STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315520	A. BUILDING _____ B. WING _____	C 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	**780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873**

(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 COMPLAINT #: NJ 152792 NJ 154485 Survey: 5/23/22 CENSUS: 115 SAMPLE: 29 + 2 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		6/24/22

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

Electronically Signed | 06/16/2022

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F 623	Continued From page 1 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623		

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify in writing regarding the transfer of a resident to the hospital to: a.) the resident, b.) the	F 623	F 623 SS=D 1. Corrective Action	

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F 623	Continued From page 3 resident's representative, and c.) the Office of the State Long-Term Care Ombudsman for 1 of 4 residents reviewed for transfers and affected 1 of 3 residents who were hospitalized (Resident #50). This deficient practice was evidenced by the following: On 5/5/22 at 9:00 AM, the surveyor observed Resident #50 in their room sitting on the bed. The resident informed the surveyor that he/she had not received any notice in writing from the facility about his/her hospitalizations. At 10:45 AM, the surveyor interviewed the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Infection Preventionist Nurse (IPN). They stated that they did not provide written notification to notify the residents, their representatives or the New Jersey State Ombudsman's office for residents that were transferred to the hospital. In addition, the DON stated, "we do not notify the ombudsman's office of anything, I didn't know we had to notify them for hospitalization, we only provide them with the information they request." At 3:04 PM, in the presence of the survey team during an additional interview with the DON, ADON, and IPN, they again stated that they were not aware that the New Jersey State Ombudsman's office was to be notified in writing when the resident was discharged to the hospital and the reason(s) for hospitalization. However, the Licensed Nursing Home Administrator (LNHA) informed the surveyors "...we did not notify the Ombudsman office." The surveyor reviewed the medical record of	F 623	• Resident # 50 continues to reside in the facility • Resident # 50 (own POA) and Ombudsman were provided written notification regarding the hospital transfer and reason for transfer from [redacted] and [redacted] 2. Identifying other residents • Residents currently residing in the facility and those who are transferred to the hospital have the potential to be affected. • DON/designee conducted hospital transfer audits to ensure resident/family/ombudsman have been notified of hospitalizations 3. Systemic Changes • DON/designee shall in-service admissions director and nurses including agency regarding a written hospital transfer notification for resident/family/ombudsman • DON/designee shall send to ensure written notification of hospital transfers are provided to resident/family/ombudsman 4. Monitoring • DON/designee shall perform audits of hospital transfers to ensure written notifications have been provided to resident/family/ombudsman daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained	

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F 623	Continued From page 4 Resident #50. The resident's Face Sheet (an admission summary) reflected that the resident's last admission to the facility was on EX Order 26.4B1, with diagnoses that included but were not limited to EX Order 26.4B1 The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order out of 15 which reflected the resident had an EX Order 26.4B1 According to Resident Admission and Discharge Tracking (ADT) Information, the resident was discharged to the hospital on EX Order 26.4B1 The nurse's Progress Note (PN) indicated that the resident was transferred to the hospital on EX Order 26.4B and was admitted to the hospital EX Order 26.4B1 EX Order 26.4B1. Further review of the nurse's PN reflected that the resident was transferred again to the hospital on EX Order 26.4B1 and was admitted to the hospital for EX Order 26.4B1 There was no documented evidence that the facility had notified the resident and his/her representative in writing regarding the reason for transfer to the hospital and that they sent a copy to a representative of the New Jersey State Long-Term Care Ombudsman. On 5/9/22 at 11:55 AM, the surveyor met with the	F 623	compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate.	

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F 623	Continued From page 5 LNHA, DON, ADON, and IPN in the presence of the survey team. The LNHA informed the survey team that there should be a written notification provided to the Ombudsman office indicating the reason for transfer when the resident was discharged to the hospital and stated, "it's supposed to have been done." The facility was unable to provide a policy regarding written notification to the State Long-Term Care Ombudsman for residents who are transferred or discharged. NJAC 8:39-4.1(a)31	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		6/24/22

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F 625	Continued From page 6 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide documented evidence that the facility had notified the resident and his/her representative in writing regarding the hospitalization, the reason for transfer, and the bed hold policy for 3 of 3 residents (Resident #8, #50 and #60) reviewed for hospitalization. This deficient practice was evidenced by the following: 1. Resident#8's Face Sheet (FS), an admission summary, reflected diagnoses that included but were not limited to EX Order 26.4B1 [redacted] According to Resident Admission and Discharge Tracking (ADT) Information, Resident#8 was discharged to the hospital on EX Order 26.4B and was readmitted to the facility on EX Order 26.4B1 A review of the nurse's Progress Note (PN) indicated that the resident was transferred to the hospital on EX Order 26.4B1 due to episodes of EX Order 26.4B1 and was admitted to the EX Order 26.4B1 [redacted]	F 625	1. Corrective Action • Resident # 8, 50 and 60 continue to reside in the facility. • Resident # 8 has been provided in writing regarding the EX Order 26.4B1 on EX Order 26.4B1 the reason for transfer and the bed hold policy • Resident # 50 has been provided in writing regarding the hospitalization on NJ Exec Order 26.4 and NJ Exec Order 26.4, the reason for transfer and the bed hold policy • Resident # 60 has been provided in writing regarding the hospitalization on NJ Exec Order 26.4B the reason for transfer and the bed hold policy 2. Identifying other residents • Residents currently residing in the facility and those who are transferred to the hospital have the potential to be affected. • DON/designee conducted audits to ensure resident/family have been notified in writing regarding hospitalizations, reason for transfer and the bed hold policy.	

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F 625	Continued From page 7 There was no documented evidence that the facility had notified the resident and his/her representative in writing regarding the hospitalization, the reason for transfer, and the bed hold policy. 2. On 5/5/22 at 9:00 AM, the surveyor observed Resident #50 in their room sitting on the bed. The resident informed the surveyor that he/she had not received anything in writing about his/her hospitalizations, the reason for transfer, or the bed hold policy. The surveyor reviewed Resident #50's medical records. The resident's FS reflected diagnoses that included but were not limited to EX Order 26.4B1 [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order [redacted] out of 15 which reflected the resident had an EX Order 26.4B1 The nurse's PN indicated that the resident was transferred to the hospital on EX Order 26.4B1 [redacted] and was admitted to th EX Order 26.4B1 [redacted] Further review of the nurse's PN reflected that the resident was transferred again to the hospital on EX Order 26.4B1 [redacted] and was admitted to the hospital for EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted] There was no documented evidence that the	F 625	3. Systemic Changes • DON/designee shall in-service admissions director and nurses including agency regarding a written hospital transfer notification, reason for transfer and bed hold policy for resident/family. • DON/designee shall send to ensure written notification of hospitalizations, reasons for transfer and bed hold policy are received by resident/family. 4. Monitoring • DON/designee shall perform audits of hospital transfers to ensure written notifications have been provided to resident/family to include reason for transfer and bed hold policy daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI to be addressed	

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F 625	Continued From page 8	F 625		

facility had notified the resident and his/her representative in writing regarding the hospitalization, the reason for transfer, and the bed hold policy.

3. Resident#60's FS reflected diagnoses that included but were not limited to EX Order 26.4B1 [redacted]

According to Resident ADT Information, Resident#60 was discharged to the EX Order 26.4B1 on EX Order 26.4B1 and was readmitted to the facility on EX Order 26.4B1.

The nurse's PN indicated that the resident was transferred to the hospital on EX Order 26.4B1 due to EX Order 26.4B1 and EX Order 26.4B1.

There was no documented evidence that the facility had notified the resident and his/her representative in writing regarding the hospitalization, the reason for transfer, and the bed hold policy.

On 5/5/22 at 3:04 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist Nurse (IPN) and were made aware of the above concern. The DON, ADON, and IPN were not aware of the requirement that the resident and the resident's representative party must be notified in writing related to hospitalizations, the reason for transfer, and the bed hold policy. The LNHA stated that he was aware of the requirements for notification and "I

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F 625	Continued From page 9 thought we were doing it." A review of the Bed Hold Policy reflected that "A written notification (signed and dated by the resident/patient and family member) shall be given to the resident/patient and family member each time of transfer for hospitalization or therapeutic leave." On 05/09/22 at 11:55 AM, the survey team met with the LNHA, DON, ADON, and IPN. No further information was provided prior to the survey team.	F 625		
F 658 SS=D	NJAC 8:39-5.1 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow professional standards of practice in accurately monitoring and documenting the heart rate ordered by a physician, documenting the site and dose of [NJ Exec Order 2] administered and the accurate administration/documentation of medication. This deficient practice was identified for 3 of 31 residents reviewed (Resident #8, #78, #358) and was evidenced by the following:	F 658	1. Corrective Action • Resident # 8 continues to reside in the facility. • Resident # 8's [EX Order 26.4B1], [EX Order 26.4B1] medications are being administered appropriately per physician's order. • Resident # 78 continue to reside in the facility. • Resident # 78 [NJ Exec Order 26.4b1] and doses for [EX Order 26.4B1] are being documented appropriately.	6/24/22

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F 658	Continued From page 10 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 case finding, 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 physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/2/22 at 11:25 AM, the surveyor inspected the medication cart #7 on the [redacted] floor. The surveyor noted an [redacted] medication used to [redacted] in the [redacted] belonging to Resident #8, [redacted]. The [redacted] bottle had a pharmacy label indicating that it was delivered to the facility on [redacted]. Upon examination of the [redacted] left in the bottle, it appeared full.	F 658	• Resident # 358 no longer reside in the facility. 2. Identifying other residents • Residents currently residing in the facility and also receiving brimonidine, latanaprost, fluticasone, lispro, and toprol XL have the potential to be affected. • DON/designee conducted an audit to ensure residents are receiving brimonidine, latanaprost, fluticasone as ordered; nurses are documenting lispro dose and injection site, and toprol XL parameters are being documented per physician orders. 3. Systemic Changes • DON/designee shall in-service nurses including agency regarding medication administration policy, documentation of insulin dose and injection site and parameters as per physician orders. 4. Monitoring • DON/designee shall perform audits on brimonidine, latanaprost, fluticasone to ensure medications are administered as ordered daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • DON/designee shall perform audits on insulin lispro to ensure doses and injection sites are being documented on EMR as ordered daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • DON/designee shall perform audits	

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F 658	Continued From page 11 On 5/2/22 at 11:30 AM, the surveyor interviewed the EX Orde floor Unit Manager/Licensed Practical Nurse (UM/LPN) who examined the EX Order 26.4B1 and confirmed that the bottle appeared full. The surveyor reviewed Resident #8's medical records. A review of the resident's Face Sheet (an admission summary) (FS) included documented diagnosis that included but were not limited to EX Order 26.4B1 EX Order 26.4B1. A review of the EX Order 26.4B1 Annual Minimum Data Set (MDS), an assessment tool used for management of care, revealed a Brief Interview for Mental Status (BIMS) score of EX of 15 which reflected that the resident's NJ Exec Order 26.4b1 was EX Order 26.4B1. A review of the NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR) for Resident #8 indicated that there was a physician order for EX Order 26.4B1 The May 2022 eMAR also indicated a physician order, initially ordered by the physician on EX Order 26.4B1. Both orders indicated that the EX Order 26.4B1 were for a diagnosis of EX Order 26.4B1 EX Order 26.4B1). There was also a documented physician order	F 658	on toprol XL to ensure parameters are followed and documented as per physician orders daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI to be addressed as appropriate	

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included in the EX Order 26.4B1 eMAR for EX Order 26.4B1 EX Order 26.4B1 initially ordered by the physician on EX Order 26.4B indicating one EX Order 26.4B1

A review of the most recent NJ Exec exam dated EX Order 26.4B1 documented a diagnosis of EX Order 26.4B1 a condition causing EX Order 26.4B1 EX Order 26.4B1 The EX Order 26.4B1) documented that Resident #8 would continue treatment with EX Order 26.4B1 and EX Order 26.4B1 .

On 5/2/22 at 11:45 AM, the surveyor returned to inspect the medication cart in the presence of the UM/LPN and was informed that there was no EX Order 26.4B1 in the medication cart.

On 5/4/22 at 9:36 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who stated that she ordered the EX Order 26.4B1 EX Order 26.4B1 . LPN#1 informed the surveyor that both medications including the EX Order 26.4B1 "was to be delivered this afternoon."

On 5/4/22 at 9:36 AM, upon inspection of the medication cart there were no EX Order 26.4B1 available for Resident #8. The surveyor inspected the EX Order 26.4B1 EX Order 26.4B1 still found in the cart. The EX Order 26.4B1 had a documented opening date of EX Order 26.4B1 and a delivery date from the pharmacy of EX Order 26.4B1 The medication found in the bottle of EX Order 26.4B1 appeared three-quarters full.

On 5/4/22 at 9:40 AM, the surveyor interviewed

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the Consultant Pharmacist (CRPh), who agreed that the EX Order 26.4B1 appeared three-quarters full. The CRPh explained that the bottle of EX Order 26.4B1 contained EX Order EX Order 26.4B, this resident was receiving EX Order 26.4B1 and should have been completed by the end of EX Order 26.4B1

On 5/4/22 at 1:30 PM, the surveyor in the presence of the CRPh compared the EX Order 26.4B1 opened bottle of EX Order 26.4B1 with that of the newly delivered, unopened bottle. The CRPh agreed that the EX Order 26.4B1 opened bottle of EX Order 26.4B1 was three-quarters full and there should have been less medication left in the bottle if it had been administered to Resident #8 in accordance with the physician's order.

Review of the EX Order 26.4B1 eMAR recorded daily administration of EX Order 26.4B1, and EX Order 26.4B1 except for EX Order 26.4B1 when Resident #8 was in the hospital.

Review of the EX Order 26.4B1 eMAR recorded daily administration of EX Order 26.4B1 and EX Order 26.4B1 except for EX Order 26.4B1 when Resident #8 was in the hospital.

On 5/5/22 at 12:11 PM, the surveyor interviewed the EX Order 26.4B1 who stated that Resident #8 had EX Order 26.4B1 and it was a EX Order 26.4B1 that would have to be treated with medication forever. She stated that stopping the medication increases the EX Order 26.4B1 causing EX Order 26.4B1 of the EX Order 26.4B1 and could cause EX Order 26.4B1 EX Order 26.4B1 to the EX Order 26.4B1.

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F 658	Continued From page 14 On 5/9/22 at 11:19 AM, the surveyor interviewed the provider pharmacy pharmacist (RPh) who revealed the previous delivery dates of the three medications reviewed. The RPh informed the surveyor that the bottle of EX Order 26.4B1 contained a EX Ord-day supply and was delivered to the facility on EX Order 26.4B1 and EX Order 26.4B, the EX Order 26.4B1 contained a EX Ord day supply and was delivered on EX Order 26.4B1 and EX Order 26.4B1 and the EX Order 26.4B1 contained a NJ Exp-day supply and was delivered on EX Order 26.4B1, Ex Order 26.4B1. On 5/9/22 at 11:55 AM, the surveyor informed the facility Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Infection Preventionist Nurse (IPN) of the findings from 5/2/22, 5/4/22 and 5/9/22. They did not have any further information or were able to explain why these situations occurred. 2. On 5/2/22 at 12:00 PM, the surveyor observed Resident #78 in their room seated in a wheelchair. The surveyor reviewed Resident #78's medical records. The FS for Resident #78 which indicated that the resident was admitted to the facility with a diagnosis which included EX Order 26.4B1 [redacted]	F 658		

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F 658	Continued From page 15 The EX Order 26.4B1 Physician Order (PO) revealed an order dated EX Order 26.4B1 for EX Order 26.4B1 NJ Exec Order 26.4 route EX Order 26.4B1 for for a NJ Exec Order 26.4b1 if NJ Exec Order 26.4b1 and if EX Order 26.4B1 The EX Order 26.4B1 PO revealed an order dated EX Order 26.4B for EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 t 9:00 AM for EX Order 26.4B1 and an order dated EX Order 26.4B for EX Order 26.4B1 NJ Exec Order 26.4b1 by EX Order 26.4B1 daily at 9:30 PM EX Order 26.4B1 The EX Order 26.4B1 eMAR revealed an order dated EX Order 26.4B1 for EX Order 26.4B1) EX Order 26.4B1 EX Order 26.4B1 if NJ Exec Order 26.4b1 and if NJ Exec Order 26.4b1 call the Medical Doctor. An order dated EX Order 26.4B for EX Order 26.4B1 EX Order 26.4B1 once daily at 9:00 AM for NJ Ex.Order 26.4(b)(1) and an order dated NJ Exec Order for EX Order 26.4B1 NJ Exec units by EX Order 26.4B1 route daily at 9:30 PM for EX Order 26.4B1. The EX Order 26.4B1 eMAR revealed that the injection sites for EX Order 26.4B1 were not documented 11 out of 80 times that NJ Exec Order were administered and 47 out of 59 times that EX Order 26.4B1 EX Order 26.4B1 were administered.	F 658		

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F 658	Continued From page 16 The EX Order 26.4B1 eMAR also revealed that nurses did not document the dose of EX Order 26.4B1 for NJ Exec Order 26.4b1 on 13 out of 59 times that the EX Order 26.4B were administered. On 5/3/22 at 12:10 PM, the surveyor interviewed LPN#1 who's the medication nurse for Resident #78. LPN #1 stated that she was not documenting the EX Order 26.4B1, but she was unable to tell the surveyor why the NJ Exec Order 26 dosage was not documented on the eMAR. On 5/3/22 at 12:20 PM, the surveyor interviewed the Consultant Pharmacist who stated that the facility should have been documenting the NJ Exec Order 26 and the EX Order 26.4B1 administered for EX Order 26.4B1 NJ Exec Order 26.4b1. On 5/3/22 at 12:30 PM, the surveyor interviewed Resident #78's medication nurse and also the UM/LPN who acknowledged that she did not document the EX Order 26.4B1 injection sites on the eMAR. UM/LPN stated that she should have documented the NJ Exec Order 26.4b1 on the eMAR for Resident #78's EX Order 26.4B. UM/LPN was unable to answer the surveyor question regarding the NJ Exec Order 2 dose for the NJ Exec Order 26.4b1 not being documented on the eMAR. On 5/5/22 at 10:04 AM, the surveyor interviewed the UM/LPN on the EX Order 26.4B1 unit. The UM/LPN told the surveyor that she was in-service regarding the documentation of the eMAR. She stated that she was unaware that the NJ Exec Order 26 site location was a required documentation but stated that the dose of NJ Exec Order 2 administered should have been documented on the eMAR	F 658		

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F 658	Continued From page 17 On 5/5/22 at 1:20 PM, the surveyor met with the LNHA, DON, ADON and the IPN, and no further information was provided by the facility. A review of the facility's policy for Administering Medications dated 9/30/21 and was provided by the DON indicated the following: "As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered b. The dosage c. The route of administration d. The injection site (if applicable) e. Any complaints or symptoms for which the drug was administered f. Any results achieved and when those results were observed and g. The signature and title of the person administering the drug." 3. On 4/26/22 at 12:15 AM, the surveyor observed Resident #358 in his room eating lunch. The surveyor reviewed Resident #358's medical records. The FS for Resident #358 which indicated that the resident was admitted to the facility with diagnoses which included EX Order 26.4B1 [redacted].	F 658		

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F 658	Continued From page 18 The EX Order 26.4B1 PO revealed an order dated EX Order 26.4B1 give one tablet by mouth daily hold for EX Order 26.4B1 EX Order 26.4B1 The EX Order 26.4B1 eMAR revealed an order dated EX Order 26.4B1 for EX Order 26.4B1 . The eMAR revealed that the nurse failed to document the resident's HR on the eMAR from EX Order 26.4B1 through EX Order 26.4B1 On 4/27/22 at 11:00 AM, the surveyor interviewed a Licensed Practical Nurse#2 (LPN#2) who was Resident #358's medication nurse. LPN #2 stated that she will check Resident #358's HR every morning prior to administering the resident's EX Order 26.4B1 . LPN #2 stated that she should have documented the NJ Exec Order 26.4b1 in the eMAR. On 4/27/22 at 12:44 PM, the surveyor met with the DON, IPN, ADON, and the LNHA, and no further information was provided by the facility.	F 658		
F 684 SS=D	NJAC: 8-39-27.1 (a) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/24/22

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F 684	Continued From page 19 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to administer an NJ Exec Order 26.4b1 medication for a period of 14-hours which caused a resident EX Order 26.4B1 This deficient practice was identified for 1 of 5 residents reviewed for medication management (Resident #256). The evidence was as follows: On 5/3/22 at 10:18 AM, two surveyors observed Resident #256 sitting upright in a wheelchair. At that time, the resident agreed to be interviewed and the resident was interviewed in a private conference room. The resident stated that he/she was at the facility for EX Order 26.4B1, but added that, "EX Order 26.4B1 ." The resident began to elaborate that yesterday on NJ Exec Order 2 at 10 AM, he/she met with the EX Order 26.4B1 about feeling "EX Order 26.4B1 " and requested an EX Order 26.4B1 . The resident stated that the physician agreed and prescribed a EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1). On that same date and time, the resident stated that at 11 AM, Resident #256 asked for a dose of the EX Order 26.4B1 from LPN#2 who replied that the physician had not yet written the medication order. The resident then stated that he/she waited until 3 PM and asked the same nurse for EX Order 26.4B1. The resident stated that	F 684	1. Corrective Action • Resident # 256 continues to reside in the facility. • Resident # 256 is currently receiving EX Order 26.4B1 as ordered by EX Order 26.4B1 and is being followed by EX Order 26.4B1 2. Identifying other residents • Residents currently residing in the facility with new orders for Xanax have the potential to be affected. • DON/designee conducted an audit to ensure residents with orders for Xanax have received the medication delivery from pharmacy. 3. Systemic Changes • DON/designee shall in-service nurses including agency regarding the electronic back up medication supply to ensure timeliness of medication administration • The facility policy titled "Principles of Medication Administration" has been updated to reflect the process to administer as needed medications. 4. Monitoring • DON/designee shall perform audits of new orders for Xanax to ensure availability and timely administration daily x 7 days, then weekly x 4 weeks then monthly x 3 months or until sustained compliance is achieved.	

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F 684	Continued From page 20 LPN#2 replied that the order "went in at 2:15 PM and that he did not have it yet." The resident stated that he/she called the front desk at 2:30 PM, and the Receptionist stated that the pharmacy sends medications once they have enough orders. The resident stated to the Receptionist EX Order 26.4B1 EX Order 26.4B1 Furthermore, the resident stated that at 5 PM he/she requested a medication for NJ Exec Orde because he/she had not received the EX Order 26.4B1 yet and on EX Order 26.4B1 he/she asked the Registered Nurse (RN) EX Order 26.4B1?" and the RN stated they were not. The resident stated at that point he/she was EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 The resident reported that he/she stated to the RN EX Order 26.4B1 EX Order 26.4B1 At this time during the interview, the surveyor observed that the resident was EX Order 26.4B1 Also, the resident stated that the RN again stated to him/her that the medication was still not available. At that time, the resident informed the surveyors that it wasn't until he/she became EX Order 26.4B1 that a short time later he/she received the EX Order 26.4B1 The resident stated to the surveyor that the "the [medications] helped" with the EX Order 26.4B1. A review of Resident #256's medical record reflected the following: The Resident Face Sheet (an admission summary) reflected that the resident was	F 684	• Audit results shall be submitted to QAPI and addressed as appropriate.	

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F 684	Continued From page 21 admitted to the facility and had diagnoses which included but were not limited to EX Order 26.4B1 [redacted] An additional diagnoses list in the resident's electronic medical record reflected that the resident had a diagnosis of EX Order 26.4B1 [redacted] and it was entered into the electronic medical record on EX Order 26.4B1 [redacted]. The surveyor attempted to review the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in an effort to obtain the brief interview for mental status (BIMS) score. However, the MDS revealed that the assessment had not yet been completed. The resident only had an entry MDS dated EX Order 26.4B1 [redacted]. The surveyor reviewed the Social History and Assessment dated EX Order 26.4B1 [redacted] which reflected that the resident had an EX Order 26.4B1 [redacted]." A review of the medical progress note dated 5/2/22 at 11:43 AM, reflected that the resident had EX Order 26.4B1 [redacted] also reflected that the resident had EX Order 26.4B1 [redacted] and to start EX Order 26.4B1 [redacted] It indicated that prescription was given to the nurse, and that it was "Discussed with Nursing." A review of the resident's hybrid medical record reflected the corresponding physician's order	F 684		

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dated [redacted] on the Physician's Order Form for the [redacted] as needed. There was also a hard copy of a Prescription Pad sheet which indicated that the [redacted] was indicated for "[redacted]."

A review of the Physician's Orders entered into the electronic medical record reflected an order for [redacted]

A review of the electronic Medication Administration Record (eMAR) for [redacted] reflected that the [redacted] was not administered until [redacted] (This is a period of approximately 14 hours from the time it was initially ordered).

The eMAR for May 2022 further revealed that there were two other doses administered on [redacted] three doses administered on [redacted], two doses administered on [redacted] and three doses administered on [redacted] and [redacted]

Further review of the resident's progress notes reflected the following:

A medical progress note dated [redacted] at 10:21 AM reflected that the resident reported [redacted] with the new prescription of [redacted]

A nursing note dated [redacted] at 10:31 PM, reflected that the resident had [redacted], and that [redacted] were not effective however a dose of [redacted] was effective.

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F 684	Continued From page 23 A nursing note dated [NJ Exec Order 2] at 2:41 PM, reflected [EX Order 26.4B1] given with [NJ Exec Order 26.4] A review of the residents Care Plan Activity Report printed out by the DON on 5/5/22 at 3:32 PM, did not reflect documentation related to Resident #256's new diagnosis of [EX Order 26.4B1] On 5/5/22 at 2:06 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Infection Prevention Nurse (IPN). At that time the DON stated that a care plan should reflect a resident's current status and should be specific to the resident. She further stated that "you should be able to read a care plan and know which resident it is talking about." On 5/6/22 at 10:30 AM, the surveyor interviewed the IPN in the presence of the survey team. She stated that if there was a new order for a resident and that medication was in the electronic back-up medication supply, it should have been administered to the resident. She further stated that the nurse should not have waited until the pharmacy delivered the medication. She stated that if a [NJ Exec Order 26.4] needed to be removed from the electronic back-up medication supply, a witness was required. She provided the surveyor a list of medications that were available in the back-up supply which included the [EX Order 26.4B1] medication, [EX Order 26.4B1] In addition, she provided the surveyor with a "Transaction" print	F 684		

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	315520	A. BUILDING _____ B. WING _____	C 05/23/2022

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F 684	Continued From page 24 out dated [NJ Exec Order 26], which indicated that [EX Order 26.4B] was not dispensed from the electronic back-up medication supply. On 5/6/22 at 11:00 AM, in the presence of the survey team, the surveyor attempted to call the 7 AM -3 PM day shift LPN #2 that worked on [NJ Exec Order] and cared for Resident #256. There was no answer, and the surveyor left a message and requested a return phone call. On 5/6/22 at 11:16 AM, in the presence of the survey team, the surveyor attempted to call the 11 PM-7 AM night shift RN that worked on [NJ Exec Order] into [NJ Exec Order] and cared for Resident #256. There was no answer, and the surveyor left a message and requested a return phone call. On 5/6/22 at 1:33 PM, the surveyor interviewed the Social Worker in the presence of the survey team. He stated that he had met with the resident multiple times and that the resident had not brought up any issues with him with the exception of [NJ Exec Order 26.4b1]. The Social Worker told the surveyor that Resident #256 "[NJ Exec] ." The Social Worker was unaware that the resident had a new diagnosis of [EX Order 26.4B1] medication. On 5/9/22 at 11:00 AM, the surveyor conducted a phone interview with the 11 PM-7 AM night shift RN who cared for the resident from [EX Order 26.4B1] into [EX Order 26.4B1]. He stated that the resident "[EX Order 26.4B1] He stated that on [EX Order 26.4B1] the resident went to the nursing station and approached him "[EX Order] [EX Order 26.4B1] with a [EX Order 26.4B1]. He stated that the resident requested [EX Order 26.4B] and stated that he/she	F 684		

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F 684	Continued From page 25 "has been asking for EX Order 26.4B1 since 10 AM." He stated that at that time the medication had not yet arrived from the pharmacy. He stated that the resident was yelling, EX Order 26.4B1, and EX Order 26.4B1 "EX Order 26.4B1 EX Order 26.4B1." He further stated that he tried to NJ Exec Ord the resident, however Resident #256 "was EX Order 26.4B1 and that the resident "EX Order 26.4B1 [the resident] was EX Order 26.4B1." The RN stated that he was the "only one in the building who had access" to the electronic back-up medication supply. He stated that even though EX Order 26.4B1 was available in the electronic back-up medication supply, it required two people with access codes to retrieve the medication, and therefore it could not be accessed. The surveyor asked about the documentation of this, and the RN could not speak to why he had not documented this or notified the Physician. On 5/9/22 at 11:17 AM, the surveyor interviewed the IPN. She stated that the resident's LPN who worked on NJ Exec Order2 on the 7 AM-3PM shift did not have access to the electronic back-up medication supply, because he was from an agency. She further stated that during the week, during the day shift there would have been two nurses available who had access to the electronic back-up medication supply to retrieve the EX Order 26.4B EX Order 26.4B1 for the resident. On 5/9/22 at 11:47 AM, the surveyor interviewed the residents primary Physician. She stated that the resident had not exhibited EX Order 26.4B1 prior to EX Ord visit on EX Order 26.4B. She stated that a nurse requested that she visit the resident due to signs of EX Order 26.4B1 The Physician stated that the resident had an	F 684		

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F 684	Continued From page 26 EX Order 26.4B1 related to concerns about NJ Exec Order 26.4b1. She stated that she evaluated the resident and wrote an order before noon on NJ Exec Order 2 for EX Order 26.4B1. In addition, she stated that the nurse was aware that the prescription was written. The Physician stated that she was unaware that there was a delay in the administration of EX Order 26.4B to the resident. She stated that if the resident did not get the EX Order 26.4B1 until after EX Order 26 the next day, "that is too long; that's almost [redacted] hours; that is an unreasonable amount of time for a resident to wait for an EX Order 26.4B1." She stated that she had seen the resident since she prescribed the EX Order 26.4B1 and that the resident was responding well to the medication. The Physician stated that the resident EX Order 26.4B1 On 5/9/22 at 11:55 AM, the surveyor interviewed the ADON in the presence of both the survey team and the facility's LNHA, DON, and IPN. She stated that "there should always be two people in the building who have access" to the electronic back-up medication supply. On 5/9/22 at 11:27 AM, the ADON provided the surveyor with an investigation for Resident #256. The investigation acknowledged that the electronic back-up medication supply "should have been used to administer the medication until NJ Exec Order 26.4b1 arrived." A review of the [Electronic Back-Up Medication Supply brand name redacted] Station Policy dated 10/1/20, included that the "...system requires two entries to access..." In addition, it included that "Only designated nurses will have access privileges to controlled medications."	F 684		

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F 684	Continued From page 27 A review of an undated facility policy, "Principles of Medication Administration" did not reflect the process to administer as needed medications. A review of an undated facility policy, "Behavioral Assessment, Intervention and Monitoring", reflected that the nursing staff should identify and document specific details regarding changes in an individual's mental status or behaviors, including onset, intensity, frequency, including any precipitating factors or triggers. It further reflected that the interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms including anxiety and to care plan the findings from the comprehensive assessment including interventions to relieve the resident's distress. NJAC 8:39-27.1(a)(b); 27.2(h)	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documents it was determined that the facility failed to, a.) follow physician orders for [redacted] and b.) clarify existing [redacted] orders for	F 695	1. Corrective Action • Resident # 23 continues to reside in the facility. • Resident # 23 [redacted] orders have	6/24/22

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F 695	Continued From page 28 1 of 2 residents reviewed for EX Order 26.4B1 (Resident #23). This deficient practice was evidenced by the following: On 4/26/22 at 12:11 PM, during the initial tour of the facility, the surveyor observed an EX Order 26.4B1 NJ Exec Order 26.4b1 EX Order 26.4B1) in the room of Resident #23. The EX Order 26.4B1 EX Order 26.4B1 was rolled up and, in a bag, placed in the handle of the NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 was not on during observation. The surveyor asked the resident when he/she wore EX Order 26.4B1 and the resident stated they wore it EX Order 26.4B1 The surveyor reviewed the following medical records of Resident #23. The Face Sheet (admission summary) revealed that the resident was admitted to the facility with medical diagnosis included but not limited to EX Order 26.4B1 The admission Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, indicated the resident had a Brief Interview of Mental Status of EX out of 15 which indicated that Resident #23 had a EX Order 26.4B1. The NJ Exec Order 26.4b1 Resident Medication Administration Record (RMAR) reflected the	F 695	been clarified with the physician. • Resident # 23 NJ Exec Order 26.4b1 results are being documented. • Resident # 23 care plan has been updated to include a NJ Exec Order 26.4b1 focus on NJ Exec Order 26 use. 2. Identifying other residents • Residents currently residing in the facility with orders for oxygen have the potential to be affected. • DON/designee conducted an audit of residents with orders for oxygen use to ensure orders are appropriate, pulse oximeters are obtained and documented, and care plans reflect the use of oxygen per Physician order. 3. Systemic Changes • DON/designee shall in-service nurses including agency to ensure oxygen orders are appropriate and transcribed accurately on EMR. • DON/designee shall in-service nurses including agency to ensure pulse oximeters are obtained and documented as ordered. • DON/designee shall in-service nurses including agency to ensure oxygen use is reflected in respiratory care plan. 4. Monitoring • DON/designee shall perform audits of oxygen orders to ensure accuracy, ensure pulse oximeters are obtained and documented, and care plans reflect oxygen use daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until	

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F 695	Continued From page 29 following physician orders for [redacted]: 1. [redacted] Administer [redacted] to resident if pulse [redacted] was [redacted] as needed (PRN) 2. [redacted] ([redacted] if [redacted]) at [redacted] There was no documentation that the above two conflicting physician orders for [redacted] were clarified. According to the vital sign monitoring [redacted] section of the Electronic Medical Record (EMR) the only [redacted] documented was on [redacted] and the result was [redacted], the surveyor could not locate any further documentation of staff monitoring the resident's [redacted] status. The RMAR for the month of [redacted] included the order to administer [redacted] if the [redacted] was less than [redacted]. There were no [redacted] results documented and there was no evidence of signatures from the staff. The surveyor reviewed the Treatment Administration Record (TAR) for [redacted] and it did not include [redacted] checks. On 4/28/22 at 9:40 AM, the surveyor observed the resident in bed, awake. The resident was not wearing [redacted] and the [redacted] was turned off.	F 695	sustained compliance is achieved. • Audit results shall be submitted to QAPI and addressed as appropriate.	

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F 695	Continued From page 30 On 4/28/22 at 9:45 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) caring for the resident. The surveyor asked if the resident wore [NJ Exec Order 26.], and the CNA said, "they wear it sometimes, I think it was on yesterday". On 4/28/22 at 9:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was caring for Resident #23 and asked if the resident wore [EX Order 26.4B1]. The LPN stated, "yes, but not always though." The surveyor asked what the order for the [EX Order 26.4B1] was and the LPN stated, "EX Order 26.4B1 [redacted]" The surveyor asked if a [EX Order 26.4B1] level was being checked and she said "[NJ Exec Order 26.4b1] [redacted]". The surveyor asked where it was documented and she replied, "I found it in the progress notes." The surveyor asked if it was checked on regular intervals and she told the surveyor that the resident had medications with parameters, so they should check it then. The LPN could not give the surveyor regular intervals of when the EX Order 26.4B1 status was to be assessed. On 4/28/22 at 10:41 AM, the surveyor reviewed the resident's care plan. The care plan did not include a [NJ Exec Order 26.4b1] focus or that the resident utilized [redacted]. The surveyor reviewed the electronic medical record which had the resident's admission care plan and the current care plan and neither care plan included a [NJ Exec Order 26.4b1] focus on [EX Order 26.4B1]. The surveyor asked the Unit Manager/Licensed Practical Nurse (UM/LPN) who was responsible for care plan, and she stated, "me, but I have been on the med cart every day."	F 695		

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F 695	Continued From page 31 On 5/2/22 at 12:56 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Infection Preventionist Nurse (IPN), to review the surveyor's findings. No additional information was provided. A review of the facility policy titled, "Oxygen Administration" with a revision date of 2/26/21. Under the section titled Assessment, number six indicated the residents arterial gases and oxygen saturation, if applicable was to be assessed. NJAC-8:39-25.3	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a.) the appropriate monitoring of [redacted] was done in accordance with standards of practice; b.) a [redacted] management admission assessment was completed; and c.) a care plan was initiated to address [redacted] management for 1 of 5 residents reviewed for [redacted] Resident #60. This was evidenced by the following: On 5/4/22 at 10:10 AM, the surveyor observed	F 697	1. Corrective Action • Resident # 60 continues to reside in the facility. • Resident # 60 [redacted] assessment has been completed. • Resident # 60 care plan has been updated to address [redacted] management. 2. Identifying other residents • Residents currently residing in the facility receiving Tramadol medication as needed have the potential to be affected.	6/24/22

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F 697	Continued From page 32 Resident #60 sitting in their wheelchair, [redacted] to the surveyor's questions. The surveyor asked the resident how she was doing and the resident answered that she was 'EX Order 26.4B1 and denied [redacted] during the interview. During the interview of the surveyor on that same date and time, the resident stated that their preferred [redacted] medication for [redacted] was EX Order 26.4B1. The resident further stated that the EX Order 26.4B1 is "[redacted]." The resident was knowledgeable of their current EX Order 26.4B1. The resident informed the surveyor that she can ask the nurse for EX Order 26.4B1 when needed and it was being given to the resident promptly. The resident further stated that the [redacted] The resident's Face Sheet (an admission summary) reflected that Resident #60 was admitted to the facility with diagnoses that included but were not limited to [redacted] The Quarterly Minimum Data Set (QMDS), an assessment tool used for management of care, dated EX Order 26.4B1 revealed a Brief Interview for Mental Status (BIMS) score of [redacted] of 15 which indicated that the resident was EX Order 26.4B1. The QMDS under [redacted] Management showed that Resident #60 experienced EX Order 26.4B1. Further review of the medical record revealed that there was no care plan initiated to address Resident #60's [redacted] management.	F 697	• DON/designee conducted an audit of residents on PRN tramadol to ensure pain re-assessments are performed and documented. 3. Systemic Changes • DON/designee shall in-service nurses including agency regarding pain assessment documentation for the effectiveness of pain medication after administration • DON/designee shall in-service nurses including agency regarding the completion of Pain Assessment upon admission/readmission. • DON/designee shall in-service nurses including agency regarding Pain Management Policy 4. Monitoring • DON/designee shall perform audit on Pain re-assessment documentation for the effectiveness of pain medication after administration daily x 7 days, weekly x 4 weeks, monthly x 3 months or until sustained compliance is achieved. • DON/designee shall perform audit on Pain Assessment completion upon admission/readmission daily x 7 days, weekly x 4 weeks, monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI and addressed as appropriate.	

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F 697	Continued From page 33 A review of the assessment titled, "Admission EX Order 26 Assessment" initiated on EX Order 26.4B1 was not completed. The Physician's re-admission progress notes dated EX Order 26.4B1 documented the resident's diagnosis that included but not limited to EX Order 26.4B1 EX Order 26.4B1 The resident's EX Order 26.4B1 electronic Medication Administration Record (eMAR) showed a physician's order dated EX Order 26.4B for a EX Order 2 medication, EX Order 26.4B1) by EX Order 26 route every 12 hours as needed (PRN) for EX Order 26.4B1 , EX Order 2 scale of a EX Order A review of the EX Order 26.4B1 eMAR indicated that the resident received EX Order 26.4B1 EX Orde by mouth EX Order 26.4B1) on the following dates and times: EX Order 26.4B1 [redacted]	F 697		

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F 697	Continued From page 34 EX Order 26.4B1 [redacted] The clinical progress notes or the eMAR's did not reflect evidence that the resident was assessed for the effectiveness of the [redacted] medication after it was administered on the corresponding dates and times. During an interview with the surveyor on 5/3/22 at 11:14 AM, the Licensed Practical Nurse (LPN) acknowledged to the surveyor that the resident received [redacted] medication PRN when requested by the resident. The surveyor asked the LPN if a [redacted] care plan should be developed. The LPN stated, "it should be" to help the staff provide care and meet the resident's needs. The LPN acknowledged to the surveyor that there was no care plan initiated since the resident's admission to the facility and did not provide any information on why it was not initiated. On 5/5/22 at 10:50 AM, the surveyor interviewed the LPN /Unit Manager (LPN/UM) who acknowledged that there was no care plan initiated for Resident #60 to address the [redacted] management. During an interview with the surveyor on 5/6/22 at 9:21 AM, the Registered Nurse (RN) acknowledged that a [redacted] assessment must be completed upon resident's admission/re-admission. The RN further stated, [redacted] is important to assess to establish a base line for a resident."	F 697		

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F 697	Continued From page 35 On that same date and time, the RN stated to the surveyor the importance to re-assess the resident after giving any [EX Order 26] medication for effectiveness and to document in the progress notes. Then the surveyor reviewed Resident #60's progress notes in the presence of the RN who agreed that there was no re-assessment documentation of the effectiveness of the [EX Order 26] medication. On 5/6/22, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team who stated, "I certainly think that it would be appropriate" for the nursing staff to document effectiveness of [EX Order 26.4B1] medication in the progress notes to know if the [EX Order 26] medication was working for the resident. A review of the facility's policy titled; "Pain Assessment" reflected under procedure 1.) A Pain Assessment will be completed for any resident with objective/subjective symptoms of pain, upon admission/readmission, quarterly, and as needed. A review of the facility's policy dated 9/2021 titled, "Pain Management" reflected that an assessment after the administration of p.o. (by mouth) medication should be done at least one hour after the medication has been administered. The results of this assessment will be documented in the clinical progress notes. A review of the facility's policy dated 9/2021 revealed under "Policy Interpretation and Implementation" 1.) Comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS).	F 697		

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F 697	Continued From page 36 A review of the facility's policy titled "Admission Assessment and Follow Up: Role of the Nurse" reflected to conduct supplemental evaluations (following facility forms and protocol) including: pain evaluation. On 5/9/22 at 1:20 PM, the survey team met with the Administrator, DON, Assistant Director of Nursing, Infection Control Nurse, and the Pharmacy Consult. There was no additional information provided. NJAC 8:39-27.1 (a)	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical records, it was determined that the facility failed to: a.) sequence medications according to a resident's [NJ Exec Order 26.] schedule and notify the physician for missed doses and b.) complete the resident [NJ Exec Order 26.] assessments and document on the [NJ Exec Order 26.4b] communication sheets. This deficient practice was identified for 4 of 4 residents reviewed for [NJ Exec Order 26.] (Resident #1, #23, #60, and #156). The evidence was as follows:	F 698	1. Corrective Action • Resident # 1 and # 156 no longer reside at the facility. • Resident # 23 and # 60 continue to reside at the facility. • Resident # 23 and # 60 [NJ Exec Order 26.4] Communication forms are currently being completed including the resident's assessment upon return from [NJ Exec Order 26.]. 2. Identifying other residents • Residents currently residing in the facility and receiving dialysis have the	6/24/22

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F 698	Continued From page 37 1. On 4/25/22 at 11:33 AM, during the initial tour, the Registered Nurse (RN) informed the surveyor that Resident #1 would routinely leave for EX Order 26.4B1 [redacted]) services on Tuesday, Thursday, and Saturday from around 6:00 AM and would return to the facility between 11:00 AM to 1:00 PM. On 4/27/22 at 11:19 AM, the surveyor interviewed Resident #1. The resident was responding appropriately to the surveyor's questions, and confirmed that their [redacted] was every Tuesday, Thursday, Saturday, and the pickup time was around 6:00 AM and returned to the facility between 11:00 AM to 1:00 PM. The surveyor reviewed Resident #1's medical records. The Face Sheet (FS), an admission summary, reflected that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 . The hybrid (paper and computer generated) medical records showed that Resident #1 goes out to the [redacted] center on Tuesday, Thursday, and Saturday every week. The April 2022 electronic Resident Medication Administration Record (eRMAR) reflected the following medications plotted to be administered at 9:00 AM: EX Order 26.4B1 [redacted] (mg) fo [redacted]	F 698	potential to be affected. • DON/designee conducted an audit of residents receiving dialysis to ensure that Dialysis Communication forms, pre/post assessments are documented, medications are administered as ordered and care plans are updated. 3. Systemic Changes • DON/designee shall in-service nurses including agency regarding Dialysis policy. • DON/designee shall in-service nurses including agency regarding the completion of Dialysis Communication forms to include pre and post assessments of resident. • DON/designee shall in-service nurses including agency regarding medication administration for dialysis residents to ensure medications are administered as ordered. • Unit Manager shall review Dialysis Communication Forms to ensure completion. 4. Monitoring • DON/designee shall audit dialysis communication forms daily x 7 days then weekly x 4 weeks then monthly x 3 months or until sustained compliance is achieved. • DON/designee shall audit dialysis medications to ensure medications are administered as ordered daily x 7 days, then weekly x 4 weeks then monthly x 3 months or until sustained compliance is achieved.	

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F 698	Continued From page 38 in patients with NJ Exec Order 26.4b1), NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 A review of NJ Exec Order 26.4b1 eRMAR also reflected that a symbol of an asterisk in the "Legend" represented that a medication was "Not Administered (see last section)." Resident #1's medical record revealed that the following medications were plotted on the eRMAR for NJ Exec Order 26.4b1 EX Order 26.4B1 (EX Order 26.4B1) EX Order 26.4B1 by mouth three times daily at EX Order 26.4B1. This medication was not administered by a nurse on EX Order 26.4B1 at 9:00 a.m. The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1 and the "Reason" was EX Order 26.4B1]".	F 698	• DON/designee shall audit Dialysis Care Plans to reflect resident status daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI to be addressed as appropriate.	

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EX Order 26.4B1 EX Order 26.4B1 once daily in the morning at 9:00 AM was not administered on NJ Exec Order 26.4 and NJ Exec Order 26.4. The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1 the "Reason" EX Order 26.4B1

EX Order 26.4B1 tablet by mouth once daily at 9:00 AM. This medication was not administered by a nurse on EX Order 26.4B1. The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1 nd the "Reason" was EX Order 26.4B1

EX Order 26.4B1 This medication was not administered by a nurse on NJ Exec Order 26.4 and NJ Exec Order 26.4 at 9:00 AM. The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1 and the "Reason" was EX Order 26.4B.

EX Order 26.4B1 capsule by mouth twice a day at 9:00 AM and 5:00 PM This medication was not administered by a nurse on EX Order 26.4B1 and EX Order 26.4B1 The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1 and EX Order 26.4B1 9:00 AM and the "Reason" was EX Order 26.4B".

EX Order 26.4B1 tablet by mouth once daily at 9:00 AM. This medication was not administered by a nurse on EX Order 26.4B1. The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1, EX Order 26.4B1 and the

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"Reason" was EX Order 26.4B1

EX Order 26.4B1 by mouth three times a day with meals, do not crush at EX Order 26.4B1. This medication was not administered by a nurse on EX Order 26.4B1. The "Reason" was "Office Visit." This medication was also not administered on EX Order 26.4B1 and the "Reason" was EX Order 26.4B1

EX Order 26.4B1 by mouth EX Order 26.4B a day at EX Order 26.4B1. This medication was not administered by a nurse on EX Order 26.4B1 and the "Reason" was " EX Order 26.4B

EX Order 26.4B1 EX Orde at 9:00 AM and 5:00 PM. This medication was not administered on EX Order 26.4B1 at 9:00 AM and the "Reason" was EX Order 26.4B. This medication was also not administered on EX Order 26.4B1 at 9:00 AM and the "Reason" was EX Order 26.4B1"

EX Order 26.4B1 EX Order 26.4B1 per day at EX Order 26.4B1. This medication was not administered on EX Order 26.4B1 and the "Reason" was EX Order 26.4B1

The surveyor reviewed the Consultant Pharmacist Recommendations (CPR) to Nursing dated NJ Exec Order 26.4 at 7:21 AM, which reflected a Consultant Pharmacist's (CP) recommendation to, "Schedule all medications in relation to NJ Exec Order 26.4 chair times: EX Order 26.4B1 3, A.M. EX Order 26.4B1 etc..."

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F 698	Continued From page 41 The [redacted] Communication Log" (a communication tool between the facility and the [redacted] Center) which revealed that the log sheet for the resident assessment was not filled out by the facility upon the resident's return to the facility on the following dates: EX Order 26.4B1, EX Order 26.4B1 [redacted]. The surveyor reviewed the nursing Progress Notes which indicated that the nurses did not reflect consistent documentation of the assessment of Resident#1's vital signs and [redacted] after returning from the [redacted] for month of [redacted] except for dates [redacted]. On 05/02/22 at 10:10 AM, the Licensed Practical Nurse/Unit Manager#1 (LPN/UM#1) informed the surveyor that the documented [redacted] in the last section of eMAR represented EX Order 26.4B1." He also stated that [redacted] and "Office Visit" in the last section of the [redacted] eRMAR meant that the resident was out for his/her [redacted] appointment. On that same date and time, LPN/UM#1 acknowledged to the surveyor that the resident's 9:00 a.m. medications were not given and administered on his/her [redacted] days. LPN/UM#1 stated that the resident's 9:00 a.m. medications during [redacted] days "should've been adjusted, but it wasn't done." Furthermore, LPN/UM#1 stated that the resident's primary physician was not notified of the missed 9:00 am medications on [redacted] days. He further stated that the physician "should have been notified" to discuss the resident's [redacted] days and time of leaving and returning to the facility	F 698		

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F 698	Continued From page 42 and to verify medication administration time adjustments on [NJ Exec] days vs non-[NJ Exec] days. On 5/4/22 at 10:10 AM, the surveyor interviewed LPN/UM#1. LPN/UM#1 reviewed the resident's [NJ Exec Order 26.4] Communication Log sheets in the presence of the surveyor. LPN/UM#1 acknowledged that the nurses were "not filling in" the [EX Order 26.4B1] communication sheets upon the resident's return to the facility. He further stated that the nurses "should've filled in" the [EX Order 26.4B1] Communication Log sheets and recorded the resident's vital signs and the [NJ Exec Order 26.4b1] "as soon" as the resident returned to the facility. On 5/5/22 at 11:17 AM, the surveyor interviewed LPN/UM#1 with regard to the above [NJ Exec Order 26.4] [NJ Exec Ord] to nursing. LPN/UM#1 informed the surveyor that the pharmacy consultant's recommendations to nursing dated [EX Order 26.4B1] were "not followed through" until the surveyor's inquiry on [EX Order 26.4B]. On 5/5/22 at 2:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Infection Control Nurse (IPN). The ADON stated that the nurse receiving the resident who was returning from the [NJ Exec] should check the resident's vital signs and [NJ Exec Order 26.4b1] for a [NJ Exec Order 26.4b1] (determines if the [EX Order 26.4B1] access functioning properly) "right away, immediately" upon the resident's return to the facility from the [EX Order 26.4B1] On 5/9/22 at 1:20 PM, the survey team met with the LNHA, DON, ADON, IPN, and CP. No additional information was provided to the survey team to refute the surveyor's findings.	F 698		

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F 698	Continued From page 43 2. On 04/25/22 at 11:06 AM, during the initial tour of the facility the resident was out of the building at the [EX Order 26.4B1] center and was unavailable for an interview. The surveyor reviewed the medical records of Resident #23. The FS revealed that the resident with diagnosis included but not limited to [EX Order 26.4B1] [redacted] The admission MDS dated [EX Order 26.4B1], indicated that Resident #23 had a BIMS score of [redacted] out of 15, meaning the resident had [EX Order 26.4B1] [EX Order 26.4B1] Review of section O of the MDS, titled special procedures/treatments, indicated the resident went to the [EX Order 26.4B1] center for treatments prior to admission to the facility. The physician orders in the [NJ Exec Order 26.4b1] Electronic Medical Record (EMR) which revealed the following order dated [NJ Exec Order 26.4B] [EX Order 26.4B1]; MON- WED - FRI via wheelchair, [NJ Exec Order 26.4b1] Chair time: 6 am pick up: 5 - 5:30 am, Return time: 10 am." Further review of the physician orders showed the following order dated [NJ Exec Order 26.4] : Monitor [NJ Exec O] [EX Order 26.4B1] [redacted] and	F 698		

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F 698	Continued From page 44 maintain [redacted] and intact every shift. The surveyor reviewed the care plan initiated on [redacted] which included a focus of [redacted]). [redacted]. One of the interventions on the care plan was that communication would occur between the facility skilled nursing staff and the [redacted] center related to the care needs of patient. The [redacted] communication book which had the forms for [redacted], reflected a total o[redacted] treatments. The forms contained three sections, one to be filled out prior to leaving facility, one for the [redacted] center to complete following the treatment at the [redacted] center and one section to be completed when the resident returned to the facility. Each section included vital signs and assessment of the [redacted] access. After review of the communication forms, it revealed that 15 of the 27 forms were blank in section three, meaning when the resident returned from the [redacted] center the facility did not complete the resident's assessment. On 4/26/22 at 11:56 AM, the surveyor interviewed Resident #23 who was in bed. Resident #23 stated, [redacted]." The surveyor asked the resident how the [redacted] center did the treatments (meaning which type of [redacted] was being used for [redacted]) and the resident said, [redacted]. On 5/4/22 at 10:29 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN). The LPN told the surveyor that before the resident	F 698		

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goes to [redacted] the residents' [redacted] and [redacted] are checked and the [redacted] is checked. The information then gets documented in the communication form book that goes with the resident to [redacted] The LPN stated when the resident returns from [redacted], the vitals are checked again and the [redacted] site would be assessed and "it gets put in the bottom of the page in the book, we do the top and bottom of the paper in the book".

On 5/4/22 at 10:35 AM, the surveyor interviewed LPN/UM#2 regarding the [redacted] process. The LPN/UM told surveyor that vital signs [redacted] are checked and the [redacted] site checked for a [redacted] (determines if [redacted] access functioning properly) and everything gets documented in the [redacted] communication book. On return from [redacted] LPN/UM#1 stated, "the [redacted] and the [redacted] are checked, and it's also put in the book, on the bottom of the communication sheet." The surveyor asked why it was important to check the blood pressure on return from [redacted] they can be [redacted]. The surveyor asked why some pages were blank and LPN/UM#2 could not speak to it.

On 5/6/22 at 11:15 AM, the surveyor reviewed the dialysis policy in the presence of the ADON. The undated policy, titled "Dialysis Policy", contained a section titled, "Resident Care Information" which said the facility and the center shall provide each other with resident care information and other documentation relevant to the proper care of the resident including but not

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F 698	Continued From page 46 limited to medical, social, nursing and other care plans and such other additional resident care and documentation as requested and necessary by each party's attending physicians. The facility shall provide the center with the care planning needs of their residents. The surveyor asked the ADON if there was a policy related to the nurse-to-nurse communication between facility and dialysis center and she responded, "I'm not sure, but I can add it to this policy". 3. On 4/27/22 at 9:42 AM, the surveyor observed Resident #60 in the doorway of the bedroom in a wheelchair. The resident stated that the resident went to [NJ Exec] every Monday, Wednesday and Fridays and treatment started at 2 PM. The resident stated that he/she returned from [NJ Exec] on the 3 PM to 11 PM evening shift but could not state whether or not he/she was consistently assessed by the nurse upon return. The surveyor reviewed Resident #60's medical records. The resident's FS reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, [NJ Exec Order 26.4b1] [redacted] A Quarterly MDS dated [EX Order 26.4B1] reflected a BIMS score of [EX Ord] out of 15 which reflected a fully intact cognition. It further reflected [EX Order 26.4B1] [redacted] The Physician's Orders for [EX Order 26.4B1] reflected an [EX Order 26.4B1] [NJ Exec] on [EX Order 26.4B1] [redacted]	F 698		

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F 698	Continued From page 47 at 2 PM. Care Plan Activity Report provided by the ADON and printed on [NJ Exec Order] at 10:44 AM, reflected a [NJ Exec Order 26.4] goal that "Resident will tolerate [NJ Exec Order 26.] without complications as evidenced by [NJ Exec Order] and no episodes of [EX Order 26.4B1] The resident's [NJ Exec Order 26.4b] Communication Log" sheets from [NJ Exec Order 26.4b1] reflected that eight (8) out of 13 [NJ Exec Order 26.4b] nursing facility assessment sections were not completed, specifically on [NJ Exec Order 26.] [NJ Exec Order 26.] [NJ Exec Order 26.4INJ Exec Order 26.4b1] [NJ Exec Order 26.], [NJ Exec Order 26.], [NJ Exec Order 2], and [NJ Exec Order 26.]. It indicted that "Upon Return", the residents vital signs should have been evaluated as well as assessment to the [NJ Exec] " The progress notes for the dates noted above did not reflect documented evidence for assessments of the resident [NJ Exec Order 26.4b1] On 5/5/22 at 9:32 AM, the surveyor interviewed the LPN/UM#3. In the presence of the surveyor, LPN/UM#3 reviewed the resident's "[NJ Exec Order 26.4b] Communication Log" sheets from [NJ Exec Order 26.4] to [NJ Exec Order 26.] The LPN/UM#3 acknowledged that eight (8) out of 13 [NJ Exec Order 26.4b] nursing facility assessment sections were not completed and should have been done and documented. She stated that "the nurse just did not do it." She stated that the day shift nurse fills out the top of the log which reflected the resident's status prior to leaving for [NJ Exec], so that the [NJ Exec] facility was aware. She then stated that the [NJ Exec] center completed their section on the form which included [NJ Exec Order 26.4b1] and any other pertinent	F 698		

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F 698	Continued From page 48 information related to the resident's appointment; [redacted]."	F 698		

On that same date and time, LPN/UM#3 stated that "it is important to assess the resident upon return to make sure the [redacted], not [redacted] and that the vital signs are stable especially if something happened at the [redacted] center." LPN/UM#3 further stated that the resident returned on the 3 PM - 11 PM evening shift and "the nurse knows to fill this out" and that "there is no 3 - 11 supervisor" and that "the 3-11 supervisor would be responsible to oversee it was being done."

On 5/5/22 at 2:06 PM, the survey team met with the LNHA, DON, ADON and IPN. The ADON stated that when a [redacted] resident returned from a treatment, the nurse should assess the resident's [redacted] and that the resident was stable. She further stated that she would immediately assess the resident to ensure that there were no acute changes. In addition, she stated that this information should have been documented on the "[redacted] Communication Log" sheets.

On 5/5/22 at 3:00 PM, the DON stated that the nurse that received the resident [redacted] was responsible to ensure the [redacted] form was completed and that there was a nursing supervisor on the 3-11 shift Tuesday and Thursday only.

4. On 04/25/22 at 12:15 PM, the surveyor observed Resident #156 inside the their room

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F 698	Continued From page 49 eating lunch. The surveyor reviewed Resident #156's medical records. The FS of Resident #156 revealed that the resident was admitted to the facility with diagnosis that included but not limited to EX Order 26.4B1 The admission MDS dated EX Order 26.4B1, indicated that Resident #156 had a BIMS score of EX Ord out of 15, meaning the resident was EX Order 26.4B1. Review of section EX Ord of the MDS, titled special procedures/treatments, indicated the resident was a EX Order 26.4B1 resident on admission. The physician orders in the EMR which showed the following order: EX Order 26.4B1; MON-WED - FRI schedule Chair time at 3 PM." Resident #156's individualized care plan which had a focus on the EX Order 26.4B1 with the goal that the resident will tolerate NJ Exec Order 26.4 without complication as evidenced by EX Order 26.4B1 of EX Order 26.4B1, and the resident NJ Exec Order 26.4b1 and maintain patency of same with an effective date of NJ Exec Order 26.4. There were no interventions documented for this individualized care plan. A review of Resident #156's EX Order 26.4B1 communication book which had the forms for EX Order 26.4B1, a total of EX Order 26.4B1 treatments. The communication forms revealed	F 698		

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F 698	Continued From page 50 that 2 of the 14 forms were blank in section one, meaning that the resident assessment was not complete prior to being sent to [NJ Exec Order 26.4]. The [NJ Exec Order 26.4] communication forms also showed that 11 of the 14 forms were blank in section three, meaning when the resident returned from the [NJ Exec Order 26.4] center the facility did not complete the resident's assessment. On 5/4/22 at 10:10 AM, the surveyor interviewed the LPN/UM#1 on the [EX Order 26.4B1] unit. The LPN/UM#1 stated that the [EX Order 26.4B1] communication book must be filled out by nurses prior to the resident going out on [EX Order 26.4B1] and must also be filled out [EX Order 26.4B1 NJ]. Nurses need to document the resident's vital and check [NJ Exec Order 26.4b1] both prior and upon returning from [NJ Exec Order 26.4b]. He further stated that nurses who don't document the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] information are not following the facility policy. NJAC 8:39-2.9, 27.1(a)	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		6/24/22

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F 755	Continued From page 51 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to: a.) keep accurate accountability records of NJ Ex.Order 26.4(b)(1) in 2 of 3 residents reviewed for NJ Exec Order 26.4b1 accountability (Resident# 47 and #63) and b.) acquire important medications for a resident's EX Order 26.4B1 EX Order 26.4B for 1 of 1 residents (Resident #78). This deficient practice was evidenced by the following: 1. On 5/5/22 at 9:20 AM, the surveyor interviewed Resident #47 who was in their room and stated that they were comfortable. The surveyor reviewed Resident#47's medical records.	F 755	F 755 SS=E 1. Corrective Action • Resident # 47 continue to reside in the facility. • Resident # 63 continue to reside in the facility. • Resident # 63 EX Order 26.4B1 is being administered as ordered and documented on EMAR as well as the narcotic declining inventory sheet. • Resident # 78 continues to reside in the facility and has not gone EX Order 26 from the facility.	

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F 755	Continued From page 52 Resident #47's Face Sheet (FS), an admission summary, that documented diagnosis including but not limited to EX Order 26.4B1 EX Order 26.4B1 EX Order2, and EX Order 26.4B1 . Resident #47's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated EX Order 26.4B1 showed Brief Interview for Mental Status (BIMS) score of EX Ord of 15 which indicated that the resident's EX Order 26.4B1 EX Order 26.4B1 . On 5/2/22 at 11:25 AM, the surveyor inspected medication cart #7 on the EX Order2 floor. The surveyor noted five nurse's entries on the back of the EX Order 26.4B1 medication, EX Order 26.4B1 EX Order 26.4B1 tablet NJ Exec Order 26.4b1 Record sheet belonging to Resident #47 that was titled, "Destroyed/Wasted Medication Doses." There was an entry for Dose #14 as "popped out," #13 as "wasted," #12 as "popped out," #9 as "wasted," and #8 as "wasted," that included 2 nurses' signatures. The dates of these entries coincided with the dose #14 was NJ Exec Order 26.4b1 at 9:30 PM which was also documented as administered on the eMAR, #13 was NJ Exec Order 26.4b1 at 9:00 PM which was also documented as administered on the NJ Exec Order 26.4b1 electronic Medication Administration Record (eMAR), #12 was NJ Exec Order 26.4b1 at 9:00 PM which was also documented as administered on the NJ Exec Order 26.4b1 eMAR, #9 was NJ Exec Order 26. at 8:45 PM which was also documented as administered on the NJ Exec Order 26.4b1 eMAR and #8 was NJ Exec Order 26. at 8:42 PM which was also documented as administered on the NJ Exec Order 26.4b1 eMAR.	F 755	2. Identifying other residents • Residents currently residing in the facility and receiving oxycodone has the potential to be affected, • Residents currently residing in the facility who have orders for LOA and require insulin medication have the potential to be affected. • DON/designee conducted an audit of residents who request LOA to ensure appropriate medications are provided upon leaving the facility. 3. Systemic Changes • DON/designee shall in-service nurses including agency regarding narcotic administration, documentation on EMAR, completion of narcotic inventory sheet to ensure the facility maintains accurate records of controlled substances. • DON/designee shall in-service nurses including agency regarding LOA policy and protocols to ensure residents acquire medications as ordered by the physician and provided to the resident/family prior to LOA to include instructions. • DON/designee shall in-service nurses including agency regarding documentation related to a resident's detailed info when leaving for and returning from LOA. • DON/designee shall in-service nurses including agency regarding pharmacy related protocols related to extended LOA including which type of medications are provided and not provided by pharmacy. • DON/UM shall ensure any requests for LOA are reviewed and addressed.	

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F 755	Continued From page 53 The surveyor reviewed the EX Order 26.4B1 EX Order 26.4B1 eMAR which all had a physician's order documented for EX Order 26.4B1. The physician's order was EX Order 26.4B1) every [redacted] hours as needed for EX Order 26.4B1. Review of the NJ Exec Order 26.4b1 Record sheet revealed removal of EX Order 26.4B1 documented on EX Order 26.4B1 at 9:00 PM. There was no entry on the EX Order 26.4B1 eMAR for EX Order 26.4B1 documenting as administered to Resident #47. Review of the NJ Exec Order 26.4b1 Record sheet revealed removal of EX Order 26.4B1 documented on NJ Exec Order 26. at 9:00 PM, NJ Exec Order 26. at 9:00 PM, and NJ Exec Order 26.4b1 at 9:00 PM. There were no entries on the NJ Exec Order 26.4b1 eMAR for any of the doses removed documenting as administered to Resident #47. Review of the NJ Exec Order 26.4b1 Record sheet revealed removal of EX Order 26.4B1 documented on EX Order 26.4B1. There was no entry on the EX Order 26.4B1 eMAR for the EX Order 26.4B dose removed documenting as administered to Resident #47. Review of the facility Principles of Medication Administration section 9. documents: a. Sign controlled medication sheet after you remove medication from stock bottle/unit dose package. b. Administer controlled medication c. Sign medication administration record 2. On 5/5/22 at 10:00 AM, the surveyor interviewed Resident #63 who was in their	F 755	4. Monitoring • DON/designee shall audit narcotic documentation on EMAR, narcotic declining sheet to ensure the facility maintains accurate records of controlled substances daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • DON/designee shall audit nurses' progress notes related to scheduled LOA to ensure LOA protocols are followed and residents acquire medications as ordered by the physician and provided to the resident/family prior to LOA to include instructions daily x 7 days, then weekly 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate	

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wheelchair and stated that they experienced [EX Order 2] after their admission to the facility but was feeling [NJ Exec Order 26.4b1]

The surveyor reviewed Resident #63's FS that documented diagnosis including but not limited to [EX Order 26.4B1]

[EX Order 26.4B1]

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On 5/2/22 at 11:25 AM, the surveyor inspected medication cart #7 on the [EX Orde] floor. The surveyor noted a nurse's entry on the back of the [EX Order 26.4B1] [NJ Exec Order 26.4b1] Record sheet belonging to Resident #63 that was titled, "Destroyed/Wasted Medication Doses." There was an entry for '[NJ Exec Order 26.4b1]," that included two nurses' signatures but did not include a date.

The surveyor reviewed the [EX Order 26.4B1] eMAR and found two physician's orders documented. The physician's orders were [EX Order 26.4B1] [EX Orde] hours as needed for [EX Order 26.4B1] and [EX Order 26.4B1] needed for [EX Order 26.4B1]

Review of Resident #63's Annual MDS dated [NJ Exec Order 26.] with a BIMS score of [EX Ord] of 15 which indicated that the resident's [EX Order 26.4B1].

The eMAR for [EX Order 26.4B1] revealed

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F 755	Continued From page 55 administrations of EX Order 26.4B1 tablet on [redacted]. The NJ Exec Order 26.4b1 eMAR revealed administrations of EX Order 26.4B1 [redacted] The Individual Patient's NJ Exec Order 26.4b1 Record, a perpetual inventory documented all the above dates administered as well as additional tablets for EX Order 26.4B1 [redacted] removed from inventory and not documented as administered. The additional dates are [redacted] A comparison of the Individual Patient's NJ Exec Order 26.4b1 Record and the NJ Exec Order 26.4b1 eMAR reveals [redacted] tablet of EX Order 26.4B1 signed as removed from inventory on [redacted] at 12:00 PM and [redacted] at 8:00 AM, but it was never documented as administered on the NJ Exec Order 26.4b1 eMAR. On 5/6/22 at 1:12 PM, the surveyor informed the facility Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Infection Preventionist Nurse (IPN) of the findings on [redacted] and [redacted]. They were neither able to provide any further information nor were able to explain why these discrepancies occurred.	F 755		

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3. On 5/2/22 at 12:05 PM, the surveyor interviewed Resident #78 who was seated in a wheelchair inside the resident's room. The resident informed the surveyor that he/she left the facility on an EX Order 26.4B1 on EX Order 26.4B1 and returned to the facility the following morning EX Order 26.4B1). Resident #78 stated to the surveyor that prior to leaving the facility the nurse handed a bag containing EX Order 26 medication. The resident stated when they got to their brother's house the bag contained NJ Exec Order 26.4b1 EX Order 26.4B1 for NJ Exec Order 2 and EX Order 26.4B1 and EX Order 26.4B1. The resident stated that their brother had a EX Order 26.4B1 and NJ Exec Order 26.4b1, and they were able to check their EX Order 26.4B1 which was EX Order.

The surveyor reviewed Resident #78's medical records.

The Admission Record for Resident #78 which indicated that the resident was admitted to the facility with a diagnoses which included EX Order 26.4B1 .

The Quarterly MDS dated EX Order 26.4B with a BIMS score of NJ Exe of 15, meaning the resident had a EX Order 26.4B1. Review of section I of the MDS, titled Active Diagnoses, indicated under EX Order 26.4B1 .

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The [redacted] Physician's Orders (PO) revealed an order dated [redacted] for [redacted] route [redacted] times per day for [redacted] for a [redacted]: if [redacted] call the Medical Doctor.

According to the [redacted] revealed an order dated [redacted] for the [redacted] for [redacted] and an order dated [redacted] for the [redacted] daily at 9:30 PM for [redacted]

The facility's Request for Pass Medications (RPM) revealed that the request form was filled out for Resident #78 and indicated that the resident will out on pass from 10 AM on [redacted] until 11 AM on [redacted]. The form was filled out on [redacted] and it requested that medications to be sent by [redacted]. The RPM contained a list of medication with their quantities. The list contained [redacted] and [redacted].

The [redacted] Electronic Medication Administration Record revealed on [redacted] at 7:30 AM that Resident #78's [redacted] and that the resident was administered [redacted]

A review of the facility progress notes (PN) revealed that there was no note documenting that the resident was going on a [redacted]. Further,

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there was no documentation as to when and how the resident had returned from the EX Order 26.

On 5/3/22 at 10:05 AM, the surveyor called the provider pharmacy and interviewed the provider Pharmacist (RPH). The RPH stated that the Pharmacy didn't supply EX Order 26.4B1 and over the counter medications for a leave of absence. The RPH stated that the facility was aware that the pharmacy doesn't supply EX Order 26.4B for a EX Order 26

On 5/5/22 at 10:11 AM, the surveyor interviewed Resident #78's medication nurse, a Licensed Practical Nurse (LPN). The LPN stated that she should have documented in the progress notes that the resident was leaving on a EX Order 26 and should have written a progress note when the resident returned to the facility. The LPN indicated that she did not review the medication with Resident #78, she stated that she handed the resident a bag of medication. After further questioning, the LPN stated that she supplied no EX Order 26.4B1 to the resident prior to leaving the facility. She also admitted that she did not provide Resident #78 with education and stated she was by herself, and it was the first time she had a resident EX Order 26.4B1.

On 5/5/22 at 11:00 AM, the surveyor interviewed the 3rd floor Licensed Practical Nurse/Unit Manager (LPN/UM#1). LPN/UM#1 informed the surveyor that she was unaware that the pharmacy doesn't provide EX Order 26.4B1. She stated that she was not educated by the facility regarding medications that are not provided by the pharmacy. She further stated that when a resident is EX Order 26.4B1 it was facility protocol that a nurse receiving the medication

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F 755	Continued From page 59	F 755		

must review all medications. If a medication is missing the nurse should contact the pharmacy. If the pharmacy is unable to provide a medication, then the nurse should call the physician. She also stated that the nurse must review the medication with the resident or a resident representative prior to the resident leaving the facility. She told the surveyor that Resident #78 was a[EX Order 26.4B1] and that she would have never let the resident leave the facility without their[EX Order 26.4B1]

On 5/5/22 at 11:31 AM, the surveyor interviewed LPN/UM#2 on the [NJ Exec Order 26.4b1] unit, LPN/UM#2 who stated that he received the pharmacy delivery that contained Resident #78's[EX Order 26] medications. He told the surveyor that facility protocol was for the receiving nurse to deliver the medication to each unit. It's the responsibility of the unit nurse to review all their medications. He told the surveyor that he was unaware that the pharmacy won't supply[EX Order 26.4B1]. He told the surveyor that he was never educated about the medications not supplied for[EX Order 26.4B]. He also noted that the nurse receiving the[EX Order 26] medication must review and make sure that all requested medication is accounted for and if a medication is missing, they need to contact the provider pharmacy. He also stated that if a pharmacy was unable to supply a medication that the nurse needs to call the physician. He also stated that the nurse must review[EX Order 26] medications with the resident and that he would have never allow a resident to leave the facility without a vital medication such as[EX Order 26.4B1].

A review of the facility's Policy for Leave of Absence Policy that was undated and was

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	315520	A. BUILDING _____ B. WING _____	C 05/23/2022

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F 755	Continued From page 60 provided by the DON indicated the following: "2. Physician Order: Supervisors shall secure a physician order permitting a requested LOA. The order for a LOA shall be written in the Residents medical records and include any special instructions for the LOA. E.g. specifying medications and/or treatments to be carried out while on LOA or which may be delayed unit the Resident return from LOA..." 5. Care While Out on LOA: If the Resident's physician orders care to be provided while the Resident is out on LOA, the facility shall provide instructions on the Resident and/or the Resident's Responsible Party, as appropriate. In addition, the Nursing Supervisor is responsible for notifying the Food Service Director and other including the Activities Director, Physical Therapy, etc. When the Resident will be away from the facility during meal, activity or therapy hours and when the Resident has returned. On 5/3/22 at 2:15 PM, the surveyor met with the LNHA, DON, Assistant Director of Nursing (ADON) and the IPN, and there was no additional information provided by the facility.	F 755		
F 756 SS=D	NJAC 8:39- 29.4(b)2 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		6/24/22

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F 756	Continued From page 61 §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 observation, interview, and record review, it was determined that the facility failed to: a.) ensure that the Consultant Pharmacist (CP) reported irregularities in the drug regimen to the physician and the facility, and b.) follow-up on	F 756	F 756 SS=D 1. Corrective Action • Resident # 101 continues to reside in	

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F 756	Continued From page 62 the CP's recommendations and report a medication irregularity for 1 of 6 residents reviewed for medication management (Resident #101). This deficient practice was evidenced by the following: On 4/25/22 at 11:29 AM, the surveyor observed EX Order 26.4B1 The surveyor reviewed Resident #101's medical records that revealed the following: The resident's Face Sheet (an admission summary), revealed that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 unspecified EX Order 26.4B1 . According to the NJ Exec Order 26.4b annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care indicated a Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1 of 15, which reflected that the resident's NJ Exec Order 26.4b1 was EX Order 26.4B1. The NJ Exec Order 26.4b1 Resident Medication Administration Record (RMAR) revealed an order dated EX Order 26.4B1 for a medication used to EX Order 26.4B1 EX Order 26.4B1, EX Order 26.4B1	F 756	the facility. • Resident # 101 continues to receive EX Order 26.4B1 and EX Order 26.4B1 and NJ Exec Orde are obtained and documented per physician orders. • Consultant pharmacist has been notified to address missing documentation related to medication parameters. • The CPMRR recommendations created between EX Order 26.4B1 have been addressed related to EX Order 26.4B1 parameters. 2. Identifying other residents • Residents currently residing in the facility with orders for metoprolol and midodrine have the potential to be affected. • DON/Designee conducted an audit for residents taking metoprolol and midodrine to ensure blood pressures are obtained and parameters are documented and followed per physician orders. • CPMRR for April have been audited to ensure recommendations have been addressed. 3. Systemic Changes • The consultant pharmacist shall be present in the facility and have increased hours every month as agreed upon by the administrator. • Pharmacy consultant reports shall be completed by Unit Manager and submitted to DON upon completion. • DON/designee shall in-service nurses including agency regarding Medication	

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F 756	Continued From page 63 (mg) give one tablet (tab) by oral route every eight (8) hours. The orders specified to hold for [redacted] for diagnosis of [redacted]. The above order for [redacted] was signed as administered on [redacted] by nurses. There was no evidence that the [redacted] was taken and documented in accordance with the physician orders in the [redacted] RMAR. The [redacted] RMAR showed an order dated [redacted] for a medication used to [redacted] tab. The order specified to give [redacted] by [redacted] route three times per day [redacted]) before meals with [redacted] was above [redacted] for [redacted] The above order for [redacted] was signed by nurses as administered in the [redacted] RMAR. The following dates showed that the [redacted] was administered without regard to the physician hold parameters and the [redacted] [redacted] documented and left a dash sign (according to the legend in the RMAR, which indicated not documented).	F 756	Administration policy to ensure medications are given in accordance with the orders and following parameters as indicated. • DON/designee shall in-service nurses including agency regarding the pharmacy recommendations report to ensure these are addressed timely. 4. Monitoring • DON/designee shall audit metoprolol and midodrine orders to ensure parameters are being followed per physician order daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • DON/designee shall audit pharmacy consultant reports for completion monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate.	

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According to the Interim Medication Regimen Review dated [EX Order 26.4B1] which included consultant pharmacist recommendations to nursing, it did not reveal recommendations addressing the [EX Order 26.4B1] and nurses not documenting the [NJ Exec Ord] in accordance with the physician's order.

The Consultant Pharmacist's Medication Regimen Review (CPMRR) for recommendations created between EX Order 26.4B1 revealed a recommendation to "Please clarify [EX Order 26.4B1] hold on [EX Order 26.4B1] Hold for [EX Order 26.4B1]?" The provided CPMRR did not have follow-through documentation to show that the recommendations were acted upon.

Furthermore, the [EX Order 26.4B1] RMAR continued to show that the medication was administered when the EX Order 26.4B1 and the order for [EX Order 26.4B1] was not followed. The [EX Order 26.4B1] RMAR for [EX Order 26.4B1] for dates [EX Order 26.4B1] [EX Order 26.4B1] were signed as administered by nurses even after the CPMRR recommendations above that was created between EX Order 26.4B1.

On 5/2/22 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) of the [EX Order 26.4B1] unit on the [EX Order] floor. The LPN/UM informed the surveyor that Resident #101 was on EX Order 26.4B1 with NJ Exec Order 26.4b1. She further stated that the [EX Order 26.4B1] must be checked before administering medications and documented in the RMAR.

At that same date and time, the surveyor and the LPN/UM reviewed the electronic medical records

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F 756	Continued From page 65 to verify if the orders for both medications were being followed. Afterward, the surveyor asked the LPN/UM why there was EX Order 26.4B1 documented in the NJ Exec Order 26.4b1 RMAR EX Order 26.4B1 NJ Exec Order 26.4 through EX Order 26.4B1 and she stated "I don't know." The LPN/UM further stated that she was the nurse on dates EX Order 26.4B1. The surveyor again asked the LPN/UM why she administered the EX Order 26.4B1 on those dates when the NJ Exec Order 26.4b1 EX Order and she responded, "I don't know." She indicated that there was NJ Ex to the resident. On 5/2/22 at 12:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Infection Preventionist Nurse (IPN) and were made aware of the surveyor's findings. On 5/3/22 at 1:35 PM, the surveyors met with the LNHA, DON, Assistant Director of Nursing (ADON), and the IPN. The ADON informed the surveyors that the nurse should have checked and documented the resident's EX Order 26.4B1 before administering EX Order 26.4B1 medications. On 5/5/22 at 9:51 AM, the surveyor in the presence of the survey team interviewed the CP. The CP informed the surveyor that he's in the facility 18 to 24 hours per month and "usually" every second week of the month to do the medication record review for Long Term Care (LTC) and Subacute residents. The CP stated that the handwritten recommendations will be provided to the charge nurse on the same date of visit for the charge nurse to follow up	F 756		

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recommendations for nursing and physician and then the typewritten report to follow and submitted to the DON.

At that time, the surveyor asked the CP why he did not identify on [EX Order 26.4B1] Interim Medication Regimen Review the irregularity of the [EX Order 26.4B1] medication when the [NJ Exec Order 26.4b1] was not documented when the medication was administered. The CP did not respond.

On 5/5/22 at 11:27 AM, the surveyor asked the LPN/UM if she responded to the CP's reviews for [NJ Exec Order 26.4] and [NJ Exec Order 26.4b1], the LPN/UM did not answer.

A review of the facility Administering Medications policy that was provided by the DON with a review date of 9/21 included "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation: Medications must be administered in accordance with the orders, including any required time frame and parameters ...The following information must be check/verified for each resident prior to administering medications: a. Allergies to medications; b. Vital signs, if necessary ..."

The facility Physician Medication Orders policy that was provided by the DON with a review date of 9/21 included "Policy Interpretation and Implementation ...8. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the Pharmacist on a monthly basis ..."

According to the Consultant Pharmacist Retainer

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F 756	Continued From page 67 Agreement that was provided by the LNHA included "The consultant pharmacist shall be responsible for the general supervision of the facility's pharmaceutical services which include the following: 1. Monthly or Quarterly reviews, as required by state and federal regulation, of the medication (MRR) of each facility patient with written, dated and signed reports of any irregularities noted being delivered to the Director of Nursing, the facility Administrator or their appointed designee ..." NJAC 8:39-29.3 (a)(1)	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		6/24/22

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F 758	Continued From page 68 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently monitor, document, and evaluate the ongoing benefits of continued use of EX Order 26.4B1 medications for 1 of 5 residents reviewed for unnecessary medications, (Resident# 101). This occurred for a total of 26 months. The deficient practice was evidenced by the following:	F 758	1. Corrective Action • Resident # 101 continues to reside in the facility and currently receives EX Order 26.4B1 medications per physician orders. • Resident # 101 EX Order 26.4B1 monthly review has been updated to ensure monitoring of target behaviors and adverse effects, documentation, and evaluation of ongoing benefits of EX Order 26.4B1 medications. • Pharmacy consultant has reviewed	

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F 758	Continued From page 69 On 4/25/22 at 11:29 AM, the surveyor observed Resident #101 laying on an NJ Exec Order 26.4b1 [redacted]. The resident told the surveyor that he/she NJ Exec Order 26.4b1 . The surveyor reviewed the medical record for Resident #101, which revealed the following: The resident's Face Sheet (an admission summary), revealed that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] According to the EX Order 26.4B1 Annual Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care indicated a Brief Interview for Mental Status (BIMS) score of EX Ord [redacted], which reflected that the resident's NJ Exec Order 26.4b1 [redacted]. The AMDS indicated that Resident #101 received EX Order 26.4B1 and EX Order 26.4B1 on a routine basis. The NJ Exec Order 26.4b1 Resident Medication Administration Record (RMAR) revealed that the resident was on EX Order 26.4B1) EX Order 26.4B1 EX Order 26.4B1) and EX Order 26.4B1 three times a day EX Order 26.4B1 with a start date of NJ Exec Order 26.4b1 [redacted]. The EX Order 26.4B1 RMAR also showed that the resident was taking EX Order 26.4B1 EX Order 26.4B1 EX Order 26 a day (EX Orde) for EX Order 26.4B1 with a start date of EX Order 26.4B1 . The resident's EX Order 26.4B1 Monthly Review	F 758	Resident # 101 EX Order 26.4B1 monthly review. 2. Identifying other residents • Residents currently residing in the facility and receiving psychoactive medications have the potential to be affected. • DON/designee conducted an audit of residents receiving psychoactive medications to ensure monthly psychotropic reviews are being completed. 3. Systemic Changes • Pharmacy consultant shall address and sign monthly psychotropic reviews during facility visit. • DON/designee shall in-service nurses including agency regarding the monthly psychotropic review and monitoring of target behaviors and adverse effects, documentation, and evaluation of ongoing benefits of psychoactive medications • DON/designee shall in-service nurses including agency regarding psychoactive medication policy. 4. Monitoring • DON/designee shall audit psychotropic monthly reviews to ensure completion monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI to be addressed as appropriate.	

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(PMR) was last documented in EX Order 26.4B1. The EX Order 26.4B1 PMR revealed that the resident was on medications EX Order 26.4B1 EX Order 26.4B1 ith NJ Exec Order 26.4b1 noted. The target behaviors were documented and signed by the multi-disciplinary team.

Further review of the RMAR showed that the order for EX Order 26.4B1 was started on NJ Exec Order 26.4b. Also, the order for EX Order 26.4B1 . In addition, the EX Order 26.4B1 order for NJ Exec O was ordered on EX Order 26.4B1.

The NJ Exec Order 26.4 NJ Exec Order 26.4b1 Progress Note (PN) written by the revealed that Resident #101 was from a NJ Ex.Order 26.4(b)(1) with a diagnosis of EX Order 26.4B1 were EX Order 26.4B1 EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4B1 used to EX Order 26.4B1. The EX Order 26.4B1 documentation was incomplete and did not include complete dosing information.

Furthermore, the EX Order 26.4B1 PN with the incomplete EX Order 26.4B1 consultation note revealed that the Examination part of the PN was not checked for the resident's NJ Exec Order 26.4b1 o describe if it was better, or worse, or the same.

A review of the EX Order 26.4B1 RMAR showed the following medications with a start order date of EX Order 26.4B1 and signed daily by nurses as

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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 758		F 758		

Continued From page 71

administered from EX Order 26.4B1

EX Order 26.4B1

EX Order 26.4B1 by [redacted] give [redacted] tab every [redacted] hours for EX Order 26.4B1.

EX Order 26.4B1

EX Order 26.4B1

There was no further documentation to reflect that the resident was being monitored routinely with the use of EX Order 26.4B1 medications after the EX Order 26.4B1 PMR when there was medication changes that happened from EX Order 26.4B1 and to reflect the current EX Order 26.4B1 medications that were listed in the EX Order 26.4B1 RMAR.

On 4/28/22 at 9:45 AM, the surveyor interviewed the Temporary Nurse Aide (TNA). The TNA informed the surveyor that she was the assigned aide of Resident #101. The TNA stated that the resident was EX Order 26.4B1, required extensive to total assistance with activities of daily living (ADLs), and had [redacted]

On 5/2/22 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who informed the surveyor that the residents on EX Order 26.4B1 medications were being monitored for targeted behavior monthly with the use of the PMR that was filed in a white binder. At that time, the LPN/UM showed the white binder that included the [redacted] floor [redacted]

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	315520	A. BUILDING _____ B. WING _____	C 05/23/2022

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F 758	Continued From page 72 unit's residents with EX Order 26.4B1 medications that were separated by month from EX Order 26.4B1 EX Order 26.4B1 She further stated that the PMR was a tool used to determine if EX Order 26.4B1 EX Order 26.4B1 was appropriate. On that same date and time, the surveyor asked the LPN/UM if Resident #101 was on EX Order 26.4B1 medications and to show the PMR. Both the surveyor and the LPN/UM checked the white binder of PMR and the resident's hybrid medical records (combination of paper, scanned, and computer-generated records). The surveyor asked the LPN/UM why there was no PMR done after EX Order 26.4B1 when the LPN/UM mentioned that it should be done monthly because the resident was on EX Order 26.4B1 medications. The LPN/UM stated, "I can only do much," and that she works as a medication (med) nurse every day including other responsibilities of a Unit Manager that's why the PMR was not done. Furthermore, the LPN/UM confirmed that there was no further documentation of the monthly behavior monitoring that included target behavior and adverse effects with the use of EX Order 26.4B1 and EX Order 26.4B1 medications according to the facility policy and protocol. On 5/2/22 at 12:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Infection Preventionist Nurse (IPN) and were made aware of the above concerns. On 5/3/2022 at 1:35 PM, the survey team met with the LNHA, DON, Assistant Director of	F 758		

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F 758	Continued From page 73 Nursing (ADON), and IPN. The surveyor asked the DON if she knew that the PMR documentation was stopped after EX Order 26.4B1 and she responded "no." On that same date and time, the ADON informed the survey team that it was the facility practice and protocol of the interdisciplinary team to meet monthly to discuss resident's EX Order 26.4B1 medications including targeted behavior, decide for a EX Order 26.4B1 to be documented in the PMR filed in the binder where the EX Order 26.4B1 relied on their consultation. She further stated that the PMR should have been done. On 5/4/22 at 12:54 PM, the surveyor followed-up with the DON and IPN who provided a copy of facility policy about the use of EX Order 26.4B1 medications specifically for EX Order 26.4B1 and EX Order 26.4B1 use. The facility provided a copy of the EX Order 26.4B1 drugs policy and did not include NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. On 5/5/22 at 9:51 AM, the surveyor in the presence of the survey team interviewed the Consultant Pharmacist (CP). The CP informed the surveyor that it was his responsibility to check the resident's medical records for documentation of targeted behavior and effectiveness of medication including monitoring of adverse effects of the use of EX Order 26.4B1 medications to provide recommendations of possible gradual dose reduction based on the occurrence or frequency of target behaviors. On that same date and time, the surveyor asked the CP if he was aware that the last documentation for PMR was in NJ Exec Order 26.4b1.	F 758		

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F 758	Continued From page 74 The CP stated that he was not sure why there was no monthly documentation for behavior monitoring and that he can not remember when was the last time he signed the interdisciplinary team meeting for the monthly EX Order 26.4B1 medications review of Resident #101. He further stated, "this is now something I should check and get back to you." On 5/5/22 at 2:04 PM, the survey team met with the LNHA, DON, ADON, and IPN who were made aware of the the surveyor's findings and that the CP was not aware that there was no further documentation of the monthly behavior of the resident after NJ Exec Order 26.4b1. On 5/9/22 at 11:12 AM, the surveyor interviewed the CP. The CP informed the surveyor that after review, there was no monthly behavior monitoring for EX Order 26.4B1 medications of Resident #101 and that EX Order 26.4B1." A review of the Consultant Pharmacist Retainer Agreement that was provided by the LNHA included "Appendix A Baseline Consultant Pharmacist MRR services for facility will include: ...Psychotropic, actuarial tracking and reporting for skilled facilities or as a requested for assisted living facilities ...."	F 758		
F 761 SS=D	NJAC 8:39-29.3(a); 29.8; 33.2(a) 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	F 761		6/24/22

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F 761	Continued From page 75 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 properly remove medications with shortened expiration dates (expired). This deficient practice was observed in 2 of 4 medication carts inspected, as evidenced by the following: A. On 5/2/22 at 10:30 AM, the surveyor inspected the [redacted] floor unit, Medication cart #5 and the findings were as follows: 1. The surveyor noted EX Order 26.4B1 EX Order 26.4B1 which was delivered to the facility for Resident #84 on [redacted] from the provider pharmacy. The documented opening	F 761	1. Corrective Action • Medication cart # 5 and # 7 have been re-inspected and the following outdated medications have been removed, discarded and reordered: EX Order 26.4B1 [redacted] 2. Identifying other residents • Residents currently residing in the facility and receiving short time expiration medications have the potential to be affected. • DON/designee conducted an audit of	

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F 761	Continued From page 76 date for the EX Order 26.4B1 was EX Order 26.4B. EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B, EX Order 26.4. B. On 5/2/22 at 11:15 AM, the surveyor inspected the EX Order floor unit, Medication cart #7 and the findings were as follows: 1. The surveyor noted EX Order 26.4B1 EX Order 26.4B1) which was delivered to the facility for Resident #78 on EX Order 26.4B1 from the provider pharmacy. The documented opening date for the EX Order 26.4B1 was EX Order 26.4B1. EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1, EX Order 26. 2. The surveyor noted NJ Exec Order 2 EX Order 26.4B1 EX Order 26.4B1) which was delivered to the facility for Resident #86 on EX Order 26.4B1 from the provider pharmacy. The documented opening date for the EX Order 26.4B1 was EX Order 26.4B1. EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1 EX Order 26. 3. The noted EX Order 26.4B1 EX Order 26.4 which was delivered to the facility for	F 761	medication carts to ensure no other medications are outdated or expired. 3. Systemic Changes • Pharmacy consultant shall gather any expired medications from medication carts and submit to DON office to be discarded during monthly visits to ensure medications removed are not inadvertently placed back in the medication carts. • DON/designee shall in-service nurses including agency regarding medication dating and labeling, expiration dates, removal from medication cart and proper disposal. 4. Monitoring • DON/designee shall audit medication carts for expired or outdated medications daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI to be addressed as appropriate.	

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F 761	Continued From page 77	F 761		

Resident #20 on EX Order 26.4B1 from the provider pharmacy. The documented opening date for the EX Order 26.4B1 was EX Order 26.4B1.

EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1 EX Order 26.4

4. The surveyor noted NJ Exec Order 2 EX Order 26.4B1 EX Order 26.4B1) which was delivered to the facility for Resident #4 on EX Order 26.4B1 from the provider pharmacy. The documented opening date for the EX Order 26.4B1 bottle was EX Order 26.4B1.

EX Order 26.4B1 NJ Exec Order 26.4b1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1.

5. The surveyor noted NJ Exec Order 26 EX Order 26.4B1 EX Order 26.4B1 which was delivered to the facility for Resident #20 on EX Order 26.4B from the provider pharmacy. The documented opening date for the EX Order 26.4B1 EX Order 26.4B1.

EX Order 26.4B1 u/ml EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1

On 5/4/22 at 9:40 AM, the surveyor interviewed the Consultant Pharmacist (CRPh) who stated that he had removed all the expired EX Order 26.4B1 on his last visit to the facility, EX Order 26.4B1 The CRPh explained that he provides a handout

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F 761	Continued From page 78 documented all the expiration time frames of [NJ Exec Order 2] for easy review. He informed the surveyor that he removed the expired [EX Order 26.4B1] from the medication cart and handed all of them to the unit manager so that they could be reordered and then destroyed. He could not explain how they ended up in the medication carts. On 5/5/22 at 10:00 AM, the surveyor interviewed the unit manager Licensed Practical Nurse (LPN). The LPN informed the surveyor that the CRPh handed the expired [EX Order 26.4B1] to her when he had visited the previous week. The LPN explained that she had placed them into medication room for destruction and had ordered new [EX Order 26.4B1] from the provider pharmacy. The LPN explained that the [EX Order 26.4B1] might have been placed back into the cart when noted in the medication room. On 5/2/22, 5/4/22 and 5/9/22 the issue was presented to the Administrator, Director of Nursing (DON), Assistant Director of Nursing, and the Infection Preventionist. There was no further information supplied by the facility. A review of the facility's Administering Medications that was provided by the DON with a reviewed date of 9/21 included " The expiration date on the medication label must be checked prior to administering. When opening multi-dose container, the date shall be recorded on the container..." NJAC 8:39- 29.4(b)2	F 761		
F 836 SS=F	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)	F 836		6/24/22

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F 836	Continued From page 79 §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation, the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state	F 836	F 836 SS=F 1. Corrective Action	

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F 836	Continued From page 80 of New Jersey. This deficient practice was identified to affect all residents in the facility residing on 3 of 3 units (Diamond, Emerald, and Sapphire). This deficient practice was evidenced by the following: 1. On 4/26/22 at 9:52 AM, the surveyor interviewed Resident#20's responsible party (RP) via phone interview. The RP stated that there was a concern with short of staff which most of the time was on weekends and holidays "like the NJ Exec Order 26.4b1 NJ Exec Order 26.4b." The RP further stated that because of short staff, the EX Order 26.4B1 care was affected and that management "should provide enough staff because staff can only do much." The NJ Exec Order 26.4 Quarterly Minimum Data Set (QMDS), an assessment tool used in management of care, reflected a Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1 which means that the resident's cognitive status was EX Order 26.4B1. The QMDS showed that the resident required the total assistance of two staff with EX Order 26.4B1 A review of the 7 AM-3 PM day shift assignment sheet for the EX Order 26.4B1 unit for EX Order 26.4B1 revealed a census of 42 with three CNAs assigned. The CNA assigned to Resident #20 had a total of 15 residents which did not meet New Jersey State minimum staffing requirements for a 1 CNA to 8 Resident ratio. On 5/3/22 at 10:32 AM, two surveyors observed Resident #20 lying on a bed with a EX Order 26.4B1 EX Order around the resident on the EX Order 26.4B1	F 836	• The Staffing coordinator was re-inserviced on the requirement of C.N.A ratios for each shift. 2. Identifying other residents • Residents currently residing in the facility have the potential to be affected. 3. Systemic Changes • The Staffing Coordinator was in-serviced to ensure there is sufficient staff per shift. • Staffing Coordinator shall offer bonuses for staff to ensure proper coverage. • The Facility has contracted with a new vendor who provides Agency staff to ensure staff to resident ratios are met per requirements. • The Facility will proactively hire staff thru open houses, media ads and advertisements. • DON/designee shall in-service the staffing coordinator regarding staffing ratio requirements and to report daily findings to DON/Administrator. 4. Monitoring • DON/designee shall audit daily staffing reports daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate	

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F 836	Continued From page 81	F 836		

the resident and on the resident's bed sheet. The EX Order 26.4B1 appeared to be EX Order 26 and EX Order 26.4B1 .

During an interview with the surveyor on 5/3/2022 at 1:02 PM, the CNA stated she had 15 residents in her assignment including Resident#20. The CNA informed the surveyor that she did not have a chance to do the morning care by 10:32 AM because it was "busy today." She further stated that this was the first time that the resident was EX Order 26.4B1. The CNA was not aware of the New Jersey State minimum staffing requirements for a 1 CNA to 8 Resident ratio.

2. The surveyor reviewed the NJ Exec Order 26 QMDS for Resident #70 which revealed a EX Order 26.4B1 skill for NJ Exec Order 26.4b1 was EX Order 26.4B1. The QMDS assessment revealed that the resident required an extensive assistance of two-persons with EX Order 26.4B1 and one person assist with EX Order 26.4B1.

A review of the 7 AM - 3 PM day shift assignment sheet for the EX Order 26.4B1 unit for EX Order 26.4B1 revealed that the EX Order 26.4B1 unit had a census of 42 with one CNA and one Temporary Nursing Aide (TNA) assigned. The TNA assigned to Resident#70 had a total of 20 residents which did not meet New Jersey State minimum staffing requirements for a 1 CNA to 8 Resident ratio.

On 5/2/22 at 10:39 AM, the surveyor in the presence of the LPN observed Resident #70 lying on a bed with a EX Order 26.4B1 There was a EX Order 26.4B1 with the EX Order 26.4B1 on the EX Order 26.4B pad.

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F 836	Continued From page 82 The LPN acknowledged that the EX Order 26.4B1 and EX Order 26.4B1 was EX Order 26.4B1. The LPN further stated that it was a typical ratio of CNA to a resident in the unit during the day shift was 1 CNA to 20 residents. The LPN was not aware of the New Jersey State minimum staffing requirements for CNA. On that same date at 11:19 AM, the surveyor interviewed the TNA. The TNA stated that she did not get a chance to do EX Order 26.4B1 "yet" because "people" need to get up for breakfast first. 3. The surveyor reviewed the NJ Exec Order 26.4b1 Annual MDS (AMDS) for Resident #101 which reflected a BIMS score of EX Order 26.4B1 which indicated that the resident's EX Order 26.4B1 The AMDS showed that the resident required total assistance of one person assist with EX Order 26.4B1. A review of the 7 AM - 3PM day shift assignment sheet for the EX Order 26.4B1 unit. The TNA assigned to Resident#101 had a total of 20 residents which did not meet New Jersey State minimum staffing requirements for a 1 CNA to 8 Resident ratio. On 5/2/22 at 10:31 AM, two surveyors observed Resident#101 lying on a bed wearing a hospital gown EX Order 26.4B1 with the EX Order 26.4B1 and EX Order 26.4B1 There was a EX Order 26.4B1 EX Order on the bed sheets and covers underneath, which resembled the EX Order 26.4B1 of EX Order 26.4 During an interview with the surveyor on 5/2/22 at 11:29 AM, the TNA informed the surveyor that	F 836		

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SOMERSET WOODS REHABILITATION & NURSING CENTER	**780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873**

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F 836	Continued From page 83 when she came in today at 7:00 AM, she was not able to check the resident fo[EX Order 26.4B1] because she was the only aide in the [EX Orde]-floor unit for a total of 42 residents and they were short staffed. The TNA stated that she had to prioritize distributing the breakfast trays for all residents to be able to eat. She further stated that the other CNA came around 8:30 AM-9:00 AM. On that same date and time, the TNA stated that was the reason why the [EX Order 26.4B1] was provided later than usual. On 5/2/22 at 12:56 PM, the survey team met with the LNHA, DON, and the Infection Preventionist Nurse (IPN) and were made aware of the above concerns. On 5/4/22 at 9:21 AM, the surveyors met with the LNHA, DON, and the IPN. The DON informed the surveyors that the TNA had to attend to another resident, and "other things" why Resident#101 was [EX Order 26.4B1] The surveyor asked the DON if the lack of staff that will attend to residents' [EX Order 26.4B1] is the reason why the above residents were found [EX Order 26.4B1] according to the TNA and CNA that was interviewed by the surveyors? The DON did not respond. 4. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	F 836		

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F 836	Continued From page 84	F 836		

established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/2021:

One Certified Nurse Aide (CNA) to every eight residents for the day shift.

One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and

One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

1. A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" completed by the Director of Nursing (DON) for the period of 4/10/22 through 4/23/22, revealed the staffing to resident ratios did not meet the minimum requirement.

The facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staffing for residents on 1 of 14 overnight shifts as follows:

-04/10/22 had 5 CNAs for 106 residents on the day shift, required 14 CNAs.
-04/10/22 had 7 total staff for 106 residents on the overnight shift, required 8 total staff.
-04/11/22 had 12 CNAs for 106 residents on the day shift, required 14 CNAs.

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F 836	Continued From page 85 -04/12/22 had 11 CNAs for 106 residents on the day shift, required 14 CNAs. -04/13/22 had 12 CNAs for 106 residents on the day shift, required 14 CNAs. -04/14/22 had 12 CNAs for 112 residents on the day shift, required 14 CNAs. -04/15/22 had 10 CNAs for 112 residents on the day shift, required 14 CNAs. -04/16/22 had 12 CNAs for 112 residents on the day shift, required 14 CNAs. -04/17/22 had 8 CNAs for 111 residents on the day shift, required 14 CNAs. -04/18/22 had 11 CNAs for 111 residents on the day shift, required 14 CNAs. -04/19/22 had 9 CNAs for 110 residents on the day shift, required 14 CNAs. -04/20/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -04/21/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -04/22/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -04/23/22 had 7 CNAs for 112 residents on the day shift, required 14 CNAs. On 5/6/22 at 09:54 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who was made aware of the staffing findings. On 5/6/22 at 10:00 AM, the surveyor interviewed the Staffing Coordinator (SC). The SC informed the surveyor that it was her responsibility to find staff to meet the required numbers. The SC further stated that if the numbers were low, she would notify the Assistant Director of Nursing and the Director of Nursing (DON).	F 836		

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F 836	Continued From page 86 Refer to F677	F 836		
F 865 SS=D	NJAC 8:39-5.1 (a) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was identified that the facility failed to identify and implement interventions to address the Consultant Pharmacist (CRPh) concerns regarding expired medications through their Quality Assurance and Performance Improvement program (QAPI). This deficient practice was identified for 2 of 3 facility units inspected. The evidence was as follows:	F 865	1. Corrective Action • A QAPI has been initiated related to expired medications from the pharmacy consultant report. • Medication cart # 5 and # 7 have been re-inspected and the following outdated medications have been removed, discarded and reordered: NJ Exec Order 26.4b1 [redacted]	6/24/22

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F 865	Continued From page 87 A. On 5/2/22 at 10:30 AM, the surveyor inspected the [redacted] floor unit, Medication cart #5 and the findings were as follows: 1. The surveyor noted EX Order 26.4B1 [redacted] which was delivered to the facility for Resident #84 on [redacted] from the provider pharmacy. The documented opening date for the EX Order 26.4B1 [redacted] was [redacted] EX Order 26.4B1 [redacted] has a 28 day expiration date once opened. This would have deemed this medication to have been expired after [redacted] B. On 5/2/22 at 11:15 AM, the surveyor inspected the [redacted] floor unit, Medication cart #7 and the findings were as follows: 1. The surveyor noted EX Order 26.4B1 [redacted] which was delivered to the facility for Resident #78 on [redacted] from the provider pharmacy. The documented opening date for the EX Order 26.4B1 [redacted] bottle was [redacted] EX Order 26.4B1 [redacted] has a 28 day expiration date once opened. This would have deemed this medication to have been expired after [redacted] 2. The surveyor noted EX Order 26.4B1 [redacted] r (u/ml) which was delivered to the facility for Resident #86 on [redacted] from the provider pharmacy. The documented opening date for the EX Order 26.4B1 [redacted] bottle was	F 865	2. Identifying other residents • Residents currently residing in the facility have the potential to be affected. 3. Systemic Changes • Regional Director of Clinical Services shall in-service DON/Administrator regarding QAPI process to identify issues, initiate interventions and evaluate effectiveness of QAPI. 4. Monitoring • DON/designee shall audit pharmacy consultant recommendations to ensure issues identified are addressed and submitted to QAPI as appropriate monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to QAPI to be addressed as appropriate.	

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F 865	Continued From page 88	F 865		

EX Order 26.4B1

EX Order 26.4B1 NJ Exec O NEX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1, EX Order 26.4

3. The surveyor noted EX Order 26.4B1 EX Order 26.4B1 NJ Exec Order 2 which was delivered to the facility for Resident #20 on EX Order 26.4B from the provider pharmacy. The documented opening date for the EX Order 26.4B1 ml bottle was NJ Exec Order 26.4.

EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1 NJ Exec Orde.

4. The surveyor noted EX Order 26.4B1 EX Order 26.4B1) which was delivered to the facility for Resident #4 on EX Order 26.4B1 from the provider pharmacy. The documented opening date for the EX Order 26.4B1 bottle was EX Order 26.4B1.

EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1.

5. The surveyor noted EX Order 26.4B1 which was delivered to the facility for Resident #20 on EX Order 26.4B from the provider pharmacy. The documented opening date for the EX Order 26.4B1 EX Order 26.4B1 was EX Order 26.4B1.

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F 865	Continued From page 89 EX Order 26.4B1 has a 28 day expiration date once opened. This would have deemed this medication to have been expired after EX Order 26.4B1. On 5/4/22 at 9:40 AM, the surveyor interviewed the Consultant Pharmacist (CRPh) who stated that he had removed all the expired EX Order 26.4B1 on his last visit to the facility, EX Order 26.4B1. The CRPh explained that he provides a handout documented all the expiration time frames of NJ Exec Order 2 for easy review. He informed the surveyor that he removed the expired EX Order 26.4B1 from the medication cart and handed all of them to the unit manager so that they could be reordered and then destroyed. He could not explain how they ended up in the medication carts. medications should be monitored On 5/4/22 at 11:01 AM, the Assistant Director of Nursing presented the surveyor with the Consultant Pharmacist Quarterly Report dated NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Both reports documented, "Expired and discontinued medications should be removed daily. Expired medications should be monitored and removed. Check for dating of open vials and EX Order 26.4B1 pens." The NJ Exec Order 26.4b1 Consultant Pharmacist Quarterly Report further documented, "Al NJ Exec Order 26 should be replaced by the pharmacy 28 days after the first puncture whether refrigerated or not. It is suggested that al NJ Exec Order 26 be stored in the refrigerator until first used, then stored in the med cart for 28 days, then reordered and discarded." Review of the facility QAPI Goals/Purpose Statement explains, "Our purpose is to provide	F 865		

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F 865	Continued From page 90 excellent quality resident/patient care and services. Our nursing home has a Performance Improvement Program which systematically monitors, analyzes and improves it's performance to improve resident/patient outcomes." Review of "a. Our QAPI plan addresses: i. Clinical Care-monitor existing Quality Improvement/Quality Monitoring results, internal monitors for falls, medication errors, pressure ulcers, incident reports, infection reports. The Quality of Care Team meets monthly with Medical Director and others to address "care concerns." Review of "Guidelines for Performance Improvement Project (PIP) Teams i. Potential topics for PIP's are identified through a prioritization process in the QAPI Committee." In addition, "The QAPI Committee meets at least quarterly to discuss the previous QAPIs and how to better the facilities practices." On 5/2/22 at 11:00 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that the night nurse was required to inspect all medication carts and remove all expired medications. On 5/2/22 at 12:30 PM, the surveyor informed the Director of Nursing (DON), Administrator (LNHA), IP and Assistant Director of Nursing (ADON) of the expired medications. The surveyor asked if there were any follow ups or QAPI to the monthly and quarterly recommendations made by the CRPh referring to the expired medications. The LNHA stated that the facility has been educating staff and are constantly working on the expired	F 865		

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F 865	Continued From page 91 medication issue. On 5/9/22 at 10:30 AM, the surveyor interviewed the LNHA who stated that he follows up with QAPI plans and monitors the process. Review of the Quality Assurance/QAPI Sign-In Sheet dated NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 included the LNHA, IP, and DON signatures. Review of the QAPI minutes under "Pharmacy" documented, "Med carts are locked and proper order." There was no mention of expired medications listed in the Consultant Pharmacist Quarterly Report dated NJ Exec Order 26.4b1 For the NJ Exec Order 26.4b1, despite being aware of the the CRPh's quarterly report findings. On 5/4/22, 5/5/22 and 5/9/22 the surveyor met with the DON, LNHA, IP and ADON. No further information or documentation was supplied to show that QAPI was performed in reference to the identified expired medication issues. Refer to F755.	F 865		
F 880 SS=E	NJAC 8:39-33.1 (e); 33.2 (c) 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		6/24/22

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F 880	Continued From page 92 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	F 880		

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F 880	Continued From page 93 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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 review of pertinent documents, it was determined that the facility failed to: a.) perform hand hygiene in accordance with infection prevention and control standards for 2 of 3 staff and b.) ensure that residents were offered and provided hand hygiene before meals for 6 of 6 unsampled residents in accordance with the facility policies and Centers for Disease Control and Prevention (CDC) guidelines for infection prevention and control. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and	F 880	F 880 SS=E 1. Corrective Action " Hand sanitizer station was placed in the dining rooms for easy staff access. " Residents are offered hand hygiene before meals. " Staff are performing hand hygiene before and after distributing meal trays. 2. Identifying other residents " Residents currently residing in the facility have the potential to be affected. 3. Systemic Changes " DON/designee shall in-service nursing staff including agency regarding	

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F 880	Continued From page 94 COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when hands are visibly soiled, before eating, and after using the restroom." According to the U.S. CDC guidelines: Hand Hygiene in Healthcare Settings, Hand Hygiene Guidance for Healthcare Providers, page last reviewed 1/30/2020 indicated that "Healthcare facilities should require healthcare personnel to perform hand hygiene in accordance with CDC recommendations and ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. In addition, healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; After touching a patient or the patient's immediate environment; After contact with blood, body fluids, or contaminated surfaces; Immediately after glove removal." On 4/25/22 at 12:49 PM, two surveyors (Surveyor #1 and #2) conducted dining observation on the second-floor main dining room during lunch. The residents were seated at the table. Certified Nursing Assistant #1 (CNA#1) handed out a tray to one resident and then left to get the disposable clothing protectors. CNA#1 returned and then placed the clothing protectors on the residents in the room. The surveyors did not observe hand hygiene for 6 of 6 unsampled residents and of CNA #1. The Licensed Practical Nurse/Unit Manager (LPN/UM) arrived, assisted with tray setup and the surveyors did not observed hand hygiene. There was no	F 880	infection control including offering hand hygiene to residents during meal times and staff performing hand hygiene before and after distributing meal trays. " Hand wipes shall be placed with meal trays and offered to residents during meal times. 4. Monitoring " DON/designee shall audit staff during meal times to ensure residents are offered hand hygiene and staff are performing hand hygiene before and after tray distribution and meal set up daily x 7 days then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. " Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate. Root Cause Analysis (RCA) A Root Cause Analysis (RCA) has been conducted with assistance from the DON/Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) Committee and Governing Body pursuant to this DPOC. The RCA resulted in the following findings, solutions and implementations:	

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F 880	Continued From page 95 handwashing sink or hand sanitizers in the dining room. On 4/26/22 at 12:35 PM, Surveyor #2 conducted observation in the same dining room during lunch. The surveyor observed residents seated at the tables. Two CNAs in the dining room handed out trays to the residents. Hand hygiene was not offered to the residents before meals, and CNA #1 did not perform hand hygiene before and after distributing lunch trays to the residents. On 5/2/22 at 10:20 AM, Surveyor #1 interviewed CNA #1 who stated that during residents' communal dining, he would place clothing protectors on residents and help them sanitize their hands before meals. Afterward, he would sanitize his hands and then hand out food trays to residents. The surveyor asked why hand hygiene was not completed or provided to the residents'. CNA #1 stated, "we were short-staffed that day and there were no sanitizing wipes available." Furthermore, CNA #1 was aware that an Alcohol-Based Hand Rub (ABHR) was installed on the wall across the dining room. However, he stated that the food truck was parked, blocking access to the ABHR, and completely forgot it. He acknowledged that he should have obtained the sanitizing wipes, sanitized the resident's hands before meals, and performed hand hygiene before handing out the food trays to residents. On 5/2/22 at 10:51 AM, Surveyor #1 interviewed the LPN/UM who stated that during communal dining, the CNA or other staff assigned in the main dining room are expected to offer hand	F 880	Identify the event to be investigated and gather preliminary information: Facility staff failed to perform hand hygiene during meal tray distribution Facility staff failed to ensure residents were offered and provided hand hygiene before meals Describe what happened: On 4/25/22, Aide #1 handed out a tray to one resident and left to get clothing protectors and then placed them on the residents in the dining room. LPN assisted with tray set up but did not perform hand hygiene. On 4/26/22, Aide # 1 did not perform hand hygiene before and after distributing lunch trays and hand hygiene was not offered to the residents. Identify contributing factors: Adjusting to communal dining routine Inadequate awareness of involved staff members with regards to the importance of hand hygiene prior to serving meal trays and offering hand hygiene to residents Sanitizer not easily accessible since food truck was parked and blocking access. Identify Root Cause: Inadequate awareness of involved staff members with regards to the importance	

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F 880	Continued From page 96 hygiene to the residents before meals and perform hand hygiene before and after handing out trays. She further stated that the staff could wash their hands in the sink or use ABHR or sanitizing wipes. She added that there was a handwashing sink in the pantry that could be accessed through a door from the dining room. Furthermore, the LPN/UM acknowledged that hand hygiene practices were not observed during dining observation and that staff should have obtained the sanitizing wipes and cleansed residents' hands before meals. She further stated that she should have performed hand hygiene before helping with tray set up on 4/25/22 and that CNA #1 should have performed hand hygiene before handing out food trays. On 5/5/22 at 2:06 PM, the Director of Nursing (DON), in the presence of the survey team stated that hand hygiene should have been performed by the staff before handing out trays to residents. However, she could not state why the LPN/UM and CNA #1 did not perform hand hygiene on residents or themselves. At that same date and time, the Infection Preventionist Nurse (IPN) stated that due to the changes in dining settings, staff could still be adjusting to the new routine of residents eating in the main dining room and not in the room. However, she acknowledged that staff should have performed hand hygiene and sanitized residents' hands before meals. A review of facility policy titled "Infection Control Policy and Procedure" revised 9/2020, under "Procedure" Section I "Infection Prevention and	F 880	of hand hygiene prior to serving meal trays and offering hand hygiene to residents Lack of readily accessible sanitizers Design and implement changes to eliminate the root causes: Conduct dining room audits to ensure hand hygiene for staff during meal distribution and residents are performed. CDC education/training links Visual reminders for hand hygiene placed in main dining rooms Install hand sanitizing stations in main dining for easy and unobstructed access. Place hand wipes on meal trays. Evaluation Increased Staff compliance with hand hygiene during meal tray distribution. Increased staff compliance with offering hand hygiene to residents prior to meals. Directed In-Service Training The facility will provide in-service training to appropriate staff, with staff compentency validated by the Director of Nursing (DON), Medical Director or Infection Preventionist, as follows: Nursing Home Infection Preventionist Training Course	

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F 880	Continued From page 97 Control Program" under B. included that "c. Standards and transmission-based precautions to be followed to prevent the spread of infection, f. The hand hygiene procedures to be followed by staff involved in direct resident contact." On 5/9/22 at 12:10 PM, The facility provided no additional documentation to the surveyor. NJAC 8:39-19.4 (a)1 (m) (n)	F 880	Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Training will be provided to: Topline staff and infection preventionist by 6/24/2022 CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrFIMGAw Training will be provided to: Frontline staff by 6/24/2022 CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xXmYMULly7giE Training will be provided to: Frontline staff by 6/24/2022 Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks	

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F 880	Continued From page 98	F 880	https://www.train.org/cdctrain/course/1081803/ Training will be provided to: Topline staff and infection preventionist 6/24/2022 Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Training will be provided to: All staff including topline staff and infection preventionist by 6/24/2022 Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Training will be provided to: All staff including topline staff and infection preventionist by 6/24/2022 Nursing Home Infection Preventionist Training Course	

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F 880	Continued From page 99	F 880	Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Training will be provided to: All staff including topline staff and infection preventionist by 6/24/2022	
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:	F 888		6/24/22

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F 888	Continued From page 100 (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	F 888		

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F 888	Continued From page 101 as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to	F 888		

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F 888	Continued From page 102 COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that additional precautions were implemented for 2 of 7 staff who's [NJ Exec Order 26.4b1] were not up-to-date for [NJ Exec Order 26.4b1] and had an exemption in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and facility policy for infection control to mitigate the spread of [NJ Exec Order 26.4b1] This deficient practice was evidenced by the following: According to the U.S. CDC guidelines, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 2/2/22 included "Personal Protective Equipment: Ensure proper use, handling and implementation of personal protective equipment ..."	F 888	F 888 SS=C 1. Corrective Action • Staff with medical or religious exemptions have been re-inserviced regarding the required additional precautions to prevent the spread of Covid 19. • Staff with medical or religious exemptions dons N95 mask while in the facility regardless of resident or other staff interaction. 2. Identifying other residents • Residents currently residing in the facility and those not up-to-date with vaccinations have the potential to be affected.	

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F 888	Continued From page 103 On 4/25/22 at 9:42 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) during the entrance conference. The LNHA informed the surveyors that the Infection Preventionist Nurse (IPN) was not at the facility and will be back the next day. He further stated that the facility follows the CDC, Centers for Medicare and Medicaid Services (CMS), and local health department guidance for Infection Control policies and procedures. On 4/25/22 at 11:17 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who was wearing a surgical mask and eye protection on the [redacted] floor [redacted] unit. The LPN/UM informed the surveyor that she had a [redacted] and was required to use an N95 mask and eye protection when providing care, administering medications and providing treatment to residents according to the facility policy and procedure. The LPN/UM stated that the IPN had provided the education. The LPN/UM stated that she wears a surgical mask throughout the unit when not providing care. She further stated that the [redacted] unit was a long-term care, [redacted] unit. On 4/26/22 at 10:40 AM, the surveyors interviewed the IPN and informed the surveyors that she was responsible for vaccination, reporting, education, surveillance, testing, and audit with regard to infection control and [redacted]. The IPN stated that staff with [redacted] exemptions must wear an N95 mask when giving care. She further stated that staff with exemptions may use a surgical mask in the	F 888	3. Systemic Changes • Infection Preventionist shall in-service staff with medical or religious exemptions regarding the required additional precautions to prevent the spread of Covid 19 and to don N95 mask while in the facility regardless of resident or other staff interaction. 4. Monitoring • Infection Preventionist or Designee shall audit staff with medical or religious exemptions to ensure they are wearing the required additional precautions while in the facility daily x 7 days then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate.	

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F 888	Continued From page 104 facility including in the hallway when not providing care. She indicated that medication administration and treatment care were considered direct care and unvaccinated and staff with an exemption may use a surgical mask. The surveyor reviewed the facility policy and CMS guidelines that were provided by the facility that the facility follows and revealed the following: According to the undated facility Mandatory COVID-19 Vaccine Policy and Procedure-NJ that was provided by the LNHA included, "III. Additional Precautions to Mitigate the Transmission and Spread of Covid-19 For All Staff Not Fully Vaccinated for Covid-19: Staff who are not fully vaccinated, have a pending exemption request, have been granted an exemption, or who have a temporary delay in vaccination approval must adhere to additional precautions based on national infection prevention and control standards for unvaccinated health care personnel that are intended to mitigate the spread of COVID-19. The facility will take or require the following precautions, as deemed appropriate or necessary: ... .D. Staff who have not completed their primary vaccination series will be required to use a NIOSH approved N95 or equivalent or higher-level respirator (and may also be required to wear a face shield or goggles) at all times when in the facility, regardless of whether they are providing direct care to or otherwise interacting with residents ...Staff who are exempt from the COVID-19 vaccine shall still be required to follow all other facility COVID-19 related policies ..."	F 888		

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F 888	Continued From page 105	F 888		

The CMS Long-Term Care and Skilled Nursing Facility Attachment A-Revised that was provided by the IPN included "Implementation of this guidance will occur according to the timeframes and parameters identified in either QSO-22-07-ALL-Revised effective December 28, 2021, QSO-22-09-ALL-Revised effective January 14, 2022, or QSO-22-11-ALL-Revised effective January 20, 2022 ....483.80(i)(3)(iii): Requires facilities to ensure those staff who are not yet fully vaccinated, or who have a pending or been granted an exemption, or who have a temporary delay as recommended by the CDC, adhere to additional precautions that are intended to mitigate the spread of COVID-19 ....Requiring staff who have not completed their primary vaccination series to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients ..."

A review of the Staff Vaccine reports that were provided by the IPN on 4/26/22 revealed that there were a total of 155 staff in the facility including the in-house staff, agency, and the physician. The staff vaccination reports also showed that there were 13 religious and 3 medical exemptions.

On 5/3/22 at 10:29 AM, the surveyor observed the Registered Nurse (RN) coming out of the resident's room from the EX Order 26.4B1 unit, a NJ Exec Order 26.4b1 unit with a surgical mask and goggles in use and directly went to her med cart that was parked in front of the nursing station. At that time, there were three male residents seated near the RN's medication cart

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F 888	Continued From page 106 with two residents wearing a mask and another resident not wearing a mask and were all four feet away from the RN. On that same date and time, the surveyor interviewed the RN who informed the surveyor that she had a NJ Exec Order 26.4b1 from the NJ Exec Order 26.4b1. The RN stated that as per facility protocol, she was being tested for NJ Exec Order 26.4b1 twice a week and "I know you're looking for my N95 mask, I have it in my pocket," and then the RN pulled her N95 mask from her left side of the uniform pocket where her cellphone was located. Then, the RN placed the N95 mask on top of the med cart where a piece of paper, a portable blood pressure machine, and where other medication administration supplies were located. Furthermore, the surveyor asked the RN what was the facility instructions for wearing an N95 mask for staff with exemptions to the NJ Exec Order 26.4b1 9 NJ Exec Order 26.4. The RN stated that an N95 respirator mask should be worn when providing care that included med administration and treatment care. She further stated that she may use the surgical mask in the facility including in the hallway. Then the surveyor asked the RN if she was allowed to store her N95 mask inside her uniform pocket and place it directly on top of the med cart and she stated "I was not told otherwise." On 5/3/22 at 1:35 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing (ADON), and IPN, and were made aware of the surveyor's findings. NJAC 8:39-5.1(a); 19.4(a)	F 888		

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a safe and sanitary environment in 1 of 1 laundry rooms in accordance with the facility policy and procedures. This deficient practice was evidenced by the following: On 5/6/22 at 9:52 AM, the surveyor toured the laundry room with the Director of Housekeeping (DH) and in the presence of two other surveyors. The surveyor observed a staff member sitting next to two tables where linens are folded and stacked. The surveyors observed an unopened single served carton of milk and cold cereal on table # 1. The staff member stated, "those were from last night." The DH stated that the food items should not be left on the table; she then removed the items afterward. At the same time, the surveyors observed two used disposable face shields, one reusable face shield, a personal cellphone, and a gold watch on table #2. Again, the staff member removed the items, and the DH stated to the staff member that there should not be any items on the table. Then, the surveyors entered the washing	F 921	F 921 SS=D 1. Corrective Action • Personal items have been removed from the tables and metal shelf rack containing clean linen in the laundry department. • A lid has been placed to cover the trash bin in the washing machine room soiled linen area. 2. Identifying other residents • Residents currently residing in the facility have the potential to be affected. 3. Systemic Changes • IP shall in-service laundry staff regarding the policy Donning and Doffing of PPEs to ensure used items are discarded in appropriate covered trash bins. • Housekeeping Director shall in-service laundry staff regarding storing clean linens to ensure personal items are not near clean linens and tables are clean and sanitized in the laundry area. 4. Monitoring • Housekeeping director or Designee	6/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315520	A. BUILDING _____ B. WING _____	C 05/23/2022

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F 921	Continued From page 108 machine room from the folding area and observed a metal shelf rack with folded clean linens. In addition, the surveyors observed two used disposable face shields and a personal plastic water bottle placed next to the clean folded linens. The DH could not state why used PPEs and personal items were on the folding tables and the shelf rack, but acknowledged that there shouldn't be any items in those areas. From the washing machine room, the surveyors entered the soiled linen room. The surveyors observed a tall, uncovered plastic trash bin with trash and yellow disposable gowns. The DH stated that the staff disposes of their used PPE and regular trash in one trash bin. She further stated that she was unsure if the trash bin should be covered or if used PPE should have a designated trash bin. On 5/6/22 at 11:29 AM, the Infection Preventionist Nurse (IPN), in the presence of the survey team, stated that she expected the staff in the laundry area to have a designated covered trash bin to dispose of the PPE after use. She further stated that the staff had designated lockers to place their personal items and acknowledged that staff should not have put their personal items on the tables or the linen rack. A review of laundry policy titled " Laundry Operations Manual", revised 01/2022. Under " Storing Clean Linen" "Safety Precautions", it was indicated to make sure folding areas and tables are clean, sanitized and free of defects or damage. A review of policy titled "Donning and Doffing of	F 921	shall audit laundry staff regarding proper disposal of PPEs in covered bins and ensuring no personal items are placed near clean linens daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate.	

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F 921	Continued From page 109 PPEs" under "Procedure" it indicated the following: 5. Gowns c. Discard in appropriate trash bin; 7. Eye protection-Face shields c. Place the used face shield in designated trash bin On 5/9/22 at 12:01 PM, the facility administration was unable to additional documentation to the surveyor. NJAC 8:39-31.4 (a)	F 921		

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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 the interview, and record review, it was determined that the facility failed to a.) ensure staffing ratios were met for 14 of 14 day shifts and 1 of 14 overnight shifts reviewed and this deficient practice had the potential to affect all residents. b.) ensure that the facility complies with applicable state rules and regulations with regard to the New Jersey Department of Health (NJDOH) Vaccination Mandate for [NJ Exec Order 26.4b1] to mitigate the spread of [NJ Exec Order 26.4b1]. There were a total of 15 out of 27 staff that were eligible for [NJ Exec Order 26.4b1] as of [NJ Exec Order 26.4].	S 560	1. Corrective Action • The Staffing coordinator was re-inserviced on the requirement of C.N.A ratios for each shift. 2. Identifying other residents • Residents currently residing in the facility have the potential to be affected. 3. Systemic Changes • Staffing Coordinator shall offer bonuses for staff to ensure proper	6/24/22

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

Electronically Signed — 06/16/22

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S 560	Continued From page 1 This deficient practice was evidenced by the following: Reference: New Jersey State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care	S 560	coverage. • The Facility has contracted and will continue to contract with new vendors who provide Agency staff to ensure staff to resident ratios are met per requirements. • The Facility will proactively hire staff thru open houses, media ads and advertisements. • DON/designee shall in-service the staffing coordinator regarding staffing ratio requirements and to report daily findings to DON/Administrator. 4. Monitoring • DON/designee shall audit daily staffing reports daily x 7 days, then weekly x 4 weeks, then monthly x 3 months or until sustained compliance is achieved.	

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S 560	Continued From page 2 staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ..." According to the NJDOH Executive Directive No. 21-011 (Revised) revised 4/6/22, Protocols for COVID-19 Testing and Vaccination Reporting for Covered Settings Pursuant to Executive Order Nos. 252, 253, 264, 283, and 290 included "Whereas, pursuant to Executive Order No 290 (2022), covered health care settings that are also subject to the CMS rule must maintain a policy that requires covered workers to have received their primary COVID-19 vaccination series in accordance with the CMS rule, and be otherwise up to date on COVID-19 vaccinations, including a booster, by April 11, 2022 or within three weeks of becoming eligible for a booster dose ..." 1. A review of the "New Jersey Department of Health Long Term Care Assessment and Survey	S 560		

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S 560	Continued From page 3 Program Nurse Staffing Report" completed by the Director of Nursing (DON) for the period of 4/10/22 through 4/23/22, revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staffing for residents on 1 of 14 overnight shifts as follows: -04/10/22 had 5 CNAs for 106 residents on the day shift, required 14 CNAs. -04/10/22 had 7 total staff for 106 residents on the overnight shift, required 8 total staff. -04/11/22 had 12 CNAs for 106 residents on the day shift, required 14 CNAs. -04/12/22 had 11 CNAs for 106 residents on the day shift, required 14 CNAs. -04/13/22 had 12 CNAs for 106 residents on the day shift, required 14 CNAs. -04/14/22 had 12 CNAs for 112 residents on the day shift, required 14 CNAs. -04/15/22 had 10 CNAs for 112 residents on the day shift, required 14 CNAs. -04/16/22 had 12 CNAs for 112 residents on the day shift, required 14 CNAs. -04/17/22 had 8 CNAs for 111 residents on the day shift, required 14 CNAs. -04/18/22 had 11 CNAs for 111 residents on the day shift, required 14 CNAs. -04/19/22 had 9 CNAs for 110 residents on the day shift, required 14 CNAs. -04/20/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -04/21/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. -04/22/22 had 10 CNAs for 110 residents on the day shift, required 14 CNAs.	S 560		

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S 560	Continued From page 4 -04/23/22 had 7 CNAs for 112 residents on the day shift, required 14 CNAs. On 5/6/22 at 09:54 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and made aware of the staffing concern. On 5/6/22 at 10:00 AM, the surveyor interviewed the Staffing Coordinator (SC). The SC informed the surveyor that it was her responsibility to find staff to meet the required numbers. The SC further stated that if the numbers were low, she would notify the Assistant Director of Nursing and the DON. A review of the facility policy [name redacted] Staffing Policy and Procedure with a review date of 9/21 included ratio guidelines and the goal of the policy stated the facility is to provide adequate staffing to meet needed care and services for our resident population. 2. On 4/25/22 at 9:42 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) during the entrance conference. The LNHA informed the surveyors that the Infection Preventionist Nurse (IPN) was not at the facility and will be back tomorrow. He further stated that the facility follows the CDC, Centers for Medicare and Medicaid Services (CMS), and local health department guidance for Infection Control policies and procedures including NJ Exec Order 26.4b1. According to the Staff Vaccine report that was provided by the IPN revealed that there was a total of 155 staff including in-house staff, agency, and physicians. The following were the breakdown of Staff vaccine reports as of NJ Exec Order 26.4:	S 560		

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S 560	Continued From page 5 In-house staff=11 were eligible for NJ Exec Order 26.4b1 more than three months ago, are scheduled for booster clinic on NJ Exec Order 26.4b and two were given written/verbal discipline. Agency staff=three were eligible for boosters more than three months ago and were scheduled on NJ Exec Order 26.4. Physicians=four were eligible for boosters more than three months ago. On 4/27/22 at 9:24 AM, the survey team interviewed the IPN who informed the surveyors that the facility was not in compliance with the NJDOH regulation with regard to vaccination. The IPN stated that the facility was "in the process for compliance" by providing the eligible staff with a verbal and written warning. She further stated that the facility had a scheduled Vaccine Booster Clinic on NJ Exec Order 26.4. On 4/27/22 at 9:58 AM, the surveyors met with the IPN and she provided an incomplete copy of the Executive Directive (ED) No. 21-011 (Revised). The IPN informed the surveyors that according to ED No.21-011 the facility has 60 days from the ED to comply as long as the facility had a plan of correction and provides actions that included warnings to the staff. The surveyor asked the IPN where in the ED the 60 days was written that they have 60 days to comply with the NJ Exec Order 26.4b1 and she stated "there was nothing in the ED about 60 days, but that is how we interpret it that we have 60 days from April 11, 2022, to comply with the booster." On 5/2/22 at 12:54 PM, the survey team met with the LNHA, DON, and IPN and were made aware of the above concerns. The LNHA and IPN were	S 560		

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S 560	Continued From page 6 under the impression that the facility complied with the [NJ Exec Order 26.4b1] Vaccine mandate of NJDOH and both stated that they thought that the facility have 60 days from April 11, 2022, to comply. A review of the 2022 facility's Mandatory COVID-19 Vaccine Policy and Procedure Policy and Procedure-NJ that was provided by the LNHA included "Staff is required to be vaccinated (boosted when eligible) in order to return from suspension or will be terminated after the 14 day suspension if Up to date status is not achieved."	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by:	S1405		6/24/22

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S1405	Continued From page 7 Based on interview and review of five recently hired employee files, it was determined that the facility failed to ensure that 2 of 5 newly hired employees (Registered Nurse #1 and Registered Nurse #2) completed a health history or received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: On 4/25/22 during the Entrance Conference, the Team Coordinator (TC) requested a list of all new employees hired within the last [redacted]. On 5/4/22 at 11:30 AM, The surveyor reviewed five new employee files. Review of the employee files revealed the following: 1. Registered Nurse #1 (RN #1) was hired on [redacted]. There was no documented evidence that the employee completed a health history or received an examination by a physician two weeks prior to the first day of employment or upon employment. 2. RN #2 was hired on [redacted]. There was no documented evidence that the employee completed a health history or received an examination by a physician two weeks prior to the first day of employment or upon employment. On 5/5/22 at 01:21 PM, the surveyor expressed her concern to the Licensed Nursing Home Administrator, Director of Nursing (DON),	S1405	S 1405 1. Corrective Action • Registered Nurse #1 and # 2 have completed and received Physician examinations. 2. Identifying other residents • Residents were not affected. 3. Systemic Changes • Regional Director of Clinical Services shall in-service DON/Employee Health regarding the requirements to complete a health history and receive an examination by physician or Advance practice nurse. 4. Monitoring • Employee Health shall audit new hire health files for completion of physician examination weekly x 3 months or until sustained compliance is achieved. • Audit results shall be submitted to Quality Assurance and Performance Improvement (QAPI) committee and addressed monthly or more as appropriate.	

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S1405	Continued From page 8 Infection Preventionist, and Assistant Director of Nursing. On 5/5/22 at 2:05 PM, the surveyor interviewed the DON. The DON acknowledged that the physicals were not completed. The DON stated, "we overlooked the physical evaluation for these two staff members." The DON also stated that she believed that she had 30 days from an employee's date of hire to complete the physical examination. A review of the facility policy, Employee Health with a reviewed date of 9/21 indicated, "Policy: It is the policy of Somerset Woods to provide a physical exam to all new hires. Procedures: 1. The Medical director of designee will assume the responsibility for the exam. 2. Each new employee will have a physical exam done within 30 days of employment. 3. In the event the employee requests to obtain a complete physical from their personal physician the Medical Director will review the results."	S1405		

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
315520 Y1	A. Building B. Wing Y2	7/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873

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 F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 06/24/2022	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 06/24/2022	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/24/2022
ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 06/24/2022	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 06/24/2022	ID Prefix F0697 Reg. # 483.25(k) LSC	Correction Completed 06/24/2022
ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 06/24/2022	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 06/24/2022	ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 06/24/2022
ID Prefix F0758 Reg. # 483.45(c)(3)(e)(1)-(5) LSC	Correction Completed 06/24/2022	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 06/24/2022	ID Prefix F0836 Reg. # 483.70(a)-(c) LSC	Correction Completed 06/24/2022
ID Prefix F0865 Reg. # 483.75(a)(2)(h)(i) LSC	Correction Completed 06/24/2022	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/24/2022	ID Prefix F0888 Reg. # 483.80(i)(1)-(3)(i)-(x) LSC	Correction Completed 06/24/2022

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315520 Y1	A. Building B. Wing Y2	7/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873

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 F0921 Reg. # 483.90(i) LSC	Correction Completed 06/24/2022				

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?
5/23/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
18109 Y1	A. Building B. Wing Y2	7/27/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873

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 06/24/2022	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 06/24/2022	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 5/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315520	A. BUILDING **1A** B. WING _____	**05/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	**780 OLD NEW BRUNSWICK ROAD** **SOMERSET, NJ 08873**

(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
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		6/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and interview on 5/20/22, the facility failed to establish and maintain a comprehensive Emergency Preparedness Program, that is updated at least annually and to provide updates to key personnel, including a list of phone numbers for the recall of staff and contacts needed in the event of an emergency. This deficient practice was evidenced by the following: Document review and interview on 5/22/22 at approximately 9:15 AM, revealed 'Disaster Manual Plan' did not include an annual update of the provided document indicating, that the emergency preparedness manual was reviewed by staff other than the Director of Maintenance, dated 2/1/22. The previous Administrator had signed the review document sign-off form, but the current Administrator, Medical Director, Director	E 004	1. The current Administrator, DM (Director of Maintenance), DON, and Medical Director all reviewed and signed the updated Emergency Preparedness Plan (EPP) on 6/8/2022. The EPP was sent to the Franklin Township OEM, Somerset County OEM, and Fire Marshal for review and signatures. 2. All residents have the potential to be effected. 3. DM will ensure the EPP is reviewed and updated at least annually or as needed with the required signatures. 4. DM will present any changes and updates to the EPP at the QA meetings for the next 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 004	Continued From page 2 of Nursing, Franklin Township OEM, Somerset County OEM and Fire Marshal had not signed and dated the document. The finding was verified by the Maintenance Director at the time of the observation. It was noted that day-1 (5/20/22) of the Life Safety Code survey was the Maintenance Director's last day at the facility. The Administrator was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.2(e), 31.6(i)	E 004		
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 5/20/22 and 5/23/22, was found to be in noncompliance with the 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 EXISTING Health Care Occupancy The facility is a 4-story building that was opened in 4/25/2016, It is composed of Type I fire resistant construction. The facility is divided into 8- smoke zones. The generator does approximately 40 % of the building. The facility utilized 1135 waivers allowing for regulatory flexibility during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315520	A. BUILDING **1A** B. WING _____	**05/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	**780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873**

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K 000	Continued From page 3 31, 2020. The flexibility did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 148 certified beds. At the time of the survey the census was 111. The facility utilized 1135 waivers allowing for regulatory flexibility during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibility did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 62 certified beds. At the time of the survey the census was 45.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of	K 161		6/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 161	Continued From page 4 stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on interviews and record review from 5/23/22, the facility failed to provide an acceptable construction type and protected wall-ceiling assembly in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1. This deficient practice	K 161	1. The building construction type was verified as 3A-Masonry/Wood. DM(Director of Maintenance) ordered 2-hour fire rated coating for the metal decking and it will be applied on the 3 identified areas (Medical records room,	

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K 161	Continued From page 5 was evidenced by the following: An interview was conducted based on observation and interviews on 5/20/22, in the presence of the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, They were unable to confirm the building construction type. They did provide accurate floor plans identifying smoke barrier walls, firewalls, shafts, hazardous areas, and exits for the life safety code survey. The plans indicated that in order to continue the 2-hour fire protection rating, the fire rated coating must remain in place. From 9:00 AM, to 3:00 PM, The following areas missing the fire rated coating : 1. The ground floor Medical Records room, decking and beam (truss) was missing approximately 1' section of fire rated coating. 2. The ground floor storage room A, was missing approximately 1' x 1' section of fire rated coating around 2 large pipes. 3. The ground floor storage room C, was missing approximately 11" section of fire rated coating. The findings were verified by the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, at the times of observation The Administrator was informed of the finding at the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.2(e)	K 161	Storage room A and Storage room C no later than 6/24/22 2. Residents on floor one have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all areas maintain the required fire rated coating. 4. DM will present his findings at the QA meetings for the next 4 quarters.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101	K 222		6/24/22

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K 222	Continued From page 6 Egress Doors 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 7 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic 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 observation and interviews on 5/20/22, in the presence of the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, it was determined that the facility failed to ensure that the 15-second delayed egress feature on 1 of 8 exit discharge doors (with this feature) observed would activate properly when tested. This deficient practice was evidenced by the following: At 1:04 PM, the Surveyor observed that the floor #3 south stairwell #1 exit/egress door when activated with the delayed 15-second egress feature, which was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door's egress feature did	K 222	1. DM (Director of Maintenance) contacted the facility□s low voltage vendor. On 6/16/22 they adjusted the emergency exit on stairwell # 1 (south) floor #3 to unlock and release after 15 seconds. 2. Residents residing on floor 3 have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all exits unlock and release after pushing for 15 seconds. 4. DM will present his findings at the QA meetings for the next 4 quarters.	

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K 222	Continued From page 8 not function with in the 15-second time frame. The door remained closed until approximately 20-seconds. The door had a keypad that opened the door, and according to the Maintenance Director, the fire alarm would release the device if it is activated. During the observation, the Maintenance Director and Administrator confirmed the finding in an interview. The Administrator was notified of the findings at the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222		
K 227 SS=F	Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/20/22, it was determined that the facility failed to comply with the requirements of NFPA 101:2012 sect. 7.2.5 pertaining to exit ramps as evidenced by the following: The deficient practice was evidenced for 1 of 1	K 227	1. The DM (Director of Maintenance) and administrator contacted the facility□'s original architect. The architect provided new drawings to include planters along both sides of the landing which will eliminate the tripping hazard by ensuring all people exiting only discharge onto the	6/24/22

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K 227	Continued From page 9 exit/egress ramps by the following: At 11:00 AM, the surveyor observed with the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, that outside the stairwell #3 exit/egress discharge (top landing) concrete pad, approximately 40" wide by approximately 24" long approximately 5" high. The ramp contained landscape block installed on the left side down to the ramp discharge level. The provided floor plans did not indicate if or when the landscape block was installed or the top landing dimensions with the installed block that would cause a tripping hazard. 19.2.2.6 RAMPS: 7.2.5.3.2 -landings #(3) every landing shall have a width not less than the width of the ramp 19.2.3 Capacity of Means of Egress 19.2.3.4* 7.2.5.3 Ramp Details: 7.2.5.3.2 Landings (1) through (7) 7.2.5.3.3 Drop-Offs The facility's Administrator was informed of the above finding during the Life Safety Code survey exit conference on 5/23/22.	K 227	flat surface straight ahead. DM/Designee will complete the work by 6/24/2024. 2. Residents and staff residing on the left wing (ramp side) of the facility have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all exits discharge onto safe landings. 4. DM will present his findings at the QA meetings for the next 4 quarters.	
K 271 SS=E	NJAC 8:39-31.1(c) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in	K 271		6/24/22

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	315520	A. BUILDING **1A** B. WING _____	**05/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	**780 OLD NEW BRUNSWICK ROAD** **SOMERSET, NJ 08873**

(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 271	Continued From page 10 elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain unobstructed exit discharges free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10 and 7.1.10.1. This deficient practice was evidenced for 1 of 1 obvious access routes in the event of an emergency. On 5/23/22 the surveyor observed in the occupied smoking courtyard that the coded gate, leading to the public way was observed to have a hard surface up to the coded gate, but it was observed that the area after the gate was not a level walking surface of hard packed all-weather travel surface. The exit discharge included approximately 40' section of grass lawn with no hard path to the public way. The assistant Maintenance staff member confirmed the finding during the observation. The Maintenance staff member and Administrator indicated that the coded gate opened with the activation of the fire alarm. It was confirmed with the Assistant Maintenance staff member that in the event of an emergency the gate would be the obvious route to the public way instead of going back into the building to exit.	K 271	1. Signage was posted on the door to the courtyard and the courtyard gate clearly indicating "NO EXIT". Per the building evacuation plan there is no exit from the courtyard. The facility's posted evacuation plan and exit signs are directing to exits at the ends of the hallways away from the courtyard. A strobe was also installed in the courtyard at the door to the building directing people to the facility's evacuation path per plan. 2. All residents and staff using the courtyard and on the first floor have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all exits lead to an all-weather travel surface. 4. DM will present his findings at the QA meetings for the next 4 quarters.	

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	315520	A. BUILDING **1A** B. WING _____	**05/23/2022**

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K 271	Continued From page 11 The finding was verified by the Administrator during the time of the observation. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7 NFPA 101:2012- 19.2 Means of Egress Requirements	K 271		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation on 5/20/22, in the presence of the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, it was determined that the facility failed provide a battery backup emergency light above the emergency generator's (2) transfer switches, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: At 12:05 PM, the Surveyor observed in the ground floor at the ATS- 1 and ATS- 2 emergency generator transfer switch locations, that the area was not equipped with battery back-up emergency lighting, independent of the building's electrical system and emergency generator. The Maintenance Director and Administrator, both confirmed the finding during the observations.	K 291	1. DM (Director of Maintenance) ordered two emergency battery backup emergency lights they will be installed at both generator transfer switch locations no later than 6/24/22. 2. All residents have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all emergency lighting is properly installed and operational. 4. DM will present his findings at the QA meetings for the next 4 quarters.	6/24/22

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K 291	Continued From page 12 The Administrator was notified of the finding at the Life Safety Code exit conference on 5/20/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/20/22, it was determined the facility failed to provide illuminated exit signs, that were readily visible for 1 of 8 exit signs observed on the ground floor. This deficient practice was evidenced by the following: During the Life Safety Code tour with the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, an inspection of the ground floor illuminated exit signs revealed that the exit sign by the elevator, when tested did not provide any illumination. The Maintenance Director and Administrator confirmed the finding during the observation. The Administrator was informed of the finding at	K 293	1. DM (Director of Maintenance) repaired the exit sign near the service elevator on the ground floor and confirmed it illuminates properly. 2. Employees utilizing the ground floor service area have the potential to be affected. No residents are affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all exit and directional signs are clear and properly illuminated. 4. DM will present his findings at the QA meetings for the next 4 quarters.	6/24/22

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K 293	Continued From page 13 the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.2.10.1	K 293		
K 345 SS=E	Fire Alarm System - Testing and Maintenance 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 observation and interview, the facility failed to provide and maintain an initiating device in operating condition at all times in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.4.1, 9.6, 4.6.12.1. The deficient practice was observed for 1 of 318 initiating devices as per the provided documentation from the facility vendor. On 5/23/22 the Surveyor and Administrator reviewed the fire alarm inspection report dated 12/15/22. The report indicated that the initiating device on the 3rd floor of the facility identified as the Emerald unit hallway by room #322 failed operation. The Administrator indicated he would call the fire alarm vendor to see if the repair was completed,	K 345	1. The facility's vendor was immediately contacted and they repaired the initiating device on the 3rd floor near room 322 on 6/2/2022. 2. Residents on the 3rd floor have the potential be affected. 3. DM (Director of Maintenance) will include in his preventative maintenance program a quarterly facility wide audit ensuring all items on the fire alarm inspection report are addressed and properly functioning. 4. DM will present his findings at the QA meetings for the next 4 quarters.	6/24/22

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K 345	Continued From page 14 but as of the Life Safety Code exit conference on 5/23/22, no further repair documentation was provided. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.4.1, 9.6, 4.6.12.1.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview conducted on 5/23/22, in the presence of the Life Safety Code tour with the Maintenance Director, Federal CMS-LSC surveyor, and Administrator, it was determined that the facility failed to ensure that their automatic sprinkler system was inspected/tested at the required 3- year full trip	K 353	1. The facility□s fire sprinkler vendor was immediately contacted and on 5/26/22 they performed the 3 year full trip test on the 2 dry systems and the 5 year internal inspection on all 3 systems (2 dry 1 wet) and the results were satisfactory. 2. All residents have the potential to be	6/24/22

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K 353	Continued From page 15 test for the 2-dry systems and 5-year interval for the wet system in accordance with the National Fire Protection Association (NFPA) 25. This deficient practice was evidenced for 3 of 3 systems (2-dry and 1-wet system) by the following: At 10:05 AM, the surveyor reviewed the facility's automatic sprinkler system inspection reports. The most recent documentation by the facility vender on 2/1/22, 11/8/21, 8/16/21 and 5/7/21 all indicated N/A for the 5-year internal obstruction investigation of the pipe. It was also unknown when the inspection of the system was last conducted. The surveyor interviewed the Maintenance Director and Administrator and they both acknowledged that they was unsure why the system's were not inspected. The Maintenance Director and Administrator could not provide documentation on when the 5-year internal obstruction investigation of the fire sprinkler pipe was last conducted. The Administrator called the facility fire sprinkler vendor, and they did not have any records as to when the inspection was last conducted by the end of the survey. The Administrator provided an undated document work order for the 3rd year full trip test of the two dry sprinkler systems and 5th year internal inspection of 1-wet and 2-dry systems. NFPA 25 requires an internal inspection of the fire sprinkler system piping every five years; this needs to be conducted to inspect for the presence of foreign organic material that can cause obstructions to pipe and sprinklers.	K 353	affected. 3. DM (Director of Maintenance) will include in his preventative maintenance program a quarterly facility wide audit ensuring all maintenance and testing of the automatic sprinkler systems is conducted. 4. DM will present his findings at the QA meetings for the next 4 quarters.	

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K 353	Continued From page 16 The Administrator was notified of the deficiency at the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 25	K 353		
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	K 363		6/24/22

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K 363	Continued From page 17 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 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 observation and interview on 5/20/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 14 of 50 resident room doors observed and was evidenced by the following: The following resident room doors, when closed left a gap at the top of the room door approximately 1/4 to 1/2 inch, due to a malfunction in the door hardware installation: # 204, 207, 208, 209, 210, 310, 313, 319, 320, 321, 323, 324, 327 and 328. An interview was conducted with the Maintenance Director at the time of the	K 363	1. DM (Director of Maintenance) adjusted the hinges on 14 doors (Room # 204,207, 208, 209, 210, 310, 313, 319, 320, 321, 323,324, 327, and 328) to close the gaps. 2. Residents on the second and third floor (In rooms # 204,207, 208, 209, 210, 310, 313, 319, 320, 321, 323,324, 327, and 328) have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring all doors properly close without any gaps. 4. DM will present his findings at the QA meetings for the next 4 quarters.	

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K 363	Continued From page 18 observations who confirmed the above findings. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
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 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	K 918		6/24/22

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K 918	Continued From page 19 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 observation and interview on 5/23/22, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generators, was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 11:00 AM, the Surveyor, Maintenance staff member and Administrator, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed. An interview was conducted during the observation with the Maintenance staff member and Administrator, where they stated that at the time of observation, the exterior generator was observed to not have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	1. The facility's generator vendor was immediately contacted and they installed a remote emergency shut off switch on 6/10/22 2. All residents and staff have the potential to be affected. 3. DM (Director of Maintenance) will include in his preventative maintenance program a quarterly audit ensuring the remote generator shut off switch is operational 4. DM will present his findings at the QA meetings for the next 4 quarters.	

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K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/02/22, the facility did not prohibit the use of extension cords and power strips, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does	K 920	1. DM (Director of Maintenance) immediately removed the extension cords and power strip from the electric room and ceiling and removed the bug zapper from the wall. 2. All residents and staff have the potential to be affected. 3. DM will include in his preventative maintenance program a quarterly facility wide audit ensuring no areas are utilizing	6/24/22

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K 920	Continued From page 21 not ensure prevention of an electrical fire or electric shock hazard. This deficient practice was evidenced for 1 of 10 areas observed by the following: At 11:55 AM, the Surveyor, Maintenance Director, Federal CMS-LSC surveyor, and Administrator, observed in the ground floor electric room that an orange extension was plugged into a multi-outlet power strip, the power strip was then plugged into a duplex wall outlet. The orange extension cord was then observed to be running above the drop ceiling tile into the exit/egress corridor then by removing a ceiling tile, the orange extension cord was then observed to be plugged into a bug light. The bug light was mounted on the upper wall of the exit/egress corridor and plugged above the drop ceiling into the orange extension cord. The finding was verified by the Surveyor, Maintenance Director, Federal CMS-LSC surveyor, and Administrator, at the time of the observation. The Administrator was notified of the findings at the Life Safety Code exit conference on 5/23/22. NJAC 8:39-31.2(e)	K 920	extension cords and power strips as a substitute for adequate wiring. 4. DM will present his findings at the QA meetings for the next 4 quarters.	

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
315520 Y1	A. Building B. Wing Y2	8/1/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET WOODS REHABILITATION & NURSING CENTER	780 OLD NEW BRUNSWICK ROAD SOMERSET, NJ 08873

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 E0004 Reg. # 483.73(a) LSC	Correction Completed 06/24/2022	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
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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	
5/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO