STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE CALDWELL, NJ 07006

(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 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		
F 000	INITIAL COMMENTS Standard Survey: 10/12/23 Census: 28 Sample Size: 13 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 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		10/29/23

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

Electronically Signed | 10/21/2023

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

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F 582	Continued From page 1 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to issue the	F 582	PLAN OF CORRECTION	

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F 582	Continued From page 2 proper required Skilled Nursing Facility Beneficiary Notices for 3 of 3 residents (#10, #28, #29) reviewed for facility change notifications. The deficient practice was evidenced by the following: On 10/5/23 at 09:00 AM, the facility presented the surveyor with a list of residents who were discharged from the facility within 6 months and should have received Beneficiary Notices. The surveyor reviewed 3 of the residents (Resident #10, #28, #29) which were discharged from a Medicare Part A stay at the facility and were documented as having a discontinuation of their Medicare Part A insurance payment to the facility. Resident #10 was admitted to the facility on EX Order 26.4B1. The last documented covered day of coverage for Medicare Part A service was EX Order 26.4B1 The resident continued their stay in the facility. The facility did not present the resident or the Power of Attorney with the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055. Resident #28 was admitted to the facility on EX Order 26.4B1 The last documented covered day of coverage for Medicare Part A service was EX Order 26.4B1 The resident was discharged home on EX Order 26.4B1 The facility did not present the resident with the required Notice of Medicare Non-Coverage (NOMNC) Form CMS-10123 to notify them of the termination of insurance. Resident #29 was admitted to the facility on EX Order 26.4B1. The last documented covered day of coverage for Medicare Part A service was	F 582	483.10(g)(17)(18)(i)-(v) F582 Medicaid/Medicare Coverage/Liability Notice 1.) POTENTIAL AFFECT FOR RESIDENT(S): There was no actual harm to residents #10, #28, #29. The administrator met with the residents identified 48hrs prior to each discharge from Medicare A, explaining the decision to end Medicare coverage and their right to appeal the decision made by the facility. Residents #10, #28,#29 stated they understoon and agreed with the decisio, declining the option to appeal. Administrator did not use the correct forms for the three identified residents and did not document in the EMR that the residents were informed. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: There was no harm to the other residents. No other resident has been discharged from Medicare A. The facility staff and administrator were reeducated during the survey process regarding the correct process to follow when the facility makes the decision to discharge a resident from Medicare A, including using the correct forms. 3.) SYSTEMIC CHANGES: A new process of documenting in the	

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F 582	Continued From page 3 EX Order 26.4B1 EX Order 26.4B1. The resident was discharged home on [redacted]. The facility did not present the resident with the NOMNC Form CMS-10123 to notify them of the termination of insurance. On 10/11/23 at 1:10 PM, the surveyor informed the Administrator and the Director of Nursing that the Beneficiary Notices were not provided to Residents #10, 28, and 29 to notify them of the termination of Medicare insurance benefits. The administrator confirmed the process was not followed with these 3 residents mentioned above. No additional information was provided. NJAC 8:39-5.1	F 582	resident record was added to ensure that residents being discharged from Medicare A are properly informed at least 48 hours prior to discharge. The administrator and/or designee will now document in the resident record once the decision to discharge from Medicare A. The administrator educated facility staff regarding this process on October 20, 2023, including using the correct CMS forms depending on whether or not the resident will be discharged out of the facility or remain in the facility. 4.) MONITORING: Administrator will ensure correct discharge from Medicare A services by monitoring in EMR weekly all upcoming Medicare A discharges to ensure that it has been documented properly in the resident's record at least 48 hrs prior to discharge. 5.) IMPLEMENTATION: October 25, 2023: The Steering Committee of the QAPI will review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI committee for at least one year.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 637		10/21/23

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F 637	Continued From page 4 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a significant change assessment was completed for 1 of the 13 residents (Resident #1). Resident #1 was noted with more than three areas of [redacted] with EX Order 26.4B1 [redacted], and Nutritional Status on the [redacted] Quarterly (Q) MDS (Minimum Data Set), an assessment tool used to facilitate the management of care. The deficient practice was evidenced by the following: On 10/04/23 at 11:10 AM, during the initial tour, the surveyor observed the resident lying in bed, alert and awake, able to answer some of the surveyor's inquiries. The surveyor observed the tray of covered food untouched on the overbed table. Resident#1 stated he/she did not want to eat breakfast and would eat lunch instead. Certified Nurse Assistant (CNA) #1, who worked in the facility for [redacted], noted that the resident sometimes does not eat breakfast. On 10/10/23 at 11:55 AM, the surveyor interviewed the Dietitian who stated that Resident #1 generally EX Order 26.4B1, ate a lot of	F 637	PLAN OF CORRECTION CRF 483.20(b)(2)(ii) F637 1.) POTENTIAL FOR RESIDENT: There was a potential to affect Resident #1 who was noted with more than three areas of EX Order 26.4B1 [redacted] condition and nutritional status in the quarterly MDS note dated [redacted]. A significant change MDS was completed for resident #1 on [redacted] 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: There is a potential to affect other residents. MDSC reviewed all current MDS assessments for accuracy to minimize any possible affect on any other residents. The IDCP team will look ahead and anticipate those at risk for a significant change and not expected to return to their baseline within the window of the 14 days. 3.) SYSTEMIC CHANGES: The MDSC will run a ADL/Sig change analysis report weekly to identify residents with areas of decline. Staff will be informed of residents with pattern of	

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F 637	Continued From page 5 EX Order 26.4B1 and was given different options. The Dietitian stated that she would alert the food director to provide the resident with some other foods and that the EX Order 26.4B1 at times. The Dietitian stated that Resident #1 had EX Order 26.4B1. The Dietitian also stated that the resident usually ate in the main dining room but not recently. On 10/10/23 at 12:26 PM, the surveyor interviewed the Director of Nursing (DON), who has worked in the facility for NJ Exec. Order 26:4.b.1, and agreed that the resident had a diagonosis of EX Order 26.4B1. The DON added that despite the changes with the increase in EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1, EX Order 26.4B1, EX Order 26.4B1, and BIMS, the facility decided not to make a significant change unless the resident was going to be placed on EX Order 26.4B1 services. On 10/11/23 at 11:35 AM, the surveyor interviewed the MDS Coordinator (MDSC) and stated that when she reviewed the resident for the NJ Exec. Order 26:4 QMDS, she told DON that the resident had a lot of changes. The MDSC stated that the DON suggested that the facility needed to first rule out if there are any acute changes due to EX Order 26.4B1) or EX Order 26.4B1 before they proceeded to make significant changes. The MDSC stated, "I don't know what's going on in the last few months." The surveyor reviewed the hybrid medical record for Resident #1. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1	F 637	decline in ADLs. Weekly IDCP/Residents at Risk (RAR) meetings will review and discuss residents at risk and determination of Significant MDS assessment will be decided. All IDCP team members along with the clinical staff including CNA's were educated on the definition of a significant change and the importance of anticipating the probability that a resident will not be returning to their baseline assessment with in 2 weeks. In-service was completed on 10/20/2023 by DON. b. Our current process will be modified to change the reference day to 7 days earlier. This will allow the team to identify current concerns and anticipate when a resident meets the definition for significant change. This will ensure changes in resident condition will be captured. 4.) MONITORING: The DON and/or designee will monitor the dashboard and communicate with the MDSC RN twice a week or more frequently as needed to ensure any significant changes are captured. Detailed communication regarding every section of the MDS will occur prior to coding completion. 5.) IMPLEMENTATION: October 25, 2023 A Steering Committee of the QAPI will meet on October 25, 2023 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at	

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F 637	Continued From page 6 EX Order 26.4B1 A review of the QMDS dated EX Order 26.4B1 reflected the following: -Brief interview for mental status (BIMS) score of EX out of 15, which indicated that the resident had EX Order 26.4B1 . -The EX Order 26.4B1 Interview (EX Order 26.4B1) EX Order 26.4B1 reflected that the resident's total score was EX Order 26.4B1 which indicated EX Order 26.4B1 . - The number of coded was EX Order 26.4B1 EX Order 26.4 . - The EX Order 26.4B1 was coded at EX Order 26 pounds - The EX Order 26 condition was coded other EX Order 26 EX Order 26.4B1 . A review of the annual MDS (AMDS) dated EX Order 26.4B1 reflected the following: - BIMS score of EX Order out of 15, indicating that the resident had EX Order 26.4B1 EX Order 26.4B1 . - The EX Order 26.4B1 Interview (EX Order 26.4B1) reflected that the resident's EX Order 26.4B1 score is NJ Exec. Ord EX Order indicating EX Order 26.4B1 . - The number of coded was EX Order 26.4 - The EX Order 26.4B1 was coded at EX Order lbs. (pounds) - The EX Order 26.4B1 was coded EX Order A review of the Order Summary Report (OSR) with an order date of EX Order 26.4B1 in the morning started on EX Order 26.4B1 and EX Order 26.4B1 apply to EX Orde EX Order 26.4B1 every day shift for EX Order 26.4B1 EX Order 26.4 Apply EX Order 26.4B1 and EX Order 26.4 with a EX Order 26.4B1 started on EX Order 26.4B1	F 637	least one year.	

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F 637	Continued From page 7 A review of the EX Order 26.4B1 Follow-Up Form dated EX Order 26.4B1 under Interval History, with the handwritten notes, stated, "Patient EX Order 26.4B1 EX Order 26.4B1 Patient with EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 then lack contact. EX Order 26.4B1 is in EX Order 26.4B1 Patient with EX Order 26.4B1." Under Medication orders/changes with the handwritten notes, stated, 'EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4B1 A review of nurses' notes revealed that Resident #1 had a EX Order 26.4B1 incident on EX Order 26.4B1 and EX Order 26.4B1 with EX Order 26.4B1. A review of the care plan initiated on EX Order 26.4B1 indicated that Resident #1 is at EX Order 26.4B1 secondary to a EX Order 26.4B1 trend over the last few months - lbs., on EX Order 26.4B1 lbs., on EX Order 26.4B1 lbs., and on EX Order 26.4B1 lbs. A review of nurses' notes on EX Order 26.4B1 and EX Order 26.4B1 revealed that the resident is EX Order 26.4B1 A review of the nurse's note on EX Order 26.4B1 revealed that EX Order 26.4B1 and EX Order 26.4B1 were EX Order 26.4B1 for EX Order 26.4B1 On 10/11/23 at 01:12 PM, the surveyors interviewed the DON, Interim DON, and Administrator but did not comment further. According to the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2023. A Significant Change Status Assessment (SCSA)	F 637		

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F 637	Continued From page 8 is appropriate when: - There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and - The resident's condition is not expected to return to baseline within two weeks. NJAC 8:39-11.2(i);13.1(d)	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete portions of the Minimum Data Set (MDS), an assessment tool, to accurately reflect the residents' status as of the Assessment Reference Date (ARD) for 2 of 13 residents reviewed (Resident #24 and Resident #1). The deficient practice was evidenced by the following: 1. On 10/05/23 at 11:43 AM, the surveyor interviewed the Resident #24 in the resident's room. The resident was sitting on the wheelchair. The resident stated the last time they [redacted] was about [redacted] ago. The resident was able to [redacted] On 10/05/23 at 11:56 AM, the surveyor	F 641	PLAN OF CORRECTION 483.20(g) F641 Accuracy of Assessments This facility will develop and implement a comprehensive person-centered plan of care that accurately reflects diagnosis upon admission as well as accuracy of documentation in the MDS and on each individual PLan of Care to accurately reflect the resident (s) current status. The plan of care is reviewed quarterly, annually and with changes that may affect the plan of care for the individualized resident(s). (residents #1, #24) 1.) POTENTIAL FOR RESIDENT(S): There was a potential to affect resident #1 and resident #24. Resident #24 MDS was rescheduled for [redacted] to correct the	10/21/23

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F 641	Continued From page 9 interviewed the Certified Nursing Assistant (CNA), who has been working at the facility for [redacted]. The CNA stated to the surveyor that the resident requires a [redacted] transfer and [redacted]. On 10/05/23 at 12:25 PM, the surveyor interviewed the Registered Nurse (RN). The RN stated, the resident had orders for [redacted], and [redacted]) on admission [redacted] and on [redacted] for [redacted]. The nurse stated she had never seen the resident [redacted] but needs assistance with all her ADLs. On 10/10/23 at 09:17 AM, a record review of the electronic health record revealed the following Medical Diagnoses: [redacted] The resident's MDS Assessment Reference Date (ARD) of [redacted] Admission Assessment revealed in Section C, the resident's Brief Interview for Mental Status (BIMS), a scoring scale for cognition impairment, the resident scored [redacted] points -indicates [redacted]); In Section G, the resident's [redacted] on the corridor did not occur for the [redacted] look back period; The resident's functional limitation in Range of Motion (ROM) was coded on the MDS as [redacted]. The Quarterly MDS on [redacted] revealed: The	F 641	inaccuracy. Resident #1 MDS reference date was scheduled [redacted] to accurately assess her status as it specifically relates to her cognition and mood. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: There is a potential to affect other residents. All resident's MDS were reviewed by the MDSC, completed on October 16th, 2023 and followed by a meeting with the DON to discuss.There was no actual harm to the other residents. The MDS, Care plan and Plan of Care (POC) must be individualized to each particular resident and match accurately. 3.) SYSTEMIC CHANGES: Each team member, including the CNA's, were educated the week of 10/16/23 by the DON reinforcing the importance of documentation/coding in the MDS and on each individual Plan of Care (POC) to accurately reflect the individual resident's current status The Social Worker was educated on PHQ-9. The Social Worker will document the PHQ9 assessment score in the progress notes upon completion of scheduled MDS. 4.) MONITORING: At the weekly Resident at Risk (RAR)/IDCP meeting, all participating team members will sign the MDS review stating that their portion of the MDS is accurate. DON and MDSC will review individual sections and validate the accuracy. All assessments and the Plan of Care (POC) must consistently reflect the current status of the individual	

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F 641	Continued From page 10 resident's BIMS score was [redacted]; The resident was coded in the MDS as requiring [redacted]; The resident was [redacted] in the room; The resident was coded as [redacted] or twice; Functional Limitation in ROM, the resident was coded as [redacted]. On 10/10/23 at 12:20 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident was [redacted] when the resident was admitted, and a [redacted] was used for transfer and the resident [redacted] in the facility. She also stated that the resident [redacted] or was [redacted]. She stated she completed the MDSs assessments and the resident interviews with another person, an MDS Coordinator, helping part time remotely. On 10/10/23 at 12:35 PM, the surveyor interviewed the PT and OT therapists. Both therapists stated the resident has [redacted] during [redacted]. The PT provided the surveyor with the PT Evaluations for [redacted] and on [redacted], which indicated the Prior Level of Function (PLOF), and the current level was that the resident was [redacted]; In addition, the resident's [redacted] ROM were within functional limits. The PT stated, the resident's [redacted] is [redacted] it is a combination of [redacted] and the size of the resident. The [redacted] Plan of Care note written by the MDS	F 641	residents and be validated as accurate. This will be monitored by the DON and MDSC. 5.) Oct. 25,2023 A Steering Committee of the QAPI is scheduled for October 25, 2023 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	

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	315471	A. BUILDING _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE CALDWELL, NJ 07006

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F 641	Continued From page 11 Coordinator stated the resident was [NJ Exec. Order 26:4.b.1] [redacted]. The Resident's Care Plans revealed the resident was [redacted] with the use of a [redacted]. The interventions did not include anything related to [redacted]. On 10/11/23 at 11:20 AM, the surveyor interviewed the MDS Coordinator, who stated she works [NJ Exec. Order 26:4.b.1] and does not come in the facility. The MDS Coordinator confirmed that she does not look at rehabilitation therapy notes. The MDS Coordinator stated coding would have been gathered from the CNA Point of Care documentation in the electronic health record. On 10/11/23 at 12:30 PM, the surveyor interviewed DON, who confirmed the coding on the Quarterly MDS [redacted] for [redacted] in corridor was incorrectly coded. The DON submitted documentation from the CNAs on the Point of Care electronic health record which revealed the resident was EX Order 26.4B1 [redacted] from EX Order 26.4B1 [redacted]. The surveyor discussed findings with Administrator and the DON. The DON confirmed the resident has no limitation of ROM on EX Order 26.4B1. On 10/12/23 at 10:15 AM, the DON provided the surveyor with the undated MDS Policy and Procedure. The policy indicated when the MDS is completed, "Each individual team member who completes a portion of the assessment must sign and certify its accuracy."	F 641		

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F 641	Continued From page 12	F 641		

2. On 10/04/23 at 11:10 AM, during the initial tour, the surveyor observed the resident lying in bed, alert and awake, able to answer some of the surveyor's inquiries. The surveyor observed the tray of covered food untouched on the overbed table. Resident#1 stated he/she did not want to EX Order 26.4B1 [redacted]. CNA #1, who worked in the facility for [redacted] NJ Exec. Order 26:4.b.1., stated that the resident sometimes did not eat breakfast.

On 10/10/23 at 11:45 AM, the surveyor observed Resident #1 untouched a tray of covered food on the overbed table. The surveyor interviewed the residents and asked if they were offered something else. Resident #1 stated he/she did not want anything and EX Order 26.4B1

The surveyor reviewed the hybrid medical record for Resident #1.

The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 [redacted]

A review of the quarterly MDS (QMDS) dated EX Order 26.4B [redacted] reflected that the resident had a BIMS score of [redacted] EX O out of 15, indicating that the resident had EX Order 26.4B1. The EX Order 26.4B1 Interview (PHQ-9) ([redacted] EX Order 26.4B1 symptom scale) reflected that the resident's EX Order 26.4B1 score is [redacted] EX Order 26.4B1 indicating EX Order 26.4B1.

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F 641	Continued From page 13 A review of QMDS dated EX Order 26.4B1, the 12 weeks look back period from EX Order 26.4B1, reflected the following nurses' notes: A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "Sr. in room, EX Order 26.4B1 and EX Order 26.4B1" and "Sr appears EX Order 26.4B1. Suggested Sr go to solarium for am activities. Sr. replied, EX Order 26.4B1 A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "Sr. EX Order 26.4B1 EX Order 26.4B1," and "Sr. stated EX Order 26.4B1 was EX Order 26.4B1 and EX Order 26.4B1 A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed "Reported EX Order 26.4B1 EX Order 26.4B1." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "Monthly behavior note summary: Sr has EX Order 26.4B1, remaining in her room, EX Order 26.4B1 EX Order 26.4B1." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "Sr. EX Order 26.4B1 EX Order 26.4B1 A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: EX Order 26.4B1 made to administer am medications, and Sr. EX Order 26.4B1 On 7/31/23 at 12:24 PM, EX Order 26.4B1 Note: Resident has been more EX Order 26.4B1 the past few weeks than usual. In past was an isolated day now and then but now it has been more often;	F 641		

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F 641	Continued From page 14 resident has also shown EX Order 26.4B1 and has EX Order 26.4B1. When EX Order 26.4B1 EX Order 26.4B1 the dining room or attend recreational or religious activities." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4 revealed: EX Order 26.4B1 EX Order 26.4B1." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4 revealed: "Discussed in IDT/RAR meeting: recent period of EX Order 26.4B1 and EX Order 26 A review of Resident Summary dated EX Order 26.4B1 EX Order 26 under: Emotional - with handwritten notes under comments stating, "Periods of EX Order 26.4B1 S/S EX Order 26.4B1. Social - with handwritten notes under comments stating, EX Order 26.4B1 Eating habits - with handwritten notes under comments stating, 'EX Order 26.4B1 EX Order 26.4B1 A review of the Care Plan initiated on EX Order 26.4B1 indicated that Resident #1 has EX Order 26.4B1 related to a history of a EX Order 26.4B1 and lived with other sisters for EX Order years with symptoms of EX Order 26.4B1. On 10/10/23 at 12:11 PM, the surveyor interviewed the Social Worker (SW), who has worked in the facility NJ Exec. Order 26:4.b.1. SW stated that he/she does Sections D and E. SW process in doing the sections is interviewing the resident	F 641		

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F 641	Continued From page 15 and will look back three months for documentation. The surveyor asked about the resident's PHQ-9. SW stated that he/she doesn't know what PHQ-9 is and is not familiar with or paying attention to the score. The SW said he/she doesn't look at the score; him/her job is answering questions and reviewing the nurse's notes. She added that he/she is in the facility for 10 hours a week, reads the progress notes, looks at the whole quarter, and examines everyone else's messages. SW stated that most of the residents he/she knows well. The SW responded that he/she thought the resident was getting more [NJ Exec. Order 26:4.b.1] and gave a score of [EX O] in the interview. SW stated, "As I've said, I don't look at the score." On 10/10/23 at 12:26 PM, the DON/MDS Coordinator, who has worked in the facility for [NJ Exec] years, stated that the score of [EX O] is [EX Order 2] and agreed that the resident has [EX Order 26.4B1] [EX Order 26.4B1]. According to the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2023. SECTION D: MOOD Intent: The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. 3. The surveyor reviewed the hybrid medical	F 641		

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F 641	Continued From page 16 record for Resident #1. A review of the QMDS dated EX Order 26.4B1 did not reflect the resident's Rejection of Care - Presence and Frequency - Did the resident reject evaluation, or care coded NJ Exec. Order 26:4.b.1 . A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26 AM revealed: "Sr. EX Order 26.4B1 EX Order 26.4B1. Sr repeatedly stated EX Order 2 did not feel "Well.", RN asked sister to be more specific Sr replied "I don't know." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "Multiple attempts made to administer am medications and Sr. EX Order 26.4B1 " A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "CNA reported Sr. refusing any assist with morning care." A review of the Nurse's noted dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "Sr EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 Offered assistance to get dressed and completed hygiene. Sr. replied "I don't want to." On 10/11/23 at 11:24 AM, the surveyor interviewed the MDSC and stated that the SW, who has worked 10 hours per week, does sections D and E. On 10/11/23 at 01:12 PM, the surveyors interviewed the DON, Interim DON, and Administrator but did not comment further. According to the Centers for Medicare and	F 641		

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F 641	Continued From page 17 Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2023. SECTION E: Rejection of Care: A resident's rejection of care might be caused by an underlying neuropsychiatric, medical, or dental problem. This can interfere with needed care that is consistent with the resident's preferences or established care goals. In such cases, care rejection behavior may be a problem that requires assessment and intervention. NJAC 8:39-33.2(d)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		10/21/23

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F 656	Continued From page 18 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 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 a comprehensive, person-centered care plan for a resident with a EX Order 26.4B1 [redacted] in accordance with federal guidelines. This deficient practice was identified for 1 of the 13 residents reviewed for NJ Exec. Order 26:4.b.1 investigation (Resident#20). The deficient practice was evidenced by the following: On 10/05/23 at 11:14 AM, the surveyor interviewed the resident, EX Order 26.4B1 .	F 656	PLAN OF CORRECTION 483.21(b)(1)(3) Development/Implement Comprehensive Care Plan F656 This facility will develop and implement a comprehensive person-centered plan of care that includes diagnosis on admission that may reflect changes in the resident condition. The comprehensive care plan should address the resident's medical, nursing and psychosocial wellbeing. The plan of care is reviewed quarterly, annually and with changes that may affect the plan of care for the individual resident	

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F 656	Continued From page 19 Resident #20 was observed talking about the parents and becoming emotional while wiping the tears from his/her eyes. The surveyor reviewed the hybrid medical record for Resident #20. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 (EX Order 26.4B1). A review of the quarterly MDS (QMDS) dated EX Order 26.4B1 reflected that the resident had a brief interview for mental status (BIMS) score of EX Order 26.4B1 out of 15, indicating that the resident had EX Order 26.4B1 . The Resident Mood Interview (PHQ-9) EX Order 26.4B1) reflected that the resident's total EX Order 26.4B1 score is two (2), indicating EX Order 26.4B1 . A review of the resident's comprehensive care plan did not include that the resident had a diagnosis of EX Order 26.4B1 A review of the Order Summary Report (OSR) with an order date of EX Order 26.4B1 EX Order 26.4B1 in the evening for depression related to unspecified EX Order 26.4B1 A review of the Monthly behavioral note dated EX Order 26.4B1 and timed at EX Order 26.4B revealed: "Sr.	F 656	(Resident #20) 1) POTENTIAL FOR RESIDENT: The IDCP care plan did not reflect Resident #20 has an admission diagnosis of EX Order 26.4B1 as it pertains to long-term EX Order 26.4B1 . Resident #20 was treated for EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 The documentation supports sundowning, wanting to go home, EX Order 26.4B1 and EX Order 26.4B1 . The IDCP was updated on October 17,2023 with the IDCP team including input from the RN's, APN, SW. CNA's that is reflective of a diagnosis of EX Order 26.4B1 and cognitive deficits. 2) POTENTIAL AFFECT ON OTHER RESIDENTS: There was a potential for but no actual harm to other residents. The DON reviewed all IDCPs including running a report on all residents who have a diagnosis of EX Order 26.4B1 to ensure all had a care plan specific to their EX Order 26.4B1 diagnosis. We identified 3 residents requiring a care plan for EX Order 26.4B1 . Individual care plans were created for those identified residents. Every week care plans are reviewed for upcoming MDS quarterly review. There is an IDCP for each resident at the facility and will be prepared by the IDCP team. The team, with input from the RN as primary care provider, CNA, and appropriate department members that are essential to providing care consistent with the goal of maintaining the highest level of function.	

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F 656	Continued From page 20 [Name] has episodes of EX Order 26.4B1, EX Order 26.4B1 and EX Order 26.4B1." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: 'EX Order 26.4B1, EX Order 26.4B1." A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4 revealed: "Sr. [Name] has EX Order 26.4B1 with EX Order 26.4B1. EX Order 26.4B1 documented of EX Order 26.4B1, one with EX Order 26.4B1 A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4 revealed: "seen by [Name] APN EX Order 26.4B1 A review of the Nurse's note dated EX Order 26.4B1 and timed at EX Order 26.4B1 revealed: "She consumed about 40% of her breakfast. She EX Order 26.4B1 EX Order 26.4B" A review of care planning policy revision date on 01/06/23 revealed under "Interpretation and Implementation 2. Diagnosis b. A nursing diagnosis is developed and placed in the Interdisciplinary Care Plan. 3. Planning and Setting Goals c. Goals must be stated in terms if behavior that is both specific and measurable within a specific amount of time." On 10/11/23 at 01:12 PM, the surveyors interviewed the DON, Interim DON, and Administrator but did not comment further. NJAC 8:39-11.2(d)	F 656	The care plan will be individualized, current and consistent with medical regime and nursing practice. The IDCP will be reviewed quarterly, annually and with changes in resident condition that may affect the plan of care for the individual resident. 3) SYSTEMIC CHANGES: All resident IDCP's were reviewed by DON. Will continue to review each resident IDCP to reflect changes in the individual resident condition that may affect the plan of care for that resident. Ongoing education of all nursing staff by DON regarding development and implementation of comprehensive, individualized Care Plans. Review of the individual resident medical record for signs and symptoms compatible with sundown syndrome, associated depressive disorder and cognitive deficits to ensure the comprehensive plan of care is accurate for the diagnosis. Education with professional clinical staff to review diagnosis and treatments. To identify the difference between, as well as similarities, of sundown syndrome, cognitive impairment, depression and other diagnosis found in the elderly. Review the most recent BIMS and PHQ-9 score on Residents at Risk (RAR) and with the IDCP team. The IDCP team must also complete as a minimum a quarterly and comprehensive annual review to ensure the IDCP is current, individualized and remains consistent with	

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F 656	Continued From page 21	F 656	the medical regime and nursing practice. 4) MONITORING: The DON or designee will continue to review residents as scheduled. In addition, weekly Resident at Risk (RAR) will be discussed and the plan of care updated as appropriate. The DON will run a diagnosis report weekly to monitor a diagnosis of depression. The IDCP team will continue to be reviewed and updated to remain current at minimum quarterly and annually. 5) IMPLEMENTATION: October 25, 2023: A Steering Committee of the QAPI will meet on October 25, 2023 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		10/21/23

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ST CATHERINE OF SIENA	**7 RYERSON AVENUE CALDWELL, NJ 07006**

(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 657	Continued From page 22 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review and review of pertinent facility documentation, it was determined that the facility failed to update and revise a Care Plan to include a [redacted] for one (1) of 13 residents, (Resident #4), reviewed for care plans. This deficient practice was evidenced by the following: On 10/4/23 at 12:03 PM, the surveyor observed in the kitchen area of the dining room a sign which read "ATTENTION ... Don't EVER give [Resident #4] in room [redacted] [redacted] [redacted] " On 10/4/23 at 12:18 PM, the surveyor observed Resident #4 seated in a [redacted]-chair ([redacted] y) with his/her lunch tray on an overbed table in front of the resident. The lunch tray had a [redacted] lunch and there was a spoon and a fork provided. The	F 657	PLAN OF CORRECTION: 483.21(b)(2)(i)-(iii) F657 Comprehensive Care Plans This facility will develop and implement a comprehensive person-centered plan of care that is reflective of changes to the resident condition. The plan of care is reviewed quarterly, annually and with changes that may affect the plan of care for the individualized resident (resident #4) 1.) POTENTIAL FOR RESIDENT: The IDCP care plan did not reflect Resident #4 should not have [redacted] as part of the utensil set given at meals. Resident #4 was refusing to return, keeping the knives and choosing to use them as a bookmark. The IDCP was updated on October 10, 2023 with the IDCP team including input from the RN's certified nursing assistants, and	

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	315471	A. BUILDING _____ B. WING _____	10/12/2023

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F 657	Continued From page 23 resident stated that he/she had already eaten lunch. On 10/5/23 at 11:11 AM, the surveyor interviewed the Registered Nurse (RN) who provided medications for Resident #4. The RN stated that the resident was EX Order 26.4B1 and had EX Order 26.4B1 [redacted]. The RN added that the resident had a EX Order 26.4B diet. On 10/5/23 at 11:34 AM, the surveyor interviewed the Food Service Aide (FSA) in kitchen area of dining room. The surveyor, with the FSA, reviewed the sign posted regarding not to give Resident #4 EX Order 26.4B at meals. The FSA stated the sign was put there because the resident was keeping the EX Order 26.4B1 and putting them in his/her books. The FSA added that severa EX Order 26.4B1 were found in the resident's EX Order 26.4B in his/her room and that nursing was aware. The FSA added that when the EX Order 26.4B were removed the resident became EX Order 26.4 because he/she thought they were marking his/her books. The surveyor reviewed the medical record for Resident #4. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 A review of the quarterly Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 revealed that the resident had a brief interview for mental status (BIMS) score of EX Orde out of 15 indicating the resident had a EX Order 26.4B1 .	F 657	appropriate food and nutrition staff. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: There is a potential to affect other residents. There is an IDCP for each resident at the facility and will be prepared by the IDCP team. The team, with input from the RN as primary care provider, certified nursing assistant, and appropriate department members that are essential to providing care. The care plan will be individualized, current and consistent with medical regime and nursing practice. The DON reviewed all resident's IDCP's on October 20, 2023 to ensure they were up to date and reflected the individual resident being reviewed. No additional revisions were needed. All Care Plans are reviewed quarterly, annually and with changes in resident condition that may affect the plan of care for the individual resident. 3.) SYSTEMIC CHANGES: Each resident's IDCP was reviewed by DON on 10/20/2023 to ensure they were current and reflected the individual resident. The IDCP team will complete, as a minimum, a quarterly and comprehensive annual review and with changes in resident condition to ensure the IDCP is current, individualized and remains consistent with the medical regime and nursing practice. 4.) MONITORING: The DON or designee will continue to review residents as scheduled. In addition, weekly resident at risk (RAR) will be discussed and the plan of care	

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F 657	Continued From page 24 A review of the electronic progress notes (EPN) dated 11/18/22 at 13:15 (1:15 PM) completed by the Director of Nursing (DON) revealed the following: "While on environmental rounds, found prayer book with EX Order 26.4B1 Explained [he/she] needed to return them, and "book marks" will be provided. Resident #4 EX Order 26.4B1 "the EX Order 26.4B1 EX Order 26.4B1 !" removed for safety." A review of the individualized interdisciplinary care plan (IDCP) revealed there was no area of focus or interventions regarding that the resident was not to receive any knives with meals. On 10/10/23 at 10:36 AM, the surveyor, in the presence of the DON, interviewed the certified nursing assistant (CNA) who stated that the resident was able to eat by themself after setting up and was only supplied a fork and spoon for meals because the resident would keep the EX Order 26.4B1 . On 10/10/23 at 10:37 AM, the DON added to the interview of the CNA and stated that she had done rounds one day and found that the resident was EX Order 26.4B1 . The DON added that the resident would put the EX Order 26.4B1 as if using them as a EX Order 26.4B1 . The DON stated that the resident thought they were his/her property and using the EX Order 26.4B1 his/her place in the book. The DON stated that she thought the issue would be included in the IDCP. At that time, the surveyor with the DON reviewed the resident's IDCP. The DON acknowledged that there was no revision completed regarding that the resident was not to have EX Order 26.4B1 The	F 657	updated as appropriate. IDCP will continue to be reviewed and updated to remain current at minimum quarterly and annually. 5.) IMPLEMENTATION: October 25, 2023 A Steering Committee of the QAPI is scheduled for October 25, 2023 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	

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F 657	Continued From page 25 DON acknowledged that there was a sign posted in the kitchen area. On 10/10/23 at 11:20 AM, the DON provided the surveyor with an updated IDCP for Resident #4. The DON stated that she had revised the resident's IDCP to include the concern with the [EX Order 26.4B] . On 10/11/22 at 1:02 PM, the survey team met with the Licensed Nursing Home Administrator and the DON. The DON stated that she was responsible for developing and updating the IDCP with input from the nurses. The DON acknowledged that the issue with the [EX Order 26.4B] for Resident #4 should have been added to the IDCP. A review of the facility's policy titled Care Planning-Resident dated as revised 1/6/23 and was provided by the DON reflected that "each resident has an IDCP that is current, individualized, and consistent with the medical regimen." In addition, the policy reflected that "Between interdisciplinary conferences, each discipline adds interventions to the interdisciplinary care plan when initiated and discontinues interventions when completed." "Interdisciplinary cooperation should be evident in plans of care, when appropriate." NJAC 8:39-11.2(e)(1)(2)(h)(i), 27.1(a)(b)	F 657		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		10/21/23

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F 755	Continued From page 26 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed 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 follow monitoring guidelines during medication administration in accordance with acceptable standards of clinical practice. The deficient practice was identified for one (1) of two (2) nurses, who administered medications to one (1)	F 755	PLAN OF CORRECTION: 483.45(a)(b)(1)-(3) Pharmacy Services/Procedures F755 1.) POTENTIAL FOR RESIDENT: A antihypertensive medication was	

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F 755	Continued From page 27 of seven (7) residents (Resident #5) and was evidenced by the following: 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." On 10/11/2023 at 8:28 AM, the surveyor observed a Registered Nurse (RN) preparing to administer [redacted] medications to Resident #5 which included EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted]. The surveyor then observed the RN administer the [redacted] medications. The surveyor did not observe a NJ Exec. Order 26:4.b.1 being obtained from the resident. Upon returning to the medication cart, the RN electronically entered a NJ Exec. Order 26:4.b.1 result of [redacted] for the [redacted] medication. The surveyor interviewed the RN who stated that she entered a value for a NJ Exec. Order 26:4.b.1 that was obtained earlier that day to determine whether to administer the medication. The surveyor reviewed the medical record for Resident #5.	F 755	prescribed by a physician with parameters for administration for Resident #5. The order was transcribed correctly including medication name, time, dose, route and parameters to hold if the systolic pressure was less than [redacted]. The RN did not take the blood pressure on Resident #5 immediately prior to the administration of the EX Order 26.4B1 PO as prescribed. Resident #5 was assessed and blood pressure taken same day as identified by surveyors, October 11, 2023. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: There is a potential affect on other residents. To minimize any potential effect on any other residents all clinical staff were in-serviced by DON on Oct 13th, 16th, 17th 2023 on the medication administration policy including the importance of BP parameters being taken immediately prior to medication administration as indicated in the physicians orders. 3.) SYSTEMIC CHANGES: Education of the nurses and clinical staff by DON. The nurse will review all medication orders to ensure accuracy in transcription and orders are being fully excecuted as written by the physician. 4.) MONITORING: The DON or designee will continue monthly audits. The current audits will be expanded to review the time of the parameters (BP) prior to the administration of the medication to ensure	

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F 755	Continued From page 28 A review of the Order Summary Report reflected a physician's order for EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted] A review of the electronic medication administration record reflected 'EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted] with an administration time of EX Order 26.4B1 [redacted] A review of the Weights and Vitals Summary reflected that the NJ Exec. Order 26:4.b.1 [redacted] had been taken 8:06 AM on 10/11/23. On 10/11/23 at 10:15 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated, vitals should be taken before the medication, specifically right before giving the medication. The DON also stated that the RN may have done the blood pressures earlier in anticipation that she would be followed for medication pass. On 10/11/23 at 1:02 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The DON acknowledged that the nurse should have obtained a blood pressure just prior to administration of the medication. A facility policy dated as revised 2023 for Medication Administration was provided by the DON which reflected "This Center's Resident/Patients' medications are administered	F 755	medication administration is appropriate and parameters are followed. Pharmacist will contine monthly audits to ensure compliance and report findings to the DON and LNHA. 5.) IMPLEMENTATION: October 25, 2023 A Steering Committee of the QAPI is scheduled for October 25, 2023 to review the statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	

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F 755	Continued From page 29 in accordance with the Resident/Patients' Primary Care Physician orders and the pharmaceutical guidelines. Medication Administration is conducted in a systematic manner in accordance with the Resident/Patient's medication regimen." It also reflected "13.) Read Physician orders for hold parameter prior to administration of medication. a) Blood Pressure b) Heart Rate c) Pulse Oximetry" NJAC 8:39-11.2(b), 29.2(d)	F 755		

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
315471 Y1	A. Building B. Wing Y2	11/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE CALDWELL, NJ 07006

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 F0582	Correction	ID Prefix F0637	Correction	ID Prefix F0641	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g)	Completed
LSC	10/29/2023	LSC	10/29/2023	LSC	10/29/2023
ID Prefix F0656	Correction	ID Prefix F0657	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	10/29/2023	LSC	10/29/2023	LSC	10/29/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2023	☐ YES ☐ NO

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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 10/05/2023, and St. Catherine of Siera facility 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 3-story building that was built in 1960's, with Resident sleeping rooms on the second floor. It is composed of Type I fire resistant construction. The facility is divided into 3 smoke zones. The facility has a generator.	K 000		
K 291 SS=E	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 and interview on 10/05/2023 in the presence of facility management, it was determined that the facility failed to: Provide a functioning battery backup emergency light above the emergency generator's transfer switch location, 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:	K 291	PLAN OF CORRECTION NFPA 101 (2012) K291: Emergency Lighting 1.) POTENTIAL HARM FOR RESIDENT: Potential to affect safe operation of emergency generator. There was no direct harm to any resident. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS:	10/18/23

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

Electronically Signed | 10/18/2023

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

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K 291	Continued From page 1 On 10/05/2023 during the survey entrance at approximately 09:50 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested, does the facility have an emergency generator. The MD told the surveyor, yes we have an emergency generator. Starting at approximately 10:07 on 10/05/2023 in the presence of the facility MD a tour of the building was conducted. At approximately 10:42 AM, an inspection inside the basement level Main Electrical room where the emergency generator's transfer switch was located , the surveyor observed one battery back-up emergency light . When the surveyor depressed the emergency lights test button, the light did not function (did not light up) properly. The MD confirmed the finding at the time of observation. On 10/05/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	Potential to affect safe operation of emergency generator. There is a potential to affect others residents. 3.) SYSTEMIC CHANGES: Battery was replaced on 10/06/23. 4.) MONITORING: Director of Maintenance added a inspection tag to the emergency lighting and will do monthly checks/dating the tag. 5>0 IMPLEMENTATION: The Steering Committee of the QAPI is scheduled for October 25, 2023 where we will review the statement of deficiency and plan of correction. Thereafter it will be reported quartely to the QAPI Committee for at least a year.	
K 293 SS=E	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	K 293		10/25/23

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ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 293	Continued From page 2 (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 review of facility provided documentation on 10/05/2023 in the presence of facility management, it was determined that the facility failed to: 1) To provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate	K 293	PLAN OF CORRECTION NFPA 101 K293 (2012) Two (2) illuminated exit signage missing to clearly identify the exit assess path to reach an exit discharge door. 1.) POTENTIAL FOR RESIDENT: Potential to affect safe evacuation during an emergency. There was no direct harm to any resident. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: Potential to affect safe evacuation during an emergency. There is a potential for residents to be affected. 3.) SYSTEMIC CHANGES: a. Exit signs were ordered on 10/5/23. They will be installed by 10/25/2023. 4.) MONITORING: Maintenance Director (MD) using Quality Indicators as the monitoring tool will ensure all exit signage is illuminated and visable when fire doors are shut. This will be a monthly check/audit and reported through the Safety Committee to the quarterly QAPI committee. 5.) IMPLEMENTATION: A Steering Committee of the QAPI is scheduled for October 25th, 2023 to review the statement of deficenecy and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING **01** B. WING _____	**10/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 293	Continued From page 3 and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 10/05/2023 during the survey entrance at approximately 09:50 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms are in the facility. The MD told the surveyor that there are 30 Resident sleeping rooms on the second (2nd.) floor A review of the facility provided lay-out identified the facility is a three-story building with the Long Term Care section is on the second (2nd.) floor with 30 Resident sleeping rooms three (3) stairwells that Resident, Staff and Visitors would use in the event of an emergency to exit the building from the 2nd. floor. The second (2nd.) has two sets of corridor smoke doors that divide the floor into three (3) smoke compartments. Starting at approximately 10:07 on 10/05/2023 in	K 293		

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	315471	A. BUILDING **01** B. WING _____	**10/12/2023**

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ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 293	Continued From page 4 the presence of the facility MD a tour of the building was conducted. During the building tour the the surveyor observed two (2) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, 1) At approximately 11:21 AM, while standing near the Nurses Station looking down the corridor towards Resident room #219, there is a set of corridor double smoke doors that are held in the open position with magnetic hold open devices. These magnetic hold open devices would release with the activation of the buildings fire alarm system. With the double smoke doors in the closed position you could not see the illuminated exit sign on the other side of the double smoke doors. 2) At approximately 11:22 AM, while standing near the Nurses Station looking down the corridor towards Resident room #214, there is a set of corridor double smoke doors that are held in the open position with magnetic hold open devices. These magnetic hold open devices would release with the activation of the buildings fire alarm system. With the double smoke doors in the closed position you could not see the illuminated exit sign on the other side of the double smoke doors. The MD confirmed the findings at the times of observations. On 10/05/2023 during the survey exit at approximately 1:20 PM, the surveyor informed	K 293		

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K 293	Continued From page 5 the Administrator of the deficiency. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 10/05/2023, in the presence of facility Management it was determined that the facility failed to ensure that 1 of 9 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 10/05/2023 during the survey entrance at approximately 09:50 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 311	PLAN OF CORRECTION NFPA 101 (2012) Vertical openings-Enclosure K311 1.) POTENTIAL FOR RESIDENT: Potential to affect means of egress/smoke zone. There was no direct harm to any resident. 2.) POTENTIAL AFFECT ON OTHER RESIDENTS: Poitential to affect means of egress/smoke zone	10/18/23

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ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 311	Continued From page 6 A review of the facility provided lay-out identified the facility is a three-story building with 30 Resident sleeping rooms on the second (2nd.) floor, common areas with three (3) stairwells that Resident, Staff and Visitors would use in the event of an emergency to exit the building from the 2nd. floor. Starting at approximately 10:07 on 10/05/2023 in the presence of the facility MD during a tour of the building the surveyor inspected and conducted closure test of nine (9) exit access doors leading into exit stairways with the following results, 1) At approximately 11:27 AM, during a closure test of the second (2nd.) floor stairway "C" (next to resident room #202) corridor exit access door, when the door was opened to a 90 degree opening to the door frame and allowed to self-close, the door did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the door latching device stopped short of the door frames keeper and did not positive latch into its frame. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire.	K 311	There is a potential to affect other residents. 3.) SYSTEMIC CHANGES: Door identified as out of compliance was adjusted on 10/5/23. 4.) MONITORING: The Director of Maintenance, using the Quality Indicators as the monitorimng tool, will ensure testing of fire doors is done monthly in addition to the annual inspection of all fire doors. Testing will be reported to the QAPI Steering Committee on October 25, 2023. 5.) Implementation: A Steering Committee of the QAPI is scheduled for October 25, 2023 to review statement of deficiency and plan of correction. Thereafter it will be reported quarterly to the QAPI Committee for at least one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING **01** B. WING _____	**10/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	**7 RYERSON AVENUE** **CALDWELL, NJ 07006**

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K 311	Continued From page 7 The MD confirmed the finding at the time of observations. On 10/05/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		10/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315471	A. BUILDING **01** B. WING _____	**10/12/2023**

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K 321	Continued From page 8 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/05/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 10/05/2023 during the survey entrance at approximately 09:50 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story building with the Long Term Care section is on the second (2nd.) floor with 30 Resident sleeping rooms. The facility also utilizes the basement with Mechanical rooms, Offices, Commercial Laundry, Main Electrical room and Boiler room. Starting at approximately 10:07 on 10/05/2023 in the presence of the facility MD a tour of the building was conducted. During the building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors,	K 321	PLAN OF CORRECTION NFPA 101 (2012) K321 Hazardous Areas-Enclosure 1.) POTENTIAL FOR RESIDENT: Potential to affect means of egress. There was no direct harm to any residents. 2.) POTENTIAL AFFECT ONOTHER RESIDENTS: Potential to affect means of egress. There is a potential to affect other residents. 3.) SYSTEMIC CHANGES: Closure was installed on identified door 10/6/2023. 4.) MONITORING: The Director of Maintenance using Quality Indicators as the monitoring tool will check all egress doors to ensure all doors operating correctly monthly. 5.) IMPLEMENTATION: A Steering Committee of the QAPI is scheduled on October 25, 2023 to review the statement of deficiency and plan of correction. There after it will be reported quarterly to the QAPI Committee for at	

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K 321	Continued From page 9 1) At approximately 10:16 AM, an inspection inside the Basement level Activities office was performed. At this time the surveyor observed multiple combustible boxes filled with Personal Protective Equipment (PPE). There were gowns, gloves and masks in the boxes. At this time MD told the surveyor this is the area where the facility stores all the Facilities' PPE. The surveyor observed that the corridor door leading into this room had no means to self-close the door into its frame. The Activities Office room was larger than 50 square feet. With this corridor door not closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Activities Office is the primary and/ or secondary egress route in the event of a fire. The MD confirmed the finding at the time of observations. On 10/05/2023 during the survey exit at approximately 1:20 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101.	K 321	least one year.	

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
315471 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE OF SIENA	7 RYERSON AVENUE CALDWELL, NJ 07006

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	10/25/2023	LSC K0293	10/25/2023	LSC K0311	10/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0321	10/25/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2023	☐ YES ☐ NO