	Correction	ID Prefix A0973	Correction
Reg. # 8:36-5.6(b)(1-7)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.6(a)(5)	Completed
LSC	08/30/2024	LSC	06/20/2024	LSC	06/20/2024
ID Prefix A0981	Correction	ID Prefix A1249	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(a)(4)	Completed	Reg. # 8:36-17.7	Completed	Reg. #	Completed
LSC	06/20/2024	LSC	08/31/2024	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	
6/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
10a001 Y1	A. Building B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE FLORENCE	901 BROAD STREET FLORENCE, NJ 08518

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 A0235	Correction	ID Prefix A0269	Correction	ID Prefix A0310	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.1(a)	Completed	Reg. # 8:36-3.4(a)(1)	Completed
LSC	06/30/2024	LSC	06/30/2024	LSC	06/20/2024
ID Prefix A0355	Correction	ID Prefix A0515	Correction	ID Prefix A0517	Correction
Reg. # 8:36-4.1(a)(1)	Completed	Reg. # 8:36-5.6(a)	Completed	Reg. # 8:36-5.6(b)(1-7)	Completed
LSC	06/20/2024	LSC	06/25/2024	LSC	08/30/2024
ID Prefix A0571	Correction	ID Prefix A0891	Correction	ID Prefix A0973	Correction
Reg. # 8:36-5.10(a)(6)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.6(a)(5)	Completed
LSC	08/30/2024	LSC	06/20/2024	LSC	06/20/2024
ID Prefix A0981	Correction	ID Prefix A0983	Correction	ID Prefix A1249	Correction
Reg. # 8:36-11.7(a)(4)	Completed	Reg. # 8:36-11.7(a)(5)	Completed	Reg. # 8:36-17.7	Completed
LSC	06/20/2024	LSC	06/20/2024	LSC	08/31/2024
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	
6/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO