STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 1/13/23 CENSUS: 53 SAMPLE: 14+12 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. The following Immediate Jeopardy (IJ) situations were identified for F 835, F 880, and F 886. During a standard survey conducted on 1/3/23 through 1/13/23, the survey team identified the following: F 835 s/s L The Administrator failed to ensure: -Immediate action was taken to initiate contact tracing and testing upon the identification of a Ex Order 26. 4B1 staff member, Registered Nurse #1 (RN #1), who was symptomatic and provided care to 9 residents on 1 of 2 units and tested Ex Order 26. 4B1 while at work on Ex Order 26. 4B1 -Conduct contact tracing to identify residents and staff who had close contact with symptomatic Ex Order 26. 4B1 residents (Resident #33 and #235) -A process was in place to conduct immediate resident and staff testing upon identification of a Ex Order 26. 4B1 staff member (RN #1) who provided care to 9 residents on 1 of 2 units while working on Ex Order 26. 4B1, and for two residents who	F 000		

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

Electronically Signed | 02/06/2023

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 tested Ex Order 26. 4B1 (Residents #33 and #235) - The facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, - The facility's Outbreak Plan and COVID-19 policies were followed to prevent exposure and mitigate the spread of COVID-19, a deadly, highly transmissible infectious disease. The facility was notified of the IJ on 1/11/23 at 1:15 PM. The facility submitted an acceptable removal plan on 1/12/23 at 12:00 PM. The facility continued to remain out of compliance for no actual harm with the potential for more than minimal harm that is not IJ. F 880 s/s L The facility failed to ensure: -Immediate action was taken to initiate contact tracing upon the identification of a Ex Order 26. 4B1 staff member, Registered Nurse #1 (RN #1), who was symptomatic and provided care to 9 residents on 1 of 2 units and tested Ex Order 26. 4B1 while at work on Ex Order 26. 4B1 2. -Conduct contact tracing to identify residents and staff who had close contact with symptomatic Ex Order 26. 4B1 residents (Resident #33 and #235) -Ex Order 26. 4B1 surveillance and monitoring were completed for the residents, -A process was in place to conduct immediate resident and staff testing upon identification of a Ex Order 26. 4B1 staff member (RN #1) who provided care to 9 residents on 1 of 2 units while working on Ex Order 26. 4B1, and for two residents who	F 000		

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F 000	Continued From page 2 tested Ex Order 26. 4B1 (Residents #33 and #235) -The facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control -The facility's Outbreak Plan and COVID-19 policies were followed to prevent exposure and mitigate the spread of COVID-19, a deadly highly transmissible infectious disease. The facility was notified of the IJ on 1/5/23 at 3:35 PM. The facility submitted an acceptable removal plan on 1/6/23 at 1:13 PM. The facility continued to remain out of compliance for no actual harm with the potential for more than minimal harm that is not IJ. F886 s/s L The facility failed to ensure: -A symptomatic Registered Nurse #1 (RN #1) notified the supervisor, prior to the start of her shift on Ex Order 26. 4B1 that she was ill -A process was in place to conduct immediate resident and staff testing upon identification of a Ex Order 26. 4B1 staff member (RN #1) who provided care to 9 residents on 1 of 2 units while working on Ex Order 26. 4B1, and for two residents who tested Ex Order 26. 4B1 (Residents #33 and #235) The facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control -The facility's Outbreak Plan and COVID-19 policies were followed to prevent exposure and mitigate the spread of COVID-19, a deadly, highly transmissible infectious disease.	F 000		

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F 000	Continued From page 3 The facility was notified of the IJ on 1/5/23 at 3:35 PM. The facility submitted an acceptable removal plan on 1/6/23 at 1:13 PM. The facility continued to remain out of compliance for no actual harm with the potential for more than minimal harm that is not IJ.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		3/1/23

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F 656	Continued From page 4 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and/or implement a person-centered comprehensive care plan that addressed all of the resident's medical needs and diagnosis for 6 of 14 residents (Residents #52, #235, #14, #21, #56 and #50) reviewed for comprehensive care plans. The deficient practice was evidenced by the following: 1. On 1/3/23 at 11:05 AM, the surveyor observed Resident #52 lying in the bed, alert and awake. Resident #52 stated they were admitted to the facility to receive *Ex Order 26. 4B1* [redacted] and showed to the surveyor the [redacted] to the *Ex. Order 26. 4B1*. The surveyor reviewed the hybrid medical record	F 656	F656 - Comprehensive Care Plans Element #1 Corrective Actions Residents #52, #235, #56 and#14 no longer reside at the Center. Resident #21 s care plan and CNA Kardex has been updated for use of *Ex Order 26. 4B1*. Resident #50 s *Ex Order 26. 4B1* [redacted] has been updated to specify the *Ex Order 26. 4B1* interventions required by this Resident. Element #2 Identification of at Risk Residents All residents have the potential to be affected by this practice. Element #3 Systemic Change Licensed nursing staff were re-educated regarding development and	

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F 656	Continued From page 5 of Resident #52 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated [redacted], which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that that the resident was [redacted]. The MDS assessment also indicated the resident had active diagnoses of [redacted]. Physician's orders for Resident #52, dated [redacted], which read: '[redacted] Use [redacted] one time a day for [redacted] until [redacted]". A review of the resident's progress notes, dated [redacted], indicated the resident had a [redacted] to the right [redacted]. A review of the resident's care plans, revealed there was no care plan related to the resident's [redacted] diagnosis or receiving an [redacted]. On 1/9/23 at 12:49 PM, the surveyor interviewed Registered Nurse #3 (RN #3) about care plans and Resident #52. RN#3 stated care plans were initiated by nurses upon admission and triggered on the resident's admission assessment. RN# 3 stated residents on [redacted] should have care plans based on their [redacted]. The surveyor with RN #3 reviewed the care plans for Resident #52. There was no care plan for the resident's	F 656	implementation of person centered comprehensive care plans focusing on addressing infections, transmission based precautions, oxygen use, contractures, and use of splints, paired care, and documentation of specific dialysis services and care needs, based on physician orders. Element #4 Quality Assurance Director of Nursing (DON)/Designee will conduct five random careplan audits weekly for 4 weeks and monthly for 3 months to assure the careplans address all resident needs and have resident specific interventions. Results will be discussed with the interdisciplinary team as appropriate. DON/Designee will report findings to QAPI committee x 4 months	

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F 656		F 656		

Continued From page 6

Ex Order 26. 4B1 or primary diagnosis of *Ex Order 26. 4B1*.

RN#3 acknowledged Resident #52 should have had a care plan for their *Ex Order 26. 4B1*. RN# 3 further stated the Director of Nursing (DON), managers, and charge nurses were responsible for reviewing and updating care plans.

On 1/12/23 at 10:46 AM, the surveyor interviewed the Infection Preventionist (IP) about care planning and Resident #52. The IP stated it would be expected for residents receiving *Ex Order 26. 4B1* to have a care plan. The surveyor informed the IP of discussion with RN#3 and that there was no care plan for Resident #52 who was receiving *Ex Order 26. 4B1*.

On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant #1 (QAC #1), QAC #2, and Regional Director of Operations of the care plan concerns for Resident #52. There was no verbal response provided.

On 1/13/23 at 10:44 AM, the surveyor met with the Administrator, Medical Director, QAC #1, and IP. QAC #1 stated the resident was NJ Exec. Order 26:4.b.1 and no further information could be presented.

2. On 1/3/23 at 12:32 PM, the surveyor observed Resident #235 sitting at the bedside, alert and awake. Resident #235 was on *Ex Order 26. 4B1* for *Ex Order 26. 4B1*. Resident #235 was aware they had been quarantined on

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F 656	Continued From page 7 Ex Order 26 for a couple of days due to testing Ex Order 26. 4B1 [redacted]. The surveyor reviewed the electronic medical record (EMR) of Resident #235 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated Ex Order 26. 4B1, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the resident had Ex Order 26. 4B1 [redacted]. The MDS assessment also indicated the resident had active diagnoses that included: *Ex Order 26. 4B1* [redacted]. Physician's order for Resident #235, dated Ex Order 26. 4B1, which read: '*Ex Order 26. 4B1* [redacted] Give 3 tablet by mouth two times a day for *Ex Order 26. 4B1* for [redacted] Days". There was no physician order for Ex Order 26 for the resident. A review of the resident's progress notes indicated the resident had tested Ex Order 26. 4B1 [redacted] on Ex Order 26. 4B1 after reporting symptoms that included NJ Exec. Order 26:4.b.1, and NJ Exec. Order. The resident was placed on Ex Order 26 and started on Ex Order 26. 4B1 medication treatment. A review of the resident's care plans, revealed there was no care plan related to the resident's *Ex Order 26. 4B1* diagnosis and having Ex Order 26 in place. 01/09/23 11:08 AM, the surveyor interviewed RN #3 about care plans. RN#3 stated care plans were initiated by nurses upon admission and	F 656		

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F 656	Continued From page 8 triggered on the resident's admission assessment. RN# 3 stated residents should have care plans based on their Ex Order 26. 4B1 and treatment. RN#3 acknowledged residents who were Ex Order 26. 4B1 or who were on Ex Order 26 should have a care plan in place. On 1/11/23 at 12:53 PM, the surveyor informed the DON of the interview with RN#3 and that there was no *Ex Order 26. 4B1* for Resident #235. The DON stated there should be a care plan for *Ex Order 26. 4B1* residents and residents on Ex Order 26. The surveyor informed the DON that there were no care plans found for Resident #235 related to *Ex Order 26. 4B1* diagnosis or Ex Order 26. The DON acknowledged the resident should have had a care plan and would review. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant #1 (QAC #1), QAC #2, and Regional Director of Operations of the care plans concerns for Resident #235. There was no verbal response. On 1/13/23 at 10:44 AM, the surveyor met with the Administrator, Medical Director, QAC #1, and IP. QAC #1 stated no further information could be presented as the resident was already NJ Exec. Order 26:4.b.1 3. During the initial tour of the facility on 01/03/23 at 10:03 AM, the surveyor observed Resident #14 sitting in the wheelchair with Ex Order 26. 4B1 administered by *Ex Order 26. 4B1*. The *Ex Order 26. 4B1* was dated Ex Order 26. 4B1. According to the Admission Record, Resident #14 was admitted to the facility with diagnoses which	F 656		

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F 656	Continued From page 9 included, but were not limited to, Ex Order 26. 4B1 [redacted] The resident's most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, reflected that Resident #14 was NJ Exec. Order 26:4.b.1[redacted] A review of the Electronic Medical Record physician orders on Ex Order 26. 4B1 at 10:02 AM, did not include a physician order for Ex Order 26. 4B1 [redacted]. A review of the Ex Order 26. 4B1 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include orders for Ex Order 26. 4B1 [redacted]. A review of the resident's Care Plan did not identify that Resident #14 used Ex Order 26. 4B1 [redacted]. The Director of Nursing (DON) provided Resident #14's Care Plan which revealed a Creation Date of Ex Order 26. 4B1 [redacted] that the resident 'Ex Order 26. 4B1 [redacted]' with interventions that included, encourage resident positioning upright, and maintain Ex Order 26. 4B1 [redacted] as ordered. During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned Licensed Practical Nurse (LPN) #1, reported that the unit manager was responsible for creating and updating care plans. LPN #1 further advised, "There isn't one (a unit manager). If something needs to be added, I try to do it myself. But I don't have time." When asked if Ex Order 26. 4B1 [redacted] is a common care planned topic, LPN #1 reported, "Yes, how long, when, how much." Upon reviewing the resident's care plan LPN #1 confirmed, "I don't see it on the care plan".	F 656		

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F 656	Continued From page 10 During an interview with the surveyor on 01/09/23 at 12:55 PM, the DON identified that [redacted] should be identified on the care plan. Upon reviewing Resident #14's care plan, the DON confirmed, "Yes, I don't see it on the care plan." 4. During the initial tour of the facility on 01/03/23 at 10:03 AM, the surveyor observed Resident #21 with a [redacted] to the [redacted]. The surveyor observed a [redacted] located on the resident's bedside table. Resident #21 stated that they can apply and remove it without assistance. According to the Admission Record, Resident #21 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]. The resident's most recent Annual Minimum Data Set (MDS), dated [redacted], reflected Resident #21 was identified as being [redacted]. The MDS also indicated that Resident #21 had functional limitation in [redacted] on one side of the [redacted]. The MDS further revealed that Resident #21 required extensive assistance and was dependent on staff for most [redacted]. During the resident's Record Review on [redacted] at 10:02 AM, it was observed that Resident #21's ongoing Care Plan did not identify the [redacted] and the [redacted] intervention. During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned LPN #1, reported the unit manager was responsible for creating and updating care plans. LPN #1 further advised,	F 656		

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F 656	Continued From page 11 "There isn't one (a unit manager). If something needs to be added, I try to do it myself. But I don't have time." When asked if [redacted] are common care planning topics, LPN #1 responded, "Yes." When asked to identify what would be documented, LPN #1 stated, "The interventions to prevent worsening condition, how long for [redacted], how often." When asked if the resident had a care plan for a [redacted], LPN #1 responded, "Well, that would be night shift; but no, I do not see any." During an interview with the surveyor on 01/09/23 at 12:55 PM, the DON identified that the care plans were auto populated upon admission and updated by the nurses. When asked if [redacted], and [redacted] should be identified on a resident's care plan, the DON responded, "Yes, absolutely." Upon review of Resident #14's care plan, the DON confirmed, "I don't see it. It should be on there." 5. On 01/03/23 at 11:30 AM during the initial tour of the facility, the surveyor observed Resident #56 lying in bed awake. The resident had a [redacted] and wore a [redacted] that supported the affected area. The resident proceeded to inform the surveyor that last evening he/she was on the bed side [redacted] and pressed the call bell for assistance when an aide responded and had an attitude about the resident using the call bell for [redacted] assistance. The resident stated that he/she pressed the call bell a second time and when the resident asked the aide to empty the commode the aide stated, "You are not the only ...one!" The resident stated that the incident was	F 656		

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F 656	Continued From page 12 reported immediately, and the Director of Nursing (DON) and was satisfied with how the facility handled the incident. According to the Admission Record Report (an admission summary, Resident #56 was admitted to the facility in Ex Order 26. 4B1 with diagnosis which included but were not limited to: Ex Order 26. 4B1 [redacted]. Review of Resident #56's Admission Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident was Ex Order 26. 4B1. The Functional Status portion of the MDS indicated that the resident required extensive assistance for Ex Order 26. 4B1 of one person and total dependence of one person for toileting. Review of Resident 56's care plan revealed an entry that was initiated on Ex Order 26. 4B1, Focus: The resident was at risk for Ex Order 26. 4B1 [redacted] self-care deficit as evidenced by Ex Order 26. 4B1 [redacted] related to physical limitations/left [redacted], Goal: Resident to receive assistance necessary to meet [redacted] needs, Interventions: included: resident to have paired care (initiated on Ex Order 26. 4B1). The entry was revised by both the DON and the Infection Preventionist (IP). Further review of Resident #56's care plan revealed that on Ex Order 26. 4B1, the IP created an entry	F 656		

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F 656	Continued From page 13 which revealed: Focus [NJ Exec. Order] [redacted] towards staff [Ex Order 26. 4B1] [redacted] using profanity and yelling to [Ex Orde] [redacted]. Goal: Will not be [NJ Exec. Order 26-4] [redacted] towards others. Interventions included but were not limited to paired care. On 01/04/23 at 12:38 PM, the DON provided the surveyor with an investigation that was dated [Ex Order 26. 4B1] [redacted] at 6:00 PM, that was sent to the New Jersey Department of Health (NJDOH). Review of the investigation revealed that Resident #56 alleged that a nurse aide was rough while care was provided after the resident had [Ex Order 26. 4B1] [redacted] and felt that the aide had a bad attitude. The DON specified that the resident was placed on "paired care going forth and a toileting schedule." The DON documented that the Certified Nursing Assistant (CNA) was suspended until the investigation was completed. Further review of the investigation revealed that the conclusion which included review of statements, and follow-up with the resident, the allegation was unsubstantiated, and the resident stated, "I am receiving good care and I feel safe." Seven residents were interviewed, and no concerns were noted. During an interview with the surveyor on 01/11/23 at 11:41 AM, the surveyor interviewed the DON who stated that "Paired Care" was implemented after the resident's first allegation which occurred on [Ex Order 26. 4B1] [redacted]. The DON stated that when the second allegation occurred on [Ex Order 26. 4B1] [redacted], the CNA admitted that she had not looked at the Kardex (a medical patient information system) prior to providing resident care, and went into the resident's room alone, instead of with another CNA as required in accordance with the resident's	F 656		

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F 656	Continued From page 14 care plan. The DON stated that she had given the aides an in-service about paired care, but hand not provided them with any reference materials. On 01/11/23 at 12:35 PM, the surveyor observed Resident #35 lying in bed awake. The resident complained that his/her [redacted] had not felt good but the nurse, Licensed Practical Nurse (LPN #3) checked the resident's vitals and performed a [redacted] which was [redacted]. The surveyor asked if the nurse attended to the resident alone or with another staff member. The resident stated that one nurse or one aide responded when the call bell was pressed. The resident stated that he/she had only seen the nurse today and the person who delivered the lunch tray. The resident further stated that everything had been great and there had been no further issues. During an interview with the surveyor on 01/11/23 at 12:45 PM, CNA #2 stated that she cared for Resident #56 quite a few times before. She described the resident as independent with care and stated that the resident required set up for care and transfers. She stated that when the resident had to get out of bed, she just locked the wheels on the chair and stood there for supervision. CNA #2 stated that she worked for an agency and floated throughout the facility where needed. CNA #2 stated that she had not reviewed Resident #56's Kardex since she began working at the facility on [redacted], as she had not gained access to the system. CNA #3 stated that she looked through other staff's access and did not see anything special noted for Resident #56. CNA #2 stated that they did not give any type of report at the facility otherwise. During an interview with the surveyor on 01/11/23	F 656		

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F 656	Continued From page 15 at 12:49 PM, LPN #3 stated that Resident #56 had behaviors and Ex Order 26. 4B1. LPN #3 stated the DON stated that two CNAs and two nurses must respond to the call bell when the resident called. When LPN #3 was asked if she went into the resident's room with another nurse she stated, "I never had problems with the resident, I just help him/her right away." When the surveyor asked LPN #3 if she delegated to CNA #2 that two staff were required to respond to Resident #56's call bell, she stated that she did not think that CNA #2 who was assigned to the resident, knew that two aides were supposed to respond to the resident. LPN #3 stated that one day, she was unsure of the date, a CNA on the night shift was rude to the resident and she had reported it to the DON. LPN #3 stated that the DON did an in-service and told us to answer the light with two people after the incident. During an interview with the surveyor on 01/12/23 at 11:24 AM, the IP stated that Resident #56 was placed on paired care after an incident was called into the NJDOH. The Administrator who was present stated that the facility could not substantiate the resident's allegations and implemented the care plan. The facility was unable to provide the surveyor with documented evidence that care paired care was implemented as described within the resident's care plan. 6. During the initial tour of the facility on 01/03/23 at 11:45 AM, the surveyor observed Resident #50 seated in a wheelchair at the bedside. The resident had a Ex Order 26. 4B1 that was covered with a Ex Order 26. 4B1 that was not dated. The resident stated that he/she attended Ex Order 26. 4B1 on Monday, Wednesday and Friday from 11 AM to 3 PM. The	F 656		

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F 656	Continued From page 16 resident stated that he/she was unsure if the facility staff monitored the [redacted] post-treatment. According to the Admission Record Report (an admission summary), Resident #50 was admitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted]. Review of Resident #50's Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was [redacted]. Active diagnosis included but were not limited to: [redacted]. Review of Resident #50's care plan revealed an initial entry that was dated [redacted], [redacted] days after the resident was admitted to the facility, with a Focus aimed at: [redacted]. Goals included: Will be free from infection and resident will have no signs or symptoms of complications related to [redacted]. Interventions included: Assist resident with [redacted] and [redacted] as needed. Watch for [redacted] and match level of assistance to resident's current energy level, Encourage rest periods as resident requires. Monitor and report changes in [redacted]: NJ Exec. Order 26:4.b.1 and	F 656		

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F 656	Continued From page 17 Ex Order 26. 4B1. The entry failed to specify the resident's scheduled Ex Order 26. 4B1 days and time, method of transport, the type of Ex Order 26. 4B1 that the resident had and related required interventions to ensure the Ex Order 26. 4B1 remained patent and free from specific signs and symptoms of infection. Review of Resident #50's Admission/Re-admission Evaluation, Assessment dated Ex Order 26. 4B1, revealed that the resident required Ex Order 26. 4B1 while a patient, but failed to specify whether the resident received Ex Order 26. 4B1 or Ex Order 26. 4B1. Further review of the evaluation revealed that a Ex Order 26. 4B1 which was available for selection was not initiated, which provided the following options for selection: Focus: The resident needs Ex Order 26. 4B1, Goal: The resident will have no s/sx (signs and symptoms) of complications from Ex Order 26. 4B1, Some of the Interventions that were available for selection included but were not limited to: Do not draw blood or take Ex Order 26. 4B1 in Ex Order 26. 4B1, Encourage resident to go for the scheduled Ex Order 26. 4B1, monitor/report to MD s/sx of infection to Ex Order 26. 4B1: NJ Exec. Order 26:4.b.1 or Ex Order 26. 4B1, Monitor/report to MD s/sx of the following: NJ Exec. Order 26:4.b.1. Review of Resident #50's Order Summary Report (OSR) revealed that on Ex Order 26. 4B1, an order was placed for the resident to be Ex Order 26. 4B1 post-midnight Sunday Ex Order 26. 4B1, for procedure of revision of Ex Order 26. 4B1	F 656		

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F 656	Continued From page 18 Ex Order 26. 4B1 on Ex Order 26. 4B1 at 7:00 AM. Further review of the OSR revealed that an order was placed on Ex Order 26. 4B1 for the resident to attend Ex Order 26. 4B1 on Monday, Wednesday, Friday at 11 AM p/u (pick up) time 10 AM. Review of Resident #50's PN dated 12/5/22 at 12:44 PM, which was written by Licensed Practical Nurse/Charge Nurse (LPN/CN #1) and revealed that she received a call from a Physician's Group regarding the resident having an upcoming procedure scheduled on Ex Order 26. 4B1 at 7 AM, "due to issues with his/her Ex Order 26. 4B1 ". Further review of the PN revealed that on Ex Order 26. 4B1, the Nurse Practitioner (NP) documented that the resident underwent Ex Order 26. 4B1 and Ex Order 26. 4B1 after he/she was found to have almost complete Ex Order 26. 4B1 evaluation yesterday during a Ex Order 26. 4B1 of the Ex Order 26. 4B1 ..Ex Order 26. 4B1 swelling unchanged, Ex Order 26. 4B1, Ex Order 26. 4B1 yesterday. During an interview with the surveyor on 01/10/23 at 11:47 AM, the Registered Nurse Supervisor (RNS) stated that whoever served in the role of Supervisor initiated the care plans which included Ex Order 26. 4B1. The RNS explained that a Ex Order 26. 4B1 should have included the Ex Order 26. 4B1 and scheduled days, and Ex Order 26. 4B check which included assessment for bleeding, Ex Order 26. 4B1. The RNS stated that nurses were responsible to update the care plan in response to a new event such as a Ex Orde or Ex Order 26. 4B1.	F 656		

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F 656	Continued From page 19 During an interview with the surveyor on 01/13/23 at 9:50 AM, the Infection Preventionist (IP) stated that the *Ex Order 26. 4B1* should have been implemented upon admission to the facility and should have included site, inspection, monitor for signs and symptoms of bleeding, and note any fluid intake or dietary restrictions. During an interview with the surveyor on 01/13/23 at 10:45 AM, the Quality Assurance Consultant (QAC #1) stated that the *Ex Order 26. 4B1* for Resident #50 was implemented on *Ex Order 26. 4B1* at 11:51 AM, into the Electronic Health Record (EHR), but it should have been implemented upon admission to the facility and should have included the *Ex Order 26. 4B1* . The surveyor reviewed the facility policy titled, "Care plan preparation, long term care", with a reviewed date of 5/20/2022. Under Introduction, it read: "A care plan is an individualized, written action plan for a resident's care, treatment, and services that is based on the resident's medical, nursing, physical, mental, and psychosocial needs and preferences". The care plan must include: "interventions that describe the services the interdisciplinary team employs to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. "Under Documentation, it read: "Document all pertinent resident problems, expected outcomes, interventions, and evaluations of expected outcomes." Both the DON and Administrator provided the surveyor with the same copy of an undated facility policy titled, "Dialysis Guidelines." Review of the policy revealed that the Purpose: To provide guidelines for centers providing dialysis services	F 656		

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F 656	Continued From page 20 in house. This includes hemodialysis and peritoneal dialysis. When the surveyor inquired to see if there was a specific policy for residents whose dialysis treatments were completed at an off-site dialysis center, the Administrator stated that was the only policy she had. Further review of the policy revealed the following: If a center provides dialysis services, there is collaboration between the center and a Medicare certified dialysis facility. The center remains responsible for the overall quality of care the patient receives. A coordinated comprehensive care plan for dialysis treatments is developed with input from both the interdisciplinary team (IDT) and dialysis facility staff. The patient's plan of care identifies the patient specific parameters ordered by the medical practitioner for nutritional and fluid needs, lab results, blood pressure, weights, and other vial signs as well as who to notify of concerns and which medications should be given or not given. In order to assure that the dialysis needs of the patient are met in the case of an emergency, the care plan should identify acute care settings that would be able to meet the patient's need for dialysis ....Both the center and dialysis facility are responsible for shared communication regarding patients receiving dialysis services, either offsite or onsite ...Collaborative communication includes information regarding: ...dialysis adverse reaction/complications and/or recommendations for follow up observations and monitoring including those related to the vascular access site or peritoneal dialysis catheter ... NJAC 8:39-27.1 (a), 11.2 (d) NJAC 8:39-11.2 (f)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		3/1/23

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F 658	Continued From page 21 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined the facility failed to consistently follow standards of professional clinical practice with regard to: a) accurately documenting medication administration for 1 of 1 residents (Resident #52) reviewed for [redacted], b) adhering to physician's orders for [redacted] medication parameters, clarification of physician's orders and adherence to the facility Medication Administration policy for 3 of 4 residents observed during medication administration pass (Residents #185, #186 and #187), and c. administering [redacted] to a resident without physician orders for 1 of 3 residents (Resident # 14) reviewed for [redacted]. This deficient practice was identified as follows: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 658	F658 Services Provided to Meet Professional Standards Element #1 Corrective Actions " Residents #52, #185, #186, #187, and #14 no longer reside at the Center. " Registered Nurse (RN) #1 who provided care to Resident #52 were counseled and re-educated about proper documentation of the administration of medication on the medication administration record (MAR) on 2/15/23. " Licensed Practical Nurse (LPN) #3 that provided care to Residents #185, #186, and #187 was counseled and re-educated about administering medications in compliance with physician orders, documenting administration of medication on the medication administration record (MAR), and following proper procedure for obtaining vital signs and holding medications with parameters as ordered. A med pass competency was completed for LPN#3. " The [redacted] was replaced at the time of the surveyor observation during the survey. [redacted] was updated on [redacted] Element #2 Identification of at Risk Residents " All residents have the potential to be affected by this practice.	

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F 658	Continued From page 22 physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice is evidenced by the following: 1.) The surveyor reviewed the hybrid medical records of Resident #52 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated Ex Order 26. 4B1, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that that the resident was Ex Order 26. 4B1 [redacted]. The MDS assessment also indicated the resident had active diagnoses of Ex Order 26. 4B1 [redacted]. A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated Resident #52 had a physician order, dated Ex Order 26. 4B1, which read: Ex Order 26. 4B1 [redacted]	F 658	Element #3 Systemic Change " Licensed Nurses received re-education on following standards of professional clinical practice for accurately documenting medication administration including dating oxygen tubing, following physician orders for administration of medications and hold parameters, and notification of the physician when medication administration is delayed. Element#4 Quality Assurance " Director of Nursing (DON)/designee will conduct random medication administration competencies weekly for 4 weeks and monthly for 3 months to ensure professional clinical standards are being followed for medication administration and following physician orders. Director of Nursing/designee will complete weekly random audits times 4 weeks and monthly x 3 months of labeling and dating of oxygen tubing and ensuring that orders for oxygen are obtained prior to oxygen administration. Findings will be analyzed by the DON/Designee and reported in aggregate quarterly to the QAPI committee for further direction.	

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F 658	Continued From page 23 one time a day for Ex Order 26. 4B1 until Ex Order 26. 4B1". The eMAR also had a physician order entry, discontinued date on Ex Order 26. 4B1 that read: 'Ex Order 26. 4B1 intravenously one time a day for Ex Order 26. 4B1 until Ex Order 26. 4B1". A review of the December 2022 eMAR for Resident #52 revealed that on Ex Order 26. 4B1, the Ex Order 26. 4B1 medication scheduled for 2000 and on Ex Order 26. 4B1 the Ex Order 26. 4B1 medication scheduled for 0600, there were no nurse signatures for those entries. On 1/12/23 at 10:46 AM, the Infection Preventionist (IP) was informed about concern that there were no nurse signatures documented for days identified on the Ex Order 26. 4B1 entry in the Ex Order 26. 4B1 eMAR. The IP stated she would follow up and provide further information. On 1/12/23 at 1:32 PM, the IP informed the surveyor that the Ex Order 26. 4B1 medication entries identified were not signed and that the physician was notified. The IP further stated she contacted RN#1 who worked on Ex Order 26. 4B1 and RN#1 stated she would have to look at her notes when she came into work to see what happened. The IP stated the other nurse, who did not sign the eMAR no longer worked at the facility. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant #1 (QAC #1), QAC #2, and Regional Director of Operations of the above concerns for no nurses' signatures on the eMAR for Ex Order 26. 4B1	F 658		

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F 658	Continued From page 24 medication on Ex Order 26. 4B1 . On 1/13/23 at 9:40 AM, the surveyor interviewed the IP on the above concerns. The IP stated if the nurses could not administer a medication, or a dose was missed that the physician would be made aware. The IP further stated the nurses were expected to review their eMAR assignment at the end of the shift to ensure all medications were administered and signed for. On 1/13/23 at 10:24 AM, the surveyor interviewed RN #1 about missed signature for Ex Order 26. 4B1 on the Ex Order 26. 4B1 eMAR. RN#1 stated she spoke with the IP yesterday (Ex Order 26. 4B1), who asked her about the missing signatures for the Ex Order 26. 4B1. RN #1 stated she could not recall what happened since it was, "so long ago". RN #1 stated she tried to check her documentation when she came into work last night but still wasn't sure what happened on Ex Order 26. 4B1. RN #1 acknowledged it would be expected for the physician to be notified if there were any changes with a resident's medication, such as a missed dose, delayed medication, or need to change the time for a medication. On 1/13/23 at 10:44 AM, the surveyor met with the Administrator, Medical Director, QAC #1, and IP. QAC #1 stated an incident report was to be done and they would reach out to the nurses to provide re-education. The surveyor reviewed the undated facility policy titled, "Medication and Treatment Administration Guidelines, Long-Term Care". Under Documentation, it read: "Medications and treatments administered are documented immediately following administration or per state	F 658		

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F 658	Continued From page 25 specific standards", "Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented on the clinical record including the name and dose of the medication and reason the medication was not administered", and "The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift". NJAC 8:39-11.2 (b); 29.2(d) 2.) On 01/05/23 at 9:22 AM, the surveyor observed Licensed Practical Nurse (LPN #3) as she reviewed the Electronic Medication Administration Record (EMAR) and prepared medications to administer to Resident #185 which included but were not limited to: *Ex Order 26. 4B1* [redacted], Hold for a *Ex Order 26. 4B1* [redacted] less than *Ex Order* and an order for *Ex Order 26. 4B1* [redacted] Give one tablet by mouth one time a day for *Ex Order 26. 4B1* [redacted] Hold for *Ex Order 26* less than *Ex Order*. LPN #3 stated that although Resident #185's *Ex Order 26* was *Ex Order 26. 4B1* and met the parameters to hold the *Ex Order 26. 4B1* and could give the *Ex Order 26. 4B1* [redacted], she would hold both dosages of *Ex Order 26. 4B1* [redacted] as she wanted to wait until the resident returned from *Ex Order 26. 4B1* to re-check the resident's *Ex Order 26. 4B1* and administer the medications at that time if the resident's *Ex Order 26. 4B1* reading was within the physician's specified parameters. LPN #3 did not sign either of the medications that were	F 658		

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F 658	Continued From page 26 scheduled at 9:00 AM as not administered and did not phone the physician to obtain permission to administer the medications later in the day to coordinate with the resident's Ex Order 26. 4B1 schedule as described. At 9:56 AM, the surveyor observed LPN #3 as she reviewed the EMAR and prepared medications to administer to Resident #187 which included but were not limited to: Ex Order 26. 4B1 Give 1 (one) packet by mouth one time a day for Ex Order 26. 4B1 . The order failed to specify how the medication should be prepared for administration. LPN #3 then proceeded to open the packet of Ex Order 26. 4B1 and emptied the contents, a powder, into a medicine cup which contained apple sauce. LPN #3 stated that it was the resident's preference to mix the medication in apple sauce since the resident did not like the taste. At 10:20 AM, LPN #3 informed the Nurse Practitioner (NP) who was present on the nursing unit at that time, that she was unable to administer Resident #187's Ex Order 26. 4B1 that was scheduled for 9:00 AM, as the order specified to give two Ex Order 26. 4B1 tablets scheduled to be administered at 9:00 AM and there was only one Ex Order 26. 4B1 tablet in stock. The NP granted permission for LPN #3 to instead give NJ Exec. Order 26:4.b. Ex Order 26. 4B1 and noted that she planned to change the administration time to five PM instead. LPN #3 failed to address clarification of orders with the NP for Resident #187's Ex Order 26. 4B1 order which failed to contain directions for administration or the Ex Order 26. 4B1 medications that were not administered to	F 658		

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F 658	Continued From page 27 Resident #185 at 9:00 AM in accordance with the physician's orders. At 10:25 AM, LPN #3 reviewed the EMAR as she prepared medications for Resident #186 which included but were not limited to: *Ex Order 26. 4B1* [redacted] topically two times a day (9:00 AM and 5:00 PM) for *Ex Order 26. 4B1* dose. LPN #3 stated that she would not administer *Ex Order 26. 4B1* as directed because the resident had not yet received AM care. LPN #3 stated that she did not chart *Ex Order 26. 4B1* as not administered, as she intended to sign the entry later after she administered the medication. LPN #3 also administered: *Ex Order 26. 4B1* by mouth one time a day for *Ex Order 26.* hold for *Ex Order 26. 4B1* and *Ex Order 26. 4B1* [redacted] Give 1 (one) tablet by mouth one time a day for *Ex Order 26.* hold for *Ex Order 26* [redacted]. LPN #3 maintained that the resident's *Ex Order 26. 4B1* [redacted] this AM was *Ex Order 26. 4B1* and she based medication administration on that *Ex Order 26. 4B1* value. At 11:00 AM, LPN #3 concluded signing out Resident #186's medications that were administered which included *Ex Order 26. 4B1* [redacted], Give 1 (one) scoop by mouth one time a day for *Ex Order 26. 4B1*. LPN #3 stated that she was required to advise the NP that the *Ex Order 26. 4B1* was administered late, as the medication that was scheduled for administration at 9:00 AM, turned red on the computer screen of the EMAR when she attempted to sign the medication out as administered at 11:00 AM. At 11:01 AM, The surveyor interviewed LPN #3 post-medication administration observation. LPN	F 658		

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F 658	Continued From page 28	F 658		

#3 stated that she obtained the resident's [redacted] at 8:00 AM and utilized the readings for *Ex Order 26. 4B1* medication administration during the medication pass observation. When the surveyor asked LPN #3 what the facility policy was for the timing of *Ex Order 26. 4B1* reading values used for *Ex Order 26. 4B1* medication administration based on physician ordered parameters LPN #3 stated, "I do not know what the policy allowed for."

During a later interview with the surveyor on 01/05/23 at 3:07 PM, LPN #3 stated that at 9:00 AM, Resident #185 had an order to hold the dosage of *Ex Order 26. 4B1* [redacted] to be held for a [redacted] less than [redacted], and the resident had a [redacted] of [redacted] and the medication was not held as indicated. LPN #3 stated that she instead waited until the resident returned from [redacted] and rechecked the resident's *Ex Order 26. 4B1* which was [redacted] and both [redacted] medications (*Ex Order 26. 4B1* [redacted]) were administered. LPN #3 further stated that she notified the NP before that, about 30 minutes ago. LPN #3 stated that she feared the resident's *Ex Order 26. 4B1* would drop too low during *Ex Order 26. 4B1* LPN #3 stated that she should have gotten an order to change the medication administration time to be given when the resident returned from *Ex Order 26. 4B1*.

LPN #3 further stated that the order for Resident #187's *Ex Order 26. 4B1* [redacted], did not specify how to the medication was required to be prepared for administration and the order should have been clarified prior to administration to ensure that it was ok to mix the medication in applesauce.

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F 658	Continued From page 29 LPN #3 further stated that Resident #186's administration time for Ex Order 26. 4B1, ordered twice daily, should have been adjusted so that the medication could have been administered after AM care had been completed after 11 AM. LPN #3 further stated that she obtained resident Ex Order 26. 4B1 readings at 8 AM, and it was better if she repeated the Ex Order 26. 4B1 reading at the time of Ex Order 26. 4B1 medication to ensure accuracy. During an interview with the surveyor on 01/06/23 at 10:53 AM, the Licensed Practical Nurse/Charge Nurse (LPN/CN #1) stated that Ex Order 26. 4B1 medications were required to be held according to physician ordered parameters at the time the medication was due as you only had one hour before or one hour after the medication time was scheduled to administer it and are not permitted to administer the medication beyond that time frame because it interfered with the medication schedule. LPN/CN #1 stated that LPN #3 should have notified the NP that the Resident #185's Ex Order 26. 4B1 medications interfered with Ex Order 26. 4B1 and documented the conversation, and checked for new orders. LPN/CN #1 explained Ex Order 26. 4B1 should be rechecked if it had been more than one hour since the value was obtained and scheduled Ex Order 26. 4B1 medications were due to ensure that there had not been any Ex Order 26. 4B1 fluctuations. LPN/CN #1 further stated that a request for a time change should have been requested to change Resident #186's order for Ex Order 26. 4B1	F 658		

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F 658	Continued From page 30 administration to coordinate with the resident's care. LPN/CN #1 further stated that, "An order for [redacted] should have specified to administer the medication in 8 (eight) ounces of water and should have been clarified prior to administration in applesauce as it was never assumed." During an interview with the surveyor on 01/11/23 at 11:00 AM, the Infection Preventionist (IP) who stated she was also responsible for Staff Development, stated that LPN #3 should have decided not to administer medications one hour after the scheduled administration time. The IP stated that the residents [redacted] should have been repeated prior to medication administration as it had been approximately 90 minutes and vital signs ([redacted] readings) should have been obtained prior to [redacted] medication administration to ensure accuracy. The IP further stated that LPN #3 should have obtained an order to change the time of administration of [redacted] if she was concerned about giving it prior to AM care or administered the medication within parameter guidelines of a one-hour window (one hour before scheduled due time, or one hour after scheduled due time). The IP concluded the interview by stating that the order for [redacted] should have been clarified with the physician prior to administration in applesauce. The surveyor requested to view a copy of LPN #3's medication pass observation competency at that time which was not provided by the facility.	F 658		

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F 658	Continued From page 31 During an interview with the surveyor on 01/13/23 at 10:45 AM in the presence of the survey team, the Administrator stated that. "She had nothing further to provide regarding medications that were administered to residents outside of the scheduled parameters during the medication pass observation at this point." Review of the facility policy titled, "Medication Administration: Medication Pass" (06//21) revealed the following: ...Procedure: ...If medication is new for resident, or if medication is unfamiliar or physician order is questioned: Read original physician order, Compare original physician order with MAR (Mediation Administration Record) for accuracy, Remove medication from cart, Compare MAR with medication label for accuracy, verify allergy status, Contact physician for clarification, if needed, Read special medication administration instructions, Obtain vital signs, if applicable, and record results on MAR (Medication Administration Record), Prepare medications for administration....Medications are administered in accordance with standards of practice and state specific and federal guidelines. ...Communities are responsible for establishing a community medication time schedule and communicating the standard schedule for the center with attending medical practitioners. ...Licensed nurses and medication aides are oriented upon hire and evaluated annually in medication and treatment administration techniques and medication and treatment documentation requirements. Medication and Treatment Orders: A complete medication order includes: Date and time, Name of resident, Name of medication, Form, formula, and route of administration, Dosage or strength, Frequency, including end date orders if	F 658		

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F 658	Continued From page 32 applicable, Directions for use including the reason for use, diagnosis, or clinical indication, Medication specific parameters if applicable ...Orders are transcribed then noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders ...Documentation: Medications and treatments administered are documented immediately following administration or per state specific standards. Vital signs are taken and recorded prior to the administration of vital sign dependent medications in accordance with medical practitioner's orders ...Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented in the clinical record including the name and dose of the medication and reason the medication was not administered ....The licensed nurse or medication aide is responsible for validating documentation is completed for any medication administered during the shift. NJAC 8:39-11.2(b), 17.2 (g), 27.1 (a) 3.) During the initial tour of the facility on 01/03/23 at 10:03 AM, the surveyor observed Resident #14 sitting in the wheelchair with [redacted] administered by [redacted]. The [redacted] was dated [redacted]. On 01/06/23 at 10:15 AM, the surveyor observed Resident #14 sitting in a reclining chair with [redacted] being administered by [redacted]. The [redacted] was dated [redacted]. According to the Admission Record, Resident #14 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]	F 658		

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F 658	Continued From page 33 Ex Order 26. 4B1 [redacted].	F 658		

A review of the physician orders in the Electronic Medical Record on Ex Order 26. 4B1 at 10:02 AM, did not include physician orders for Ex Order 26. 4B1 [redacted]. A review of the Ex Order 26. 4B1 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include orders for Ex Order 26. 4B1 [redacted].

A review of the documentation provided by the Director of Nursing (DON) on Ex Order 26. 4B1, reflected Resident #14's physician orders were updated on Ex Order 26. 4B1 at 10:27 AM to include 'Ex Order 26. 4B1 [redacted] via Ex Order 26. 4B1 as needed for Ex Order 26. 4B1 [redacted] or Ex Order 26. [redacted] < Ex Order 26 [redacted] maintain Ex Order 26. 4B1 call MD if Ex Order 26. 4B1 for further orders."

During an interview with the surveyor on 01/09/23 at 11:00 AM, Certified Nursing Assistant (CNA) #1 confirmed that the administration of Ex Order 26. 4B1 required a physician order. CNA #1 also confirmed that the Ex Order 26. 4B1 should not be dated prior to the physician's order date.

During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned Licensed Practical Nurse (LPN) #1 reported that Ex Order 26. 4B1 required a physician's order. Upon reviewing Resident #14's orders, LPN#1 confirmed that the order was placed on Ex Order 26. 4B1. LPN #1 verified that the Ex Order 26. 4B1 was dated Ex Order 26. 4B1. LPN#1 stated, "It should be dated that day (the order date) and changed every 7 days."

During an interview with the surveyor on 01/09/23

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F 658	Continued From page 34 at 12:55 PM, the DON identified that Resident #14's Ex Order 26. 4B1 should not be dated Ex Order 26. 4B1 "unless that is the date the order is placed ... Let me look if there was a previous one [order]. There is no order." The surveyor reviewed an undated Facility Procedure titled, "Medication and Treatment Administration Guidelines." Under the heading "General," the procedure revealed "Centers are to follow the Orders Management Matrix for initiation of non-medication or treatment orders. All orders are to be prescribed by a medical practitioner." The surveyor reviewed the facility procedure titled, "Oxygen Administration, long term care," with a revised date of 11/28/22. Under the heading "Implementation," the procedure reflected to "Verify the practitioner's order for oxygen therapy."	F 658		
F 686 SS=E	NJAC 8:39-11.2 (b); 29.2(d) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		3/1/23

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F 686	Continued From page 35 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) evaluate and complete a *Ex Order 26. 4B1* for one resident's [redacted] in a timely manner, b.) complete weekly skin assessments for one resident and c.) discontinue a *Ex Order 26. 4B1* when resolved. This deficient practice was identified for 1 of 1 resident (Resident #29) reviewed for *Ex Order 26. 4B1* and was evidenced by the following: On 01/03/23 at 10:05 AM, the surveyor observed Resident #29's [redacted] were [redacted], and the resident was lying supine in bed on an air mattress with the head of the bed elevated. The resident stated that he/she had a [redacted] on the [redacted]. According to the Admission Record Report, the resident was admitted with diagnoses which included, but were not limited to, *Ex Order 26. 4B1* [redacted]. Review of the [redacted] Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, reflected that the resident was *Ex Order 26. 4B1* and required total care by staff for *Ex Order 26. 4B1*. The MDS further reflected that the resident had an active diagnosis of an unspecified open [redacted] to the *Ex Order 26. 4B1*. Review of the ongoing Care Plan revealed a focus that Resident #29 had an actual [redacted] with the goal to decrease/minimize	F 686	F686 Treatment/ Services to Prevent/ Heal *Ex Order 26. 4B1* Element #1 Corrective Actions • Resident #29's NJ Exec. Order 26:4.b.1 to [redacted] was discontinued as the [redacted] was resolved. *Ex Order 26. 4B1* was added per guideline. • The APWN was re-educated regarding documentation in PCC of all *Ex Order 26. 4B1* assessments, evaluations, and treatment changes. Element #2 Identification of at Risk Residents • All residents have the potential to be affected by this practice. Element #3 Systemic Changes • Licensed nurses were re-educated about the Center procedures for skin management and wound care treatment administration guidelines. Element #4 Quality Assurance • Director of Nursing (DON)/designee will conduct chart audits of five residents with pressure ulcers weekly for 4 weeks and monthly for 3 months to ensure wound management guidelines are followed. Findings will be analyzed by the DON/Designee and reported in aggregate quarterly to the QAPI committee for further direction	

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F 686	Continued From page 36 NJ Exec. Order 26:4.b.1 risks times 90 days. The Care Plan reflected the interventions to observe [redacted] with [redacted] care daily and report abnormalities, administer treatment per physician orders, and *Ex Order 26. 4B1* and treat. Review of the Order Summary Report for Order Date Range: *Ex Order 26. 4B1* reflected an order dated *Ex Order 26. 4B1* to apply NJ Exec. Order 26:4.b. to the *Ex Order 26. 4B1*, then clean the *Ex Order 26. 4B1* with NJ Exec. Order 26:4.b.1 apply *Ex Order 26. 4B1* and *Ex Order 26. 4B1* to the *Ex Order 26. 4B1* and cover with NJ Exec. Order 26:4.b.1 every day shift for *Ex Order 26. 4B1*. Further review of the *Ex Order 26. 4B1* Treatment Administration Record (TAR) reflected that the *Ex Order 26. 4B1* treatment order to the *Ex Order 26. 4B1* was discontinued on *Ex Order 26. 4B1*. Review of the Skin & Wound Evaluation V5.0 dated *Ex Order 26. 4B1* reflected that the resident had an *Ex Order 26. 4B1* to the *Ex Order 26. 4B1*. The *Ex Order 26. 4B1* had a length NJ Exec. Order 26:4.b. and width NJ Exec. Order 26:4.b.. The surveyor observed there were no Skin & Wound Evaluation V5.0 completed for the [redacted] after *Ex Order 26. 4B1* until after surveyor inquiry. On 01/13/23 at 9:00 AM, the facility provided the Skin & Wound Evaluation V5.0 dated *Ex Order 26. 4B1*, completed by the Advanced Practice Wound Nurse (APWN) reflected that the *Ex Order 26. 4B1* to the *Ex Order 26. 4B1* had resolved. This Skin & Wound Evaluation V5.0 dated NJ Exec. Order 26:4.b. was not completed until after surveyor inquiry.	F 686		

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F 686	Continued From page 37 Review of the NJ Exec. Order 26:4.b.1 TAR reflected that the nurses signed that the treatment to the Ex Order 26. 4B1 was completed daily on Ex Order 26. 4B1 [redacted]. Review of the NJ Exec. Order 26:4.b.1 TAR reflected that the nurses signed that the treatment to the Ex Order 26. 4B1 was completed daily on Ex Order 26. 4B1 [redacted]. Review of the NJ Exec. Order 26:4.b.1 TAR reflected that the nurses signed that the treatment to the Ex Order 26. 4B1 was completed daily on Ex Order 26. 4B1 [redacted]. The surveyor further observed that Resident #29's Electronic Medical Record (EMR) revealed the following: - the physician orders did not include an order for NJ Exec. Order 26:4.b.1 ; and - the nurses continued to sign the Ex Order 26. 4B1 treatment orders to the Ex Order 26. 4B1 after the Ex Order 26. 4B1 had resolved on Ex Order 26. 4B1. On 01/11/23 at 11:10 PM, the surveyor, Director of Nursing (DON) and LPN #1 observed that Resident #29's Ex Order 26. 4B1 was healed. During an interview with the surveyor on 01/11/23 at 12:08 PM, the APWN stated that she was following the Ex Order 26. 4B1 weekly and she believed it resolved in Ex Order 26. 4B1.	F 686		

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F 686	Continued From page 38 The APWN further stated that her documentation of the [redacted] would be found in the progress notes. During an interview with the surveyor on 01/11/23 at 01:08 PM, the DON stated there were no Skin & Wound Evaluation V5.0 completed for the [redacted] after [redacted] up to the date the [redacted] was discontinued on [redacted]. The facility could not provide further documentation to indicate when the [redacted] had resolved. During a follow up interview with the surveyor on 01/11/23 at 2:03 PM, LPN #1 reviewed Resident #29's orders and confirmed there was no order for a [redacted]. LPN #1 stated that the physician puts in the order for the [redacted] and we follow that. On the second floor, we complete [redacted] on shower days. Surveyor inquired, if there was no [redacted] order, when are the [redacted] completed. LPN #1 stated that the [redacted] were usually documented in the EMR under "Assessments." LPN #1 verified that the [redacted] was unavailable for him to complete for this resident under the "Assessment" tab in the EMR. LPN #1 further stated that we also had a paper assessment which could have been completed. During an interview with the surveyor 01/12/23 at 11:46 AM, Quality Assurance Consultant (QAC) #1 and QAC #2 discussed Resident #29's [redacted]. At that time, QAC #2 reviewed Resident #29's *Ex Order 26. 4B1* [redacted]. QAC #2 showed the surveyor a picture of the *Ex Order 26. 4B1* dated [redacted], which reflected that the [redacted] was	F 686		

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F 686	Continued From page 39	F 686		

resolved. The surveyor further discussed with QAC #1 and QAC #2 the concern that the resident did not have an order for [NJ Exec. Order 26:4.b.1] s. QAC #1 stated that the [NJ Exec. O] were usually completed on shower days and she he would get back to the surveyor. The surveyor further discussed with QAC #1 and #2 that the nurses continued to sign the TAR after the [Ex Order 26. 4B1] healed. QAC #1 stated that the nurses should have notified the physician that the [Ex Order 26. 4B1] had healed for new orders.

During an interview with the surveyor on 01/12/23 at 12:01 PM, Certified Nursing Assistant (CNA) #2 stated that if she observed something different about a resident's [NJ Exec. Or], she would immediately alert the nurse to look at the resident's [NJ Exec. O]. CNA #2 stated that some examples would be a [Ex Order 2] , redness or anything different from their prior [NJ Exec. O] condition.

During a follow up interview with the surveyor on 01/12/23 at 12:13 PM, LPN #1 stated that he usually goes in on shower days to assess Resident #29's [NJ Exec. Or] and he would document on the Body Audit in the EMR. For Resident #29, the CNA sees the [NJ Exec. O] during care and he observed the [NJ Exec. O] during [NJ Exec. Order 26:4.b.1] daily. LPN #1 further stated that if a resident's [Ex Order 26. 4B1] healed, he would tell the Advanced Practice Nurse, physician, or APWN and she would come and assess the [Ex Order 26. 4B1] and give me a direction to discontinue the treatment order.

During a follow up interview with the surveyor on 01/13/23 at 09:50 AM, the surveyor discussed with the APWN that the facility provided the [Ex Order 26] Skin & Wound Evaluation V5.0 dated [Ex Order 26. 4B1] which the APWN completed on

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F 686	Continued From page 40 01/09/23. The APWN stated that the Ex Order 26. 4B1 healed on Ex Order 26. 4B1 and she monitored the resident's NJ Exec. Order 26:4. weekly. The APWN further stated that if a NJ Exec. Order 26:4.b.1, she will discontinue the treatment. The surveyor inquired, why did the treatment continue. The APWN stated that there was a clarification by the nurse and she discontinued the treatment on NJ Exec. Order 26:4.b.1, as it had healed. The APWN stated, "It could be my mistake as a provider." During a follow up interview with the surveyor on 01/13/23 at 10:10 AM, the QAC #1, in the presence of the Infection Preventionist, stated that she expected the NJ Exec. Order 2 nurse to complete weekly rounds, document in the progress notes, put orders in the medical record and discontinue orders when a NJ Exec. Order 26:4.b.1. The APWN "obviously" knew that the NJ Exec. Order 26:4.b.1. The QAC #1 further stated that she expected the nurses, if a NJ Exec. Order 26:4.b.1, to communicate with the physician and get an order to discontinue the treatment. The facility did not provide further information about the weekly NJ Exec. Order 26:4.b.1. Review of the facility's Skin Management Guidelines, dated 03/2022, reflected that body audits were completed by the licensed nurse daily for patients with pressure injuries and documented in the TAR. The Guidelines further reflected that skin alterations and pressure injuries were evaluated and documented by the licensed nurse whenever there was a significant change in condition or clinically indicated. Review of the facility's Skin Quick Reference document, dated 02/2022, reflected that the facility should document in the TAR daily body audit for patients, including but not limited to, with	F 686		

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F 686	Continued From page 41 pressure injury, treatment completion, and weekly wound rounds.	F 686		
F 688 SS=E	NJAC 8:39-27.1(e) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that a resident with Ex Order 26. 4B1 of the Ex Order 26. 4B1 received appropriate services to prevent further Ex Order 26. 4B1. This deficient practice was identified for 1 of 1 residents (Resident #21) reviewed for positioning and mobility and was evidenced by the following: During the initial tour of the facility on 01/03/23 at	F 688	F688 Maintain/ Prevent Decrease in Range of Motion Element #1 Corrective Actions • A physician order was obtained for the use of the Ex Order 26. 4B1 and entered into the medical record for Resident #21. The care plan of Resident #21 was updated. Element #2 Identification of at Risk Residents • All residents have the potential to be affected by this practice.	3/1/23

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F 688	Continued From page 42 10:03 AM, the surveyor observed Resident #21 with a [redacted] to the [redacted]. The surveyor observed a [redacted] located on the resident's bedside table. Resident #21 stated that he/she can apply and remove the [redacted] without assistance. On 01/06/23 at 11:00 AM, the surveyor observed Resident #21 with a [redacted] to the [redacted]. The resident's [redacted] was observed on the bedside table. When asked how often the resident used the [redacted], he/she responded, "[redacted]." On 01/09/23 at 11:17 AM, the surveyor observed resident #21 asleep in bed with the [redacted] to the [redacted]. The resident's [redacted] was observed on the bedside table. According to the Admission Record, Resident #21 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]. Review of Resident #21's most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], identified Resident #21 as [redacted] with functional limitation in [redacted] on one side of the [redacted]. The MDS also revealed that Resident #21 required extensive assistance and was dependent on staff for most [redacted]. During the resident's Record Review on 01/06/23 at 10:02 AM, it was observed that Resident #21's	F 688	Element #3 Systemic Change • Licensed nurses were re-educated to ensure residents receive appropriate services to prevent further decrease in range of motion. • Licensed nurses will receive education on hire as part of clinical orientation regarding physician orders and use of adaptive devices. Element #4 Quality Assurance • Director of Nursing/designee will conduct walking rounds weekly for 4 weeks, then monthly for 3 months and observe residents with orders for splints or braces, and check for physician orders and interventions as appropriate on the care plans. Findings will be analyzed by the DON/Designee and reported in aggregate quarterly to the QAPI committee for further direction.	

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ongoing Care Plan did not identify the Ex Order 26. 4B1 and Ex Order 26. 4B1 intervention. A review of the Ex Order 26. 4B1 physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not address the resident's Ex Order 26. 4B1 or any interventions.

During an interview with the surveyor on 01/09/23 at 11:00 AM, Certified Nursing Assistant (CNA) #1 confirmed that Ex Order 26. 4B1 required physician orders and they are trained from the Ex Order 26. 4B1 on how to apply and remove the Ex Order 26. 4B1.

During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned Licensed Practical Nurse (LPN) #1 reported that the unit manager was responsible for creating and updating care plans. LPN #1 further advised, "There isn't one (a unit manager). If it something that needs to be added, I try to do it myself but I don't have time." When asked if Ex Order 26. 4B1 are common care planning topics, LPN #1 responded, "Yes." When asked to identify what would be documented, LPN #1 stated, "The interventions to prevent worsening condition, how long for Ex Order 26. 4B1, how often." The surveyor inquired if staff received any training as to donning and doffing the Ex Order 26.. LPN #1 explained, "Ex Order 26. 4B1 will come up and train. Everything [documentation] would be with them." Upon reviewing the resident's physician orders, LPN #1 confirmed, "Well, that would be night shift; but no, I do not see any."

During an interview with the surveyor on 01/09/23 at 12:55 PM , the Assistant Director of Rehabilitation (ADDR) reported that upon discharge from rehabilitation, the nursing staff is trained on the application and removal of a

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[redacted]. The ADDR stated that nursing was responsible for ensuring that the resident wore the [redacted], provided [redacted], and notified Rehabilitation of any changes, including the resident's refusal to wear the [redacted] or questions regarding the [redacted].

Upon review of documentation provided by the ADDR on 01/09/23 at 1:04 PM, the Therapy Communication Form revealed, "Under Splint Wear Section" that the "handroll" was identified with the instruction checked off to "apply roll to right (circled) upper extremity." Handwritten next to the entry identified "as tolerated every day".

The surveyor also reviewed the Therapy Discharge Summary signed on [redacted] at 12:42 PM revealed, "Nursing [redacted] and [redacted] assistance as requested by patient. Therapy follow up established/trained. [redacted] Established/Trained. [redacted] and [redacted] as tolerated followed by (f/b) [redacted] throughout the day/evening (as tolerated) and removed for hygiene and [redacted]. [redacted] educated and able to remove and apply [redacted] on her own as well.

During an interview with the surveyor on 01/09/23 at 12:55 PM, the Director of Nursing (DON) identified that [redacted] require physician's orders. When asked by the surveyor if the Resident has any physician's orders the DON responded, "No I don't see them". When asked if the Resident is Care Planned for the device the DON stated, "I don't see it. It should be on there."

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F 688	Continued From page 45 The surveyor reviewed the undated facility procedure titled, "Facility Braces/Splints", Under Purpose" revealed: " To maintain function range of motion, decrease muscle contractures and provide support and alignment for weakened limbs through use of braces and/or splints". Under Procedure, it documented: #1 "Verify medical practitioner's order. Order should specify what type of brace/splint should be used as well as wearing schedule". #9 "Carefully inspect skin and appearance of body part during and between applications. The surveyor reviewed an undated Facility Procedure titled, "Medication and Treatment Administration Guidelines". Under General, it revealed "Centers are to follow the Orders Management Matrix for initiation of non-medication or treatment orders. All orders are to prescribed by a medical practitioner".	F 688		
F 730 SS=F	NJAC 8:39-27.2(m) Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to provide evidence that Certified Nursing	F 730	F730 – CNA Performance Appraisal/ 12 hours education Element #1 Corrective Actions	3/1/23

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F 730	Continued From page 46 Assistants (CNAs) received annual performance evaluations and 12 hours of mandatory in-service training as required. This deficient practice was identified for 5 of 5 CNAs and was evidenced by the following: On 1/4/23 at 11:40 AM the surveyor reviewed the facility's list of CNAs and requested the in-service training and performance evaluations for 5 randomly selected who had been hired on Ex Order 26. 4B1. On Ex Order 26. 4B1 at 10:00 AM, the Human Resources (HR) director provided the surveyor with a printout of a document titled, "Transcript Report-Nurse Aide Completions with Training Hours." A review of the "Transcript Report-Nurse Aide Completions with Training Hours" included CNA #5, #6, and #7, but did not include CNA #8 or #9. Additionally, there was no evidence on the transcript provided that ensured that CNAs #5, #6, and #7 received 12 hours of in-service training. On 1/9/23 at 9:27 AM, the surveyor reviewed the transcript report with the HR director. The HR director confirmed that the transcript report did not include tracking of hours of education for the CNAs. When asked about the other two CNAs that were not on the transcript, the HR director stated that "corporate" had provided what was handed to the surveyor and she was unable to determine how many hours of education each CNA completed. During an interview with the surveyor on 1/10/23 at 8:42 AM, the Director of Nursing (DON) stated	F 730	• Performance evaluations for cited CNA's, were immediately completed, and the required 12 hours of annual education were provided. • The DON and HR director were re-educated about the requirement to complete annual performance evaluations from the date of hire for each CNA, to utilize a spreadsheet to track CNA's annual performance review due dates, and to document the required 12 hours of annual education. Element #2 Identification of at Risk Residents • All Residents have the potential to be affected by this practice. • An audit of performance evaluations of Center CNAs was completed to identify those in need of an annual review and/or 12 hours of education. Element #3 Systemic Change • HR/designee tracks compliance with completion of annual performance evaluations and required education. • Annual performance evaluations of Center CNAs were completed, and education as required provided. Element #4 Quality Assurance • The HR Director/designee will review the schedule of CNA annual performance evaluations weekly for the next four weeks then monthly for two months to ensure evaluations are completed timely and required education provided. The HR Director/designee will discuss all findings with the Director of Nursing and Administrator. Findings will be reported at the quarterly QAPI committee meeting for review and further action as	

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F 730	Continued From page 47 that there were no performance evaluations completed for the CNAs. During an interview with the Administrator, and HR director in the presence of the survey team on 01/13/23 at 10:43 AM, the HR director could not provide additional information. She stated she was responsible to monitor the CNA in-service hours to ensure each CNA receives twelve hours of training and also to ensure performance evaluations were done annually, but the DON did not have them completed. A review of an undated facility policy titled, "Employee Development" included; "Performance Appraisal ...your job performance will be reviewed 90 days after hire, transfer or promotion and annually thereafter ...In-service Training; Ongoing training is necessary to provide the highest level of quality care to our patients/residents. You will be responsible for participating in training related to your position. You will be paid for participating in mandatory training. Your supervisor and/or the HR designee will communicate those requirements to you." NJAC 8:39-43.17(b)	F 730	appropriate.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		3/1/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

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F 756	Continued From page 48 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) act on or respond to, recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 1 of 5 residents reviewed for medication regimen review (Resident #5) and was evidenced by the following:	F 756	F756 – Drug Regimen Review by Pharmacist Element #1 – Corrective Actions • The consultant pharmacist (CP) recommendations for Resident #5 were reviewed with the physician and properly addressed. • The attending physician and APN for	

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F 756	Continued From page 49 The surveyor reviewed the progress notes (PN) from Ex Order 26. 4B1 and observed that the CP generated Medication Regimen Review (MMR) PNs dated Ex Order 26. 4B1 with his recommendations to be completed by the physician. The surveyor observed that the physician did not address the CP MMR Progress Notes. During an interview with the surveyor on 01/10/23 at 10:36 AM, the surveyor asked the Director of Nursing (DON) for the physician's response to the CP recommendations for Resident #5. The DON stated that her date of hire was Ex Order 26. 4B1. The DON further stated that the CP reviewed each resident's medications monthly and generated a report which was emailed to the Medical Director and DON. The DON then printed out the recommendations, gave them to the physician to complete and the physician returned the completed CP recommendations to the DON within 30 days. On 01/11/23 at 1:30 PM, the DON provided the following CP Medication Regimen Review (MMR) Progress Notes (PN) for Resident #5: - MMR PN dated Ex Order 26. 4B1 reflected 'NJ Exec. Order 26:4.b.1 were noted." The CP recommended "please evaluate the benefit/risk of use for Ex Order 26. 4B1 " and to "please evaluate the benefit/risk of use for Ex Order 26. 4B1 order (is it still needed)?" The MMR PN further reflected a handwritten "X" for the Physician Response "Accept the recommendation(s) above, please implement as written." The MMR PN further contained a	F 756	Resident #5 were re-educated about timely completion of CP recommendations and proper completion of the Medication Regimen Review forms Element #2 Identification of at Risk Residents • All residents have the potential to be affected by this practice. Element #3 – Systemic Change • The Director of Nursing was re-educated about the need to review completion of the CP Medication Regimen Review recommendations monthly to ensure physicians properly address recommendations, note decision rationales as appropriate, and complete, sign and date the forms. Element #4 – Quality Assurance • The DON/designee will randomly audit the CP Medication Regimen Reviews for timely response with documentation of rationales weekly for one month and then monthly for two months. Findings will be reported at the quarterly QAPI committee meeting for review and further action as appropriate.	

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F 756	Continued From page 50 handwritten signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated Ex Order 26. 4B1 reflected "NJ Exec. Order 26:4.b.1 were noted." The CP recommended "please evaluate if a *Ex Order 26. 4B1* NJ Exec. Order 26:4.b.1 could be attempted at this time." The MMR PN further reflected a handwritten "X" for the Physician Response "Decline the recommendation(s) above and do not wish to implement any changes due to the reasons(s) below." The surveyor observed the "Rationale" portion of the MMR PN was blank. The MMR PN further contained a handwritten notation "*See *Ex Order 26. 4B1* note Ex Order 26. 4B1 *" and a signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated Ex Order 26. 4B1 reflected "NJ Exec were noted. No action required." The surveyor observed the form was blank and did not contain a handwritten signature or date. - MMR PN dated Ex Order 26. 4B1 reflected NJ Exec. Order 26:4.b.1 were noted." The CP recommended "Is *Ex Order 26. 4B1* still needed?" The MMR PN further reflected a handwritten "X" for the Physician Response "Decline the recommendation(s) above and do not wish to implement any changes due to the reasons(s) below." The surveyor observed the "Rationale" portion of the MMR PN was blank. The MMR PN further contained a handwritten notation "*See Diagnosis List*" and a signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated Ex Order 26. 4B1 which reflected	F 756		

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F 756	Continued From page 51 NJ Exec. Order 26:4.b.1 were noted." The CP recommended "please evaluate if a Ex Order 26. 4B1 NJ Exec. Order 26: could be attempted at this time. The MMR PN further reflected a handwritten "X" for the Physician Response "Decline the recommendation(s) above and do not wish to implement any changes due to the reasons(s) below." The surveyor observed the "Rationale" portion of the MMR PN was blank. The MMR PN further contained a handwritten notation "*See CRNP (APN) note* Ex Order 26. 4B1 " and a signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated Ex Order 26. 4B1 which reflected NJ Exec. were noted. No action required." The surveyor observed the form was blank and did not contain a handwritten signature or date. During an interview with the surveyor on 01/11/23 at 11:25 AM, the surveyor reviewed the MMR PNs with the APN and she acknowledged that she reviewed and signed the MMR PNs yesterday, Ex Order 26. 4B1 . The APN stated that the CP came monthly, reviewed each resident's medications, and made recommendations. The CP provided the recommendations to the Director of Nursing (DON) and she provided these forms to the physician and the physician would address them. If the physician was not available, their APNs would complete the task. Once the recommendations were completed, they were returned to the DON. At that time, the surveyor and APN reviewed each CP MMR PN as follows: - For the Ex Order 26. 4B1 MMR PN, the APN reviewed the PN dated Ex Order 26. 4B1 which reflected that the	F 756		

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F 756	Continued From page 52 resident had a [redacted]. The APN further stated that the [redacted] PN further reflected that Resident #5 had a history of [redacted] without complications with [redacted] between [redacted] for the last two days. The APN acknowledged that she did not fill in this rationale on the MMR PN. - For the [redacted] MMR PN, the APN reviewed the [redacted] PN and acknowledged she did not fill in the rationale on the MMR PN. - For the [redacted] MMR PN, the APN confirmed that the form was incomplete. - For the [redacted] MMR PN, the APN stated that Resident #5 had [redacted] in the [redacted] and confirmed that she did not fill in this rationale. The APN further reviewed the progress notes and confirmed that the CP recommendations were not addressed after [redacted]. - For the [redacted] MMR PN, the APN reviewed the [redacted] PN and confirmed that she did not fill in the rationale. - For the [redacted] MMR PN, the APN confirmed that the form was incomplete. At that time, the APN stated that the CP recommendations should be completed right away and voiced an understanding of completing the CP recommendations. During an interview with the surveyor on 01/13/23 at 10:48 AM, the Quality Assurance Consultant #1 acknowledged that the MMR PNs were not	F 756		

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F 756	Continued From page 53 completed in their entirety. Review of the facility's Medication Regimen Review policy dated [redacted] reflected the following: - CPs perform MMR for patients and will generate recommendations with the overall goal of promoting positive outcomes and minimizing adverse consequences. - The CP conducts review of the medical record. The findings and/or recommendations are entered in the electronic health record assessment. - The CP generates three copies of the MRR recommendations with one copy provided to the DON and retained in the MRR binder as the master tracking system, one copy provided to the Medical Director and one copy provided to the attending physician or prescriber. - The DON, or designee reviews the MRR and contacts the attending physician to review and obtain orders as warranted. The DON, or designee documents on the MRR and in the patient's clinical record, the physician order(s) and forwards the completed MRR to the DON within 30 days of the CP's review. - The attending physician documents the review and any resulting actions or orders on the MRR. - Once validated as complete, the paper copy of the MRR is filed in the patient's clinical record - Legal/Miscellaneous tab. The copy from the master tracking binder is removed and securely disposed of by placing in the secure document	F 756		

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F 756	Continued From page 54 shred box. NJAC 8:39 - 29.3 (a)(1)	F 756		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that expired medications and supplies were removed from the medication rooms and unit emergency carts where other current in use	F 761	F761 – Storage of Drugs and Biologicals Element #1 – Corrective Actions • Second Floor Medication Room o Expired medications in the second floor medication room large refrigerator	3/1/23

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F 761	Continued From page 55 items were stored, b.) ensure that each medication room refrigerator was maintained and locked, c.) ensure that each medication room refrigerator contained a secured/locked narcotics box and d.) consistently document medication room refrigerator temperatures. This deficient practice was identified for 2 of 2 units and was evidenced by the following: On 01/10/23 at 10:46 AM, surveyor #1 inspected the medication room on the second floor with the Registered Nurse Supervisor (RNS) and observed the following: 1. The RNS and surveyor #1 reviewed the medications stored in the large refrigerator and the RNS confirmed the following items were expired: one Pneumovax 23 syringe expired 11/22/22, one Famotidine Injection 40 mg/4 ml expired 09/2022 and one IV Daptomycin 500 mg/100 mg expired 01/02/23. 2. Surveyor #1 reviewed the lower cabinet to the right of the sink, in the presence of the RNS, and the RNS confirmed, that the following items were expired: one bottle of Vitamin B-6 50 mg tablets expired 12/22 and four bottles of Aspirin 325 mg expired 12/22. 3. Surveyor #1 observed that the small black refrigerator did not have a lock affixed to the refrigerator. 4. Surveyor #1 observed that both refrigerators had a Medication/Vaccine Refrigerator Temperature Log (Temp Log) affixed to each refrigerator that was incomplete. Review of the Temp Log reflected the Month, Year and Location, an area checked to record the	F 761	were removed and properly destroyed. o Expired medications and supplies in the Medication room cabinet were removed and properly destroyed. o A lock was placed on the small black refrigerator. • Third Floor Medication Room o The small refrigerator was properly defrosted. o A secured narcotic box was installed in the small refrigerator and the refrigerator locked. o Expired medications and syringes in the Medication room cabinet were removed and properly destroyed. • Third Floor Crash Cart o All expired items in the crash cart were removed and properly destroyed. o The checklist of all contents in the crash cart was updated to include expiration dates. o The expired Biohazard container spill kits were replaced. Element #2 Identification of at Risk Residents • All residents have the potential to be affected by this practice. • All crash carts, biohazard kits, and med rooms were immediately checked for any expired or improperly stored medications or supplies. Element #3 • Checking the biohazard spill kit expiration dates was added to the crash cart checklist and licensed nurses re-educated. • Licensed nurses were re-educated about the importance of removing all expired medications from the medication	

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F 761	Continued From page 56 Refrigerator temperatures only, the Day, Time (AM and PM), Refrigerator (temperature), Freezer (temperature), and Initials. Surveyor #1 reviewed the Temp Log affixed to the large refrigerator was dated January 2023. The Temp Log reflected the staff did not complete the refrigerator temperatures on 01/01/23 AM and PM, 01/02/23 AM, 01/03/23 PM, 01/04/23 AM and PM, 01/05/23 PM, 01/06/23 AM and PM, 01/07/23 AM, 01/08/23 AM, and 01/09/23 AM and PM. Surveyor #1 reviewed the Temp Log affixed to the small refrigerator was dated January 2023. The Temp Log reflected the staff did not complete the refrigerator temperatures on 01/01/23 AM and PM, 01/02/23 AM, 01/03/23 PM, 01/04/23 PM, 01/05/23 PM, 01/06/23 AM and PM, 01/07/23 AM, 01/08/23 AM, and 01/09/23 AM and PM. When interviewed at the time of the observations, the RNS stated that the refrigerators were reviewed for expired items when a resident was discharged from the facility and every two weeks. The RNS further stated that it was the nurses' responsibility and sometimes the Director of Nursing (DON) or the supervisors to review the refrigerators for expired items. The RNS confirmed there was no lock on the small refrigerator and that the large and small refrigerator Temp Logs were incomplete. The RNS stated that it was the responsibility of the day supervisor to check the refrigerator temperatures daily. On 01/10/23 at 11:51 AM, two surveyors inspected the third floor medication room with the RNS and observed the following:	F 761	room refrigerators and cabinets and returning medications to the pharmacy and destroying all narcotics per Center policy. • Licensed nursing staff received re-education to ensure refrigerator temp logs are properly completed daily per policy. • Licensed nurses were re-educated about keeping all medications refrigerators locked and refrigerated narcotics properly secured in locked narcotic boxes. Element #4 • Director of Nursing/designee will check medication room cabinets and medication refrigerators weekly for 4 weeks, then monthly for 3 months to ensure all expired medications and supplies are removed, narcotics are properly secured in a locked box in refrigerators that are locked, and temperature logs are completed per Center procedure. Findings will be discussed at clinical meetings as appropriate and reported in aggregate by the DON at the quarterly QAPI committee meeting for review and further action as appropriate. • Director of Nursing/designee will check crash carts during rounds weekly for 4 weeks, then monthly for 3 months to ensure all expired medications and supplies are removed and the crash cart checklist is signed daily by the licensed nurse per Center procedure. Findings will be discussed at clinical meetings as appropriate and reported in aggregate by	

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F 761	Continued From page 57 1. Surveyor #1 observed the small refrigerator was not locked and did not contain a secured, locked box inside of the refrigerator for narcotic medications. The small refrigerator contained the following items: three sealed boxes of one vial of Humalog, one sealed bottle of Latanoprost Ophthalmic 2.5 ml solution, three prefilled Basaglar insulin pens, two prefilled Humulin insulin pens, two prefilled Lantus insulin pens, and five prefilled Glargine pens. The surveyor #1 further observed that the ice compartment of the small refrigerator contained a thick layer of ice. At that time, the RNS confirmed the observations. 2. Surveyor #1 reviewed a storage cabinet to the right of the refrigerator and observed six 3 ml Syringe with hypodermic safety needles with an expiration date of 03/28/22. At that time, the RNS confirmed the observation. 3. Surveyor #2 reviewed the lower shelf of the bottom counter cabinet and observed the following expired medications: 19 individually wrapped Heparin Lock Flush Syringe expired 05/31/22, one sealed box of 50 individually wrapped Heparin Lock Flush Syringes expired 04/30/22 and one individually wrapped and sealed 0.9 Sodium Chloride Flush expired 09/30/22. 4. Surveyor #1 observed the Temp Log affixed to the small refrigerator was dated January 2023 and reflected the staff did not complete the refrigerator temperatures on 01/01/23 AM, 01/02/23 PM, 01/04/23 PM, 01/05/23 PM, 01/06/23 AM and PM, 01/07/23 AM and PM, 01/08/23 AM and PM, 01/09/23 AM and PM. At that time, the RNS acknowledged that the	F 761	the DON at the quarterly QAPI committee meeting for review and further action as appropriate.	

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F 761	Continued From page 58	F 761		

Temp Logs were incomplete and stated that she was nurse supervisor and it was her responsibility to check the refrigerator temperatures daily on both floors.

The two surveyors reviewed the third floor crash cart, situated near the nurses' station, and observed the following expired items: Twenty-one 0.09 oz lubricating jelly expired 12/19, and six 0.09 oz lubricating jelly expired 01/20. The surveyors further observed to the right of the crash cart, affixed to the wall, was a container which housed two Biohazard Spill Kits with an expiration date of 10/31/22.

On 01/10/23 at 12:09 PM, the two surveyors reviewed the second floor crash cart, situated near the nurses' station, and observed the following expired items: nine packets of E-z lubricating Jelly expired 3/2021, eight packets of E-z lubricating Jelly expired 1/2020, two packets of Petroleum Jelly expired 02/21, one Non-Conductive Connecting Tubing expired 11/01/21, one Inner Cannula expired 06/30/21, and one Yankauer expired 11/28/21. The surveyors observed to the right of the crash cart, affixed to the wall, was a container which housed two Biohazard Spill Kits with an expiration date of 10/31/22.

During a follow up interview with surveyor #1 on 01/10/23 at 12:39 PM, the RNS stated, "I believe the night supervisor checked the crash cart."

During a follow up interview with surveyor #1 on 01/10/23 at 1:06 PM, the RNS verified that there was no locked/secured narcotics box in the third floor refrigerator. She stated that if there was a new admission, who had a narcotic that needed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 59 to be refrigerated, that it would be stored in the second floor medication room. During an interview with surveyor #1 on 01/11/23 at 11:10 AM, the DON stated that night shift was responsible to review the medications in the medication storage rooms and return the expired medications and discontinued medications of residents to the pharmacy. It was important to review the medications for expiration dates so that we don't give expired medications to the residents. The DON expected her nurses to keep the medication rooms clean, check for expired medications, and return expired/discontinued resident medications to the pharmacy. At that time, the DON and surveyor #1 reviewed the crash cart on the second floor. The DON stated that there was a binder, which the night shift filled out to check the crash cart and the AED. The DON reviewed the crash cart and could not locate the binder. She stated that the binder was kept from survey to survey. The DON stated that she would have medical records locate the completed forms. She stated that it was important to review the crash cart for expired items because if there was a code, all items should be in date and available. The DON further stated that she expected night shift to maintain the binder, check the crash carts daily and complete the Basic Crash Cart Checklist daily. While at the crash cart, surveyor #1 and DON reviewed the Biohazard Spill Kit expiration dates. The DON confirmed the spill kits were expired and removed them from their basket on the wall. The DON was not sure if the spill kits were reviewed by the night nurse when she reviewed the crash cart and was uncertain if the spill kits were included on the Basic Crash Cart Checklist.	F 761		

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F 761	Continued From page 60	F 761		

The DON reviewed the second floor medication room with surveyor #1. The DON confirmed there was a large and small refrigerator in the medication room and stated the small refrigerator did not require to be locked because it only housed flu vaccines. The DON stated that it was the responsibility of the Nursing Supervisors to monitor the refrigerator temperatures daily and she expected that the temperatures will be monitored daily so that the medications are kept at correct temperatures.

At that time, surveyor #1 and DON discussed that the third floor refrigerator did not contain a secured, locked narcotics box. The DON further stated that the narcotics could be stored in the second floor narcotics box unless the narcotic was resident specific.

During an interview with surveyor #1 on 01/13/23 at 10:48 AM, the Quality Assurance Consultant #1 stated that the facility could not locate the binders for the crash carts.

Review of the Basic Crash Cart Checklist did not include the Biohazard Spill Kits.

Review of the facility's undated Medication and Treatment Administration Guidelines, Long-Term Care reflected that medications and biologicals are securely stored in a locked cabinet, cart, or medication room. The guidelines further reflected that controlled substances are securely stored using a double-lock system (medication cart, medication room, refrigerator, controlled substance lock box, and/or separately keyed controlled substance drawer in medication cart). The guidelines further reflected that medications

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F 761	Continued From page 61 are stored in accordance with standards of practice. Review of the facility's undated Emergency Management document reflected to use a crash cart check sheet and signature form daily to verify the contents of the crash cart. One sheet is used per cart per month. The document further reflected to check emergency care items and equipment stored in the crash cart against the crash cart checklist once a month and whenever the cart is opened to validate contents and expiration dates. The licensed nurse or designee: replaces items with expired dated, secures the cart with break-away lock and covers, signs and dates crash cart checklist. The document further reflected that checklists and signature logs are submitted to the Quality Assurance Performance Improvement committee for review and follow-up upon completion.	F 761		
F 812 SS=F	NJAC 8:39-29.4 (c)(e)(h), 29.7(b) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		3/1/23

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F 812	Continued From page 62 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined that the facility failed to a.) handle potentially hazardous foods, and maintain equipment and sanitation in a safe, consistent manner to prevent foodborne illness and b.) consistently document refrigeration temperatures for 3 out of 3 resident rooms. This deficient practice was evidenced by the following: On 01/03/23 from 9:52 AM to 10:36 AM, the surveyor observed the following in the kitchen in the presence of the Dining Services Director (DSD). 1. In a food preparation area, the surveyor observed that two of four five-pound packages of ground hamburger that were being thawed inside of a stock pot under running water within the sink, protruded halfway out of the stock pot and were not fully submerged beneath the water. The DSD stated that each package of ground beef was required to be submerged beneath the running water to ensure that they defrosted at the same time. She then proceeded to push the packages down into the stock put so that they were fully covered by the running water. Cook #1 returned to the food preparation area and acknowledged that the ground beef was not fully submerged	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary Element #1 • The hamburgers were immediately properly submerged beneath the water. • Walk-in Refrigerator o The cucumbers were discarded, and the bin cleaned. • Food Preparation Area o The can opener was immediately cleaned and added to a daily cleaning schedule. • Kitchen Galley o The stove interior and exterior spaces were cleaned and added to the daily cleaning schedule. o The items found in the oven were immediately removed and dietary staff re-educated to prevent any items being left inside the oven. o Dietary staff were re-educated regarding cleaning the stove per the equipment cleaning schedule. • DA#1 was immediately re-educated to ensure the hairnet completely covered all hair. • The small refrigerator temperature logs in rooms #334, #338, and #346 were removed and current month logs put in place.	

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F 812	Continued From page 63 beneath the running water as it was required to be to ensure a safe thawing process. Cook #1 further stated that he intended to defrost the meat to be utilized to make meat loaf to be served the next day. 2. In the walk-in refrigerator: a) On the second shelf of a three-tiered wired rack, there was a clear, plastic bin which contained one cucumber that had multiple areas of a white plaque substance, a second cucumber that appeared to have been cut in half, was not covered, and had begun to decay. There was a head of cabbage with yellow and brown outer leaves. The DSD removed the items from the bin and placed them within a smaller bin. The DSD proceeded to remove the outer leaves from the cabbage, discarded them, and stated that the cabbage was still good. She then returned the cabbage to the storage bin. The DSD stated that the cucumbers should have been discarded and removed them from storage. The surveyor noted a received date of 12/21/22 on the produce bin which failed to contain a use by date. The DSD stated that she did not know why the use by date was not specified on the produce bin as required. She further stated that produce was normally used within a week of receipt. b) On the bottom rack of a free-standing wired rack, there was an opened five-pound box of chicken thighs that were marked with a received by date of 12/29/22, the packing label failed to contain an opened date or use by date in the space provided. The DSD stated that there was another sticker on the box which contained a use by date, but it must have fallen off. When the surveyor asked the DSD why it was important to	F 812	Element #2 Identification of at Risk Residents • All residents have the potential to be affected by this practice. • Kitchen equipment was inspected and cleaned and sanitized as appropriate. Element #3 Systemic Change • An equipment cleaning schedule was reviewed and revised that assigned responsibility for cleaning areas of the kitchen by role and timeframe. Dietary staff received education regarding the cleaning schedule. • The DSD received re-education regarding proper labeling, dating, defrosting and storage of food to prevent contamination. • Dietary staff received re-education regarding proper use of hairnets to prevent food borne illness. • The Dining Services Director (DSD) and Kitchen staff were re-educated regarding labeling and dating of all food products in all refrigerators and freezers in the kitchen and all produce bins per Center policy. • Nursing staff were re-educated about monitoring all resident refrigerators and labeling and dating any resident food items being stored in the refrigerators and logging refrigerator and freezer temps daily. Element #4 Quality Assurance • The Dining Services Director/designee conducts weekly inspections of the kitchen to assure compliance with all sanitation, food storage, labeling and dating, and food handling and preparation regulations.	

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F 812	Continued From page 64 ensure that an opened date and a use by date were written on an opened package of chicken, a potentially hazardous food, she stated that the chicken would be cooked today and served tomorrow and failed to provide a rationale. c) In a food preparation area: The surveyor observed a can opener that was mounted on the front of the table in the food preparation area. The DSD removed the can opener from the holder upon request and the blade of the can opener was visibly soiled and had a dried, black substance on the anterior blade and a single strand of an orange substance was noted on the upper portion of the blade cover. The DSD stated that she personally cleaned the can opener in the dishwasher on Saturday, 12/31/22. The DSD stated that a soiled can opener could cause contamination. The DSD stated that the PM Cook should have cleaned it. The DSD stated that there was no cleaning schedule in place to ensure that the can opener was cleaned. d) In the presence of the DSD and Cook #2 in the galley of the kitchen: The surveyor observed that the cooking surface of a six-burner stove had a thick layer of a black, shiny substance encrusted on the interior and exterior surfaces of all six of the burners and there was also a moderate amount of a thick, yellow dried substance that was also noted on the burners. The DSD stated that the stove was last cleaned on 12/23/22 and was required to be cleaned every 15 days. The DSD further stated that the stove would be cleaned this Friday, 01/06/23.	F 812	Findings will be discussed with the Administrator and reported in aggregate by the DSD at the quarterly QAPI committee meeting for review and further action as appropriate. • The Maintenance Director/designee is monitoring Resident room refrigerator temperature logs weekly for one month and monthly thereafter to be sure they are completed and monitored for safe temperatures. Findings will be discussed with the Administrator and reported in aggregate by the DSD at the quarterly QAPI committee meeting for review and further action as appropriate.	

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F 812	Continued From page 65	F 812		

The surveyor requested that the DSD open the oven door that was beneath the six-burner stove. The DSD stated that the oven was not utilized by the facility. When the DSD opened the oven door, a cloth rag was noted on the top rack of the oven, and a cleaning utensil (scraper) was noted on the bottom rack of the oven. Both the inside of the oven door and the floor of the oven were heavily soiled with dried white and yellow food particles. The DSD removed the cloth rag and stated that it posed a potential fire hazard. Cook #2 who was present at that time, stated that she cleaned the inside of the oven on 01/01/23, and the rag was not there at that time.

On 01/12/23 from 12:25 PM to 1:05 PM, during a follow-up visit to the kitchen, the surveyor observed the following in the presence of the DSD:

The surveyor observed Dietary Aide (DA) #1, who wore a hair net that only covered her ponytail and left the top and anterior portion of her hair uncovered as she approached the food service line that was in process. When interviewed, DA #1 stated that her hair was covered, but the hair net must have slipped off. The DSD who was present, stated that DA #1's hair should have been completely covered by the hair net to prevent contamination on the food service line.

During an interview with the surveyor on 01/13/23 at 9:46 AM, the Infection Preventionist (IP) stated that if DA #1's hair was not fully covered by the hair net, hair could end up in the food or an entire container of food could become contaminated.

During an interview with the surveyor on 01/13/23

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F 812	Continued From page 66 at 11:17 AM, the Dining Services District Manager (DSDM) stated that the six-burner stove top should have been cleaned daily. The Administrator who was present at that time stated, "It was dirty." The DSDM then agreed to furnish the surveyor with the kitchen cleaning schedule. At 11:57 AM, in a later interview with the DSDM, he stated that, "There was no process in place for a cleaning schedule in the kitchen previously, but there should have been." Review of the facility policy titled, "Food: Preparation" (Revised 09/17) revealed the following: Procedures: ...Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use ...The Cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: ...Completely submerging the item under cold water (at a temperature of 70 degrees F or below) that is running fast enough to agitate and float loose ice particles; Review of the facility policy titled, "Use By" Dating Guidelines (Rev. 12/01/15) revealed the following: Ready to eat*, Time/Temperature Control for Safety Foods included but were not limited to: ...Produce Date With: "Use by" date seven days after opening ...Meats, eggs, and other frozen items that are placed in the refrigerator to thaw: Poultry "Use by" date 1-2 days ... Review of the facility policy titled, "Equipment"	F 812		

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(Revised 09/17), revealed the following: Policy Statement: All foodservice equipment will be clean, sanitary, and in proper working order. Procedures: All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris. The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed ...

Review of the facility policy titled, "Staff Attire" (Revised 09/17) revealed the following: All employees wear approved attire for the performance of their duties. Procedure: All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained ...
2. During the initial tour on 01/03/23, the surveyor observed the small refrigerators in rooms 334, 338, and 346. Attached to each refrigerator was a Refrigerator/Freezer Temperature Log (Temp Log) dated October 2022. The Temp Log reflected columns for the Date, Time, Internal Temp, Other Temp, and Initials to record the temperatures of the refrigerators daily.

The Temp Logs further reflected that the forms were not completed for each day of the month as follows:

- The Temp Log from room 334 reflected the following dates were blank: 10/01/22, 10/02/22, 10/03/22, 10/04/22, 10/05/22, 10/06/22, 10/08/22, 10/09/22, 10/10/22, 10/11/22, 10/12/22, 10/13/22,

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F 812	Continued From page 68 10/14/22, 10/15/22, 10/17/22, 10/18/22, 10/19/22, 10/20/22, 10/21/22, 10/22/22, 10/23/22, 10/24/22, 10/26/22, 10/27/22, 10/28/22, 10/29/22, 10/30/22, and 10/31/22. - The Temp Log from room 338 reflected the following dates were blank: 10/01/22, 10/02/22, 10/03/22, 10/04/22, 10/05/22, 10/06/22, 10/08/22, 10/09/22, 10/10/22, 10/11/22, 10/12/22, 10/13/22, 10/14/22, 10/15/22, 10/17/22 reflected the "Time" of "11:", 10/18/22, 10/19/22, 10/20/22, 10/21/22, 10/22/22, 10/23/22, 10/24/22, 10/26/22, 10/27/22, 10/28/22, 10/29/22, 10/30/22, and 10/31/22. - The Temp Log from room 346 reflected the following dates were blank: 10/01/22, 10/02/22, 10/03/22, 10/04/22, 10/05/22, 10/06/22, 10/08/22, 10/09/22, 10/14/22, 10/15/22, 10/16/22, 10/19/22, 10/20/22, 10/21/22, 10/22/22, 10/23/22, 10/25/22, 10/26/22, 10/27/22, 10/28/22, and 10/31/22. During an interview with the surveyor on 01/05/22 at 1:25 PM, Resident #31 stated that the staff cleaned out the refrigerator yesterday. During an interview with the surveyor on 01/11/23 at 10:49 AM, the Administrator stated that the in-room resident refrigerator logs are to be completed daily and "I know they are not being done." The night shift was assigned to monitor the temperatures, and the Maintenance Department will place new temperature logs on each refrigerator monthly. The Certified Nursing Assistants (CNA) will check the temperatures daily on night shift. The Administrator stated, "I am well aware that it is not happening and I talk about it all the time. I just hired a new Maintenance Director; and I hope it will be up and running soon." The Administrator stated that it	F 812		

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was important to make sure that the food holds the correct temperature so that the residents do not get sick.

During an interview with the surveyor on 01/12/23 at 12:29 PM, CNA #3 stated that he worked on the 3-11 shift and that he was instructed to take the temperature of the refrigerators in resident rooms and make sure they are clean and nothing was spoiled. CNA #3 stated that the temperature should be recorded on the door of the refrigerator; and that normally, the 11-7 shift was assigned to do this task, but we help each other out.

During an interview with the surveyor on 01/13/23 at 10:26 AM, Registered Nurse (RN) #1 stated that she worked three days per week on night shift. She was instructed that the CNAs were to monitor the temperatures of the in-room refrigerators, to check the refrigerators for expired items and to make sure the refrigerators were clean. RN #1 stated that the temperature logs were maintained in a binder for a month or two months. RN #1 further stated, "I don't see the CNAs doing it."

During an interview with the surveyor on 01/13/23 at 10:47 AM, Quality Assurance Consultant #1 stated that the in-room refrigerator logs were inconsistent. The surveyor requested to review the refrigerator log binder. The facility could not provide the binder.

Review of the facility's Food From Outside Sources and In-Room Refrigerators, with an Original Date of 11/2020, reflected:
"If personal in-room refrigerators are used:
- A staff member designated by the administrator

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F 812	Continued From page 70 monitors the condition, temperature and maintenance with regard to food safety in the refrigerator. ... - A temperature log is kept and responsibility for checking and recording temperatures is assigned by the administrator or director of nursing." NJAC 8:39-17.2(g)	F 812		
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 observation, interviews, medical record review and other pertinent facility documentation, it was determined that the facility's Administrator failed to ensure that the facility was in compliance with the following regulatory requirements, which affected the safety of all the residents in the facility. The Administrator failed to ensure: 1.) immediate action was taken to initiate contact tracing upon the identification of a Ex Order 26. 4B1 staff member, Registered Nurse #1 (RN #1), who was symptomatic and provided care to 9 residents on 1 of 2 units and tested Ex Order 26. 4B1 while at work on 12/24/22, 2) conduct contact tracing to identify residents and staff who had close contact with symptomatic Ex Order 26. 4B1 residents (Resident #33 and #235), 3.) a process was in place to conduct immediate resident and staff testing upon identification of a Ex Order 26. 4B1 staff and residents, 4.)	F 835	F835 Administration Element #1 Corrective Actions ¿ F880, F886, and F835 removal plans were submitted, accepted, and implemented. The F835 removal plan was accepted and verified as implemented during an onsite visit by the New Jersey Department of Health (NJDOH) surveyors on January 12, 2023. ¿ At the direction of the Administrator contact tracing was completed for Registered Nurse #1 and Residents #33 and #235 who tested Ex Order 26. 4B1 who were placed on NJ Exec. Order 26:4.b and cases were reported to the local and state Departments of Health for the Ex Order 26. 4B1 beginning Ex Order 26. 4B1.	3/1/23

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F 835	Continued From page 71 Ex Order 26. 4B1 were completed for the residents, 5.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and 6.) the facility's Outbreak Plan and Ex Order 26. 4B1 policies were followed to prevent exposure and mitigate the spread of Ex Order 26. 4B1, a deadly highly transmissible infectious disease. The Administrator's failure to ensure facility wide infection control prevention standards, policies and procedures were implemented and immediately conduct contact tracing and testing upon the identification of Ex Order 26. 4B1 staff and residents to prevent the spread of Ex Order 26. 4B1, a contagious infectious and potentially deadly virus, posed a serious and immediate risk to the health and well-being of all staff and residents for contracting Ex Order 26. 4B1. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 1/11/23. The removal plan was accepted and verified as implemented by the survey team during an onsite visit conducted on 1/12/23. The IJ began on Ex Order 26. 4B1 when the former Director of Nursing (DON) who was primarily responsible for infection control left the facility without notice. On 12/24/22 at 7:00 PM, RN #1 reported to work while NJ Exec. Order 26:4.b.1, proceeded to provide care for 9 residents in 1 of 2 resident units, and tested Ex Order 26. 4B1 on Ex Order 26. 4B1 at 10:00 PM. The Infection Preventionist (IP) stated that the contact tracing policy was never initiated for the 9 residents on the RN's	F 835	¿ The Administrator directed additional contact tracing be immediately completed for any Residents or staff considered close contacts. ¿ At the direction of the Administrator Ex Order 26. 4B1 was immediately completed for all close contacts of RN#1 and Residents #33 and#235. ¿ The Administrator immediately reviewed the contact tracing policy on Ex Order 26. 4B1 and compared it again to CDC and NJDOH Guidance related to the proper procedure to follow when a newly identified case of Ex Order 26. 4B1 is identified. ¿ Center Infection control preventionist initiated the spreadsheet for Close Contact□s required testing. Covid 19 surveillance testing was initiated and completed on 1/5/2023. Contact tracing and Line listing was updated and sent to the local department of health ¿ Regional Director of Operations (RDO), Administrator, Medical Director, and Director of Nursing (DON) held an ad-hoc QAPI meeting on 1/11/2023 to discuss survey findings and corrective actions. Element Two □ Identification of at Risk Residents ¿ All residents have the potential to be affected by these practices. Element Three □ Systemic Changes ¿ Regional Director of Operations re educated Administrator on Covid 19 process and outbreak response plan on 1/11/23	

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F 835	Continued From page 72 assignment. Three residents on the RN's assignment were immunocompromised and had a diagnosis of *Ex Order 26. 4B1* [redacted], 1 of the 3 immunocompromised residents was not *Ex Order 26. 4B1* [redacted]. Three additional residents were not *Ex Order 26. 4B1* [redacted]. Additionally, two symptomatic residents tested positive in the facility on *Ex Order 26. 4B1* [redacted]. There was no contact tracing or subsequent resident testing performed. There were no consistent *Ex Order 26. 4B1* [redacted] completed for the residents. The IP stated that she did not have a line list or notify the local health department of the positive cases. There was no screening or education provided to visitors entering the facility. The IP stated she was following the direction and guidance of the Administrator. The Administrator stated that she assumed that the IP was aware of her responsibilities and fulfilling her role as the IP. Refer to F880L and F886L as it pertains to the facility's failure to ensure the implementation of infection control practices and precautions during an identified *Ex Order 26. 4B1* [redacted]. This deficient practice was evidenced by the following:	F 835	¿ The Administrator directed the Director of Nursing to: o re-educate the infection preventionist on utilization of the Contact tracing worksheet and testing criteria after a resident or staff tests positive for COVID-19. o counsel and re-educate the RN that tested positive on employee health guidelines/reporting symptoms prior to shift via phone/call out. o re-educate staff on employee health guidelines of reporting symptoms of illness prior to starting shift via phone. o re-educate licensed nurses on completing COVID -19 surveillance assessments to be completed for the residents using the COVID 19 assessment form in the EHR. o re-educate the Interdisciplinary team and receptionists on the Center's screening process upon entry to the Center. Element Four □ Quality Assurance ¿ Regional Director of Operations (RDO) will be notified by the Administrator daily of all COVID19 positive residents and staff and actions taken including completion of contact tracing and testing of all close contacts. ¿ The RDO with the Administrator or designee will complete a weekly audit for 4 weeks of COVID19 positive residents and staff to ensure contact tracing and testing as appropriate has been completed. The results of the findings will be submitted to the QAPI Committee. The QAPI committee will meet and determine further actions and audits based on trend	

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F 835	Continued From page 73 A review of the Administrator's job description provided by the facility revealed the following: Manages all business related activity to achieve the organization's vision and supporting strategies and assures that the company image as an ethical and high quality provider of health services is maintained. Communicates new Policy and Procedures and regulations to staff to ensure compliance. Ensures that facility operations comply with local, state, and federal standards, laws, and licensing and certifying bodies. Understands and uses company policies, procedures and compliance program to promote quality of care. Develops all facility policies consistent with corporate guidelines. During the entrance conference on 1/3/23 at 11:00 AM, the Infection Preventionist (IP), along with the DON, informed the surveyors there were two *Ex Order 26. 4B1* residents (Resident #33 and Resident #235) in the facility on the NJ Exec. Order 26:4.b unit. The IP stated she started in the facility in NJ Exec. Order 26:4.b.1 and was responsible for staff development and infection control. The IP stated that the Administrator was currently on vacation. On 1/4/23 at 9:18 AM, Surveyor #2 asked the DON for the facility line list (a table that contains key information about each case in an outbreak). The DON stated that there was no line list and that it had not been done since the prior DON had left. She stated she had started at the facility in NJ Exec. Order 26:4.b.1 and was not aware there wasn't a line list until yesterday (Ex Order 26. 4B1). On 1/4/22 at 10:00 AM, Surveyor #1 reviewed the	F 835	and analysis. ¿ The Nursing Home Administrator or designee will audit to validate visitor screening is being completed. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Element Four □ Quality Assurance ¿ Director of Nursing or designee will audit to validate contact tracing and COVID-19 surveillance testing is completed upon identification of a new resident or staff positive case. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will be reported by the Director of Nursing/designee at the quarterly QAPI committee meeting for review and further action as appropriate. ¿ Director of Nursing or designee will audit to validate any new resident or staff COVID-19 positive case is reported to the Department of health utilizing the state required line list. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will be reported by the Director of Nursing at the quarterly QAPI committee meeting for review and further action as appropriate. ¿ Director of Nursing or designee will audit to validate respiratory surveillance assessments are completed on residents who are symptomatic or identified as close contacts. Audits will be completed daily for 5 days, weekly for 3 weeks, and	

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F 835	Continued From page 74 facility's Ex Order 26. 4B1 titled "Ex Order 26. 4B1 Employee Detail", which revealed RN #1 was Ex Order 26. 4B1 on Ex Order 26. 4B1. An additional review revealed that the onset of symptoms was on Ex Order 26. 4B1 and the last day RN #1 worked was Ex Order 26. 4B1. Surveyor #1 reviewed the Ex Order 26. 4B1 that included RN #1 with the DON and IP. The DON stated RN #1 tested Ex Order 26. 4B1 at work on Ex Order 26. 4B1 and had Ex Order 26. 4B1, for a couple of days before. The DON stated RN #1 did not work on Ex Order 26. 4B1 and worked on Ex Order 26. 4B1 for the 7 pm to 7 am shift on the NJ Exec. Order 26:4 r unit. The DON further stated RN #1 should not have come in NJ Exec. Order 26:4.b.1 and should have tested before her shift. The DON stated she did not do contact tracing and would have to check the documentation for residents tested. The surveyor asked the IP about the line list for Ex Order 26. 4B1 in the facility. The IP stated she was new, did not have access to everything, and was not sure of the line list. The IP confirmed the line list was not completed and was following up with the LHD about it. The IP stated the previous DON was completing the line list and was not sure of the date the previous DON had left. During a telephone interview with Surveyor #1 On 1/4/23 at 11:57 AM, RN #1 stated she started feeling NJ Exec. on Ex Order 26. 4B1 and called NJ Exec. Order 26: to the Registered Nurse Supervisor (RNS) on Ex Order 26. 4B1 and Ex Order 26. 4B1. RN #1 stated she was NJ Exec. Order 26:4., and reported to the RNS that she was NJ Exec. Order 26:4.b.1." She stated the RNS stated, "ok" and did not ask any further questions. RN #1 stated it was "holiday time" and	F 835	then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will be reported by the Director of Nursing at the quarterly QAPI committee meeting for review and further action as appropriate. Completion Date: March 1, 2023	

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F 835	Continued From page 75 "if you call out before the holiday, you don't get time and a half". RN #1 stated she went back to work on Ex Order 26. 4B1 and thought she was ok since she called her primary doctor who gave her NJ Exec. Order 26:4.b.1 and she also took Ex Order 26. 4B1. RN #1 stated she still had a NJ Exec. Order 26:4.b.1 when she went to work. RN #1 said she received report from the outgoing nurse, checked on her residents, and did her first medication administration pass before testing herself at 10:00 PM and tested Ex Order 26. 4B1. The surveyor asked if she had told anyone that she was not NJ Exec. Order 26:4.b.1 or about her symptoms on Ex Order 26. 4B1. RN #1 stated, "Who was I gonna tell...there was no one ... only nurses" and she had called the DON at 10:00 PM after testing Ex Order 26. 4B1. RN#1 stated the DON told her that she had to go home and could not work as she tested Ex Order 26. 4B1. RN #1 said she gave report to the other nurse and went home. The surveyor asked RN #1 why she tested herself at 10:00 PM and not before that time. RN #1 replied that the outgoing nurses wanted to give report to go home, and she did not want to keep them waiting. RN #1 stated that no one from the facility had called her to ask about contact tracing including residents she had contact with. RN #1 stated she had education about Ex Order 26. 4B1 in 2020 and 2021 and acknowledged that the facility had stated if a staff member had symptoms or was Ex Order 26. 4B1 that the staff member should not come to work. On 1/4/23 at 11:54 AM, the IP provided the surveyor RN#1's timecard which revealed RN #1 worked on Saturday Ex Order 26. 4B1, clocked in at 7:00	F 835		

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F 835	Continued From page 76 PM, and clocked out at 10:45 PM. On 1/4/23 at 12:38 pm, the IP provided the surveyor with the assignment of RN #1 on Ex Order 26. 4B1, which included 9 residents (Resident #236, #69, #239, #47, # 80, #63, #240, #238 and #52). The IP stated that the residents who were exposed were not tested and there was no documentation that the residents were tested. The IP stated she was new in training, but that she was responsible to ensure they were doing the correct thing and the residents should have been tested. Additionally, the IP stated that the contact tracing policy was not initiated. A review of the medical records for the 9 residents that were assigned to RN #1 on Ex Order 26. 4B1, included three immunocompromised residents: Resident #236 who had a diagnosis that included Ex Order 26. was receiving Ex Order 26. 4B1, and Ex Order 26. 4B1 ; Resident #240 who had a diagnosis that included Ex Order 26. 4B1 ; and Resident #238, who had a diagnosis that included Ex Order 26. 4B1. Four of the residents (Resident #236, #69, #239, and #47) were NJ Exec. Order 26:4.b.1 and 5 residents (Resident # 80, #63, #240, #238, and #52) were Ex Order 26. 4B1 according to the facility's resident Ex Order 26. 4B1 . The Ex Order 26. 4B1 and	F 835		

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F 835	Continued From page 77	F 835		

progress notes relating to Ex Order 26. 4B1 for the 9 residents' electronic medical records were not consistent and were not completed every shift as per the facility's "COVID-19 Clinical Monitoring and Measures Plan" policy. The policy indicated a Screening UDA [User Defined Assessment] which included vital signs was to be completed every shift for residents in the affected unit (where a resident tested positive or positive employee worked).

On 1/4/23 at 12:53 PM, the IP provided to the surveyor a copy of the facility's "Contact Tracing Worksheet", dated Ex Order 26. 4B1, and "COVID-19 Outbreak and Contact Tracing Tool", dated Ex Order 26. 4B1. The IP confirmed this was not initiated after positive staff and resident cases in the facility. The Contact Tracing Worksheet indicated the process for contract tracing when a Ex Order 26. 4B1 case was identified, which included recording Ex Order 26. 4B1 demographic and exposure data on the Ex Order 26. 4B1 and Contact Tracing Tool, identifying the first day of symptoms, determining where the symptomatic individual visited and others who were in close contact with the Ex Order 26. 4B1 individual. The Ex Order 26. 4B1 was to be completed for staff and residents, included the Ex Order 26. 4B1 individual's date of symptom onset, assignment for staff, room number for resident, potentially exposed individuals, if they were in close contact, for how long, and PPE (personal protective equipment, clothing or equipment worn to protect the person from infection) used during contacts.

On 1/4/23 at 1:05 PM, Surveyor #1 and Surveyor #2 interviewed the IP and the DON about the process of testing residents and staff, after a

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F 835	Continued From page 78 positive case. The IP stated testing should be twice a week, Ex Order 26. 4B1 results are logged in the computer's "Ex Order 26. 4B1" and there was a surveillance log in which results were written for staff testing. The IP stated there was no log for residents, positive results were found on the resident's medical record, and was not sure where negative results would be documented. The DON stated resident testing, whether positive or negative results, should be documented in the electronic medical record's progress notes. The surveyor requested from the DON and IP documentation of any resident testing conducted. On 1/4/23 at 1:55 PM, Surveyor #1 interviewed the IP about the two Ex Order 26. 4B1 residents in the facility. The IP stated the two residents were tested because they had symptoms. The IP stated she would check and provide information on contact tracing and resident testing. A review of the progress notes provided by the IP revealed that Resident #235 had NJ Exec. Order 26:4.b.1 , and tested Ex Order 26. 4B1 on Ex Order 26. 4B1, and Resident #33 had a NJ Exec. Order 26:4.b.1 and tested Ex Order 26. 4B1 on Ex Order 26. 4B1. During a follow-up interview with Surveyor #2 on 1/5/23 at 10:58 AM and 12:03 PM, the IP stated there was no process in place to ensure resident testing was done. The IP stated contact tracing should have been done for Ex Order 26. 4B1 residents and testing of residents in contact but was not done. The surveyor asked for the contact information of the LHD, and the IP handed an email address to the surveyor and stated that she did not have a phone number for the LHD and had not notified the LHD of any of the positive	F 835		

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F 835	Continued From page 79	F 835		

cases. She stated after the former DON left the facility, she was "pulled into so many directions" and was following the direction and guidance of the Administrator.

On 1/11/23 at 9:35 AM, the surveyor interviewed the DON who provided the infection control policy. The policies for isolation precautions, PPE, Infection Surveillance, outbreak investigations, and antibiotic stewardship had a review date of 7/2021. The DON stated she could not find the policy reviewed for the year 2022 and that the infection control policy was reviewed and approved in January 2023. The DON provided policies with an Annual Review page signed by the DON, Administrator, IP, and Medical Director, dated 1/9/2023.

During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated that the former DON had left without notice in November and the IP had "a solid week of training" and spent a day with the Quality Assurance Consultant. She stated when the DON left, she had assigned the IP to be a Unit Manager on one of the units for oversight and she (the IP) should have been "juggling everything." The Administrator stated she would let the IP know if something needed to be addressed and the IP was responsible for in-services, following up with tracking of covid positive residents, ensuring testing was being done, completing surveillance after a positive case, and checking the residents on the assignment after a positive staff case. The Administrator stated she could not recall a positive staff case on Ex Order 26. 4B1. The surveyor informed the Administrator of RN #1, Ex Order 26. 4B1 [redacted], and contact tracing concerns. The Administrator stated after a Ex Order 26. 4B1 [redacted]

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F 835	Continued From page 80 case, it was expected for the residents to be tested for Ex Order 26. 4B1 and that staff was instructed not to come in to work when NJ Exec. Order 26:4.b. to test before starting their shift. The Administrator further stated the LHD should have been notified after the first Ex Order 26. 4B1 case and that the IP had a contact in the LHD but was not sure who. The Administrator acknowledged the facility's infection control policies and procedures should be reviewed annually and could not recall if the policy was reviewed in 2022. The Administrator stated the DON and herself were responsible for ensuring policies were reviewed. The Administrator stated she was not aware that there was no line list and that there was no contact with the LHD. The Administrator stated she assumed the IP was doing what she was supposed to do and was not following up with her. She stated there was no team meeting held to discuss RN #1 testing Ex Order 26. 4B1 on Ex Order 26. 4B1. The Administrator stated that she and the DON would be responsible for ensuring the IP was carrying out her responsibilities. During an interview with Surveyor #1 on 1/13/23 at 8:45 AM, the Human Resource Director confirmed that the last day of the prior DON was on Ex Order 26. 4B1. The surveyor reviewed the IP's competency checklist, a twelve page document, titled "Infection Preventionist Orientation Plan and Skills Competency Checklist" which was dated Ex Order 26. 4B1. Review of the checklist revealed 84 out of 92 tasks were not completed. A review of the Job Description provided for the IP with a date of hire of Ex Order 26. 4B1 did not indicate	F 835		

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F 835	Continued From page 81 her role and responsibilities as an IP. A review of an undated facility's policy titled "Outbreak Plan" included the following: Under Testing, Refusal of Testing & Isolation/Cohorting, it read "ProMedica Piscataway will continue to test healthcare personnel and residents for Covid-19 in accordance with CDC, CMS, and LHD guidelines."; Under Reporting Requirements, it read "Any resident or staff suspected or diagnosed according to State-specific criteria shall be promptly reported to appropriate local and/or state health department officials, included but not limited to NHSN". The policies provided did not further address COVID-19 surveillance. A review of the facility's policy titled "COVID-19 Clinical Monitoring and Measures Plan", dated 10/10/22, indicated that when any employee tests positive or a resident (who was not previously being cared for in transmission based precautions [TBP]) tests positive for COVID-19, enhanced measures should be implemented. Enhanced measures included but were not limited to, a Screening UDA (User Defined Assessment) consisting of vital signs every shift for residents in the affected unit (where a resident tested positive or positive employee worked), identifying potential staff, visitor, and other resident prolonged exposure, notification to local department of health of any positive COVID-19 test results, and to refer to CDC Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures to determine status of employee. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 09/23/22, included but was not limited to the definition of "Close	F 835		

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F 835	Continued From page 82 contact " refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing revealed that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. A review of CDC guidance "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2", revised 9/23/22, indicated if healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the	F 835		

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F 835	Continued From page 83 facility and ability to identify close contacts. The guidance further indicated the following: A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed; The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission; Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status; Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5	F 835		
F 880 SS=L	NJAC 8:39- 19.1(a); 19.2(a)(c),8:39-27.1(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		3/1/23

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F 880	Continued From page 84 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 85 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure: 1.) immediate action was taken to initiate contact tracing upon the identification of a Ex Order 26. 4B1 [redacted] staff member, Registered Nurse #1 (RN #1), who was symptomatic and provided care to 9 residents on 1 of 2 units and tested Ex Order 26. 4B1 [redacted] while at work on NJ Exec. Order 26:4.b.1 2) conduct contact tracing to identify residents and staff who had close contact with symptomatic *Ex Order 26. 4B1* residents (Resident #33 and #235) 3.) *Ex Order 26. 4B1* [redacted] were completed for the residents, 4.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and 5.) the facility's Outbreak Plan and *Ex Order 26. 4B1* were followed to prevent exposure and mitigate the spread of *Ex Order 26. 4B1* [redacted].	F 880	F880 Infection Control Element #1 Corrective Actions Part A ¿ The immediate jeopardy removal plan was submitted, accepted, and implemented. The removal plan was accepted and verified as implemented during an onsite visit by the New Jersey Department of Health (NJDOH) surveyors on January 6, 2023. ¿ Contact tracing was immediately completed and documented for RN #1 and all close contacts and Ex Order 26. 4B1 [redacted] completed. The Director of Nursing (DON) counseled and re-educated RN #1 that tested Ex Order 26. 4B1 about employee health guidelines and the process to report symptoms prior to the shift via phone. ¿ Contact tracing was immediately completed and documented for Residents	

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F 880	Continued From page 86 The facility's system-wide failure to immediately conduct contact tracing upon the identification of Ex Order 26. 4B1 staff and residents to prevent the spread of Ex Order 26. 4B1 , posed a serious and immediate risk to the health and well-being of all staff and residents for contracting Ex Order 26. 4B1. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 1/5/23 at 3:35 PM. The removal plan was accepted and verified as implemented by the survey team during an onsite visit conducted on 1/6/23. The IJ situation began on Ex Order 26. 4B1 at 7:00 PM, when RN #1 reported to work NJ Exec. Order 26:4.b.1 , proceeded to provide care for 9 residents in 1 of 2 resident units, and tested Ex Order 26. 4B1 on Ex Order 26. 4B1 at 10:00 PM. The Infection Preventionist (IP) stated that the contact tracing policy was never initiated for the 9 residents on the RN's assignment. Three residents on the RN's assignment were Ex Order 26. 4B1 and had a diagnosis of Ex Order 26. 4B1 . 1 of the 3 immunocompromised residents was not Ex Order 26. 4B1 . Three additional residents were not Ex Order 26. 4B1 . Additionally, two symptomatic residents tested	F 880	#33 and #235 and all close contacts and Ex Order 26. 4B1 completed. ¿ COVID -19 surveillance assessments are completed for Center residents using the COVID 19 clinical monitoring tool. ¿ Visitor screening and education was immediately implemented. ¿ Signage was placed as appropriate on entry to the Center and on Resident room doors of positive and/or exposed residents regarding transmission based precautions and the use of PPE. ¿ The Center COVID 19 Outbreak plan will be reviewed by the Infection Control Preventionist consultant to comply with COVID19 federal, state, and local regulations and guidance. ¿ An ICAR assessment will be completed by the Infection Control Preventionist consultant and reviewed with nursing management and the Administrator. ¿ Registered Nurse #1 and Residents #33 and #235 who tested Ex Order 26. 4B1 were placed on isolation, and the cases were reported to the local and state health departments for the Ex Order 26. 4B1 beginning on Ex Order 26. 4B1. - Ex Order 26. 4B1 testing was initiated and completed on Ex Order 26. 4B1. Contact tracing and Line listing was updated and sent to the local department of health Part B ¿ COVID19 signage was placed on the main entry doors to the Center. ¿ The Center front desk receptionist	

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F 880	Continued From page 87 positive in the facility on Ex Order 26. 4B1 . There was no contact tracing or subsequent resident testing performed. There were no consistent Ex Order 26. 4B1 [redacted] completed for the residents. The IP stated that she did not have a line list or notify the local health department of the positive cases. There was no screening or education provided to visitors entering the facility. The IP stated she was following the direction and guidance of the Administrator. This deficient practice was evidenced by the following: Refer to F 886L Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 9/23/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. Reference: Centers for Disease Control and Prevention (CDC) guidance, "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2", revised 9/23/22. During the entrance conference on 1/3/23 at 11:00 AM, the Infection Preventionist (IP), along with the Director of Nursing (DON), informed the surveyors there were two Ex Order 26. 4B1 residents (Resident #33 and Resident #235) in the facility on the NJ Exec. Order 26:4 r unit. The IP stated she started working in the facility in NJ Exec. Order 26:4.b.1 and	F 880	was counseled and re-educated about the proper use of PPE, COVID19 screening of visitors, and visible signage regarding PPE and COVID19 education information was placed at the reception desk. ¿ The Infection Control Preventionist consultant will provide re-education to the Administrator and management team regarding contact tracing, COVID19 testing and surveillance monitoring and assessment in accordance with local, state, and federal regulations and guidance to mitigate the spread of COVID19. - The Infection control Preventionist consultant reviewed the centers annual facility's infection control and infection prevention plan and polices on 2/12/23 Handwashing competencies and hand hygiene re-education will be completed for the dietary Services Director, the dietary staff to ensure compliance with sanitation. The Current center CNAs were re-educated about hand hygiene between resident rooms during the meal pass. A hand hygiene competency was completed. Current CNAs received re-education about providing residents with hand hygiene prior to serving their meals. LPN #2 was reeducated about completing hand hygiene prior to entering the medication cart and preparing resident medications for administration. A hand hygiene competency was completed. Element #2 ¿ All residents have the potential to be	

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F 880	Continued From page 88 was responsible for staff development and infection control. The IP stated that the Administrator was currently on vacation. On 1/4/23 at 9:18 AM, Surveyor #2 asked the DON for the facility line list. The DON stated that there was no line list and that it had not been done since the prior DON had left. She stated she had started at the facility in NJ Exec. Order 26:4.b.1 and was not aware there was not a line list until yesterday (Ex Order 26. 4B1). On 1/4/23 at 10:00 AM, Surveyor #1 reviewed the facility's Ex Order 26. 4B1 titled "COVID-19 Employee Detail", which revealed RN #1 was Ex Order 26. 4B1 on Ex Order 26. 4B1. An additional review revealed that the onset of symptoms was on Ex Order 26. 4B1 and the last day RN #1 worked was Ex Order 26. 4B1. During an interview with Surveyor #1 and Surveyor #2 on 1/4/23 at 11:05 AM, the IP, in the presence of the DON, stated the facility's infection control practice was based on the infection control manual and facility policies based on corporate, CDC guidelines and guidance from the Local Health Department (LHD). The IP stated COVID-19 testing was conducted twice a week and in between that time if someone was symptomatic. The IP stated the residents and staff were tested twice a week on Mondays and Thursdays. Surveyor #1 reviewed the Ex Order 26. 4B1 that included RN #1 with the DON and IP. The DON stated RN #1 tested Ex Order 26. 4B1 at work on Ex Order 26. 4B1 and had NJ Exec. Order 26:4.b.1 that included NJ Exec. Order 26:4.b.1, for a	F 880	affected by this practice. Element #3 Part A ¿ The Director of Nursing (DON) re-educated the infection preventionist (IP), and Licensed Nurses on utilization of the Contact tracing worksheet and testing criteria after a resident or staff tests positive for COVID-19. ¿ The Director of Nursing re-educated staff about employee health guidelines to report symptoms of illness prior to starting shift via phone. ¿ Licensed nurses will be re-educated about completion of COVID-19 surveillance assessments for the residents. ¿ The Interdisciplinary team and receptionists were re-educated about the Center's screening process upon entry to the Center. Part B ¿ The eleven infection control directed in-services are being completed for topline, frontline, and all staff as outlined in the Initial Notice letter DPOC and proof of completion posted on ePOC and emailed as required to NJDOH. Hand hygiene re education and competency were completed for nursing and dietary staff. Element #4 ¿ Infection Control Preventionist consultant or designee will complete random hand hygiene observations of 5 employees weekly x 4 and monthly x 2.	

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F 880	Continued From page 89 couple of days before. The DON stated RN #1 did not work on Ex Order 26. 4B1 and worked on Ex Order 26. 4B1 for the 7 pm to 7 am shift on the NJ Exec. Order 26:4.b.1 unit. The DON further stated RN #1 should not have come NJ Exec. Order 26:4.b.1 and should have tested before her shift. The DON stated she did not do contact tracing and would have to check the documentation for residents tested. The surveyor asked the IP about the line list (a table that contains key information about each case in an outbreak) for Ex Order 26. 4B1 in the facility. The IP stated she was new, and did not have access to everything, and was not sure of the line list. The IP confirmed the line list was not completed and was following up with the LHD about it. The IP stated the previous DON was completing the line list and was not sure of the date the previous DON had left. Surveyor #2 requested the contact information for RN #1, timecards, and residents assigned to RN #1 on Ex Order 26. 4B1. During a telephone interview with Surveyor #1 On 1/4/23 at 11:57 AM, RN #1 stated she started NJ Exec. Order 26:4.b.1 on Ex Order 26. 4B1 and called NJ Exec. Order 26: to the Registered Nurse Supervisor (RNS) on Ex Order 26. 4B1 . RN #1 stated she was NJ Exec. Order 26:4.b.1 " She stated the RNS stated, "ok" and did not ask any further questions. RN #1 stated it was "holiday time" and "if you call out before the holiday, you don't get time and a half". RN #1 stated she went back to work on Ex Order 26. 4B1 and thought she was ok since she called her primary doctor who gave her NJ Exec. Order 26:4.b.1, and she also took Ex Order 26. 4B1. RN #1 stated she still had a	F 880	Findings will be reported by the Director of Nursing at the quarterly QAPI committee meeting for review and further action as appropriate. ¿ Director of Nursing or designee will audit to validate contact tracing and COVID-19 surveillance testing is completed upon identification of a new resident or staff positive case. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will be reported by the DON at the quarterly QAPI committee meeting for review and further action as appropriate. ¿ Director of Nursing or designee will audit to validate any new resident or staff COVID-19 positive case is reported to the Department of health utilizing the state required line list. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will be reported by the Director of nursing or designee at the quarterly QAPI committee meeting for review and further action as appropriate. ¿ Director of Nursing or designee will audit to validate respiratory surveillance assessments are completed on residents who are symptomatic or identified as close contacts. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will	

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F 880	Continued From page 90 NJ Exec. Order 26:4.b.1 when she went to work. RN #1 said she received report from the outgoing nurse, checked on her residents, and did her first medication administration pass before testing herself at 10:00 PM and tested *Ex Order 26. 4B1*. The surveyor asked if she had told anyone that she was not NJ Exec. Order 26:4.b.1 or about her symptoms on Ex Order 26. 4B1. RN #1 stated, "Who was I gonna tell...there was no one ...only nurses" and she had called the DON at 10:00 PM after testing Ex Order 26. 4B1. RN#1 stated the DON told her that she had to go home and could not work as she tested *Ex Order 26. 4B1*. RN #1 said she gave report to the other nurse and went home. The surveyor asked RN #1 why she tested herself at 10:00 PM and not before that time. RN #1 replied that the outgoing nurses wanted to give report to go home, and she did not want to keep them waiting. RN #1 stated that no one from the facility had called her to ask about contact tracing including residents she had contact with. RN #1 stated she had education about Ex Order 26. 4B1 in 2020 and 2021 and acknowledged that the facility had stated if a staff member had symptoms or was Ex Order 26. 4B1 that the staff member should not come to work. On 1/4/23 at 11:54 AM, the IP provided the surveyor RN#1's timecard which revealed RN #1 worked on Saturday Ex Order 26. 4B1, clocked in at 7:00 PM, and clocked out at 10:45 PM. On 1/4/23 at 12:38 PM, the IP provided Surveyor #2 with the assignment of RN #1 on Ex Order 26. 4B1, which included 9 residents (Resident #236, #69, #239, #47, # 80, #63, #240, #238 and #52). The IP stated that the residents who were exposed	F 880	be reported by the Director of nursing or designee at the quarterly QAPI committee meeting for review and further action as appropriate. Completion Date: March 1, 2023	

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F 880	Continued From page 91	F 880		

were not tested and there was no documentation that the residents were tested. The IP stated she was new in training, but that she was responsible to ensure they were doing the correct thing and the residents should have been tested. Additionally, the IP stated that the contact tracing policy was not initiated.

A review of the medical records for the 9 residents that were assigned to RN #1 on Ex Order 26. 4B1, included three Ex Order 26. 4B1 residents:

Resident #236 who had a diagnosis that included Ex Order 26. 4B1 ;

Resident #240 who had a diagnosis that included Ex Order 26. 4B1 ;

and Resident #238, who had a diagnosis that included Ex Order 26. 4B1.

Four of the residents (Resident #236, #69, #239, and #47) were NJ Exec. Order 26:4.b.1 and 5 residents (Resident # 80, #63, #240, #238, and #52) were Ex Order 26. 4B1 according to the facility's resident Ex Order 26. 4B1 .

The Ex Order 26. 4B1 and progress notes relating to Ex Order 26. 4B1 and monitoring for the 9 residents' electronic medical records were not consistent and were not completed every shift as per the facility's "COVID-19 Clinical Monitoring and Measures Plan" policy. The policy indicated a Screening UDA [User Defined Assessment] which included vital signs was to be completed every shift for residents in the affected unit (where a resident

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PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

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F 880	Continued From page 92 tested positive or positive employee worked). On 1/4/23 at 12:53 PM, the IP provided Surveyor #2 a copy of the facility's "Contact Tracing Worksheet", dated Ex Order 26. 4B1, and "COVID-19 Outbreak and Contact Tracing Tool", dated Ex Order 26. 4B1. The IP confirmed this was not initiated after positive staff and resident cases in the facility. The Contact Tracing Worksheet indicated the process for contract tracing when a Ex Order 26. 4B1 was identified, which included recording Ex Order 26. 4B1 and exposure data on the Ex Order 26. 4B1, identifying the first day of symptoms, determining where the symptomatic individual visited and others who were in close contact with the Ex Order 26. 4B1 individual. The Ex Order 26. 4B1 tool was to be completed for staff and residents, included the Ex Order 26. 4B1 individual's date of symptom onset, assignment for staff, room number for resident, potentially exposed individuals, if they were in close contact, for how long, and PPE used during contacts. On 1/4/23 at 1:05 PM, Surveyor #1 and Surveyor #2 interviewed the IP and the DON about the process of testing residents and staff, after a positive case. The IP stated testing should be twice a week, Ex Order 26. 4B1 results are logged in the computer's "Ex Order 26. 4B1" and there was a surveillance log in which results were written for staff testing. The IP stated there was no log for residents, positive results were found on the resident's medical record, and was not sure where negative results would be documented. The DON stated resident testing, whether positive or negative results, should be documented in the electronic medical record's progress notes.	F 880		

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F 880	Continued From page 93 Surveyor #1 requested from the DON and IP documentation of any resident testing conducted. On 1/4/23 at 1:55 PM, Surveyor #1 interviewed the IP about the two *Ex Order 26. 4B1* residents in the facility. The IP stated the two residents were tested because they had symptoms. The IP stated she would check and provide information on contact tracing and resident testing. A review of the progress notes provided by the IP revealed that Resident #235 had NJ Exec. Order 26:4.b.1 and tested *Ex Order 26. 4B1* on Ex Order 26. 4B1, and Resident #33 had a NJ Exec. Order 26:4.b.1 with NJ Exec. Order 26:4.b.1 and tested *Ex Order 26. 4B1* on Ex Order 26. 4B1. During an interview with Surveyor #1 on 1/5/23 at 10:42 AM, the RNS stated if someone said they were NJ Exec. Order 26:4.b.1 or NJ Exec. Order 26:4.b.1, she would ask about their symptoms, how long, and when they last worked. The RNS could not recall if she received any callouts when working on Ex Order 26. 4B1. The surveyor asked the RNS if she was aware of a *Ex Order 26. 4B1* staff case on Ex Order 26. 4B1. The RNS stated she knew they had a case but does not know who it was. The RNS stated there was a schedule logbook where callouts are written. During a follow-up interview with Surveyor #2 on 1/5/23 at 10:58 AM and 12:03 PM, the IP stated there was no process in place to ensure resident testing was done. The IP stated contact tracing should have been done for *Ex Order 26. 4B1* residents and testing of residents in close contact but was not done. The surveyor asked for the contact information of the LHD, and the IP handed an email address to the surveyor and	F 880		

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stated that she did not have a phone number for the LHD and had not notified the LHD of any of the positive cases. She stated after the former DON left the facility, she was "pulled into so many directions" and was following the direction and guidance of the Administrator.

On 1/5/23 at 1:30 PM, the DON provided Surveyor #1 with the call-out log for December 2022. The call-out log was in calendar format, which included the employee's name written on the day the employee called out. RN #1's name was documented on the December 2022 call-out log for Ex Order 26. 4B1 . There was no further information documented on the call-out log.

During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated that the former DON had left without notice in November and the IP had "a solid week of training" and spent a day with the Quality Assurance Consultant. She stated when the DON left, she had assigned the IP to be a Unit Manager on one of the units for oversight and she (the IP) should have been "juggling everything." The Administrator stated she would let the IP know if something needed to be addressed and the IP was responsible for in-services, following up with tracking of covid positive residents, ensuring testing was being done, completing surveillance after a positive case, and checking the residents on the assignment after a positive staff case. The Administrator stated she could not recall a Ex Order 26. 4B1 staff case on Ex Order 26. 4B1 . The surveyor informed the Administrator of RN #1, Ex Order 26. 4B1 , and contact tracing concerns. The Administrator stated after a Ex Order 26. 4B1 , it was expected for the residents to be

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tested for Ex Order 26. 4B1 and that staff was instructed not to come in to work when sick and to test before starting their shift. The Administrator further stated the LHD should have been notified after the first *Ex Order 26. 4B1* and that the IP had a contact in the LHD but was not sure who.

The Administrator stated she was not aware that there was no line list and that there was no contact with the LHD. The Administrator stated she assumed the IP was doing what she was supposed to do and was not following up with her. She stated there was no team meeting held to discuss RN #1 testing Ex Order 26. 4B1 on Ex Order 26. 4B1. The Administrator stated that she and the DON were responsible for ensuring the IP was carrying out her responsibilities.

During an interview with Surveyor #1 and Surveyor #2 on 1/13/23 at 9:13 am, the Medical Director, stated he was made aware of the *Ex Order 26. 4B1*. The Medical Director stated that the facility followed CDC and CMS guidelines for policies and was unaware they were not being followed. The Medical Director stated he was always made aware of positive *Ex Order 26. 4B1* in the facility and testing of residents should be based on contact tracing.

The surveyor reviewed the IP's competency checklist, a twelve page document, titled "Infection Preventionist Orientation Plan and Skills Competency Checklist" which was dated Ex Order 26. 4B1. Review of the checklist revealed 84 out of 92 tasks were not completed.

A review of the Job Description provided for the

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F 880	Continued From page 96 IP with a date of hire of [redacted], did not indicate her role and responsibilities as an IP. A review of an undated facility's policy titled "Outbreak Plan" included the following: Under Testing, Refusal of Testing & Isolation/Cohorting, it read "ProMedica Piscataway will continue to test healthcare personnel and residents for Covid-19 in accordance with CDC, CMS, and LHD guidelines."; Under Reporting Requirements, it read "Any resident or staff suspected or diagnosed according to State-specific criteria shall be promptly reported to appropriate local and/or state health department officials, included but not limited to NHSN". The policies provided did not further address COVID-19 surveillance. A review of the facility's policy "Infection Control Manual", 07/10/2021 included the following: Under Surveillance, Section 4: Outbreak Investigations read, "An epidemic or outbreak is an excess over the expected or usual level of a disease within a geographic area. One case may constitute an epidemic and warrant an outbreak investigation ...The Infection Preventionist or DON, under the direction of the Medical Director, manages an outbreak investigation". Under Outbreak Strategies, it read "Upon identification of a potential outbreak, conduct an outbreak investigation. The objectives of any outbreak investigation are to describe the situation (what is happening), determine the etiology (where did the infection start), what is the agent, where is the source and what is the method of spread. It is important to identify the incubation period (interval between exposure and onset of symptoms)." A review of the facility's policy titled "COVID-19 Clinical Monitoring and Measures Plan", dated	F 880		

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F 880	Continued From page 97 10/10/22, indicated that when any employee tests positive or a resident (who was not previously being cared for in transmission based precautions [TBP]) tests positive for COVID-19, enhanced measures should be implemented. Enhanced measures included but were not limited to, a Screening UDA [User Defined Assessment] consisting of vital signs every shift for residents in the affected unit (where a resident tested positive or positive employee worked), identifying potential staff, visitor, and other resident prolonged exposure, notification to local department of health of any positive COVID-19 test results, and to refer to CDC Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures to determine status of employee. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 09/23/22, included but was not limited to the definition of "Close contact " refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed that upon identification of a single new case of COVID-19 infection in any staff or residents,	F 880		

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F 880	Continued From page 98 testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing revealed that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. A review of CDC guidance "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2", revised 9/23/22, indicated if healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. The guidance further indicated the following: A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed; The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission; Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status; Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if	F 880		

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negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.

Part B

F880 remains a deficiency at a scope and severity of an F based on the following:

Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to: 1) conduct screening or education for visitors entering the facility, 2) review annually the facility's infection control and infection prevention plan and policies, and 3) maintain proper infection control practices identified during the: a) tour of the kitchen b) dining observation, and c) medication administration observation identified on 1 of 2 Nursing Units (Second Floor), and for 1 of 2 nurses (Licensed Practical Nurse #2) observed during the medication pass.

This deficient practice was evidenced by the following:

1) On 1/3/23 at 9:05 AM, six surveyors entered the facility and were greeted by the front desk receptionist, who was not wearing a mask. The receptionist after greeting the surveyor applied a surgical mask. The receptionist instructed the surveyors to sign in with their names and date. There was no [redacted]. Surveyor #2 interviewed the receptionist about the process of visitor check-in. The receptionist stated visitors sign in who they are visiting, they do not check temperatures anymore, and was not

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F 880	Continued From page 100 sure if there were Ex Order 26. 4B1 residents in the facility. The receptionist stated there was no Ex Order 26. 4B1 of visitors since November 2022. The receptionist further stated previously they would check temperatures and had a form for visitors to fill out. There was a sign on the reception desk for all visitors to always wear a mask in the facility. There was no Ex Order 26. 4B1 observed by the main entrance or reception area. On 1/3/23 at 10:29 AM, Surveyor #2 used the elevator, where there was signage observed for visitors about Ex Order 26. 4B1, signs and symptoms, and signage that indicated a mask and face shield was required for the 2nd and 3rd-floor units. Signs were also observed in front of the elevators for visitors about Ex Order 26. 4B1, its signs and symptoms, and a small sign was noted behind the reception area that was not visible. On 1/4/23 at 8:59 AM, the surveyors entered the facility, there were no visible signs posted about Ex Order 26. 4B1 by the main entrance. On 1/4/23 at 11:05 AM, Surveyors #1 and #2 interviewed the infection preventionist (IP) and the Director of Nursing (DON) about visitor education and screening. The IP stated they did not conduct visitor screening since before she started working there and that the facility cannot close to visitors. The surveyor asked about any Ex Order 26. 4B1 for visitors. The IP stated signs were posted, though she was not sure if any were posted by the main entrance. On 1/4/23 at 11:50 AM, Surveyor #3 interviewed Guest Services/Recreation Director about visitor screening, who stated there used to be a	F 880		

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F 880	Continued From page 101 Visitors/Staff Attestation. The Visitor/Staff had their temperature taken, they answered questions about *Ex Order 26. 4B1* and then the second form had contact information and verified that the person was aware that the building had *Ex Order 26. 4B1* residents. The Guest Services/Recreation Director stated the Administrator informed the staff in November they would not be using *Ex Order 26. 4B1* forms and that she sent out an email to staff on *Ex Order 26. 4B1*. A copy of the email was provided to the surveyor. During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated in November 2022, the policy of screening visitors changed based on a zoom meeting with the corporate level nurse who provided an update on CDC guidance. The Administrator further stated visitors were given masks and were informed of proper PPE (personal protective equipment, protective clothing or equipment used to protect the body from injury or infection) to use when coming into the facility. A review of an undated facility's policy titled "Outbreak Plan" included the following: Under Screening & Protective Measures, it read "Healthcare personnel and permitted visitors entering ProMedica Piscataway will be screened for COVID-19 illness"; Under Notification Plan, it read "Signage is posted at entrance doors to alert visitors to Covid-19". A review of the facility's "Infection Control Manual" policy with a revised date of 07/2021 included the following: Section 2: Precaution Systems, under Visitor Management, it read, "Visitor management is the control of access and actions of people	F 880		

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visiting for the safety and prevention of disease transmission". The policies provided did not further address COVID-19 visitor screening and education.

2) On 1/11/23 at 9:35 AM, the surveyor interviewed the DON who provided the infection control policy. The policies for isolation precautions, PPE, Infection Surveillance, outbreak investigations, and antibiotic stewardship had a review date of 7/2021. The DON stated she could not find the policy reviewed for the year 2022 and that the infection control policy was reviewed and approved in January 2023. The DON provided policies with an Annual Review page signed by the DON, Administrator, IP, and Medical Director, dated 1/9/2023.

During an interview with the surveyor on 1/11/23 at 10:05 AM the Administrator acknowledged the facility's policies and procedures should be reviewed annually and could not recall if the policy was reviewed in 2022. The Administrator stated the DON and herself were responsible for ensuring policies were reviewed.

During an interview with the surveyor on 1/13/23 at 9:13 AM, the Medical Director stated he was not sure exactly, but believed the policies were reviewed at the last QAPI meeting in December. The surveyor informed the Medical Director that the DON and the Administrator could not find an annual infection control policy review for 2022. The Medical Director provided no direct response and further stated the interdisciplinary team discussed protocols in morning meetings.

3) On 01/03/23 at 9:52 AM, during the initial tour

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of the kitchen, the surveyor observed the Dining Services Director (DSD) who touched the lid of a trash can with her bare hands as she attempted to open the lid after the foot pedal feature malfunctioned. The DSD then proceeded to wash her hands for 14 seconds before she began the tour of the kitchen.

During an interview with the surveyor on 01/04/23 at 8:40 AM, the DSD stated that when she washed her hands yesterday in the presence of the surveyor, she sang the happy birthday song once to ensure that she washed her hands for what she thought was the appropriate length of time of 20 seconds. The DSD further stated that if she did not wash her hands for at least 20 seconds prior to the tour of the kitchen there was a concern of contamination.

During an interview with the surveyor on 01/11/23 at 10:46 AM, the Administrator stated that if the DSD had not washed her hands for at least 20 seconds prior to the tour of the kitchen, "She could have passed germs onto the food and all around the kitchen."

During an interview with the surveyor on 01/12/23 at 11:35 AM, the Infection Preventionist (IP) stated that the DSD should have washed her hands for 20 seconds prior to the tour of the kitchen to prevent the spread of infectious agents or bacteria.

On 01/12/23 at 12:25 PM, during a follow-up visit to the kitchen, the surveyor observed Dietary Aide (DA #1) who washed her hands for 32 seconds at the handwashing sink, left the water running in the sink, dried her hands on a paper towel, removed her hair net, and replaced it with a larger

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one that provided full coverage, as the one she wore only covered her ponytail, and not the front or top of her head. DA #1 then proceeded to turn off the faucet with her bare hands. When interviewed at that time, DA #1 stated that she knew that she should have used a paper towel to turn off the faucet, but she had forgotten to. The DSD who was present stated that there was a potential for contamination since DA #1 touched her hair, then touched the faucet with her bare hands. The DSD stated that DA #1's responsibilities included plating food on the food service line, which was in process during the time of the observation.

During an interview with the surveyor on 01/13/23 at 9:46 AM, the IP stated that DA #1 should have used a paper towel to turn off the faucet after she washed her hands because she re-contaminated her hands and that could have transferred to the faucet which had a potential for the spread of infection.

4) On 01/03/23 at 12:10 PM, the surveyor observed that a Dietary Aid (DA) delivered the food truck to Hall A of the Second Floor Nursing Station and proceeded to leave the unit.

At 12:11 PM, the surveyor observed Certified Nursing Assistant (CNA #4) as she approached the food truck and removed the first meal tray without first performing hand hygiene before she delivered the tray to Unsampled Resident #1. The resident requested a plastic cup. CNA #4 returned to the food truck, obtained a plastic cup, and provided it to the resident as requested. CNA #4 then exited the resident's room without first performing hand hygiene.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

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F 880	Continued From page 105 At 12:12 PM, the surveyor observed CNA #4 as she approached the food truck and reviewed Unsampled Resident #2's meal ticket before she poured coffee from a carafe into a coffee cup and placed it on the resident's tray. CNA #4 then proceeded to deliver the meal tray to the resident without first performing hand hygiene. The surveyor observed that CNA #4 did not offer to assist the resident with hand hygiene prior to the meal service. CNA #4 then exited the resident's room without first performing hand hygiene. At 12:13 PM, the surveyor observed CNA #4 who removed Unsampled Resident #3's tray from the food truck without first performing hand hygiene. The resident was asleep when she entered the room and she attempted to wake the resident by calling the resident's name without success. CNA #4 left the tray at the bedside and exited the resident's room without first performing hand hygiene. At 12:15 PM, the surveyor observed CNA #4 who removed Unsampled Resident #4's tray from the food truck without first performing hand hygiene and delivered it to the resident. CNA #4 offered the resident assistance and opened items on the tray. CNA #4 failed to offer the resident assistance to perform hand hygiene. CNA #4 exited the resident's room without first performing hand hygiene. At 12:15 PM, CNA #4 removed Unsampled Resident #5's tray from the food truck without first performing hand hygiene. CNA #4 delivered the tray to theresident's room and placed the meal tray on the resident's counter. CNA #4 then informed the resident that she would return to offer meal assistance. CNA #4 exited the	F 880		

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F 880	Continued From page 106 resident's room without first performing hand hygiene. At 12:17 PM, the surveyor observed CNA #4 as she entered the nurse's station and phoned the kitchen to report a missing meal tray. At 12:18 PM, the surveyor interviewed Unsampled Resident #1 who stated that he/she was not helped with hand hygiene prior to meal service. The resident further stated that he/she used their own personal hand sanitizer prior to the meal. At 12:23 PM, the surveyor interviewed Unsampled Resident #2 who stated that he/she washed up in the morning but was not helped with hand hygiene prior to meal service. The surveyor did not see hand wipes or hand sanitizer on the resident's tray or within the resident's reach within the room. At 12:27 PM, the surveyor interviewed CNA #4, who stated that she did not offer the residents assistance with hand hygiene prior to the meal because the residents had their own wipes. CNA #4 further stated that she did not perform hand hygiene prior to meal delivery or upon exiting the resident's rooms because there was no hand sanitizer in the halls or within the resident's rooms. CNA #4 stated that she would have to wash her hands in the resident's room and acknowledged that she did not do that today. CNA #4 stated that she washed her hands after she called the kitchen and before she went down to the kitchen to pick up a missing meal tray. CNA #4 stated that she worked at the facility for a couple of months and did not know that she was required to perform hand hygiene between	F 880		

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F 880	Continued From page 107 residents during the meal pass. CNA #4 further explained that she did not offer Unsampled Resident #2 assistance with hand hygiene prior to meal service because the resident did not ask for assistance. During an interview with the surveyor on 01/11/23 at 10:56 AM, the Administrator stated that CNA #4 should have provided the residents with hand sanitizer to clean their hands prior to meal service. She further stated that CNA #4 should have also sanitized her hands between residents or, "she could have passed bugs to different people all day long." The Administrator explained that the residents could get sick if there was something on their hands while they ate. The Administrator stated that while there may not be hand sanitizer dispensers in the hallway, there were hand sanitizer dispensers in every resident room. During an interview with the surveyor on 01/11/23 at 12:25 PM, the surveyor interviewed Registered Nurse (RN #2) who stated that she worked at the facility for NJ Exec. Order 26:4.b.1 and confirmed that there were hand sanitizer dispensers in every resident room on the unit. RN #2 stated that CNA #4 was required to wash her hands prior to the meal service to prevent the spread of infection. RN #2 stated that CNA #4 should have also assisted the residents into the bathroom to wash their hands or offered them assistance to use the hand sanitizer dispensers that were positioned on the wall within the resident rooms. RN #2 stated that in order to prevent infection residents should have performed hand hygiene prior to meals. During an interview with the surveyor on 01/11/23 at 12:31 PM, CNA #4 clarified that while there	F 880		

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was no hand sanitizer in the hallways, there was hand sanitizer mounted on the wall within the resident rooms. CNA #4 stated, "I told you before, I normally washed my hands every couple of rooms."

During an interview with the surveyor on 01/13/23 at 9:39 AM, the Infection Preventionist (IP) stated that CNA #4 should have washed her hands prior to meal service and sanitized her hands prior to exiting the resident's room. The IP stated that there was a possibility of the spread of infection between residents if hand hygiene was not performed. The IP stated that the residents should have been offered hand wipes or assisted into the bathroom to do hand hygiene before meal service. The IP further stated, "Anything on the resident's hands could be put into their system and there was a potential for infection."

5) On 01/05/23 at 08:22 AM, the surveyor observed that there was a medication cart positioned outside of an Unsampled Resident's room on the Second Floor B Hall Nursing Unit. The surveyor observed Licensed Practical Nurse (LPN #2) who walked down the hallway from the direction of the nurse's station and presented to the medication cart. LPN #2 stated that she was an Agency Nurse and had only worked at the facility a couple of times prior on the eleven to seven shift. The surveyor observed that LPN #2 had not performed hand hygiene prior to accessing the computer keyboard, computer mouse, and medication cart as she reviewed the resident's medications and attempted to locate them. LPN #2 opened the top drawer of the cart, and the second and third drawers of the medication cart as she attempted to locate the resident's medications. LPN #2 poured three oral

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F 880	Continued From page 109	F 880		

medications into a medication cup before she proceeded to open a new bottle of *Ex Order 26. 4B1* [redacted], she removed the lid, and used a plastic utensil to remove the pill from the bottle and placed it into a medication cup. LPN #2 wrote the date on the bottle with a marker and returned the bottle to the top drawer of the medication cart. LPN #2 poured five additional oral medications before she opened a new bottle of *Ex Order 26. 4B1* [redacted], and she used her fingers to remove the foil that covered the opening of the sealed bottle of medication. LPN #2 proceeded to measure one scoop of the medication into the cap of the medication, dated the bottle with a marker, and mixed the medication into a plastic cup that contained water. LPN #2 obtained a straw and placed it into the cup.

The surveyor observed that LPN #2 did not perform hand hygiene before she picked up the medications, knocked on the resident's door, awoke the resident, and adjusted the bed control to raise the head of the resident's bed prior to medication administration.

At 9:04 AM, LPN #2 returned to the medication cart and used hand sanitizer to perform hand hygiene with the hand sanitizer that was present on top of the medication cart.

At 9:16 AM, in a later interview with LPN #2, she stated that she had washed her hands after she administered medications to the last resident prior to the medication observation. LPN #2 stated that she then went to the medication room to look for a medication that she was not able to find. LPN #2 alleged that she used hand sanitizer

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F 880	Continued From page 110	F 880		

to perform hand hygiene immediately prior to the medication pass with the hand sanitizer that was on top of the medication cart which was not observed by the surveyor. LPN #2 stated that there was a chance of contamination if hand hygiene was not performed before the medication pass after she touched the medication cart, computer keyboard, and computer mouse, and before she opened new bottles of medications. LPN #2 stated that she cleaned her cart and computer components prior to the start of her shift with bleach wipes which was not observed by the surveyor.

During an interview with the surveyor on 01/06/23 at 10:53 AM, the Licensed Practical Nurse/Charge Nurse (LPN/CN) #1 stated that hand hygiene should be performed prior to accessing the medication cart and prior to going to see the resident. LPN/CN #1 stated, "You should sanitize your hands after you have touched something because you do not know what is on your hands, and that is why handwashing is so important."

During an interview with the surveyor on 01/11/23 at 11:00 AM, the Administrator stated that LPN #2 should have first sanitized her hands prior to medication preparation. The Administrator stated that she could have potentially made somebody sick by touching things, then touching medications. The Administrator stated that there could have been germs on the new bottles of medications that were opened. The Administrator stated that LPN #2 picked up germs from the bed controls which could have been transferred to the resident when the medications were administered. The Administrator further stated that the first thing LPN #2 should have done was

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F 880	Continued From page 111 to have prepared the resident, washed her hands, and then administered the medications in a sanitary manner. During an interview with the surveyor on 01/12/23 at 11:38 AM, the Infection Preventionist (IP) stated that LPN #2 should have used hand sanitizer before she poured the medications and washed her hands before she entered the resident's room after she touched any surface in the resident's room, and before she exited the resident's room. The IP stated that there was a potential to spread an infectious agent and cross-contamination. A review of the facility policy titled, "Hand Hygiene" (Reviewed 8/19/22), revealed the following: The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to a patient, and from a staff member to a patient. Therefore, hand hygiene is the single most important procedure in preventing infection. To protect a patient from health care-associated infection, hand hygiene must be performed routinely and thoroughly...Washing with soap and water is appropriate when hands are visibly soiled or contaminated with blood or other body fluids, when exposure to potential spore-forming pathogens (such as Clostridioides difficile (C-diff, results from disruption of normal healthy bacteria in the colon, often from antibiotics, and spreads from person to person by spores and can be fatal)...is strongly suspected or proven, and after using the restroom. Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact; before putting on gloves;...after contact with a patient, (if the hands aren't visibly soiled); after removing gloves; and	F 880		

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F 880	Continued From page 112 after contact with inanimate objects in the patient's environment. The CDC (Centers for Disease Control) recommends performing hand hygiene with soap and water before eating, and the WHO (World Health Organization) recommends using either an alcohol-based hand rub or soap and water before preparing food and handling medication. Handwashing: With your arms angled down under the faucet, adjust the water temperature until it's comfortably warm but not hot. Wet your hands and wrists with warm water and apply soap from dispenser...Hold your hands below elbow level to prevent water from running up your arms and back down, thus contaminating clean areas. Work up a generous lather by vigorously rubbing your hands together for at least 20 seconds...Pay special attention to the areas under your fingernails and around your cuticles and your thumbs, knuckles, and sides of your fingers and hands, because microorganisms thrive in these protected or overlooked areas...Avoid touching the sink and faucet because they're considered contaminated. Rinse your hands and wrists well, because running water flushes away suds, soiled and microorganisms. Pat your hands and wrists dry with a paper towel. Avoid rubbing, which can cause abrasion and chapping...Turn of the faucets with a paper towel to avoid recontaminating your hands. Hand sanitizing: Apply alcohol-based hand rub to the palm of one hand and then rub your hands together, covering all surfaces of your hands. Continue rubbing your hands together until all of the product has dried (usually about 30 seconds)... Review of facility policy titled, "Medication Administration: Medication Pass" (06/21) revealed the following: Procedure: Perform hand	F 880		

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F 880	Continued From page 113 hygiene...prepare medications for administration...	F 880		
F 881 SS=D	NJAC 8:39-19.1, 19.2 (a)(c), 19.4 (a)(g) Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review of facility documentation, it was determined that the facility failed to implement their protocol to monitor and track resident antibiotic use for the month of *Ex Order 26. 4B1*. This deficient practice was identified for 1 of 1 resident (Resident #52) reviewed for NJ Exec. Order 26:4.b.1 and was evidenced by the following: On 1/9/23 at 9:10 AM, the surveyor asked the DON and IP to provide information on Antibiotic Stewardship tracking and surveillance. On 1/10/23 at 9:25 AM, the DON provided the surveyor with the facility's "Antibiotic Stewardship Report" (an automated report generated from the information entered about initial resident infection trends). A review of the provided Antibiotic Stewardship Report, dated 1/9/23, indicated the monthly data for antibiotic use and infections from	F 881	F881 □ NJ Exec. Order 26:4.b.1 Element #1 " Resident #52 no longer resides at the facility. Resident #52 received the correct NJ Exec. Order 26:4.b.1 and was discharged from the Center as planned. Element #2 " All residents have the potential to be affected by this practice. Element #3 " Licensed Nursing staff, the Director of Nursing and the Medical Director received re-education regarding tracking infections daily as required by the directed plan of correction as part of the Antibiotic Stewardship program. " The Center Infection Preventionist consultant reviewed the infection control surveillance and tracking tool and re-educated the licensed nurses regarding	3/1/23

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F 881	Continued From page 114 12/1/22 to 12/31/22. The report did not detail any further information regarding specific residents, type of organisms, diagnostic tests, treatments, or durations of antibiotics. The surveyor asked the DON to provide further information regarding their Antibiotic and Infection tracking. The surveyor reviewed the hybrid medical records of Resident #52 who was being reviewed for NJ Exec. Order 26:4.b.1 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated Ex Order 26. 4B1, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that that the resident was Ex Order 26. 4B1 [redacted]. The MDS assessment also indicated the resident had active diagnoses of Ex Order 26. 4B1 [redacted]. A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated Resident #52 had a physician order, dated Ex Order 26. 4B1, which read: Ex Order 26. 4B1 [redacted] Use 1 gram intravenously one time a day for Ex Order 26. 4B1 until Ex Order 26. 4B1". The eMAR also had a physician order entry, discontinued date on Ex Order 26. 4B1 that read: Ex Order 26. 4B1 [redacted] Use 1 gram intravenously one time a day for Ex Order 26. 4B1 until Ex Order 26. 4B1".	F 881	use of the tool and communicating results daily to the DON. " The Center Infection Preventionist consultant is reviewed the antibiotic stewardship program with nursing management and the Center ICP to ensure compliance with regulations and standards of practice. Element #4 " Director of Nursing/designee will audit five residents with orders for antibiotics to validate antibiotic stewardship program has been followed weekly for 4 weeks, then monthly for 3 months. Findings will be analyzed by the DON and reported quarterly to the QAPI committee.	

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F 881	Continued From page 115 On 1/10/23 at 9:45 AM, the DON provided the surveyor with the facility's "Infection Detail Report for Excel" (a report that provides comprehensive information on residents with infections), which was dated 1/9/23. A review of the Infection Detail Report listed residents with infections from *Ex Order 26. 4B1* , which included documentation of their symptoms, diagnostic tests (if any completed), antibiotic medications and other treatments administered, and duration of the prescribed treatment. Resident #52, who was being reviewed for NJ Exec. Order 26:4.b.1 , was not listed on the report. On 1/10/23 at 10:33 AM, the surveyor interviewed the DON about NJ Exec. Order 26:4.b.1 and that Resident #52 was not listed on the report. The DON stated the IP was educated yesterday about the NJ Exec. Order 26:4.b.1 tracking and the Infection Detail Report for *Ex Order 26. 4B1* was completed yesterday. On 1/10/23 at 1:08 PM, the surveyor interviewed the IP about Antibiotic Stewardship. The surveyor asked the IP about antibiotic surveillance and tracking process. The IP stated during morning interdisciplinary meetings new admissions and residents with changes in conditions are reviewed to determine residents with infections or antibiotic treatment. The IP acknowledged the *Ex Order 26. 4B1* Antibiotic Stewardship reports were completed yesterday (1/9/23). The IP stated the *Ex Order 26. 4B1* tracking report was updated to include Resident #52 and the report for *Ex Order 26. 4B1* was currently in progress. The IP stated she was aware it had to be done and that it was her responsibility as IP. The IP further stated that she did not finish her orientation and was not aware how to complete it until she was trained yesterday	F 881		

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F 881	Continued From page 116 by the Interim DON. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant (QAC) #1, QAC #2, and Regional Director of Operations of the concerns for the Antibiotic Stewardship tracking for *Ex Order 26. 4B1* not being completed. The facility provided no additional information. A review of the facility's "Infection Control Manual" policy, dated 07/10/2021 included the following: Under Surveillance, Section 2: Monthly Surveillance, Monthly Infection Surveillance Tracking and Trending read, "Information about infections is gathered, monitored and tracked throughout the month ...The data entered generates surveillance reports which are reviewed by the Infection Preventionist for trend identification including trends that may require initiating outbreak investigations ...The Infection Preventionist monitors types of infections, symptoms, location, onset date, cultures, swabs and X-rays taken including dates and results, the type of precautions, treatment interventions initiated and the date the infection is resolved. Any patient/resident placed on antibiotics for reasons other than prophylactic i.e., pre-surgical, pre-dental procedures or non-transmissible disease conditions, should be counted on Surveillance Tracking". A review of the facility titled, "Antibiotic Stewardship", dated 07/2021, indicated under Leadership Commitment, "QMS trend reports submitted by Infection Preventionist to Antibiotic Stewardship Committee and/or QAPI/Infection Control Committees for review and consideration include: Antibiotic Stewardship Report, Infection	F 881		

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	315522	A. BUILDING _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

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F 881	Continued From page 117 Rate Report, Infection Detail Report, Question Response Drill Down Report and Monthly Infection Control Analysis Report".	F 881		
F 885 SS=D	NJAC 8:39-19.4(d)(g) Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure resident representatives	F 885	F885 Reporting-Residents, Representatives & Families Element #1	3/1/23

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F 885	Continued From page 118 were informed of a newly confirmed Ex Order 26. 4B1 diagnosis of a staff member in the facility by 5 PM the next calendar day. This deficient practice was identified for 1 of 1 staff who tested Ex Order 26. 4B1 (Registered Nurse #1) and was evidenced by the following: During the entrance conference on 1/3/23 at 11:00 AM, the surveyor requested the process of notification of confirmed and suspected Ex Order 26. 4B1 to residents and resident representatives. On 1/4/22 at 10 AM, Surveyor #1 reviewed the facility's Ex Order 26. 4B1 titled "COVID-19 Employee Detail", which revealed RN #1 was Ex Order 26. 4B1 on Ex Order 26. 4B1. On 1/5/23 at 10:01 AM, the DON informed Surveyor #2 that Ex Order 26. 4B1 results for staff and residents were entered into the facility's Ex Order 26. 4B1 and would trigger automated ("robo") calls to resident representatives. The DON further stated they started making flyers to notify the residents in the facility. On 1/9/23 at 12:30 PM, the IP provided the surveyor a report of automated calls made to resident representatives about the Ex Order 26. 4B1 on Ex Order 26. 4B1. A review of the untitled report of automated calls for the notification of resident representatives regarding the Ex Order 26. 4B1 NJ Exec. Order 26:4.b.1 case revealed the automated calls were dated as assigned on Ex Order 26. 4B1. The report included the resident's name their resident representative and indicated if a call was answered.	F 885	• Responsible parties were notified of the Ex Order 26. 4B1 Registered Nurse #1 via automated calls. • Responsible parties are notified timely of all Ex Order 26. 4B1 staff or resident cases via the Center Ex Order 26. 4B1 that sends automated calls to responsible parties. Element #2 • All residents have the potential to be affected by this practice. Element #3 • The Administrator was re-educated to ensure reporting of newly confirmed Covid-19 cases to resident representatives is completed no later than 5pm of the following day after identification of the positive case. Element #4 • Director of Nursing/designee will conduct an audit weekly for 4 weeks, then monthly for 3 months to ensure any newly confirmed Covid cases have been reported to the resident representatives. Findings will be analyzed by the DON and reported quarterly to the QAPI committee.	

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F 885	Continued From page 119 On 1/11/23 9:35 AM, the surveyor interviewed the DON about the automated call report that was dated Ex Order 26. 4B1 for notification to residents' representatives about the *Ex Order 26. 4B1* on Ex Order 26. 4B1. The DON was unable to provide any additional documentation that resident representatives were notified by Ex Order 26. 4B1 at 5 PM when the new *Ex Order 26. 4B1* case was confirmed on Ex Order 26. 4B1. The DON stated the most recent report for automated calls was on Ex Order 26. 4B1. The DON further stated it was the holiday and the automated calls go out once results were submitted to the facility's Ex Order 26. 4B1 [redacted]. During an interview with the surveyor on 1/11/23 at 10:05 AM, the Administrator stated resident representatives would be notified of Ex Order 26. 4B1 [redacted] in the facility by automated calls. The Administrator stated it was expected for resident representatives to be notified by the next day. The surveyor informed the Administrator of the concern that the report of the automated calls indicated that resident representatives were notified on Ex Order 26. 4B1 about the *Ex Order 26. 4B1* on Ex Order 26. 4B1. The Administrator acknowledged notification was delayed and stated it was because of the holiday. During an interview with the surveyor on 1/12/23 at 10:46 AM, IP stated once *Ex Order 26. 4B1* were entered into the *Ex Order 26. 4B1*, it triggered automated calls for notification. The IP stated she was responsible for entering *Ex Order 26. 4B1* [redacted] into the *Ex Order 26. 4B1*. The IP confirmed the *Ex Order 26. 4B1* was entered into the Ex Order 26. 4B1 [redacted] on Ex Order 26. 4B1, after the holiday weekend when she returned to work.	F 885		

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F 885	Continued From page 120 On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant (QAC) #1, QAC #2, and Regional Director of Operations about the concern of timely notification of Ex Order 26. 4B1 in the facility and notification for Ex Order 26. 4B1 case on Ex Order 26. 4B1 was on Ex Order 26. 4B1. No further information was presented to the surveyor. The surveyor reviewed the facility policy titled, "Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff", dated 1/27/2021. Under Procedure, "3. Positive COVID test results must be entered into the COVID Tracker as soon as received, seven days a week, to meet the requirement of calls being made by 5 pm the next calendar day following the occurrence." NJAC 8:39-5.1 (a)	F 885		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in	F 886		3/1/23

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F 886	Continued From page 121 this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.	F 886		

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F 886	Continued From page 122 §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of facility documents, it was determined that the facility failed to ensure: 1.) a symptomatic Registered Nurse #1 (RN #1) notified the supervisor, prior to the start of her shift on Ex Order 26. 4B1 that she NJ Exec. Order, 2.) a process was in place to conduct immediate resident and staff testing upon identification of a Ex Order 26. 4B1 staff member (RN #1) who provided care to 9 residents on 1 of 2 units while working on Ex Order 26. 4B1, and for two residents who tested Ex Order 26. 4B1 (Residents #33 and #235) 3.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and 4.) the facility's Outbreak Plan and Ex Order 26. 4B1 were followed to prevent exposure and mitigate the spread of Ex Order 26. 4B1 . The facility's system-wide failure to immediately conduct Ex Order 26. 4B1 upon the identification of Ex Order 26. 4B1 staff and residents to prevent the spread of Ex Order 26. 4B1 , posed a serious and immediate risk to the health and well-being of all staff and residents for contracting Ex Order 26. 4B1. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was	F 886	F886 Infection Control Element #1 ¿ F886, removal plan was submitted, accepted, and implemented. The F886 removal plan was accepted and verified as implemented during an onsite visit by the New Jersey Department of Health (NJDOH) surveyors on January 6, 2023. ¿ Center Infection control preventionist initiated the spreadsheet for Close Contact□s required testing. ¿ Broad based testing of Residents and staff was immediately completed to identify any Ex Order 26. 4B1 cases including Residents #236, #69, # 239, #47, #80, #63, #240, #238 and #52. A testing schedule was established based on the initial testing in compliance with CDC, CMS and NJDOH testing requirements and guidance. Element #2 ¿ All residents have the potential to be affected by this practice. Element #3 ¿ The Center Infection Preventionist consultant will review the Center COVID19 testing schedule to ensure compliance with current CDC, CMS and NJDOH requirements and guidance. Re-education will be provided to the	

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F 886	Continued From page 123 identified on 1/5/23 at 3:35 PM. The removal plan was accepted and verified as implemented by the survey team during an onsite visit conducted on 1/6/23. The IJ situation began on Ex Order 26. 4B1 at 7:00 PM, when RN #1 reported to work NJ Exec. Order 26:4.b.1 , proceeded to provide care for 9 residents in 1 of 2 resident units, and tested Ex Order 26. 4B1 on Ex Order 26. 4B1 at 10:00 PM. The Infection Preventionist (IP) stated there was no process in place to test the residents and staff. There was no evidence that the facility tested the 9 residents the RN had on her assignment. Three residents on the RN's assignment were Ex Order 26. 4B1 and had a diagnosis of Ex Order 26. 4B1 . 1 of the 3 immunocompromised residents was not Ex Order 26. 4B1 . Three additional residents were not Ex Order 26. 4B1 . Additionally, two symptomatic residents tested positive in the facility on Ex Order 26. 4B1 . There was no subsequent resident testing performed. This deficient practice was evidenced by the following: Refer to 880L Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 9/23/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements	F 886	Center management team. ¿ The eleven infection control directed in-services will be completed for topline, frontline, and all staff as outlined in the Initial Notice letter and proof of completion posted on ePOC and emailed as required to NJDOH. ¿ The Center Infection Preventionist consultant or designee will review the Center COVID19 testing policies and procedures for compliance with current CDC, CMS, and NJDOH requirements and guidance. ¿ The process for screening and testing staff will be reviewed by the Center IP consultant or designee for compliance with infection control regulations. ¿ Current center staff received re-education regarding the Center screening and COVID testing procedures. ¿ The consultant IP or designee will update the Center COVID Outbreak plan and will review changes with the Center administrator and management team. Element #4 ¿ Director of Nursing or designee will audit to validate COVID-19 surveillance testing is properly completed upon identification of a new resident or staff positive case. Audits will be completed daily for 5 days, weekly for 3 weeks, and then monthly for 2 months. Results will be reported to the Administrator for review and action as appropriate. Findings will be reported by the Director or designee at the quarterly QAPI committee meeting for review and further action as appropriate. Completion Date: March 1, 2023	

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F 886	Continued From page 124 During the entrance conference on 1/3/23 at 11:00 AM, the IP, along with the Director of Nursing (DON), informed the surveyors that there were two Ex Order 26. 4B1 residents (Resident #33 and Resident #235) in the facility on the NJ Exec. Order 26:4.b unit. The IP stated she started in the facility in NJ Exec. Order 26:4.b.1 and was responsible for staff development and infection control. The IP stated that the Administrator was currently on vacation. On 1/4/22 at 10:00 AM, Surveyor #1 reviewed the facility's Ex Order 26. 4B1 titled "COVID-19 Employee Detail" which revealed RN #1 was Ex Order 26. 4B1 on Ex Order 26. 4B1. An additional review revealed that the onset of symptoms was on Ex Order 26. 4B1 and the last day the RN #1 worked was Ex Order 26. 4B1. During an interview with Surveyor #1 and Surveyor #2 on 1/4/23 at 11:05 AM, the IP, in the presence of the DON, stated the facility's infection control practice was based on the infection control manual and facility policies based on corporate, CDC guidelines and guidance from the Local Health Department (LHD). The IP stated Ex Order 26. 4B1 was conducted twice a week and in between that time if someone was symptomatic. The IP stated the residents and staff were tested twice a week on Mondays and Thursdays. Surveyor #1 reviewed the Ex Order 26. 4B1 which included RN #1 with the DON and IP. The DON stated RN #1 tested Ex Order 26. 4B1 at work on Ex Order 26. 4B1 and had NJ Exec. Order 26:4.b.1 that included Ex Order 26. 4 symptoms and NJ Exec. Order 26:4.b.1, for a couple of days before. The DON stated RN #1 did	F 886		

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F 886	Continued From page 125	F 886		

not work on [redacted] and worked on [redacted] for the 7 pm to 7 am shift on the 2nd-floor unit. The DON further stated RN #1 should not have [redacted] work and should have tested before her shift. The DON stated she did not do contact tracing and would have to check the documentation for residents who were tested.

During a telephone interview with Surveyor #1 On 1/4/23 at 11:57 AM, RN #1 stated she started feeling sick on [redacted] and [redacted] to the Registered Nurse Supervisor (RNS) on [redacted]. RN #1 stated she was [redacted] and reported to the RNS that she was [redacted]." She stated the RNS stated, "ok" and did not ask any further questions. RN #1 stated it was "holiday time" and "if you call out before the holiday, you don't get time and a half".

RN #1 stated she went back to work on [redacted] and thought she was ok since she called her primary doctor who gave her [redacted], and she also took [redacted]. RN #1 stated she still had a [redacted] when she went to work. RN #1 stated she received report from the outgoing nurse, checked on her residents, did her first medication administration pass before testing herself at 10:00 PM, and tested [redacted]. The surveyor asked if she had told anyone that she was [redacted] or about her symptoms on 12/24/22. RN #1 stated, "Who was I gonna tell...there was no one ...only nurses" and she had called the DON at 10:00 PM after testing [redacted]. RN#1 stated the DON told her that she had to go home and could not work as she tested [redacted]. RN #1 said she gave report to the other nurse and went home. The

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F 886	Continued From page 126 surveyor asked RN #1 why she tested herself at 10:00 PM and not before that time. RN #1 replied that the outgoing nurses wanted to give report to go home, and she did not want to keep them waiting. RN #1 stated that no one from the facility had called her to ask about contact tracing including residents she had contact with. RN #1 stated she had education about [redacted] in 2020 and 2021 and acknowledged that the facility had stated if a staff member had symptoms or was [redacted] that the staff member should not come to work. On 1/4/23 at 11:54 AM, the IP provided the surveyor RN #1's timecard which revealed RN #1 worked on Saturday [redacted], clocked in at 7:00 PM, and clocked out at 10:45 PM. On 1/4/23 at 12:38 PM, the IP provided the surveyor with the assignment of RN #1 on [redacted], which included 9 residents (Resident #236, #69, #239, #47, # 80, #63, #240, #238 and #52). The IP stated that the residents who were exposed were not tested and that there was no documentation that the residents were tested. The IP stated she was new in training, but that she was responsible to ensure they were doing the correct thing and the residents should have been tested. A review of the medical records for the 9 residents that were assigned to RN #1 on [redacted], included three immunocompromised residents: Resident #236 who had a diagnosis that included [redacted]	F 886		

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F 886	Continued From page 127	F 886		

Ex Order 26. 4B1 [redacted];

Resident #240 who had a diagnosis that included *Ex Order 26. 4B1* [redacted];

and Resident #238, who had a diagnosis that included *Ex Order 26. 4B1* [redacted].

Four of the residents (Resident #236, #69, #239, and #47) were NJ Exec. Order 26:4.b.1 [redacted] and 5 residents (Resident # 80, #63, #240, #238, and #52) were fully vaccinated according to the facility's resident *Ex Order 26. 4B1* [redacted].

On 1/4/23 at 1:05 PM, Surveyor #1 and Surveyor #2 interviewed the IP and the DON about the process of testing residents and staff, after a positive case. The IP stated testing should be twice a week, positive NJ Exec. Order 26:4.b.1 [redacted] are logged in the computer's "COVID tracker" and there was a surveillance log in which results were written for staff testing. The IP stated there was no log for residents, positive results were found on the resident's medical record, and she was not sure where negative results would be documented. The DON stated resident testing, whether positive or negative results, should be documented in the electronic medical record's progress notes. The surveyor requested from the DON and IP documentation of any resident testing conducted.

On 1/4/23 at 1:55 PM, Surveyor #1 interviewed the IP about the two *Ex Order 26. 4B1* [redacted] residents in the facility. The IP stated the two residents were tested because they had symptoms. The IP stated she would check and provide information

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	315522	A. BUILDING _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

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F 886	Continued From page 128 on contact tracing and resident testing. A review of the progress notes provided by the IP revealed that Resident #235 had [redacted], and tested [redacted] on [redacted], and Resident #33 had a [redacted] and tested [redacted] on [redacted]. During an interview with Surveyor #1 on 1/5/23 at 10:42 AM, the RNS stated if someone said they were calling out sick or not feeling well, she would ask about their symptoms, how long, and when they last worked. The RNS could not recall if she received any callouts when working on [redacted]. During a follow-up interview with Surveyor #2 on 1/5/23 at 10:58 AM and 12:03 PM, the IP stated there was no process in place to ensure resident testing was done. The IP stated contact tracing should have been done for the [redacted] residents and testing of residents in contact but was not completed. She stated after the former DON left the facility, she was "pulled into so many directions" and was following the direction and guidance of the Administrator. During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated that the former DON had left without notice in November and the IP had "a solid week of training" and spent a day with the Quality Assurance Consultant. She stated when the DON left, she had assigned the IP to be a Unit Manager on one of the units for oversight and she (the IP) should have been "juggling everything." The Administrator stated she would let the IP know if	F 886		

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F 886	Continued From page 129	F 886		

something needed to be addressed and the IP was responsible for in-services, following up with tracking of covid positive residents, ensuring testing was being done, completing surveillance after a positive case, and checking the residents on the assignment after a positive staff case.

The Administrator stated she could not recall a positive COVID-19 staff case on Ex Order 26. 4B1. The surveyor informed the Administrator of RN #1, Ex Order 26. 4B1, and contact tracing concerns. The Administrator stated after a Ex Order 26. 4B1 case, it was expected for the residents to be tested for Ex Order 26. 4B1 and that staff was instructed not to come in to work NJ Exec. Order 26:4.b.i and to test before starting their shift.

The Administrator stated she assumed the IP was doing what she was supposed to do and was not following up with her. She stated there was no team meeting held to discuss RN #1 testing Ex Order 26. 4B1 on Ex Order 26. 4B1. The Administrator stated that she and the DON would have been responsible for ensuring the IP was carrying out her responsibilities.

During an interview with Surveyor #1 and Surveyor #2 on 1/13/23 at 9:13 AM, the Medical Director stated he was made aware of the Ex Order 26. 4B1. The Medical Director stated that the facility followed CDC and CMS guidelines for policies and was unaware they were not being followed. The Medical Director stated he was always made aware of Ex Order 26. 4B1 in the facility and testing of residents should be based on contact tracing.

The surveyor reviewed the IP's competency

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F 886	Continued From page 130	F 886		

checklist, a twelve page document, titled "Infection Preventionist Orientation Plan and Skills Competency Checklist" which was dated [redacted]. Review of the checklist revealed 84 out of 92 tasks were not completed.

A review of the Job Description provided for the IP with the date of hire of [redacted], did not indicate her role and responsibilities as an IP.

A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 09/23/22, included but was not limited to the definition of "Close contact " refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing revealed that upon identification of a new COVID-19 case in the

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F 886	Continued From page 131	F 886		

facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests.

A review of an undated facility's policy titled "Outbreak Plan" included the following: Under Evidence-Based Outbreak Response Measures, it revealed, if a new/reemergence of an infectious disease is detected, ProMedica Piscataway will follow its Infection Control policies and the measures and procedures set forth by the CDC, CMS, and LHD for guidelines and directives. Under Testing, Refusal of Testing & Isolation/Cohorting, it read "ProMedica Piscataway will continue to test healthcare personnel and residents for Covid-19 in accordance with CDC, CMS, and LHD guidelines."; Under Reporting Requirements, it read "Any resident or staff suspected or diagnosed according to State-specific criteria shall be promptly reported to appropriate local and/or state health department officials, included but not limited to NHSN". The policies provided did not further address COVID-19 surveillance.

A review of the facility's policy titled "COVID-19 Clinical Monitoring and Measures Plan", dated 10/10/22, indicated that when any employee tests positive or a resident (who was not previously being cared for in transmission based precautions [TBP]) tests positive for COVID-19, enhanced measures should be implemented. Enhanced measures included but were not limited to, a Screening UDA [User Defined Assessment] consisting of vital signs every shift for residents in the affected unit (where a resident tested positive or positive employee worked),

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F 886	Continued From page 132 identifying potential staff, visitor, and other resident prolonged exposure, notification to local department of health of any positive COVID-19 test results, and to refer to CDC Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures to determine status of employee. A review of the facility's policy titled "Testing Criteria Summary", dated 10/05/22, for newly identified COVID-19 positive staff or resident (not in TBP) in a facility/community that can identify close contacts included: For newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual and testing frequency should be performed Day 1, 3, and 5 unless a positive result is obtained. NJAC 8:39- 19.1(a); 19.2(a)(c)	F 886		

New Jersey Department of Health

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S 000	Initial Comments THE FACILITY WAS 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a. maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 7 of 14 day-shifts reviewed, b. train the two (2) appointed designated staff members and the facility staff within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency	S 560	S560 Mandatory Access to care Element #1 • There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements the weeks of 12/18/22 and 12/25/22. • Daily staffing is reviewed by the staffing coordinator and the Director of Nursing (DON)/designee and additional hours are offered to Center staff to fill vacant slots due to callouts. • Agency staff are used when Center staff cannot fill open shift slots. The	3/1/23

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

Electronically Signed | 02/06/23

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S 560	Continued From page 1 Virus [a virus that attacks cells that help the body fight infection] positive) program, and c. ensure staff were vaccinated for influenza for the 2022/2023 season and maintain a record of staff influenza vaccinations as per statute and facility policy. This deficient practice was evidenced by the following: 1.Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 12/18/22 and 12/25/22. A review of the New Jersey Department of Health	S 560	Center maintains multiple contracts with staffing agencies. • The Center will continue recruitment efforts via various forms of media to increase the number of applicants. • Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. • Direct care staff were provided with LGBTQ+ and HIV+ education to ensure compliance with New Jersey law mandating the education in NJ nursing homes when caring for residents. • *Ex Order 26. 4B1* were provided to staff without approved exemptions. Element #2 • All residents have the potential to be affected by this practice. Element #3 • Agency staff is currently being utilized to help maintain staff-resident ratios. Administrator designee will re-educate Staffing Coordinator and HR on the NJ minimum staffing mandate. The center will continue recruitment efforts using various forms of media to increase the number of applicants. • Bonuses and incentive programs have been implemented to attract and to retain current staff. • Improvements in the environment and working conditions has helped attract new staff. • Administrator/designee will ensure LGBTQI+ HIV+ training is completed for appointed designated staff members and Center staff. • DON/designee will ensure Influenza	

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S 560	Continued From page 2 Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the following: -12/18/22 had 5 CNAs for 60 residents on the day shift, required 7 CNAs. -12/19/22 had 5 CNAs for 60 residents on the day shift, required 7 CNAs. -12/24/22 had 5 CNAs for 58 residents on the day shift, required 7 CNAs. -12/25/22 had 5 CNAs for 58 residents on the day shift, required 7 CNAs. -12/27/22 had 6 CNAs for 57 residents on the day shift, required 7 CNAs. -12/28/22 had 5 CNAs for 57 residents on the day shift, required 7 CNAs. -12/30/22 had 6 CNAs for 57 residents on the day shift, required 7 CNAs. During an interview with the surveyor on 01/10/23 at 12:36 PM, the staffing coordinator stated she was aware of the ratios but there were callouts. During an interview with the surveyor on 1/11/23 at 11:15 AM, the Administrator stated she was aware of staffing ratios but was not sure what the ratios have been in the facility. 2. Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will	S 560	vaccinations are completed per Center policy and state requirements. Element #4 • The Administrator or designee will audit the staffing sheets weekly for 4 weeks then monthly for 3 months to ensure the Center is meeting the minimum staff to resident mandated ratios. Findings will be reported by the Administrator at the quarterly QAPI committee meeting for review and further action as appropriate. • The Administrator will audit compliance of the LGBTQI+ and HIV+ employee training weekly for 4 weeks then monthly for 3 months. Findings will be reported by the Administrator at the quarterly QAPI committee meeting for review and further action as appropriate. • The Administrator will audit compliance with implementation of the staff Influenza vaccination program weekly for 4 weeks then monthly for 3 months. Findings will be reported by the Administrator at the quarterly QAPI committee meeting for review and further action as appropriate. • Vacancy rates are reviewed weekly by the Director of Nursing and discussed with the Administrator. The effectiveness of strategies to attract and retain staff are discussed and strategies modified as needed. Findings are also discussed weekly with the management company that provides direct assistance with recruitment efforts.	

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S 560	Continued From page 3 be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions: The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity	S 560		

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S 560	Continued From page 4 documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records: Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality: The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's	S 560		

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S 560	Continued From page 5 intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated	S 560		

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S 560	Continued From page 6 expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQI community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. During the entrance conference on 1/3/23, the surveyor requested the names of the two staff who were designated as representing management at the facility and representing	S 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7 direct care staff and their training certificates. Additionally, the surveyor requested training for the additional staff in the facility. On 1/4/23 at 10:00 AM, the Director of Nursing (DON) provided the surveyor with a sign-in sheet date 12/12/22, titled, "Sage Care" "Creating Inclusive Communities for LGBTQ and HIV+ Older Adults. On 1/11/23 at 10:00 AM and 1/12/23 at 8:53 AM, the DON provided sign-in sheets dated 1/9/23 and 1/10/23 titled, LGBTQ+ and LGBTQ+ CNA/Nursing. On 1/12/23 at 9:00 AM, the surveyor was provided with Administrator's certificate which was dated 3/18/22. During an interview with the surveyor on 1/11/23 at 11:17 AM, the Administrator stated she completed her training in March 2022 through Sage, and currently, there was no direct care staff who was also trained. She stated the department heads were trained on 12/12/22 and the facility was in the process of training the rest of the staff. She stated the staff was required to be trained by October 2022. 3. Reference: New Jersey Department of Health (NJDOH) memo, dated 10/7/2020, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 26:2H-18.79, Influenza vaccination in health care facilities", indicated the New Jersey Governor signed into law P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute") effective 1/13/2020, in which healthcare facilities are required to:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12056	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 8 For the purposes of its annual influenza vaccination program, each health care facility shall:(1) annually provide an on-site or off-site influenza vaccination to each of its employees;(2) require that each employee at the facility receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease Control and Prevention, which vaccination shall be provided by the health care facility, except that an employee may, in lieu of receiving the influenza vaccination at the facility, present acceptable proof, comprising:(a) an attestation from the employee, which shall be submitted in a form and manner designated by the facility, of a current influenza vaccination if the employee receives the vaccination from another vaccination source, which attestation shall include the lot number of the vaccination the employee received or;(b) a medical exemption, which shall be submitted using a form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. An attestation of a medical exemption shall be subject to approval by the facility following a review by the facility to confirm the medical exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices;(3) maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee and report to the Department of Health, in a manner and according to a schedule prescribed by the commissioner, the vaccination percentage rate of its workforce in receiving influenza vaccinations as part of the facility's	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12056	A. BUILDING: _____ B. WING _____	01/13/2023

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S 560	Continued From page 9	S 560		

annual vaccination program or by other means as attested to by the workforce, as applicable. The report may also include other information that the facility deems relevant to its vaccination percentage rate, including, but not limited to, the number of employees who received medical exemptions.

During the entrance conference on 1/3/23 at 11:00 AM, the surveyor requested the Ex Order 26. 4B1 Ex Order 26. 4B1 record for the facility staff.

On 1/9/23 9:10 AM, the surveyor requested from the DON and IP (Infection Preventionist) the Ex Order 26. 4B1 for the staff.

On 1/10/23 at 9:50 AM, the DON provided the surveyor Ex Order 26. 4B1 information for the facility staff.

A review of the document titled, "Facility Roster Report", dated Ex Order 26. 4B1, revealed a list of staff members by name, with 29 of 114 staff names highlighted to indicate they had received Ex Order 26. 4B1 for the 2022/2023 season. The document did not include any further information on the Ex Order 26. 4B1 received by the staff.

On 1/10/23 at 10:06 AM, Surveyor #1 and Surveyor #2 interviewed the DON and the IP about staff Ex Order 26. 4B1. The DON and IP acknowledged on the list provided, only the names of staff highlighted in blue were vaccinated. The DON stated they offered vaccines to staff and staff with medical exemptions could decline by completing a facility declination form. The IP stated they have held Ex Order 26. 4B1 clinics previously and could not recall exactly when the last clinic was held. The DON stated they would come up with a plan

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	12056	A. BUILDING: _____ B. WING _____	01/13/2023

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S 560	Continued From page 10 today and have a Ex Order 26. 4B1 clinic today. The DON further stated they would continue to provide Ex Order 26. 4B1 clinics until all staff members were vaccinated and for staff who previously declined and were required to present a medical exemption and would have to wear a mask as per facility policy. On 1/10/23 at 10:50 AM, the IP provided Surveyor #2 Ex Order 26. 4B1 dates she had scheduled in November and December Ex Order 26. 4B1. The IP stated the consents for staff who received the Ex Order 26. 4B1 were reflected on the sign-in sheets. The IP stated the clinic times were posted at the timeclock and she was looking for the postings from the prior clinics. On 1/11/23 at 10:05 AM, the surveyors interviewed the Administrator about staff Ex Order 26. 4B1 concerns. The Administrator acknowledged the concern and stated, they were "very late with that". The Administrator further stated she was aware of the statute requiring staff Ex Order 26. 4B1 and that the IP was in the process of getting staff vaccinated. A review of the facility's policy titled, "Screening and Vaccinations", with a revised date of 05/2022 revealed under the heading Employee Influenza Vaccination Guidelines: On an annual basis, employees shall receive an influenza vaccine unless (1) the employee timely submits proof of receipt of influenza vaccination from a provider, or (2) a Request for Religious Exemption form or Medical Exemption form is submitted. In addition to the company mandatory influenza vaccination policy, some states also have specific	S 560		

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	12056	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE PISCATAWAY, NJ 08854**

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S 560	Continued From page 11 mandatory influenza vaccination requirements for employee's healthcare works as well as reporting requirements for residents and employees. Follow state specific guidelines. The documentation of administration or approved exemption for each year offered is maintained in the employee's medical file.	S 560		

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
315522 Y1	A. Building B. Wing Y2	3/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	10 STERLING DRIVE PISCATAWAY, NJ 08854

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 F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	03/01/2023	LSC	03/01/2023	LSC	03/01/2023
ID Prefix F0688	Correction	ID Prefix F0730	Correction	ID Prefix F0756	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.35(d)(7)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed
LSC	03/01/2023	LSC	03/01/2023	LSC	03/01/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0835	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70	Completed
LSC	03/01/2023	LSC	03/01/2023	LSC	03/01/2023
ID Prefix F0880	Correction	ID Prefix F0881	Correction	ID Prefix F0885	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. # 483.80(g)(3)(i)-(iii)	Completed
LSC	03/01/2023	LSC	03/01/2023	LSC	03/01/2023
ID Prefix F0886	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80 (h)(1)-(6)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/01/2023	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/13/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
12056	A. Building B. Wing	3/7/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	10 STERLING DRIVE PISCATAWAY, NJ 08854

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/01/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: J4G112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING **01** B. WING _____	**01/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE** **PISCATAWAY, NJ 08854**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/12/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/12/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 NEW health care occupancy. The facility is a three-story building with residents on the second and third floors and therapy and kitchen on the first floor. The facility has concrete flooring, concrete roofing and block bearing walls and stucco exterior. The facility is noted to be a type II (222) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 600 KW (kilowatt) diesel generator that operates at 24% of load when tested. The facility has 53 occupied beds. The facility has 11 smoke zones. .	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors	K 222		3/1/23

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

Electronically Signed | 02/06/2023

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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K 222	Continued From page 1 Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic	K 222		

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K 222	Continued From page 2 fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure exit doors equipped with delayed-egress locking systems had a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in (3.20mm) located on the door in the direction of egress that read "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS" for eight exit stairway doors in accordance with NFPA 101 (2012 edition) section 7.2.1.6.1.(4). This deficient practice had the potential to affect all 53 residents. Findings include: An observation of the stairway exit door near bedroom 331 on 01/12/23 at 9:20 AM revealed the door was provided with a delayed-egress	K 222	1.The Stairwell door near bedroom 331 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4.The Center staff will receive an in-service for the purpose of these signs. 5.The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance &	

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K 222	Continued From page 3 feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 301 on 01/12/23 at 9:50 AM revealed the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 332 on 01/12/23 at 9:55 AM revealed the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 362 on 01/12/23 at 10:00 AM revealed the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 231 on 01/12/23 at 10:10 AM revealed	K 222	Performance Improvement committee. 1 The Stairwell door near bedroom 332 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4.The Center staff will receive an in-service for the purpose of these signs. 5.The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee. 1.The Stairwell door near bedroom 362 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4 The Center staff will receive an in-service for the purpose of these signs. 5 The maintenance director or designee will share the results of this audit monthly	

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PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE** **PISCATAWAY, NJ 08854**

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K 222	Continued From page 4 the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 201 on 01/12/23 at 10:25 AM revealed the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 232 on 01/12/23 at 10:35 AM revealed the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An observation of the stairway exit door near bedroom 261 on 01/12/23 at 10:45 AM revealed the door was provided with a delayed-egress feature. The sign for the door read "Emergency exit only alarm will sound when door is opened." The exit door lacked any type of delay egress sign indicating the door would open in 15 seconds or "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". An interview with the Maintenance Director at the	K 222	for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee. 1 The Stairwell door near bedroom 231 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4.The Center staff will receive an in-service for the purpose of these signs. 5.The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee. 1.The Stairwell door near bedroom 201 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule.	

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K 222	Continued From page 5 time of each observation verified the signs on the exit doors were lacking information. He stated they thought the signs were sufficient and they did not want to mention 15 seconds on the sign, so they posted a sign next to each door stating an emergency alarm would sound. NJAC 8:39-31.1(c), 31.2(e) .	K 222	4.The Center staff will receive an in-service for the purpose of these signs. 5.The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee. 1.The Stairwell door near bedroom 232 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2 To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4.The Center staff will receive an in-service for the purpose of these signs. 5 The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee. 1.The Stairwell door near bedroom 261 received a sign on the door stating, Push until the alarm sounds door can be opened in 15 seconds. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3 Facility to perform an audit to ensure	

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K 222	Continued From page 6	K 222	that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4.The Center staff will receive an in-service for the purpose of these signs. 5.The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee. 1.The Stairwell door near bedroom 301 received a sign on the door stating, “Push until the alarm sounds door can be opened in 15 seconds”. 2.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all delayed egress doors open after 15 seconds. 3.Facility to perform an audit to ensure that all delayed egress doors open after 15 seconds on a weekly audit schedule. 4.The Center staff will receive an in-service for the purpose of these signs. 5.The maintenance director or designee will share the results of this audit monthly for three months and quarterly thereafter at the monthly QAPI Quality Assurance & Performance Improvement committee	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324		3/1/23

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K 324	Continued From page 7 Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the kitchen range hood suppression system was inspected, tested and maintained at least every six months in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, (2011 edition) section 11.2.1. This deficient practice had the potential to affect all 53 residents. Findings include: A review of the fire safety records, under "Range Hood Suppression System" tab, suppression	K 324	K324- 1. The kitchen range hood suppression system will be inspected by a certified contractor in and scheduled for six months from the most recent inspection date thereafter. The inspection paperwork will be kept on file for further review. The Maintenance Director will conduct an audit of their Life Safety Binder every six months and review with the NHA to confirm compliance with all required paperwork. The Maintenance staff will be in-serviced	

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K 324	Continued From page 8 system inspections were conducted on 05/10/22 and 10/06/21. There was no documentation to indicate an inspection was completed in November 2022 or six months prior. An interview with the Maintenance Director on 01/12/23 at 12:30 PM confirmed the inspection had not been completed. NJAC 8:39-31.1(c), 31.2(e) NFPA 96 .	K 324	on the required fire systems-related inspection codes and the importance of these regulations. The maintenance director or designee will share the results of this inspection at the monthly QAPI Quality Assurance & Performance Improvement committee.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure that two of 216 smoke detectors	K 341	1.The smoke detector located in the corridor in the Activity area near the elevators on	3/1/23

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K 341	Continued From page 9 were greater than 36 inches from ceiling fans blades in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 29.8.3.4.(6). This deficient practice had the potential to affect seven residents. Findings include: An observation of a corridor smoke detector in an activity area near the elevators on 01/12/23 at 9:30 AM revealed the smoke detector was 16 inches from a ceiling fan blade. An observation of a corridor smoke detector in an activity area near the elevators on 01/12/23 at 9:35 AM revealed the smoke detector was 16 inches from a ceiling fan blade. An interview with the Maintenance Director at the time of each observation verified the measurements of the smoke detectors to the ceiling fans blades. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 341	2nd floor was relocated from 16 inches to greater than 36 inches from the ceiling fan blade. 2.A center-wide audit will be conducted by the Maintenance staff to ensure all other ceiling fan devices are no closer than 36 inches to a smoke detector. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke detectors are installed properly throughout the center. 4.The maintenance director or designee will conduct monthly audits times 3 and report findings at the QAPI meeting monthly. 1.The smoke detector located in the corridor in the Activity area near the elevators on 3rd floor was relocated from 16 inches to greater than 36 inches from the ceiling fan blade. 2.A center-wide audit will be conducted by the Maintenance staff to ensure all other ceiling fan devices are no closer than 36 inches to a smoke detector. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke detectors are installed properly throughout the center. 4.The maintenance director or designee will conduct monthly audits times 3 and report findings at the QAPI meeting monthly.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance	K 345		3/1/23

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K 345	Continued From page 10 CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to complete a smoke detection sensitivity test every two years for all 216 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. This deficient practice had the potential to affect all 53 residents. A review of fire safety records from the "Fire Alarm" folder revealed a smoke detection sensitivity test was conducted on 03/12/20. Additional fire alarm inspections were completed on 4/29/22, 10/06/21, 03/23/21, 8/13/20; however, none of these inspections included a smoke detection sensitivity test. An interview with the Maintenance Director on 01/12/23 at 1:15 PM revealed he did not have the test from the past two years and did not have a smoke detection sensitivity test for all 216 photo electric smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	K345- 1. The two-year smoke detection sensitivity test will be completed and the results available for review upon request. The center will identify and make note in the Life Safety binder for the date of the next two-year inspection date. The Maintenance Director or designee will conduct a monthly audit x 3 that the sensitivity report is available in the Life Safety Binder and semi-annually thereafter. To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that they understand the code for this inspection and the importance of keeping the inspection time schedule. Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee	

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K 345	Continued From page 11 .	K 345		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		3/1/23

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K 363	Continued From page 12 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure corridor doors were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 18.3.6.3.1. This deficient practice had the potential to affect seven residents in the smoke zone. Findings include: An observation of one corridor door to the left the of the elevators on the third floor on 01/12/23 at 9:30 AM revealed the door contained a 16 inch wide by 12 inch high louver in the lower section of the door. The louver could not be closed. The louver would allow for the passage of smoke into the main exit access corridor. The room contained elevator equipment. An observation of one corridor door to the right the of the elevators on the third floor on 01/12/23 at 9:30 AM revealed the door contained a 16 inch wide by 12 inch high louver in the lower section of the door. The louver could not be closed. The louver would allow for the passage of smoke into the main exit access corridor. The room contained elevator equipment. An interview with the Maintenance Director at the time of each observation verified the openings in each door. NJAC 8:39-31.2(e)	K 363	1.The door to the left of the elevators on the third floor will be repaired so the door louver can close to stop the passage of smoke or the door will be replaced with a non-louvered smoke door. 2.The Maintenance director or designee will conduct an initial audit of all smoke and fire doors to make sure they are smoke tight and contain no louvers in the open position. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to smoke and fire door requirements by reviewing the 13-point door inspection list. 4.Results of door audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee 5.Same answer for the second door located on the right side of the elevators on the third floor. 1.The door to the right of the elevators on the third floor will be repaired so the door louver can close to stop the passage of smoke or the door will be replaced with a non-louvered smoke door. 2.The Maintenance director or designee will conduct an initial audit of all smoke and fire doors to make sure they are	

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K 363	Continued From page 13 .	K 363	smoke tight and contain no louvers in the open position. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to smoke and fire door requirements by reviewing the 13-point door inspection list. 4.Results of door audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee 5.Same answer for the second door located on the right side of the elevators on the third floor.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable	K 372	1.The penetrations found in the smoke wall by bedroom 318 will be sealed with an approved UL-rated through-wall	3/1/23

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K 372	Continued From page 14 of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) sections 8.5.2.1 and 8.5.6.2. This deficient practice had the potential to affect all 53 residents. Findings include: An observation of the smoke barrier wall near bedroom 318 on 01/12/23 at 1:15 PM revealed two holes, each three inches in diameter that were not sealed. An observation of the smoke barrier wall near bedroom 311 on 01/12/23 at 1:20 PM revealed two holes, each two inches in diameter that were not sealed. An observation of the smoke barrier wall near bedroom 244 on 01/12/23 at 1:25 PM revealed two holes, each two inches in diameter that were not sealed. An observation of the smoke barrier wall near bedroom 251 on 01/12/23 at 1:30 PM revealed two holes, each three inches in diameter that were not sealed. An observation of the smoke barrier wall near bedroom 218 on 01/12/23 at 1:35 PM revealed two holes, one five-inch hole and one two-inch holes in diameter that were not sealed. An observation of the smoke barrier wall near bedroom 211 on 01/12/23 at 1:40 PM revealed four, one-inch holes in diameter that were not sealed.	K 372	penetration fire stop system W-L-4046 and numbered. A copy of the approved system will be kept in the life safety manual. 2.The Maintenance director or designee will conduct an initial audit of the smoke barrier walls throughout the second and third floors monthly x3 and when vendors come into work around the smoke and firewalls. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke and firewalls are inspected on a regular basis for fire safety reasons. 4.Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee. 1.The penetrations found in the smoke wall by bedroom 311 will be sealed with an approved UL-rated through-wall penetration fire stop system W-L-4046 and numbered. A copy of the approved system will be kept in the life safety manual. 2.The Maintenance director or designee will conduct an initial audit of the smoke barrier walls throughout the second and third floors monthly x3 and when vendors come into work around the smoke and firewalls. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke and firewalls are	

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K 372	Continued From page 15 An interview with the Maintenance Director at the time of each observation verified the size and location of the noted holes. An interview with the Regional Director on 01/12/23 at 1:25 PM indicated the holes on the second floor were created by data cables and recent installation. NJAC 8:39-31.1(c), 31.2(e) .	K 372	inspected on a regular basis for fire safety reasons. 5.Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee. 1.The penetrations found in the smoke wall by bedroom 244 will be sealed with an approved UL-rated through-wall penetration fire stop system W-L-4046 and numbered. A copy of the approved system will be kept in the life safety manual. 2.The Maintenance director or designee will conduct an initial audit of the smoke barrier walls throughout the second and third floors monthly x3 and when vendors come into work around the smoke and firewalls. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke and firewalls are inspected on a regular basis for fire safety reasons. 4.Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee 1.The penetrations found in the smoke wall by bedroom 251 will be sealed with an approved UL-rated through-wall penetration fire stop system W-L-4046 and numbered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING **01** B. WING _____	**01/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE** **PISCATAWAY, NJ 08854**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 16	K 372	A copy of the approved system will be kept in the life safety manual. 2.The Maintenance director or designee will conduct an initial audit of the smoke barrier walls throughout the second and third floors monthly x3 and when vendors come into work around the smoke and firewalls. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke and firewalls are inspected on a regular basis for fire safety reasons. 4.Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee 1.The penetrations found in the smoke wall by bedroom 218 will be sealed with an approved UL-rated through-wall penetration fire stop system W-L-4046 and numbered. A copy of the approved system will be kept in the life safety manual. 2.The Maintenance director or designee will conduct an initial audit of the smoke barrier walls throughout the second and third floors monthly x3 and when vendors come into work around the smoke and firewalls. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke and firewalls are inspected on a regular basis for fire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING **01** B. WING _____	**01/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE** **PISCATAWAY, NJ 08854**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 17	K 372	safety reasons. 4.Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee. 1.The penetrations found in the smoke wall by bedroom 211 will be sealed with an approved UL-rated through-wall penetration fire stop system W-L-4046 and numbered. A copy of the approved system will be kept in the life safety manual. 2.The Maintenance director or designee will conduct an initial audit of the smoke barrier walls throughout the second and third floors monthly x3 and when vendors come into work around the smoke and firewalls. 3.To ensure continued compliance PDS, or designee, will in-service maintenance staff to ensure that all smoke and firewalls are inspected on a regular basis for fire safety reasons. 4.Results of audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		3/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING **01** B. WING _____	**01/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE** **PISCATAWAY, NJ 08854**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 18 criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the 600 KW (kilowatt) generator was tested in accordance with NFPA 110 (2010 edition) Standard for Emergency and Standby Power Systems section 8.4.1. This deficient practice had the potential to affect 53 residents.	K 918	K918- 1. The Maintenance Staff will conduct monthly load tests for the 600 KW generator moving forward and weekly generator inspection with no load for the other weeks of each month moving forward. These results will be recorded and placed in the Center's Life Safety	

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	315522	A. BUILDING **01** B. WING _____	**01/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	**10 STERLING DRIVE** **PISCATAWAY, NJ 08854**

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K 918	Continued From page 19 Findings include: A review of the facility generator logs for the 600 KW (kilowatt) diesel generator revealed there were no records of a monthly load test in May 2022, June 2022, July 2022, August 2022, September 2022, October 2022, and November 2022. A review of the facility generator logs for the 600 KW generator revealed no weekly generator inspections on 06/09/22, 06/17/22, 06/23/22, 06/30/22, 07/07/22, 07/13/22, 07/20/22, 07/27/22, 08/04/22, 08/11/22, 08/18/22, 08/25/22, 09/02/22, 09/09/22, 09/16/22, 09/23/22, 09/30/22, 10/07/22, 10/14/22, 10/21/22, 10/28/22, 11/05/22, 11/12/22, 11/19/22, 11/26/22, 12/15/22 and 12/22/22. An interview with the Regional Maintenance Director on 01/12/23 at 2:15 PM indicated he completed a load test at the end of December 2022. Further interview with the Maintenance Director at this time indicated he was a new hire and did not know why the tests and inspections were not done. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110 .	K 918	binder for review. The maintenance director or designee will conduct monthly load tests and weekly inspections and record results moving forward weekly each week moving forward until further notice. To ensure continued compliance PDS, or designee, will in-service maintenance staff on the required procedures when running the generator under load monthly and steps for the weekly inspections. Results of monthly load test and weekly audit to be reported at monthly QAPI Quality Assurance & Performance Improvement committee	

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
315522 Y1	A. Building 01 - LAPID MANOR B. Wing Y2	3/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA TOTAL REHAB + (PISCATAWAY)	10 STERLING DRIVE PISCATAWAY, NJ 08854

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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0222	03/01/2023	LSC	K0324	03/01/2023	LSC	K0341	03/01/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0345	03/01/2023	LSC	K0363	03/01/2023	LSC	K0372	03/01/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	03/01/2023	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	
1/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO