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 09/29/2023

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

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F 000	INITIAL COMMENTS Complaint #: NJ00155559, NJ00164004, NJ00158068, NJ00163524, NJ00166799 Survey Date: 9/29/23 Census: 100 Sample: 22 plus 4 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident's dignity was maintained during an *NJ Ex Order 26. 4B1* [redacted] for 1 of 1 residents (Resident # 21) reviewed for [redacted]. This deficient practice was evidenced by the	F 557	1.Corrective Action • Resident # 21 continues to reside in the facility. • Resident # 21 currently receives *NJ Ex Order 26. 4B1* with the door closed or behind room curtain to provide privacy., and with the assistance of a second staff member as needed. • [redacted] was counseled to ensure residents are provided with privacy during	10/20/23

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

Electronically Signed | 10/12/2023

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F 557	Continued From page 1 following: On 09/23/23 at 2:21 PM, the surveyor observed Resident # 21's room door open. The resident was awake out of bed and seated in a [NJ Ex Order 26. 4B1] in the center of the room and which faced the opened door. A[US FOIA (b)(6)] was administering a *NJ Ex Order 26. 4B1* . The resident's shirt was lifted exposing the *NJ Ex Order 26. 4B1*. On 09/21/23 at 2:23 PM, the surveyor interviewed the [US FOI] who stated, "it is [NJ Exec Order 26.4b1] to give the resident a [NJ Ex Order 26. 4B1]. I left the door open just in case I needed help; someone could hear me. I wouldn't give a [NJ Ex Order 26. 4B1] in the hall, but today he/she was [NJ Exec Order 26.4b1] The surveyor reviewed Resident # 21's medical record. Review of the Admission Record face sheet (an admission summary) revealed that the resident had diagnoses which included but not limited to *NJ Ex Order 26. 4B1* Review of the [NJ Ex Order 26. 4B1], quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care reflected the resident's [NJ Exec Order 26.4b1] making was *NJ Ex Order 26. 4B1*. Further review of the MDS in section [NJ E] for [NJ Exec Order 26.4b1] approaches indicated "[NJ Ex Order 26. 4B1]." Review of the Order Summary Report revealed a	F 557	administration of *NJ Ex Order 26. 4B1*. 2.Identifying other residents • Residents currently residing in the facility and receiving care related to enteral tube feeding have the potential to be affected. • DON/designee conducted an audit to identify residents who currently have enteral tube feeding to ensure these residents are being provided privacy and dignity during times of scheduled feeding. • Audit results showed no other residents were affected. 3.Systemic Changes • DON/designee shall in-service all nurses including agency regarding residents' rights pertaining to dignity and privacy when administering enteral feedings. • Pharmacy consultant will conduct enteral feeding observation and/or medication administration via enteral tube during visits. 4.Monitoring • DON/designee shall perform audits of residents receiving enteral tube feeds on each shift to ensure privacy and dignity are being maintained 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 557	Continued From page 2 physician's order (PO) dated [NJ Ex Order 26. 4B1], for [NJ Ex Order 26. 4] every three (3) hours for [NJ Exec Order 26.4b1] give *NJ Ex Order 26. 4B1* every three (3) hours. Review of the [NJ Exec Order 26.4b1] electronic medication administration record (eMAR) reflected the above corresponding PO. Review of the resident's individualized comprehensive care plan date initiated [NJ Ex Order 26. 4B1], indicated a focus area for has meals in room. The care plan goal indicated that the resident receives *NJ Ex Order 26. 4B1*. The care plan intervention dated [NJ Ex Order 26. 4B1], indicated that privacy will continue to be met due to [NJ Ex Order 26. 4]. Review of the facility's policy for [NJ Exec Order 26.4b1] Administration provided by the [US FOIA (b)(6)] indicated to provide resident with privacy. On 09/27/23 at 1:00 PM, the survey team met with the [US FOIA (b)(6)] and discussed the above observation. 09/28/23 01:06 PM, the survey team met with the [US FOIA (b)(6)]. The [US FOIA (b)] stated, "I do believe there was a breach in his/her privacy. I do feel [NJ Exec] reasoning, but still his/her privacy should have been maintained."	F 557		
F 656 SS=D	NJAC 8:39-4.1(a)12 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		10/20/23

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F 656	Continued From page 3 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 4 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to develop and implement a comprehensive care plan for 2 of 3 residents (Resident # 46 and Resident # 48) reviewed for NJ Exec Order 26.4b1 This deficient practice was evidenced by the following: 1. On 09/20/23 at 12:45 PM, the surveyor observed Resident # 46 awake and seated in a wheelchair in the main dining room for lunch. The resident was NJ Exec Order 26.4b1 and NJ Exec Order 2 Staff members were in the dining room attempting to calm and redirect the resident's NJ Exec Order 26.4b1 On that same day at 12: 49 PM, the surveyor interviewed the US FOIA (b)(6)) who stated, "this is the usual NJ Exec Order 26.4b1 for the resident." She further stated, "in the morning [the resident] is NJ Exec NJ Exec Order 26.4b1 it starts in the afternoon." The US FOIA (b) stated the NJ Exec Order 26.4b1 have not NJ Exec Order 26.4b1 but she does not know what NJ Exec Order 26.4b1 . She stated, "out of the blue he/she just NJ Exec Order 26.4b1 for no reason sometimes he/she is NJ Exec Order 26.4b1 but most times he/she is not." The surveyor reviewed Resident # 46's medical record. Review of the Admission Record face sheet (an	F 656	1.Corrective Action • Resident # 46 and Resident # 48 continues to reside in the facility. • Resident # 46 care plan was updated and interventions implemented to address NJ Exec Order 26.4b1 NJ Ex Order 26. 4B1 . • Resident # 48 care plan was updated and interventions implemented to address targeted NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 2.Identifying other residents • Residents residing in the facility and receiving psychotropic medications have the potential to be affected. • DON/designee conducted an audit to identify Residents receiving psychotropics medications to ensure that comprehensive person-centered care plans are developed and now individually address behaviors, triggers and interventions. • Audit results have been addressed and care plans updated. 3.Systemic Changes • DON/designee shall in-service Interdisciplinary team members that are responsible for care planning including nurse managers and supervisors regarding individualized comprehensive	

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F 656	Continued From page 5 admission summary) revealed that the resident had diagnoses which included but not limited to NJ Ex Order 26. 4B1 . Review of the NJ Ex Order 26. 4B1, quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care reflected a NJ Ex Order score of NJ Ex which indicated NJ Ex Order 26. 4B1 . Review of section NJ of the MDS for NJ Exec Order 26.4b1 indicated the resident NJ Exec Order 26.4b1 symptoms directed toward others one to three days a week. Review of the Order Summary Report revealed a physician's order (PO) dated NJ Ex Order 26. 4B1, for NJ Ex Order 26. 4B1 give one tablet orally two times a day for NJ Ex Order 26. 4B and a PO dated NJ Ex Order 26. 4B1, for NJ Ex Order 26. 4B1 tablet by mouth every 24 hours as needed for increased NJ Ex Order 26. 4B1 until NJ Ex Order 26. 4B1. Review of the NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 electronic treatment administration record (eTAR) revealed a PO dated NJ Ex Order 26. 4B1, to monitor for NJ Exec Order NJ Ex Order 26. 4B1 every shift for behavior. Review of the NJ Exec Order 26.4b1 Monthly Review from NJ Ex Order 26. 4B1 indicated diagnosis of NJ Ex Order 26. 4B; NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 NJ Ex Order 26. 4B1 and medication to treat the NJ Ex Order 26. 4B is NJ Ex Order 26. 4B1 twice a day. The review further revealed that the care plan for NJ Ex Order 26. 4B1 was developed and implemented.	F 656	care plans that address residents target behaviors and interventions. • DON/designee will monitor new admissions and residents with new orders for psychotropic medications to ensure an individualized and person-centered care plan is developed that addresses target behaviors, triggers and interventions. 4.Monitoring • DON/designee will review new patient care plans related to psychotropic medications and target behaviors. • DON/designee will perform a behavior care plan audit to ensure that they have comprehensive person-centered care plans that individually addressed behaviors, triggers and interventions 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 656	Continued From page 6	F 656		

Review of the NJ Ex Order 26. 4B1 from the nurse practitioner dated NJ Ex Order 26., revealed the resident presented with NJ Exec Order 26.4b1 with NJ Exec Or finding NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 No signs of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, or NJ Exec Order 26.4b1. The US FOIA (b)(6) recommended to continue NJ Ex Order 26. 4B1 by mouth twice a day and a NJ Exec Order 26.4b1 was not recommended "at this time" to avoid recurrence of target symptoms and NJ Exec Order 26.4b1

Review of the NJ Ex Order 26. 4B1 from the US FOIA (b)(6) dated NJ Ex Order 26. 4B, revealed symptoms of NJ Ex Order 26. 4B are present and have worsened. "During today's rounds NJ Exec Order 26.4b1 was observed ...presents as NJ Exec Order 26.4b1 ...signs of NJ Ex Order 26. 4B1 appear to be present."

Review of the resident's individualized comprehensive care plan revealed a focus area for NJ Ex Order 26. 4B1 medication related to diagnosis of NJ Ex Order 26. 4B initiated on NJ Ex Order 26. 4B1. The goal indicated that the resident will not experience negative side effects from NJ Ex Order 26. 4B1 use. The interventions indicated to administer medications as ordered, assess effectiveness of medication, establish appropriate diagnosis for medication use, evaluate for reduction of medication dose, and NJ Ex Order 26. 4B1 as needed. There was no evidence of an individualized care plan developed and implemented to address the resident's NJ Exec Order 26.4b1 NJ Ex Order 26. 4B1 which was being NJ Exec Order 26.4b1 every shift.

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F 656	Continued From page 7 2. On 09/20/23 at 12:31 PM, the surveyor observed Resident # 48 awake and seated in a wheelchair. The resident greeted the surveyor. The surveyor reviewed Resident # 48's medical record. Review of the Admission Record face sheet (an admission summary) revealed that the resident had diagnoses which included but not limited to *NJ Ex Order 26. 4B1* [redacted]. Review of the *NJ Ex Order 26. 4B1*, annual MDS reflected a *NJ Ex Order 26.* score of *NJ Ex* which indicated that the resident had an *NJ Ex Order 26. 4B1*. Review of section *NJ* of the MDS for *NJ Exec Order 26.4b1* indicated no *NJ Exec Order 26.4b1* Review of the Order Summary Report revealed a PO dated *NJ Ex Order 26. 4B1*, for *NJ Ex Order 26. 4B1* [redacted] give one tablet orally one time a day for *NJ Ex Order 26* [redacted]; a PO dated *NJ Ex Order 26. 4B1*, for *NJ Ex Order 26. 4B1* [redacted] IM in the morning every 3 months for *NJ Ex Order 26. 4B1*; a PO dated *NJ Ex Order 26.*, for *NJ Ex Order 26. 4B1* give 1 tablet orally at bedtime for *NJ Ex Order 26. 4B1*. Review of the *NJ Ex Order 26. 4B1* eTAR revealed a PO dated *NJ Ex Order 26. 4B1*, to monitor for target *NJ Exec Order 26.4b1* of *NJ Exec Order 26.4b1* and *NJ Exec Order 26.4b1* every shift. Review of the *NJ Exec Order 26.4b1* Monthly Review from *NJ Exec Order 26.4b1*, indicated	F 656		

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F 656	Continued From page 8	F 656		

diagnosis of 'NJ Exec Order 26.4b1 and 'NJ Exec Order 26.4b1 ; target NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The review further revealed that the care plan for NJ Exec Order 26.4b1 management was developed and implemented.

Review of the NJ Ex Order 26. 4B1 from the nurse practitioner dated NJ Ex Order 26., revealed resident was NJ Exec Order 26.4b1 with no NJ Ex Order 26. 4B1 . No evidence of NJ Ex Order 26. 4B1 , or NJ Exec Order 26.4b1 noted during rounds. A gradual dose reduction was not recommended to avoid recurrence of target symptoms and decompensation. The recommendation was to continue the aforementioned medications.

Review of the resident's individualized comprehensive care plans revealed a focus area for medication intended for management of NJ Ex Order 26. 4B1 date initiated NJ Ex Order 26. 4B1 and revised NJ Ex Order 26. 4B1 . The goal indicated that the resident will not experience NJ Exec Order 26.4b1 of medication such as. The interventions indicated no description provided, administer medications as ordered, establish appropriate diagnosis for medication use, and evaluate for reduction of medication use.

Further review of the residents individualized comprehensive care plans revealed a focus area for NJ Ex Order 26. 4B1 related to diagnosis of NJ Ex Order 26. 4B1 date initiated NJ Ex Order 26. 4B1 and revised NJ Ex Order 26. . The goal indicated that the resident will be NJ Exec Order 26.4b1 and show no signs of NJ Exec Order 26.4b1 The interventions indicated to establish appropriate diagnosis for medication use and evaluate for reduction of medication dose.

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F 656	Continued From page 9	F 656		

There was also a care plan with a focus area for medication related to diagnosis of NJ Ex Order 26. 4B date initiated NJ Ex Order 26. 4B and revised NJ Ex Order 26. . The goal of the care plan was that the resident will not NJ Exec Order 26.4b1 from NJ Ex Order 26. 4B1 use. The interventions indicated to administer medications as ordered, assess need for NJ Ex Order 26. 4B1 , establish appropriate diagnosis for medication use, and to monitor for change in NJ Exec Order 26.4b1 with medication change.

There was no evidence of an individualized comprehensive care plan to address the residents' targeted NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

On 09/21/23 at 11:09 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that the unit managers, herself, or the US FOIA (b)(6)) develop and revise care plans and at times the 3-11 shift US FOIA (b)(6) develop care plans. She could not speak to why a NJ Exec Order 26.4b1 plan was not developed to address Resident # 46's NJ Exec Order 26.4b1

On 09/27/23 at 1:00 PM, the survey team met with the US FOIA (b)(6) and the US FOIA (b) and discussed the above findings.

On 09/28/23 at12:00 PM, the survey team met with the US FOIA (b)(6) . The US FOIA (b) acknowledged that the residents should have had a care plan specific to address their behaviors. She stated that with the previous electronic medical record (EMR) they had care plans in place for their NJ Exec Order 26.4b1 but when the facility

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F 656	Continued From page 10 transitioned to a new EMR the care plans got "dropped off." Review of the facility's untitled policy provided by the [redacted] included that the facility's Care Planning/Interdisciplinary team was responsible for the development of an individual comprehensive care plan for each resident. A comprehensive care plan is developed within 14 days of completion of the resident assessment (MDS) and is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary team. NJAC 8:39-11.2(e)	F 656		
F 756 SS=D	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. §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	F 756		10/20/23

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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 756	Continued From page 11 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, record review, and review of pertinent facility documents, it was determined that the facility failed to respond in a timely manner to the US FOIA (b)(6) [redacted] monthly recommendations for 1 of 5 residents (Resident #96) reviewed for unnecessary medications. The deficient practice was evidenced by the following: On 9/21/23 at 12:10 PM, the surveyor observed Resident #96 in bed with their eyes closed. The surveyor reviewed Resident #96's medical records. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that	F 756	1. Corrective Action • Resident #96 continues to reside in the facility. • Resident #96 no longer receives [redacted] NJ Ex Order 26. 4B1 . • Resident # 96 continues to receive [redacted] NJ Ex Order 26. 4B1 . • Consultant pharmacist has been notified to continue to address 14-day stop date for as needed [redacted] NJ Ex Order 26. 4B medications and to follow up if a response has not been made within 2 days. (move to systemic change) • The Consultant Pharmacist Medication Regimen Review (CPMRR) recommendations created between [redacted] NJ Ex Order 26. have been addressed related to 14 day stop date for as needed [redacted] NJ Ex Order 26. 4B medications.	

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	315520	A. BUILDING _____ B. WING _____	C 09/29/2023

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F 756	Continued From page 12 included but not limited to *NJ Ex Order 26. 4B1* [redacted]. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident's [redacted] skills for [redacted] score was [redacted] out of 15, which indicated that the resident's [redacted] was *NJ Ex Order 26. 4B1*. A review of the Order Summary Report (OSR) (physician's order sheet) dated *NJ Ex Order 26. 4B1* revealed a Physician order (PO) dated [redacted] for *NJ Ex Order 26. 4B1* [redacted], give 1/2 tablet by mouth every 12 hours as needed for [redacted]. A further review of the OSR revealed a PO dated [redacted] for *NJ Ex Order 26. 4B1* [redacted] give 1 tablet by mouth every 8 hours as needed for [redacted] with a discontinued date of [redacted]. A review of the *NJ Ex Order 26. 4B1* [redacted] electronic medication administration record (eMAR) revealed an order dated [redacted], for *NJ Ex Order 26. 4B1* tablet, give [redacted] by mouth every 12 hours as need for [redacted]. A further review of the eMAR revealed a PO dated [redacted], for *NJ Ex Order 26. 4B1* tablet, give 1 tablet every 8 hours as needed for [redacted] with a discontinued date of [redacted]. A review of the Consultant Pharmacist (CP)-	F 756	2. Identifying other residents • Residents currently residing in the facility with orders for as needed anxiety medications have the potential to be affected. • DON/Designee conducted an audit for residents taking Lorazepam, Alprazolam, Clonazepam and Diazepam as needed to ensure there is a 14 day stop date in place. • Consultant Pharmacist Medication Regimen Review (CPMRR) for September has been audited to ensure all recommendations have been addressed. 3. Systemic Changes • Pharmacy consultant reports shall be completed by Unit Manager and submitted to DON upon completion. • DON/designee shall in-service nurses including agency regarding 14 days stop date for as needed anxiety medications. • 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 for residents taking Lorazepam, Alprazolam, Clonazepam and Diazepam as needed 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 to ensure all recommendations have been addressed.	

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F 756	Continued From page 13 Medication Regimen Review revealed the following recommendations: On [redacted] the CP recommended that an as needed [redacted] should have a stop date of 14 days. On [redacted] the CP recommended that an as needed [redacted] should have a stop date of 14 days. On 9/21/23 at 2:10 PM, the surveyor interviewed the 2nd floor Registered Nurse/Unit manager (RN#1)(UM#1) who stated that it was her responsibility to review the [redacted] recommendations. She further stated that the [redacted] would make recommendations regarding as needed [redacted] medications. RN#1/UM#1 stated that she was aware that as needed medications for [redacted] such as [redacted] should have a 14-day stop date. She was unable to speak to why the [redacted] recommendation was not followed and stated that the resident had relocated from another floor and maybe the [redacted] recommendation was missed. On 9/27/23 at 1:00 PM, the surveyor discussed the above observation and findings with the [redacted]) and the [redacted]. There was no additional information provided. On 10/2/23 at 11:45 AM, the surveyor interviewed the [redacted] who stated that all Medication Regimen Review recommendation should be address by the facility within 2 days. A review of the facility's policy "Consultant Pharmacy" dated 10/22, which was provided by the [redacted] did not include a time frame for the	F 756	• 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 756	Continued From page 14 facility's response to the [redacted] recommendations pertaining to medication irregularities. A review of the facility's policy "Medication, Antipsychotic Drugs" dated 10/22, which was provided by the DON did not include as needed anti-anxiety medications with a specific stop date. NJAC 8:39-29.3	F 756		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	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: C/O # NJ 00164044 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for a.) 5 of 14 day shifts for the period of 04/23/2023 through 05/06/2023 and 7 of 14 day shifts for the period of 09/03/2023 through 09/16/2023 and b.) ensure that all general training for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body	S 560	1. Corrective Action • The Staffing coordinator was re in-serviced on the requirement of C.N.A Ratios for each shift . • The Facility has signed up for the next available in-person training regarding LGBTQI+ Law that will be conducted by an approved entity. The Assistant Administrator and Activities Aide will receive the LGBTQI+ Law training and both have been designated to serve as points of contact for the facility regarding compliance with this policy and assist in developing a general training plan. 2. Identifying other residents • Residents currently residing in the	10/20/23

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

Electronically Signed | 10/12/23

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S 560	Continued From page 1 fight infection] positive) program for both an administrative and direct care staff member as well as the entire staff employed at the facility by a recognized training agency. Findings include: Part A Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "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 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: 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. For the 2 weeks of Complaint staffing from 04/23/2023 to 05/06/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:	S 560	facility have the potential to be affected. 3. Systemic Changes • The Facility has contracted with a new vendor who provides Agency staff to ensure staff to resident ratios are met per requirements. • Staffing Coordinator shall offer bonuses for staff to ensure proper coverage. • The Facility will proactively hire staff thru open houses, media ads, School visits for upcoming new graduate nurses. • DON/designee shall in-service the staffing coordinator regarding staffing ratio requirements and to report call outs or events that cause staffing to fall below required ratios to DON/Administrator. • Upon completion of LGBTQI+ Law training, the Assistant Administrator and Activities Aide in collaboration with DON shall in-service staff including agency regarding LGBTQI Resident Rights Policy and Procedure. 4. Monitoring • DON/designee shall audit daily staffing reports to ensure staff to resident ratios are met per requirements 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) to be addressed as appropriate • Assistant Administrator and/or Activities Aide will monitor facility's compliance related to LGBTQI Resident Rights monthly x 3 months or until	

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S 560	Continued From page 2 -04/23/23 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/29/23 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -04/30/23 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -05/01/23 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -05/06/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from 09/03/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -09/03/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/04/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/07/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/08/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/09/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.-09/10/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/11/23 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 09/28/23 at 9:56 AM, the surveyor interviewed the Staffing Coordinator who stated that she was aware of the minimum staffing requirements. She further stated that the ratio was one to eight CNAs for the 7 AM to 3 PM day shift. On 09/28/23 at 1:13 PM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) in the	S 560	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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presence of the survey team. They stated that the were familiar with the required minimum staffing ratios and the LNHA stated that the CNA to resident minimum staffing ratio was one CNA to eight residents. He further stated that the Staffing Coordinator needs to staff adequately and "most days we meet the ratios if not due to call outs."

A review of the facility-provided policy titled; "Staffing Policy and Procedure" with a reviewed date of 10/22, included that the facility "shall maintain the following minimum direct care staff to resident ratios: (1) one certified nurse aide to every eight residents for the day shift."

Part B

Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021, and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C. 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities").
The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal

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protections as everyone else regardless of their sexual orientation or health status.
Prohibited Actions
The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:
1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility;
2. Denying a request by residents to share a room;
3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10(e)(5);
4. Forbidding a resident from or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;
5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice;
6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices;
7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual

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relations;
8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and
9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6).

Resident Records
Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality
The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.

Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.

Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex,

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or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.

Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling.

Violations
A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action.

Training
Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.

The required training shall address:
1. Caring for LGBTQI+ seniors and seniors living

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S 560	Continued From page 7 with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. On 9/28/23 at 1:18 PM, the surveyor interviewed the DON and LNHA in the presence of the survey team. The LNHA stated that when the mandate first started, they had a consultant, and they did not fully understand what was required. The DON stated that she and the assistant LNHA were trained through [name redacted] and then in serviced the entire staff. She further stated that she and the LNHA received an email from the state which indicated that the training needed to be done by an approved company. They stated that it was at that time they realized they did not receive the correct training. They both acknowledged that they did not have an	S 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 8 administrative staff member and a direct care staff member trained by an approved company. In addition, they acknowledged that the entire staff were not trained by an approved company. A review of the facility-provided policy titled "LGBTQI Resident Rights Policy and Procedure" dated 2021 and provided by [name redacted] included that "the training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by ...LGBTQI seniors ... who reside in long term care facilities ..." In addition, the policy included "the facility shall designate two employees, including one employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training by March 2, 2022. The designated employees shall serve as points of contact for the facility regarding compliance with this policy and shall develop a general training plan for the facility.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT Y3
315520		10/26/2023

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 F0557 Reg. # 483.10(e)(2) LSC	Correction Completed 10/20/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 10/20/2023	ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 10/20/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
315520	A. Building B. Wing	10/26/2023

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 F0557 Reg. # 483.10(e)(2) LSC	Correction Completed 10/20/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 10/20/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
18109 (Y1)	A. Building B. Wing (Y2)	10/26/2023 (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 10/20/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/29/2023	☐ 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 _____	**09/29/2023**

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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/29/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/29/23 and was found to be in compliance 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. Somerset Woods Rehabilitation and Nursing Center is a four-story building that was built in 2016. It is composed of Type II protected construction. The facility is divided into 10-smoke zones. The generator does approximately 80% of the building as per the Maintenance Director. The current occupied beds are 107 out of 148.	K 000		

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

Electronically Signed | 10/11/2023

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