STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

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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 Complaint NJ#: 162553; 164144; 162553; 168234 SURVEY DATE: 10/30/23 CENSUS: 50 SAMPLE SIZE: 15 + 2 closed records THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. 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. During a Standard Survey conducted on 10/30/23, it was determined that effective 10/19/23, the Facility was found to have been in Immediate Jeopardy for F689L. The New Jersey Department of Health sent a Notice of Determination of Immediate Jeopardy of Non-Compliance to the Facility's Licensed Nursing Home Administrator on 10/19/23 at 4:14 PM, including the Immediate Jeopardy Template.	F 000		

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

Electronically Signed | 11/20/2023

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F 000	Continued From page 1 The Facility failed to: -ensure that 2 of 2 janitor closets containing hazardous materials were securely locked and free from the likelihood of resident access. -ensure that 2 of 2 treatment supply rooms which contained caustic, hazardous, supplies and chemicals were locked and free from the likelihood of resident's access. -follow their facility's Storage of Chemicals Policy and Procedure. On 10/19/23 at 4:45 PM, the New Jersey Department of Health received an acceptable Removal Plan. The survey team verified the implementation of the Removal Plan throughout the duration of the survey. The janitor and treatment closets remained locked. The facility installed auto-closing and auto-locking mechanisms to be placed on janitor doors and treatment storage room to eliminate risk of doors being left unsecured. The non-compliance for F689 remained at a level F on 10/20/23 for no actual harm with the potential for more than minimal harm that is not IJ.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		12/4/23

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representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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F 580	Continued From page 3 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint NJ #: 162553 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to notify the resident's representative of a change in condition for 2 of 17 residents, (Resident #6 and Resident #13) reviewed. This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #6 was admitted to the facility with the diagnoses which included, but not limited to NJ EX Order. 264b1 [redacted] The annual Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated [redacted], indicated that Resident #6 was NJ EX Order. 264b1 and required NJ EX Order. 264b1 NJ EX Order. 264b1 with activities of daily living. The MDS also indicated that Resident #6 had a history of NJ EX Order. 264b1), required assistance with [redacted], and was occasionally NJ EX Order. 264b1 and NJ EX Order. 264b1 Review of a resident progress note, dated [redacted] at 08:03 AM, reflected the following: "Note Text: NJ EX Order. 264b1 obtained. Resident awake most of th NJ EX Order. 264b1 [redacted] made comfortable,	F 580	" Residents who experience a change in condition are at risk to be affected by deficient practice. " Resident #13□s family member was notified record on [redacted]. " Resident #6 Responsible Party was notified of [redacted] test result on [redacted] and proper isolation precaution sign was placed on resident #6□s door. " LPN that received the test results for Resident #6 was identified and immediately in-serviced on facility□s Change in Condition Notification Policy. " LPN that identified Resident #13□s new NJ EX Order. 264b1 was identified and immediately in-serviced on facility□s Change in Condition Notification Policy " All Nursing staff re-inserviced on facility□s Change in Condition Notification Policy. " DON/Designee will audit up to 3 episodes of residents Change in Condition weekly X4 weeks and then Monthly X2 months to ensure the facility□s Change in Condition Notification Policy is being followed. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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NJ EX Order precautions maintained. NJ EX Ord placed to NJ EX Order. 264b1 to be done today."

According to the laboratory results for a NJ EX Order. 264b1 NJ EX Order. 264b1 dated NJNJ EX Order. 26 , Resident #6 had a NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order. 264b1). The laboratory report also indicated that the resident was to be placed on contact precautions.

The Order Summary Sheet (OSS) reflected a physician's order (PO), dated NJ EX Order. 264b1 , for the NJ EX Order. 264b1 treatment NJ EX Order. 264b1 tablet by mouth one time a day for NJ EX Order. 264b1 .

On 10/19/23 at 02:47 PM, the surveyor observed Resident #6's room and there were no signs posted on the door that indicated the resident was on Transmission-Based Precautions (NJ EX Order. 264b1 the resident's diagnosis of NJ EX Order. 4

The surveyor reviewed the resident's Care Plan (CP) and there was no documentation on the CP that the resident had NJ EX Order of the NJ EX Order or that the resident was on NJ EX Or .

On 10/20/23 09:59 AM, the surveyor interviewed the primary care Certified Nursing Assistant (CNA #1) who stated that she had been employed in the facility through the agency and had been working on and off in the facility for approximately

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a year. She stated that the resident required extensive assistance with care and that it dependeded on how his/her NJ EX Order. 264b1 was and if the resident was NJ EX Order. 264b1. The CNA stated that the resident's breathing affected how much activities of daily living he/she could perform. She stated that the resident had NJ EX Order. 264b1 (NJ EX Order. 264b1 and had good days and bad days related to his/her NJ EX Order. 264b1 status. The CNA explained that the resident was currently being treated with antibiotics for a NJ EX Order. 264b1. She stated that she was informed by the nursing staff that the resident had NJ EX O, but not informed as to what the organism was. She continued to add that she usually wore gloves when she provided care, however no personal protective equipment (PPE) was required to care for Resident #6. She stated that the Infection Preventionist (IP) usually placed signage on the resident's door and isolation bins outside a resident's room with PPE such as gloves, masks, goggles, and gowns if a resident had a contagious infection. She stated that Resident #6 utilized the NJ EX Orde in the morning to have a NJ EX Order. 264b1 and that family visited frequently.

On 10/20/23 at 10:09 AM, the surveyor conducted an interview with the primary nurse for the NJ Unit. The nurse identified herself as a Licensed Practical Nurse (LPN #1) and stated that she had been employed in the facility since NJ EX Order. 264b1. The LPN stated that Resident #6 required total care with aspects related to activities of daily living. She stated that Resident #6 was NJ EX Orde but had periods of NJ EX Order. 264b1, NJ EX Order. 264b1 and NJ EX Order. 264b1. She stated that during the day, Resident #6 had infrequent behaviors during the day and was not sure what

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behaviors she exhibited at night. The LPN stated that Resident #6 was being treated with NJ EX Order. 264b1 of the NJ EX Orde. She continued to explain that a resident with the diagnoses of NJ EX Order. 264b1 was usually on NJ EX Order. 264 precautions and the staff would have to wear all PPE, but only a gown when in contact with the urine. She confirmed that Resident #6 was not on NJ EX Order. 264 precautions and should have had caution signs posted on the door to indicate that visitors should see the nurse before entering the room. She stated that it would be important for all staff and visitors to know if PPE was required before entering the room.

The surveyor reviewed Residents #6's Progress Notes (PN) and there was no documentation in the PN that the resident's Resposible Party (RP) was notified that the resident had a NJ EX Order. 264b1 NJ EX Order. 264b1.

On 10/20/23 at 10:24 AM, the surveyor interviewed the Licensed Practical Nurse Infection Preventionist (LPN/ IP) who stated that he had been employed in the position since NJ EX Orde NJ EX Orde. He explained that if a nurse discovered or suspected that a resident had an NJ EX Order. 264b1 (does not matter what kind) the nurse was to report it to the Unit Manager and the IP. He stated that after he was notified that the resident had an NJ EX Order. 264b, he would investigate to see what organism was and then add it to the NJ EX Order. 264b1 NJ EX Order. 264b1. He would then utilize a guideline to see if the antibiotic was appropriate to use and to assure that the NJ EX Order. 264b1 was NJ EX Order. 264b1. The IP stated that he was not notified by the nurses that Resident # 6 was on NJ EX Order. 264b1. He continued to explain that if he was made aware that the resident had NJ EX Order. 264

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NJ EX Order 264[illegible] he would have assured that the resident was put on NJ EX Order 264[illegible] isolation (staff should wear PPE such gown, mask, gloves, eye protection) for someone on contact precautions. He stated that there should be signs posted on the door that indicated that the staff and visitors should see the nurse before entering the resident's room. The IP stated that it would be important that visitors and staff knew that the resident had a NJ EX Order 26401 [illegible] n so that they could wear the appropriate PPE. The IP also stated that according to the documentation in the medical record, the family was not notified that the resident had NJ EX Order 26401 NJEX Ord[illegible] The IP confirmed that the resident should have been put on NJ EX Order 264[illegible] isolation immediately after the resident was diagnosed with NJ EX Order[illegible] NJ EX Order[illegible] NJ EX Ord[illegible] and signs should have been posted on the resident's door that any visitors and staff needed to see the nurse before entering the resident's room.

On 10/20/23 at 12:02 PM, the surveyor interviewed Resident #6's representative who stated that she visited frequently. The representative stated that she knew Resident #6 had a NJ EX Order 26401 in the past, however was not aware of the NJ EX Order 26401 that Resident #6 currently had. She stated that the facility usually made her aware of this and it surprised her when the nurse told her that Resident #6 was on antibiotics for a NJ EX Or[illegible] yesterday, NJ EX Order 2640[illegible], and not when he/she was first started on the NJ EX Order 2640[illegible]. She stated that she was not notified that the infection could be NJ EX Order 26401, and that PPE was required for direct contact with the resident.

2. According to the Admission Record, Resident #13 had diagnoses which included, but were not

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limited to, NJ EX Order. 264b1 [redacted]

Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident was NJ EX Order. 264b1 [redacted]. Further review of the MDS included the resident was at risk for developing NJ EX Order. 264b1 [redacted].

Review of the Care Plan included a focus, created [redacted]3, that Resident #13 had the potential for NJ EX Order. 264b1 [redacted] areas.

Review of the Nurse's Note, dated [redacted], included, "Resident noted with NJ EX Order. 264b1 [redacted]. MD notified." The nurse's note did not include whether the resident's representative was notified.

Review of the Physician's Progress Note, dated [redacted], included, "Pt [patient] with some [redacted] noted yesterday by staff." The progress note did not include whether the resident's representative was notified of the [redacted].

Further review of the progress notes, dated [redacted] through [redacted], did not include notification to the resident's representative of the change in the resident's [redacted].

During an interview with the surveyor on 10/24/23 at 11:09 AM, the Certified Nursing Assistant (CNA #2) stated that if she observed a resident with a new [redacted], she would report it to the

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nurse.

During an interview with the surveyor on 10/24/23 at 11:21 AM, the Licensed Practical Nurse (LPN #2) stated that when a resident has a change in condition, the nurse should notify the resident's representative on the same shift that the change occurred.

During an interview with the surveyor on 10/26/23 at 11:11 AM, the Regional Director of Nursing (Regional DON), who was overseeing the nursing unit, stated that when a resident has a new NJ EX Or NJ EX Order. 264b1 the nurse should notify the resident's representative as soon as possible and document the notification in a nurse's note.

During an interview with the surveyor on 10/26/23 at 11:34 AM, the Interim Director of Nursing (Interim DON) stated when a resident has a new NJ EX Order. 264b1, the nurse should notify the resident's representative.

Review of the facility's NJ EX Order. 264b1 Risk Assessment policy, revised 12/2022, included, "Notify family, guardian, or resident update [sic] if new NJ EX Or alteration noted."

Review of the facility's Change in Condition or Status policy, revised 12/2022, included, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status," and, "Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status."

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F 580	Continued From page 10 NJAC 8:39-13.1(c)	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 thoroughly investigate an incident/accident for 1 of 5 residents (Resident #306) reviewed for accident/incidents. This deficient practice was evidenced by the following: According to the Admission Record, Resident #306 was admitted with diagnoses that included, but were not limited to, NJ EX Order. 264b1 [redacted]	F 610	" Residents who experience an incident or accident are at risk to be affected by the deficient practice. " The investigations for Resident #306□s [redacted] on NJ EX Order. 264b1, and [redacted] were completed. " All Nursing staff re-inserviced on facility policy for Accidents and Incidents □ Investigating & Reporting. " DON/Designee will review up to 3 Accident/Incident reports weekly x4 weeks and then once a month X 2 months to ensure facility policy on Accidents and Incidents □ Investigating & Reporting is	12/4/23

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F 610	Continued From page 11 NJ EX Order. 264b1 . A review of the Care Plan, initiated NJ EX Order. 264b1, included the resident was a "high risk for NJ EX hx [history] of actua NJ EX Ord." A review of the facility provided investigations showed incomplete investigations and missing witness statements for the following dates: -Unwitnessed NJ EX Order. 264b1 -Unwitnessed NJ EX Order. 264b1 -Unwitnessed NJ EX Order. 264b1 On 10/25/23 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that they document all incidents on the 24-hour report. The LPN/IP stated that each time a resident fell, or a new incident occurred then there should be a new incident report. He further stated that the nurse on that shift should be completing the incident report. When asked what was included in the incident report, the LPN/IP stated that statements needed to be collected from anyone that saw the incident and then the report was given to the Director of Nursing (DON). He further stated that the incident report should be completed right away. The LPN/IP added that it would not be considered a completed investigation if they did not obtain statements. On 10/25/23 at 10:55 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who explained the process for an unwitnessed NJ EX or if an incident occurred. The CNA stated she would stay with resident and call for the nurse, so	F 610	being followed. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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F 610	Continued From page 12 the nurse could assess the resident to ensure the resident was okay. She stated that once the resident was assessed, then she had to write a report which included what she witnessed and observations and care of the resident prior to the [redacted]. When asked who she gave the report to, she stated she gave it to the nurse and the nurse gave it to "whoever is next". She further stated that the report should be done right away because of timing to ensure "we did not forget as we have a lot to do". On 10/25/23 at 11:06 AM, the surveyor interviewed the Interim Director of Nursing (Interim DON) who stated that when an incident occurred, the staff completed an incident report and gathered statements. When asked who was responsible for completing and gathering the information, the Interim DON stated that the nurses were responsible for completing the incident report and the Unit Manager (UM) or the DON was responsible for ensuring that all the statements and assessments were completed. She then stated that once all that information was obtained, then the investigation was considered complete. The Interim DON stated the importance of completing the incident report accurately each time was to rule out injury after each incident. She further stated if the incident report did not have statements, then it was not considered a complete investigation. When asked if the unit had a UM when these incidents occurred, the Interim DON stated that there was a UM at the facility for six months, but their last day was when the survey team entered the facility. The Interim DON confirmed that there was a UM and a DON during those incidents and that the investigations should have been completed.	F 610		

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On 10/26/23 at 11:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that an incident report was completed by the nurse. She further stated that the CNA, and anyone around that saw or heard anything had to write a statement. She indicated once the statements were completed then they were given to the UM or the DON. The LPN stated that it would not be considered a complete investigation if there were no statements because the protocol was to obtain statements from everyone for the incident report.

A review of the in-service on Incident Reports dated 10/26/23, after surveyor inquiry, reflected "Program summary: completing incident reports in Risk Management. Complete incident report in [electronic medical record]. Complete individual statements forms - individual or fall. Complete neuro [neurological] checks if s/p [status post] fall.

A review of the facility's policy Accidents and Incidents - Investigation and Reporting, revised 04/20/23, included, "2. The following data, as applicable, shall be included on the Report of Incident/Accident form: e. the name(s) of witness and their accounts of the accident or incident. 4. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the DON within 24 hours of the incident or accident. 5. The DON shall ensure that the Administrator receives a copy of the Report of Incident/Accidents for each occurrence."

NJAC-8.39-4.1(a)5

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the 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	F 656		12/4/23

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F 656	Continued From page 15 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: Complaint NJ #: 162553; 164144 Based on interview, record review, and review of facility documents, it was determined that the facility failed to develop a person-centered comprehensive care plan to include the resident's: a.) NJ EX Order. 264b1 b.) NJ EX Order. 264b1 NJ EX Order. 264b1 c.) positioning during NJ EX Order. 264b1, d.) NJ EX Order. 264b1), e.) potential for NJ EX Order. 264b1, f.) NJ EX Order. 264b1, and g.) change in condition in a timely manner for 1 of 17 resident (Resident #13) care plans reviewed. This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #13 had diagnoses which included, but were not limited to, NJ EX Order. 264b1 Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the	F 656	" All residents are at risk to be affected by deficient practice. " The facility is unable to retroactively correct the deficient practice for resident #13's Comprehensive Care Plans as Resident #13 no longer resides at the facility. " All Nursing Staff re-inserviced on the requirement to initiate the plan of care upon admission, based upon admission assessment findings, and to update the care plan timely following any change in condition. " DON/Designee will review up to 2 new admissions per week and 2 long-term resident care plans per week X4 weeks and then 2 admissions and 2 long-term resident care plans per month X2 months to ensure facility policy on Comprehensive Care Plan is being followed. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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management of care, dated NJ EX Order. 264b1 included the resident was NJ EX Order. 264b1. Further review of the MDS included the resident had NJ EX Order. 264b1 on NJ EX Order. 264b1 of the resident's NJ EX Order. 264b1, which placed the resident at NJ EX Order. 264b1

Review of the Admission Assessment, dated NJ EX Order. 264b1, included the resident's fall risk assessment score was NJ EX and that a score greater than NJ EX indicated a NJ EX Order. 264b1

Review of the Readmission Assessment, dated NJ EX Order. 264b1, included the resident's NJ EX Order. 2 assessment score was NJ EX and that a score greater than NJ EX indicated a NJ EX Order. 264b1.

Review of the Morse NJ EX Or Scale assessment, dated NJ EX Order. 264b1 the resident's risk assessment score was NJ EX Order. 264b1 that a score of NJ EX or higher indicated a NJ EX Order. 264b1

Review of the Care Plan included a focus of, "I am at a NJ EX Order. 264b1 r/t [related to] my NJ EX Order. 264b1 ith corresponding interventions, which was not created until NJ EX Order. 264b1

2. Further review of the admission MDS included the resident was always NJ EX Order. 264b1 and NJ EX Order. r.

Further review of the Admission Assessment included the resident was always NJ EX Order. 264b1 of NJ EX Order. 264b1.

Review of the NJ EX Order. 264b1 Assessment,

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dated NJ EX Order. 264b1 included the resident never NJ EX Order. 264b1," and is NJ EX Order. 264b1," daily.

Further review of the Readmission Assessment included the resident was always NJ EX Order. 264b1 of NJ EX Order. 264b1.

Further review of the Care Plan included a focus of, "[Resident #13] is NJ EX Order. 264b1 and NJ EX Order. 264b1 y," with corresponding interventions, which was not created until NJ EX Order. 264b1

3. Further review of the admission MDS included the resident had a feeding tube and received NJ EX Ord or more of his/her total calories through the NJ EX Order. 264b1.

Review of the January 2023 Medication Administration Record (MAR) included a physician's order of "NJ EX Order. 264b1 NJ EX Order. 264b1 at all times during NJ EX Order. 264 and for at least NJ EX Order. 264b1 after the f NJ EX Order. 264 is stopped every shift," with a start date NJ EX Order. 264b1

Further review of the Care Plan included a focus, created NJ EX Order. 264b1 of, "I am on a NJ EX Order. 264b1 to help meet my NJ EX Order. 264b1 needs," with an intervention to, "Keep my HOB elevated at least NJ EX Order. 264 degrees while NJ EX Order. 264 is in progress for at least NJ EX Order. 264 minutes after NJ EX Order. 264 is done," which was not created until NJ EX Order. 264.

4. Further review of the admission MDS included the resident had "complaints of NJ EX Order. 264b1 NJ EX Order. 264b1

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Review of the Speech Therapy SLP (Speech Language Pathologist) Evaluation & Plan of Treatment, dated NJ EX Order. 264b1 included a diagnosis of NJ EX Order. 264b1 and a plan for "treatment of NJ EX Order. 264b1

Further review of the Care Plan included a focus of, NJ EX Order. 264b1 techniques/precautions," with corresponding interventions, which was not created until NJ EX Order. 264b1

5. Further review of the admission MDS included the resident was at risk for developing NJ EX Order. 264b1, but did not have any NJ EX Order. 264b1.

Further review of the Admission Assessment included the resident's NJ EX Order. 264b1 Scale score (tool used to assess the risk for NJ EX Order. 264b1) was NJNJ EX Ord, which indicated a high risk NJ EX Order. 264b1 NJ EX Order.2

Further review of the Readmission Assessment included the resident's NJ EX Order. 264b1 Scale score was NJ or less, which indicated a very high risk for NJ EX Order. 264b1.

Further review of the Care Plan included a focus of, "[Resident #13] has NJ EX Order. 264b1 in NJ EX Order. 264b1," with corresponding interventions, which was not created until NJ EX Order. 264b1

6. Review of the Skin Observation Tool, dated NJ EX Order. 264b1, included the resident had a NJ EX Order. 264b1

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impairment of NJ EX Order. 264b1

Review of the NJ EX Order. 26 Care Consultant Report, dated NJ EX Order. 264b1 included evaluation of a pressure ulcer to the resident's NJ EX Order. 264 classified as a NJ EX Order. 264b1

Further review of the Care Plan included a focus of, "[Resident #13] has NJ EX Order. 264b1 NJ EX Order. 264b1," with corresponding interventions, which was not created until NJ EX Order. 264b1.

7. Review of the Nurse's Note, dated NJ EX Order. 26, included the resident was receiving an NJ EX Order. 264b1 and had two episodes of NJ EX Order. 264b1 The progress note further included the physician was notified and a new order for NJ EX Order. 264b1 an NJ EX Order. 264b1 l medication, was received.

Review of a MD/NP (Medical Doctor/Nurse Practitioner) NJ EX Order. (NJ EX Order. 264b1) Visit note, dated NJ EX Order. 264b1, included the resident was seen for NJ EX Order. 264b1 which was most likely caused by NJ EX Order. 264b1 treatment. The note further included that if the NJ EX Order. 264b1 persisted, the resident may need NJ EX O testing.

Review of a MD/NP NJ EX Ord Visit note, dated NJ EX Order. 264b1, included the resident was seen for NJ EX Order. 264b1 NJ EX Order. 264b1 testing was ordered.

Review of a Nurse's Note, dated NJ EX Order. 264b1 included the resident continued NJ EX Order. 264b1 treatment and had three episodes of NJ EX Order. 264b1 NJ EX Order. 264b1

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Review of a MD/NP SAR Visit note, dated NJ EX Order. 264b1, included the resident was seen for NJ EX Order. 264b1 and NJ EX Order testing results were pending.

Review of a MD/NP NJ EX Order Visit note, dated NJ EX Order. 264b1 included the resident was seen for NJ EX Order. 264b1 which was improving.

Further review of the Care Plan included a focus of, "[Resident #13] has NJ EX Order. 264b1 t use/side effects of medication of NJ EX Order. 264b1 therapy and NJ EX Order. 264b1 which was not created until NJ EX Order. 264b1

During an interview with the surveyor on 10/24/23 at 11:21 AM, the Licensed Practical Nurse (LPN) stated the Unit Manager (UM) was responsible for creating the resident care plans, however, there currently was no UM for the facility.

During an interview with the surveyor on 10/26/23 at 11:11 AM, the Regional Director of Nursing (Regional DON), who was overseeing the nursing unit, stated that resident care plans consisted of a focus, which was the identified problem, goals that were specific to the focus, and interventions that were specific to the focus. She further stated that the purpose of a care plan was to identify resident problems and create a plan to address those issues. When asked about the time frames for care plans, the Regional DON stated that the comprehensive care plan should be created within two weeks after the resident was admitted, and if there is a change in condition, the comprehensive care plan should be revised as soon as possible. When asked about the aforementioned care plan issues, the Regional DON stated the following:

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F 656	Continued From page 21 a.) if a resident was identified as a [redacted] on admission, it should be reflected on the comprehensive care plan within two weeks of admission, b.) if a resident was identified as [redacted] on admission, it should be reflected on the comprehensive care plan within two weeks of admission, c.) if a resident had a [redacted] on admission, the comprehensive care plan should include the resident's [redacted] on the comprehensive care plan within two weeks of admission, d.) if a resident had a diagnosis of [redacted] on admission, it should be reflected on the comprehensive care plan within two weeks of admission, e.) if the resident was identified as at risk for [redacted] on admission, it should be reflected in the comprehensive care plan within two weeks of admission, f.) if the resident obtained a [redacted] the comprehensive care plan should be revised as soon as possible to reflect the change in [redacted] condition, and g.) if the resident had a change in condition, occurring multiple days, the comprehensive care plan should be revised as soon as possible to reflect the change in condition. During an interview with the surveyor on 10/26/23 at 11:34 AM, the Interim Director of Nursing (Interim DON), stated that resident care plans are created to guide the care of the resident during their stay at the facility. She further stated the time frames for creating the comprehensive care plan was within 21 days of the resident's admission and should be revised as soon as there is a change. When asked about the	F 656		

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aforementioned care plan issues, the Interim DON stated the following:
a.) if a resident was identified as a [redacted] on admission, it should be reflected on the comprehensive care plan within 21 days of admission,
b.) if a resident was identified as [redacted] admission, it should be reflected on the comprehensive care plan within 21 days of admission,
c.) if a resident had a [redacted] on admission, the comprehensive care plan should include the resident's [redacted] on the comprehensive care plan within 21 days of admission,
d.) if a resident had a diagnosis of [redacted] on admission, it should be reflected on the comprehensive care plan within 21 days of admission,
e.) if the resident was identified as at [redacted] t on admission, it should be reflected in the comprehensive care plan within 21 days of admission,
f.) if the resident obtained a [redacted], the comprehensive care plan should be revised as soon as possible to reflect the change in skin condition, and
g.) if the resident had a change in condition, the comprehensive care plan should be revised as soon as possible to reflect the change in condition.

Review of the facility's [redacted] Risk Assessment policy, revised 01/2023, included, "The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document risk factors for [redacted] and establish a resident-centered [redacted] prevention plan based on relevant assessment

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information."

Review of the facility's NJ EX Order Nutrition policy, revised 12/2022, included, "Risk for aspiration will be assessed by the Nurse and Physician and addressed in the individual care plan. Risk of NJ EX Order. 264b1 may be affected by: ... Improper positioning of the resident during NJ EX Order. 264b1"

Review of the facility's NJ EX Order. 264b1 - Clinical Protocol policy, revised 12/2022, included, "The staff and physician will identify individuals with a history of NJ EX Order. 264b1 difficulties or related diagnoses such as NJ EX Order. 264b1, as well as individuals who currently have NJ EX Order. 264b1 or NJ EX Order. 264b1 food," and, "the staff and physician will first try to identify and implement simple interventions to manage the situation."

Review of the facility's NJ EX Order. 264b1 Risk Assessment policy, revised 12/2022, included, "Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for NJ EX Order. 264b1 "

Review of the NJ EX Order. 264b1 NJ EX Order. 264b1 - Clinical Protocol policy, revised 12/2022, included, "The physician will guide the care plan as appropriate, especially when NJ EX Order. 264b1 are not healing as anticipated or NJ EX Order. 264b1 develop despite existing interventions."

Review of the facility's Change in Condition or Status policy, revised 12/2022, included, "The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status." The policy

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F 656	Continued From page 24 did not include the resident's care plan. Review of the facility's Care Plans, Comprehensive, Person-Centered policy, revised 01/2023, included, "The Interdisciplinary Team (IDT) ... develops and implements a comprehensive, person-centered care plan for each resident," and, "The comprehensive, person-centered care plan will: ... Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." Further review of the policy included, "Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process," and, "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change." NJAC8:39-11.2 (e)(f)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 162553 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) consistenly document the completion of a wound	F 658	" All residents are at risk to be affected by deficient practice. " Facility is unable to retroactively correct the deficient documentation practice for Residents #13& #41.The facility added MD order for ER transfer for	12/4/23

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F 658	Continued From page 25 treatment in accordance with a physician's order for 1 of 1 resident, (Resident #13) reviewed for pressure ulcer, b.) consistently document the positioning of a resident during and after NJ EX Order. 264b1 in accordance with a physician's order for 1 of 1 resident, (Resident #13) reviewed for NJ EX Order. 264b1 c.) consistently document the application of NJ EX Order. 264b1 in accordance with a physician's order for 1 of 1 resident, (Resident #13) reviewed for NJ EX Order. 264b1, d.) obtain a physician's order to discharge the resident from the facility in accordance with professional standards of nursing practice for 2 of 2 residents reviewed for discharge, (Residents #12 and #22) and, e.) consistently document the NJ EX Order. 264b1 in accordance with a physician's order for a 1 of 1 resident (Resident #41) with an NJ EX Order. 264b1 This deficient practice 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 or 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states:	F 658	residents #12,22 . " All nursing staff re-inserviced on facility policy for: 1) Medication/Treatment Administration Policy 2) NJ EX Order. 264b1 Care Policy 3) Physician/Practitioner Orders " DON/Designee will conduct a review on : A) 1 resident with physician orders for NJ EX Order. 2 treatments weekly X4 weeks and then monthly X2 months to ensure nursing documentation is in place. B) 1 resident with physician orders for NJ EX Order. 264b1 weekly X4 weeks and then monthly X2 months to ensure nursing documentation is in place. C) 1 resident with physician orders for NJ EX Order. 264b1 weekly X4 weeks and then monthly X2 months to ensure nursing documentation is in place. D) Emergency Hospital transfer log weekly X4 weeks and then monthly X2 months to ensure Physician order for transfer is in place. E) 1 resident with physician orders for NJ EX Order. 264b1 weekly X4 weeks and then monthly X2 months to ensure nursing documention is in place. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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"The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

1.) According to the Admission Record, Resident #13 had diagnoses which included, but were not limited to, osteomyelitis (bone infection) of the left ankle and foot.

Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ EX Order. 264b1, included the resident was NJ EX Order. 264b1. Further review of the MDS included the resident had an NJ EX Order. 264b1 that was not present on admission.

Review of the Care Plan included a focus of "[Resident #13] has NJ EX Order. 264b1 " with an intervention to "Administer treatment per NJ EX Order. 264b1 care recommendations," initiated NJ EX Order. 264b1.

Review of the NJ EX Order. 264b1 Treatment Administration Record (TAR) included a physician's order for, "NJ EX Order. 264b1 with NJ EX Or solution. Apply NJ EX Order. 264b1 to the NJ EX Order. 2. Apply NJ EX Order. 264b1 to the NJ EX Order. 264b1. Cover with an NJ EX Order. 264b1 Wrap with NJ EX Or and secure with tape. Change NJ EX Order. 264b1," with a start date of NJ EX Order. 264b1. Further review of the TAR revealed the NJ EX Order. 264b1 treatment order was not

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signed out as completed and was left blank on 04/08/23 and 04/09/23.

2.) According to the Admission Record, Resident #13 also had a diagnosis of NJ EX Order. 264b1).

Further review of the quarterly MDS included the resident had a NJ EX Order. 264b1 and received or more of his/her total calories through the

Further review of the Care Plan included a focus of, "I am on a NJ EX Order. 264b1 to help meet my NJ EX Order. 264b1," initiated , with an intervention to, "Keep my NJ EX Order. 264b1 elevated at least degrees while is in for at least NJ EX Order. 264b1 after is done."

Further review of the TAR included a physician's order for, NJ EX Order. 264b1 ," with a start date of . Further review of the TAR revealed the treatment order was not signed out as completed and was left blank on the following dates and times:

04/08/23 at 8:00 AM
04/08/23 at 11:00 AM
04/08/23 at 2:00 PM
04/09/23 at 8:00 AM
04/09/23 at 11:00 AM
04/09/23 at 2:00 PM
04/25/23 at 5:00 PM
04/25/23 at 9:00 PM

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04/30/23 at 5:00 AM

3.) Review of a [redacted] Care Consultant report, dated [redacted], included Resident #13 was seen for a follow-up evaluation of the [redacted] NJ EX Order. 264b1 .

Review of the [redacted] TAR included a physician's order for [redacted] in place at all times every shift for [redacted] prevention," with a start date of [redacted]. Further review of the TAR revealed the treatment order was not signed out as completed and was left blank on 06/23/23 evening shift and 06/28/23 evening shift.

During an interview with the surveyor on 10/26/23 at 11:11 AM, the Regional Director of Nursing (Regional DON) stated that nurses should sign off on the TAR when the treatment was completed. She further stated that if there is a blank on the TAR, there could be a reason, but if it wasn't signed for then it wasn't completed.

During an interview with the surveyor on 10/26/23 at 11:34 AM, the Interim Director of Nursing (Interim DON) stated that when the nurses sign off on the TAR, it means the treatment was completed. When asked how someone reviewing the medical record would know whether a treatment was completed if there was a blank, the Interim DON stated, "you would have to interview the nurse about the missing documentation."

Review of the Documentation of Medication/Treatment Administration policy, revised 12/2022, included, "A nurse shall document all medications and treatments administered to each resident on the resident's medication administration record (MAR) or

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treatment administration record (TAR)," and, "Administration of medication and treatment must be documented immediately after (never before) it is given." Further review of the policy included, "Documentation must include, as a minimum: ... Date and time of administration; Reason(s) why a medication or treatment was withheld, not administered, or refused (if applicable); Signature and title of the person administering the medication or treatment."

4.) On 10/20/23 at 10:28 AM, the surveyor observed Resident #12 alert, dressed, and seated in a wheelchair in his/her room.

A review of the Admission Record for Resident #12 revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ EX Order. 264b1 .

A review of Resident #12's Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate care, dated [redacted], revealed that the resident's brief interview of mental status (BIMS) score was [redacted] which indicated the resident was NJ EX Order. 264b1 . A review of the resident's MDS documentation revealed he/she was a discharged return anticipated on [redacted]

A review of Resident #12's MD/NP (Medical Doctor/Nurse Practitioner) progress note, dated [redacted] and timed at 16:58 (04:58 PM), revealed, "PLAN, Discussed with [redacted] nursing administrator, We will send to ER for evaluation ..."

A review of Resident #12's nursing progress note,

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dated [redacted] and timed at 16:59 (04:59 PM), revealed, that per (physician name), ordered to send resident out to hospital via 911 for evaluation to NJ EX Order. 264b1 [redacted]

A review of the Order Summary Report (OSR) did not include documentation of a Physician Order (PO) to transfer Resident #12 to the hospital on [redacted]

5.) On 10/20/23 at 12:31 PM, the surveyor observed Resident #22 seated in the dining area eating lunch.

A review of the Admission Record for Resident #22 revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ EX Order. 264b1 [redacted]

A review of Resident #22's Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate care, dated [redacted], revealed that the resident's brief interview of mental status (BIMs) score was [redacted], which indicated the resident was NJ EX Order. 264b1 A review of the resident's MDS documentation revealed he/she was a discharged return anticipated on [redacted], and [redacted]

A review of Resident #22's nursing progress note, dated [redacted] and timed at 05:23 (05:23 AM), revealed that at 0500 (05:00 AM) the resident was NJ EX Order. 264b1 ...EMT was called to send the resident to the ER (emergency room) and that the physician was called, awaiting call back.

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A review of Resident #22's MD/NP (Medical Doctor/Nurse Practitioner) progress note, dated [redacted] and timed at 18:44 (06:44 PM) revealed, "Notified pt (patient) had a fall 0500 this am. Sent to ER."

A review of the Order Summary Report (OSR) did not include documentation of a Physician Order (PO) to transfer Resident #22 to the hospital on [redacted]

A review of Resident #22's nursing progress note, dated [redacted] and timed at 22:41 (10:41 PM), revealed that the resident was found with his/her [redacted]) on the floor ...the physician was notified and gave an order to call 911. Emergency medical services were called, and the resident was transported to the hospital.

A review of Resident #22's MD/NP progress note, dated [redacted] and timed at 16:32 (04:32 PM) revealed, "Patient returned form [sic] (hospital name)-s/p (status post)[redacted]."

A review of the OSR did not include documentation of a PO to call 911 for Resident #22.

A review of Resident #22's nursing progress note, dated [redacted] and timed at 20:43 (09:43 PM), revealed that the resident complained of chest pains and asked to go to the ER. 911 was called and EMT transported the resident to (hospital name). MD was notified.

A review of Resident #22's MD/NP progress note,

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dated [redacted] and timed at 17:52 (05:52 PM), revealed, "Notified this afternoon, resident returned from (hospital name). Admitting dx: (diagnosis) [redacted]. No records in pcc (electronic medical record system)."

A review of the OSR did not include documentation of a PO to call 911 for Resident #22 on [redacted]

A review of Resident #22's nursing progress note, dated [redacted] and timed at 07:20 (07:20 AM), revealed that the resident was found on the [redacted] and 911 was called and the resident was transferred to (hospital name). MD made aware.

A review of Resident #22's nursing progress note, dated [redacted] and timed at 16:58 (04:58 PM), revealed that the resident returned to the facility from the hospital.

A review of Resident #22's nursing progress note, dated [redacted] and timed at 15:22 (03:22 PM), revealed that the resident was being sent to (hospital name) per his/her MD request to start an NJ EX Order. 264b1 him/her.

A review of Resident #22's MD/NP progress note, dated [redacted] and timed at 18:29 (06:29 PM), revealed, "Notified resident was [redacted] not responding, not NJ EX Order. 264b1. Resident was sent to ER yesterday for [redacted] and was sent back to RV."

A review of the OSR did not include documentation of a PO to call 911 and transfer Resident #22 to the hospital on [redacted].

A review of the OSR did not include

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documentation of a PO to transfer Resident #22 to the hospital on [redacted].

On 10/26/23 at 11:54 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that if a resident requested to go to the hospital that they would not need permission but that if the resident was unstable that the physician would have been notified and an order would have been obtained to send the resident to the hospital. The LPN stated that the order would have been documented in the progress notes.

On 10/27/23 at 09:47 AM, the surveyor interviewed the Interim Director of Nursing (IDOM) who stated that if a resident went to the hospital that the physician would have been notified to obtain an order to transfer the resident. Together, the surveyor and IDOM reviewed Resident #12's and Resident #22's electronic medical record (EMR). The IDOM acknowledged that she did not observe an order from the physician for Resident #12 to be discharged to the hospital on [redacted] The IDOM also acknowledged that she did not observe an order from the physician for Resident #22 to be discharged to the hospital on [redacted], nor [redacted] The IDOM stated it was important to make sure a physician order was documented for the best practice standard of care.

On 10/27/23 at 10:01 AM, the surveyor interviewed the Regional Director of Nursing (RDON) who stated that if a resident went to the hospital that the physician would have been notified and an order would have been obtained to transfer the resident to the hospital. The RDON stated that the physician order was needed to

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send a resident to the hospital.

On 10/27/23 at 12:05 PM, the surveyors met with the administration who were made aware that there were no physician orders for Residents #12 and #22 to be transferred to the hospital.

On 10/27/23 at 12:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Regional LNHA, in the presence of the surveyor team, who both stated that they would have expected to have seen a physician order for a resident that was sent out to the hospital.

At that time, the IDON stated, "We are starting education on that today."

6.) On 10/19/23 at 11:12 AM, during the initial tour, the surveyor observed Resident #41 inside his/her room, seated on a wheelchair. Resident #41 stated that the staff was great and had no concerns at that time. The surveyor observed that there was a NJ EX Order. 264b1 on the NJ EX Order. 264b1 of the wheelchair with a NJ EX Order. 26 cover.

According to the Admission Record, Resident #41 was admitted with diagnoses that included, but were not limited to, NJ EX Order. 264b1 [redacted] NJ EX Order. 264b1 [redacted] l

A review of the admission Minimum Data Sheet (MDS), an assessment tool, dated NJ EX Order. 264b1 [redacted],

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included the resident had a Brief Interview for Mental Status (BIMS) score of NJ EX Order. 264b1 which indicated the resident's NJ EX Order. 264b1 Further review of the MDS, in Section NJ EX Order. 264b1 and NJ EX Order. 264b1, included the resident had an NJ EX Order. 264b1.

A review of the Care Plan, initiated NJ EX Order. 264b1 included the resident had an NJ EX Order. 264b1 related to NJ EX Order. 264b1 NJ EX Order. 264b1] NJ EX Order. 264b1 which the NJ EX Order. 264b1). Further review included interventions to monitor and document NJ EX Order. 264b1 as per facility policy.

A review of the NJ EX Order. 264b1 Order Summary Report (OSR) revealed a physician's order (PO) to document output every shift for monitor NJ EX Order. 264b1 and another to document output every shift for monitoring, both ordered NJ EX Order. 264b1

A review of the Treatment Administration Record (TAR) revealed the following:

For the month of NJ EX Order. 264b1, the nurses failed to document the NJ EX Order. 264b1 for six (6) of 69 shifts.
-08/10/23 day shift, 08/11/23 day shift, 08/12/23 evening shift, 08/18/23 day shift, 08/18/23 evening shift, and 08/24/23 day shift.

For the month of NJ EX Order. 264b1 the nurses failed to document the NJ EX Order. 264b1 for six (6) of 72 shifts.
-09/08/23 night shift, 09/09/23 day shift, 09/24/23 day shift, 09/25/23 day shift, 09/27/23 day shift and 09/29/23 evening shift.

For the month of NJ EX Order. 264b1, the nurses failed

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to document the NJ EX Order: 26461 for nine (9) of 72 shifts.
-10/01/23 day shift, 10/05/23 evening shift, 10/07/23 day shift, 10/09/23 day shift, 10/10/23 day shift, 10/12/23 day shift, 10/15/23 day shift, 10/20/23 day shift, and 10/24/23 evening shift.

On 10/25/23 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the CNAs were responsible for emptying the NJ EX Order: 26461 at the end of their shift and then documented in the electronic medical record (EMR) under the CNA's tasks. She further stated that she also informed the nurse and that the nurses would also document the NJ EX Order: 26461 amount in the EMR. The CNA stated that it was important to document the NJ EX Order: 26461 because if it was too NJ EX Order: 26461 of the NJ EX Order was "not normal" then she would inform the nurse right away of any issues.

On 10/25/23 at 10:44 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that the CNAs were responsible as well as the nurses to empty the NJ EX Order: 26461 He stated that the nurses document the NJ EX Order amount in the EMR if there was a PO. He further stated that he was not sure if the CNAs were able to document the amount in the EMR, but he knew that it had the CNAs document if the resident was NJ EX Order: 26461. The LPN/IP stated that the amount should be documented every shift and that it was important to document every shift because it showed that the resident had adequate NJ EX Order: 2 , in addition to if they needed to notify the physician of any changes.

On 10/25/23 at 10:58 AM, the surveyor

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interviewed CNA who stated that she did not have any residents that had a [redacted] but was trained on what to do. She stated that she would inform the nurse the urine amount to be document in the EMR but that she would also document the [redacted] in the EMR. The CNA stated the importance of documenting the [redacted] was to ensure the resident's [redacted]."

On 10/25/23 at 11:20 AM, the surveyor interviewed the Interim Director of Nursing (Interim DON) who stated that the nurses were responsible for documenting the [redacted] in the Medication Administration Record (MAR) or TAR. She stated the importance of documenting the [redacted] was to monitor the resident to ensure the urine was [redacted] properly, there were no obstructions, and that there were no other concerns.

On 10/25/23 at 01:16 PM, the Interim DON confirmed that there were no additional documentations for the missing [redacted] on the TAR for Resident #41.

On 10/26/23 at 11:40 AM, the surveyor interviewed the LPN who stated that the nurses were responsible to document the [redacted] in the EMR. She explained the nurses documented in the progress note and in the TAR, if there was an order. The LPN stated it was important to document the [redacted] because if the intake was more than the [redacted] there could be an issue as well as the [redacted] could be out of place.

A review of the Education/Inservice Training Record provided after surveyor inquiry, reflected the program summary documenting orders in the

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MAR/TAR should be done each shift. Do not leave orders blank. example urine output, I's and O's [intake and output].

A review of the facility's NJ EX Order. 264b1 Care policy revised 12/2018, included, NJ EX Order. 264b1. Maintain an accurate record of the resident's daily NJ EX Order. 2 per facility policy and procedure."

A review of the facility's Measuring and Recording Output policy revised 12/2023, included, "The purpose of this procedure is to accurately determine the amount NJ EX Order. 26 that a resident NJ EX Order. 264b1 in a 24-hour period. Steps in Procedure 8. Record the amount noted on the NJ EX Order 7 side of the NJ EX Order 7 and NJ EX Order 7 records. Record in mLs [milliliters]. Documentation- the following information should be recorded on the bedside NJ EX Order. 264b1 record and/or in the resident's medical record: 1. The date and time the resident's NJ EX Order. 264b1 was measured and recorded. 3. The amount (in mLs) of NJ EX Order. 2. 6. The signature and title of the person recording the data."

A review of the facility policy, "Physician/Practitioner Orders," revised 12/2022, revealed, Policy Statement: The attending physician shall provide orders for the care and treatment of assigned residents. Policy Interpretation and Implementation: 1. Consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other that the resident's attending physician ...who is acting on behalf of the attending physician. A consulting physician/practitioner may include, but is not limited to, a resident's: e. Nurse Practitioner ...3. For consulting physician/practitioner orders received via

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F 658	Continued From page 39 telephone, the nurse will: a. Document the order on the physician order form, notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order. b. Call the attending physician to verify the order. c. Document the verification of the order by entering the time, date, name and title of the physician/practitioner verifying the order, and the signature and title of the person receiving the verification order. d. Follow facility procedures for verbal or telephone orders including: noting the order ... A review of the facility's Documentation and Medication/Treatment Administration policy revised 12/2022, included 1. A nurse shall document all medications and treatments administered to each resident on the resident's medication administration record (MAR) and treatment administration record (TAR)." NJAC 8:39-11.2(a), 27.1(a)	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was	F 684	" Residents with unwitnessed [redacted] at risk to be affected by deficient practice.	12/4/23

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F 684	Continued From page 40 determined that the facility failed to consistently conduct NJ EX Order. 264b1 evaluations (NJ EX Order. 264b1) after an unwitnessed resident fall for NJ EX Order. 264b1 residents, (Resident #5 and #306) reviewed for NJ EX Ord This deficient practice was evidenced by the following: 1.) According to the Admission Record, Resident #306 was admitted with diagnoses that included, but were not limited to, NJ EX Order. 264b1 A review of the Care Plan, initiated 9/NJ EX Order. 264b1 included the resident was a 'NJ EX Order. 264b1 hx [history] of NJ EX Order. 264b1." Review of the Incident Reports indicated the following: -An unwitnessed NJ EX O on NJ EX Order. 264b1: the resident was noted NJ EX Order. 264b1 on the NJ EX Or r with an NJ EX Order. 264b1 The NJ EX Order. 264b1 Checklist NJ EX Order. 2 was initiated prior to the resident being sent to the emergency room (ER). The report did not include additional NJ EX Order. checks upon returning to the facility within the 24 hours. -An unwitnessed NJ EX on NJ EX Order. 264b1: the resident was noted laying on the f NJ EX OrdNJ EX Order. 264b1 from the NJ EX Order. 264b1. The NCL was initiated but reflected vital signs (VS) from the NJ EX Order. 264b1 The report did not include accurate and completed NJ EX Order 2 checks.	F 684	" Facility is unable to retroactively correct the deficient documentation practice for Residents #5 & #306 NJ EX Order. 264b1 evaluations . " All current residents with orders for NJ EX Order. 264b1 Evaluations charts reviewed to ensure NJ EX Order. 264b1 are documented. " All nursing staff re-educated on facility Neurological Testing Policy. " DON/ Designee will audit up to 2 resident chart with orders for NJ EX Order. 264b1 Evaluations weekly X4 weeks and then monthly X2 months to ensure nursing documention is in place. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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-An unwitnessed [redacted] on [redacted]: the resident was found on the [redacted] complaining of [redacted] The report did not include an initiation of the [redacted] until 24 hours later on [redacted]. A further review did not reflect additional [redacted] checks.

-An unwitnessed [redacted] on [redacted]: the resident was found sitting on the [redacted] complaining of [redacted] A review of the [redacted] reflected VS dated [redacted] There were no additional [redacted] checks documented.

On 10/25/23 at 10:27 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated the process for an incident such as a [redacted], included that she assured the resident was okay and then got a nurse to assess the resident. She stated that once the resident was assessed and if the resident was not sent to the hospital then they would check on that resident every one to two hours for 24 hours. CNA #1 stated that the nurse completed [redacted] checks every one to two hours.

On 10/25/23 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that the process for an unwitnessed [redacted] would be for the nurse to assess the resident by checking the VS, initiate [redacted] checks, assess the resident for pain and for any injuries. The LPN/IP stated that he would then document his assessment in a progress note, reach out to the physician and inform the family. He further stated that he would then continue to assess the resident throughout the shift for any changes. When asked what was the facility's policy on neuro checks, the LPN/IP stated he believed it was every 15 minutes for one hour, then 30 minutes for one hour, and then

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every four hours for 24 hours. He explained that the [redacted] checks were documented on the [redacted] (24-hour [redacted] checks) that could be passed along to the next shift. The LPN/IP stated that they documented the incident on the 24-hour report as well as completed the [redacted]. When asked for clarification of the difference between the [redacted] and the [redacted], he stated the [redacted] was the 24-hour [redacted] checks and the [redacted] was completed with the incident report. The surveyor continued to interview the LPN/IP who stated that each time a resident [redacted], or a new incident occurred then there should be a new incident report. He further stated that new vital signs should also be completed. He emphasized that everything should be new when that incident occurred. The LPN/IP concluded that [redacted] checks were important because the resident could display an altered mental status and a change in their vital signs could be a sign and symptom that something else was occurring.

On 10/25/23 at 10:55 AM, the surveyor interviewed CNA #2 who stated the process for an unwitnessed [redacted] or if an incident occurred, she would stay with resident and call for the nurse, so the nurse could assess the resident to ensure the resident was okay.

On 10/25/23 at 11:06 AM, the surveyor interviewed the Interim Director of Nursing (Interim DON) who stated that the process for an unwitnessed [redacted] or for a resident that hit their [redacted] included, neuro checked to be initiated, complete a physical assessment, notify the physician and the responsible party. The Interim DON stated that the assessment and the [redacted] checks should be initiated immediately. She stated the importance of [redacted] checks was to

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rule out any [NJ EX Order: 26451] trauma. She further stated that for every incident there should be a new incident report as well as obtaining new vital signs and initiating [NJ EX Order] checks. She stated that the neuro checks should be every (q) 15 minutes for the first hour, then q 30 minutes for the next hour, then hourly for the next 4 hours, then every 4 hours until you get to the 24-hour mark. When asked what was the difference between the [NJ EX Order] and the [NJ EX Or], the Interim DON stated the nurse were using the NFS and every so often then the nurse would use the NCL. She explained the nurses could complete the [NJ EX Or] or the [NJ EX Order] but the downside to the [NJ EX Order] was that it only had space for one set of VS compared to the [NJ EX Or] which reflected every 15 minutes, then 30 minutes, and so on. The Interim DON and the surveyor review together the [NJ EX Order: 26451] and [NJ EX Order: 26451] incident report. At that time, the Interim DON acknowledged that the vital signs were not completed accurately and that the [NJ EX Order: 26451] vital signs were duplicated from [NJ EX Order: 26451] When asked what was the expectation of completing the [NJ EX Order: 26451] checks,The Interim DON stated that the staff were expected to do a new assessment each time the incident occurred and not use the same vital signs. She stated the importance of completing the incident report accurately each time was to rule out injury after each incident. The Interim DON also states if the resident was sent out to the ER and did not return within the 24 hours timeframe, then the checklist would be sufficient. The Interim DON did not speak to if the [NJ EX Order] checks should be completed upon return to the facility within the 24-hours.

On 10/25/23 at 01:14 PM, the Interim DON provided additional statements that she found. At that time, the surveyor and the Interim DON

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reviewed the NJ EX Order. 264 3 and NJ EX Order. 264b2 incident reports. The Interim DON acknowledged that the vital signs dated for NJ EX Order. 264b3 were inaccurate as they were dated NJ EX Order. 264b3 She also acknowledged that the NJ EX Order. 264b3 dated on NJ EX Order. 264b3 incident report were inaccurate since they were also dated NJ EX Order. 264b3.

On 10/26/23 at 11:41 AM, the surveyor interviewed Licensed Practical Nurse (LPN) who stated that the process for an unwitnessed NJ EX checks was to assess the resident by checking the VS and initiating NJ EX Order 2 checks. The LPN stated that the NJ EX Order checks were completed on the NFS, and they assessed the resident every 15 minutes for one hour, then every 30 minutes for one hour, then every one hour, and then every four hours after that for 24 hours. The LPN stated that if the resident was sent out to the ER and they returned within 24 hours, the NJ EX Order 2 checks should still be completed. The LPN explained that the NJ EX Ord was a hard copy sheet that the nurses used throughout their shift and the NJ EX Ord was documented in the electronic medical record (EMR). She stated that NJ EX Order 2 checks should be initiated at the time of the incident and for each incident.

2.) On 10/24/23 at 10:01 AM, the surveyor observed Resident #5 lying in bed. Resident #5 stated that he/she was feeling "good" and that he/she had just finished eating. When asked if the resident had a NJ EX recently, Resident #5 stated "no."

According to the Admission Record, Resident #5 was admitted with diagnoses that included, but were not limited to, NJ EX Order. 264b1

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NJ EX Order. 264b1 [redacted]).

Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's NJ EX Order. 264b1 [redacted]. Further review of the MDS revealed the resident had one [redacted] since the prior assessment.

Review of the Care Plan, dated [redacted] included the resident "is at moderate [redacted] related to NJ EX Order. 264b1 [redacted]."

Review of the Incident Report, dated [redacted], revealed that the resident had an unwitnessed [redacted] Resident #5 was found by the wheelchair on his/her bottom. Although the report noted that [redacted] checks were initiated, none were attached to the report.

Review of the Progress Notes (PN), dated [redacted] revealed that the resident [redacted] the [redacted] to the [redacted] of the [redacted], during lunch, and was found seated on their bottom. VS were stable, and the resident denied [redacted] or [redacted] No apparent injuries were noted. A further review of the PN revealed there were no

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NJ EX Order checks documented.

Review of the PN, dated NJ EX Order 26401, noted that neuro checks were in progress. There were no physical or electronic documentation of the NJ EX Order-checks related to this incident in the resident's medical record.

Review of the Assessments section in the EMR did not contain NJ EX Order-checks regarding the aforementioned incident.

On 10/24/23 at 01:10 PM, the surveyor interviewed the LPN who stated that when a resident NJ EX O, neuro checks were initiated immediately. The LPN further stated that NJ EX Order checks were initially completed at 15 minutes, 30 minutes, and then hourly.

On 10/30/23 at 11:12 AM, the surveyor interviewed the Interim DON who stated the NJ EX Order 26401 checks could not be found and acknowledged that they should have been documented.

A review of the in-service on Incident Reports dated NJ EX Order 26401, after surveyor inquiry, reflected "Program summary: completing incident reports in Risk Management. Complete incident report in [electronic medical record]. Complete individual statements forms - individual or NJ EX O Complete NJ EX Order checks if s/p [status post] NJ EX Or

A review of the facility's NJ EX Or Clinical Protocol: Assessment and Recognition, revised 12/2022, included, "2. In addition, the nurse shall assess and document/report the following: a. vital signs; e. NJ EX Order 26401 status."

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F 684	Continued From page 47 A review of the facility's NJ EX Order. 264b1 Testing Policy, revised 01/2023, included, "if a resident is suspected of having a head injury, has an unwitnessed NJ EX and it is unclear if they hit their head or a resident has a change in mental status, a NJ EX Order. 264b1 exam will be performed. "	F 684		
F 686 SS=E	NJAC 8:39-27.1(a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 162553; 1164144 Based on interview, record review, and review of facility documents, it was determined that the facility failed to address recommendations from the NJ EX Order 2 care consultant in a timely manner for 1 of 1 resident (Resident #13) reviewed for NJ EX Order. 264b1. This deficient practice was evidenced by the	F 686	" Residents with NJ EX Order. 264 are at risk to be affected by deficient practice. " Facility is unable to retroactively correct the deficient documentation practice related to Resident #13 previous NJ EX Order 2 care treatments. " All residents that are seen by the NJ EX Order. 264 Care Consultant and/or have current NJ EX Order 2 care treatment orders will have chart audits to ensure all ordered	12/4/23

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F 686	Continued From page 48 following: According to the Admission Record, Resident #13 had diagnoses which included, but were not limited to, NJ EX Order. 264b1 [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident's NJ EX Order. 264b1 [redacted]. Further review of the MDS included the resident had an NJ EX Order. 264b1 [redacted] that was not present on admission. Review of the Care Plan included a focus, revised [redacted], that, "[Resident #13] has [redacted]" with intervention to, "Administer treatment per [redacted] care recommendations," initiated on [redacted]. Further review of the Care Plan included a focus, revised 07/25/23, that Resident #13 had "increased [redacted] needs d/t [due to] NJ EX Order. 264b1 [redacted] 1. Review of an Incident Note, dated [redacted], included, [redacted] noted to resident [redacted] cm NJ EX Order. 264b1 [redacted] cm ... MD [physician] made aware, new orders to apply [redacted] while in bed, and consult [redacted] doctor." Review of the [redacted] Care Consultant [redacted] report, dated [redacted] included, the resident was seen for an initial evaluation of a [redacted]	F 686	interventions are present on the Treatment Administion Record and that there is an Registered Dietitian assessment in place. " All Nursing staff re-educated on facility: 1) NJ EX Order. 264b1 [redacted] Clinical Protocol Policy 2) Nutritional Assessment Policy " DON/Designee will audit 2 resident charts with orders for [redacted] treatment and nutritional supplements for [redacted] weekly X4 weeks and then monthly X2 months to ensure recommendations are being followed as well as facility policies. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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NJ EX Order. 264b1 classified as a NJ EX Order. 264b1 Further review of the NJ EX Order report included the recommendation to use 'NJ EX Order. 264b1 to NJ EX Order. 264b1 while in bed to NJ EX Order. 264b1

Review of the NJ EX Order. 264b1 Treatment Administration Record (TAR) revealed the treatment, "NJ EX Order. 264b1 at all times every shift for prevention," was not started until NJ EX Order. 264b2, four days after the NJ EX Order recommendation.

2. Review of the NJ EX Order report, dated NJ EX Order. 264b1, included the resident was seen for a follow-up evaluation of the NJ EX Order. 264b1 which was reclassified as an NJ EX Order. 264b1 NJ EX Order due to NJ EX Order. 264b1 covering 8 NJ EX O of the NJ EX Order. 264b1 Further review of the NJ EX Order report included the recommendation to discontinue the previous treatment and change the NJ EX Order 2 treatment to improve NJ EX Order. 264 to NJ EX Order t the NJ EX Order. 2 and immediate surrounding skin with NJ EX Order. 264b1 and allow to dry daily."

Review of the NJ EX Order. 264b1 TAR revealed the treatment, NJ EX Order. 264b1 ... Apply to NJ EX Order. 26 topically every day shift for NJ EX Order. 26" was not discontinued until NJ EX Order. 264b1, and the treatment, NJ EX Order the NJ EX Order. 2 and immediate surrounding NJ EX Order with NJ EX Order. 264b1 and a NJ EX Order. 264b1 NJ EX Order. 264b1 every day shift for NJ EX Order. 264b1 was not started until NJ EX Order. 264b1, six days after the NJ EX Order recommendation.

3. Review of the NJ EX Order report, dated NJ EX Order. 264b1, included the resident was seen for a follow-up evaluation of the NJ EX Order. 264b1 NJ EX Order. 264b1 NJ EX Order which was noted with NJ EX Order. 264b1 of the NJ EX Order. 264b1. Further review of the NJ EX Order report included the recommendation to NJ EX Order. 264b1

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NJ EX Order. 264b1."

Review of the NJ EX Order. report, dated NJ EX Order. 264b1 included the resident was seen for a follow-up evaluation of the NJ EX Order. 264b1 r and included, again, the recommendation to "NJ EX Order. 264b1."

Review of the Medical Nutrition Therapy Assessments in the evaluations tab of the resident's electronic medical record (EMR) revealed there was only one assessment completed upon the resident's admission on NJ EX Order. 264b1.

Review of the NJ EX Order. 264b1 progress notes in the resident's EMR did not include any NJ EX Order. 264b1 Notes after NJ EX Order. 264b1 when the NJ EX Order. first made the recommendation to NJ EX Order. 264b1. There were no NJ EX Order. 264b1 Notes in NJ EX Order. 264b1 that indicated the Registered Dietician (RD) addressed the resident's NJ EX Order. 264b1 or the amount of NJ EX Order. 26 needed to NJ EX Order. 264b1. NJ EX Order. 264

Review of a NJ EX Order. 264b1 Note, dated NJ EX Order. 264b1, revealed the resident was seen by the RD due to the resident's hospital stay from NJ EX Order. 264b1 to NJ EX Order. 26 3 for NJ EX Order. 264b1 and NJ EX Order. 26 NJ EX Order. 264b1. The note further indicated that the RD recommended a NJ EX Order. 264b1 supplement to assist with NJ EX Order. 264b1 and that she would continue to monitor the resident's NJ EX Order. 264 for NJ EX Order. 264b1. This was the first NJ EX Order. 264b1 Note that addressed the resident's NJ EX Order. 264b1 and the amount of NJ EX Order. 26 needed to promote NJ EX Order. 264b1 since the NJ EX Order. recommendation over one month prior.

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Review of the NJ EX Order. 264b1 Medication Administration Record (MAR) included a physician's order for "NJ EX Order. 264b1 [a NJ EX Order. 264b1 supplement] NJ EX Order. [milliliters] PO [oral] NJ EX times a day for NJ EX Order. 264b1," with a start date of NJ EX Order. 264b1.

4. Review of the NJ EX Order. report, dated NJ EX Order. 264b1, included the resident was seen for a follow-up evaluation of the NJ EX Order. 264b1 NJ EX Order. which was deteriorating after the resident's hospital stay. Further review of the NJ EX Order. report included the recommendation to "NJ EX Order. 264b1 ," and the use of, "NJ EX Order. 264b1 to NJ EX Order. 264b1 while in bed."

Further review of the NJ EX Order. reports, dated NJ EX Order. 264b1, NJ EX Order. 264b1, and NJ EX Order. 264b1 included the same recommendations made on the NJ EX Order. 264b1 NJ EX Order. report to NJ EX Order. 264b1.

Review of the NJ EX Order. 264b1 MAR and TAR did not include any physician's orders to NJ EX Order. the resident's NJ EX Order. after the NJ EX Order. 264b1 recommendation was made.

Review of the NJ EX Order. 264b1 MAR and TAR revealed a physician's order for, NJ EX Order. 264b1 to assist with NJ EX Order. 264b NJ EX Order. 264b1 pt [patient] NJ EX Order. 264 [every two hours] every shift for NJ EX Order. 264b1," which was not started unti NJ EX Order. 264b1, almost one month after the NJ EX Order. 264b1 made the recommendation. Further review of the MAR and TAR did not include a physician's order for NJ EX Order. 264b1

Review of the NJ EX Order. 264b1 MAR and TAR did not include a physician's order for NJ EX Order. 264b1.

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Review of the [redacted] MAR and TAR revealed a physician's order for, [redacted] in place at all times every shift for [redacted] prevention," which was not started until [redacted] almost three months after the [redacted] first made the recommendation.

5. Review of the [redacted] report, dated [redacted] included the resident was seen for an initial [redacted] encounter for the [redacted] Further review of the [redacted] report included the recommendation to, "apply [redacted] barrier to the [redacted] and surrounding [redacted]."

Review of the [redacted] TAR revealed a physician's order for, "[redacted] ...Apply to [redacted] every day shift for [redacted] care. [redacted] with [redacted] solution. Apply [redacted] to the [redacted] and surrounding [redacted] daily and PRN [as needed]," which was not started until [redacted], [redacted] after the [redacted] recommendation was made.

During an interview with the surveyor on 10/24/23 at 11:21 AM, the Licensed Practical Nurse (LPN) stated that when a resident has a [redacted], they are seen by the [redacted] weekly. The LPN further stated that when treatment recommendations are made, the treatments are initiated as soon as possible.

During an interview with the surveyor on 10/26/23 at 11:11 AM, the Regional Director of Nursing (Regional DON) stated when a resident has a [redacted], the resident is seen by the [redacted] weekly. She further stated that when the [redacted] makes a recommendation, the nurse notifies the physician and implements the intervention that

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same day. When asked about the RD, the Regional DON stated that the RD should be consulted when a resident has a [NJ EX Order: 264b1] in order to evaluate whether the resident needs a [NJ EX Order: 264b1] supplement.

During an interview with the surveyor on 10/26/23 at 11:34 AM, the Interim Director of Nursing (Interim DON) stated when a resident has a [NJ EX Order: 26] the resident is seen by the [NJ EX Order] weekly. She further stated that when the [NJ EX Order] makes a recommendation, the nurse will confirm the recommendation with the physician and enter the physician's order into the EMR. The Interim DON explained that this process should be done as soon as the recommendation is received. When asked about the RD, the Interim DON stated that the RD should be consulted when a resident has a [NJ EX Order: 264b1] and then the RD should document her assessment in the progress notes or under the evaluations tab in the EMR.

During an interview with the surveyor on 10/27/23 at 10:06 AM, the Regional RD, who was assisting the facility while the RD was on vacation, stated that the RD is responsible for reviewing the [NJ EX Order] reports weekly and initiating appropriate interventions. The Regional RD further stated that the RD's assessments were documented in the progress notes or evaluations tab in the EMR. When asked about [NJ EX Order] recommendation to increase dietary [NJ EX Order: 26] intake on [NJ EX Order: 26], the Regional RD reviewed Resident #13's EMR and verified that there was no indication that the RD assessed for the need to NJ EX Order: 264b1 intake in order to promote [NJ EX Order: 264b1] prior to [NJ EX Order: 264b1]. The Regional RD further stated that it is important to assess residents with [NJ EX Order: 264] for adequate [NJ EX Order: 264b1] and [NJ EX Order: 264b1] in order to

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F 686	Continued From page 54 assist with NJ EX Order. 264b1 Review of the facility's NJ EX Order. 264b1 NJ EX Order. 264b1 - Clinical Protocol policy, revised 12/2022, included, "The physician will order pertinent NJ EX Order. 264b1 treatments, including NJ EX Order. 264b1 surfaces, NJ EX Order. 264b1 and NJ EX Order. 264b1 approaches, NJ EX Order. 264b1 , etc.), and application of topical agents." Review of the Nutritional Assessment policy, revised 01/2023, included, "The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at increased risk for impaired nutrition ... Increased need for calories and/or protein - onset or exacerbation of diseases or conditions that result in a hypermetabolic state and an increased demand for calories and protein (e.g ... wounds)." Further review of the policy included, "Sources of information for the resident nutritional assessment may include the following: ... Assessments from other disciplines; ... The resident's current medical record."	F 686		
F 689 SS=L	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		12/4/23

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F 689	Continued From page 55 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe physical environment to prevent the likelihood of serious injury, harm, or death, by NJ EX Order. to: a.) ensure that two (2) janitor closets containing hazardous materials were securely locked and free from the likelihood of resident access, b.) ensure that two (2) treatment supply rooms which contained caustic, hazardous supplies and chemicals were locked and free from the likelihood of residents access, and c.) follow their facility's Storage of Chemicals Policy and Procedure. The 2 of 2 janitor closets and 2 of 2 treatment supply rooms throughout the facility, were observed to be in unsafe conditions and contained items that would be detrimental to the health and safety of the residents. This deficient practice was identified for 3 of 50 residents (Resident #44, #46, and #53), who were NJ EX Order. 264b1 and had the capability to NJ EX Order. 264b1 throughout the facility. The likelihood of a serious adverse outcome could occur through contact, inappropriate handling, or ingestion of the supplies observed in the unlocked janitor and treatment supply closets with confused, ambulatory residents gaining access to dangerous supplies and caustic chemicals which resulted in an Immediate Jeopardy (IJ) situation. The facility's Licensed Nursing Home	F 689	" Resident who are NJ EX Order. 264b1 and NJ EX Order. 264b1 have the potential to be at risk from the deficient practice. " All Janitorial supply closest and treatment supply closet were immediately locked. " Residents #44,46 & 53 were immediately assessed by nursing with no negative findings. " All facility staff immediately re-educated on facility policy of Storage of Chemicals Policy & Procedure as well as Storage of Treatment Policy and the importance of ensuring Janitorial and treatment closets are locked and secure at all times. " LNHA/Designee will observe the janitor closets and treatment storage room for appropriate closure daily x 7 days, then weekly x 4 weeks, then monthly x 2 months. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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Administrator (LNHA), Interim/Director of Nursing (I/DON), and Regional Licensed Nursing Home Administrator (R/LNHA) were made aware of the IJ situation on 10/19/23 at 4:14 PM. On 10/19/23 at 4:45 PM, the facility provided the New Jersey Department of Health (NJDOH) with an acceptable Removal Plan and the immediacy was lifted. The survey team verified the validity of the Removal Plan on site throughout the duration of the survey.

The deficient practice was evidenced by the following:

On 10/19/23 at 10:15 AM, Surveyor #1 observed a door labeled "Janitors" closet on the [redacted] unit that was open/unlocked and ajar. The surveyor did not observe staff in the hall at that time. The surveyor opened the door and observed a large bottle of disinfectant cleaner sitting on a shelf. The surveyor also observed chemical dispensers on the wall containing boxes of chemicals such as floor cleaners and disinfectants that the housekeepers utilize to clean.

On 10/19/23 at 10:20, Surveyor #1 entered an unlocked room on [redacted] Unit labeled "Supplies". Inside the unlocked door was another unsecured/unlocked room containing [redacted] that residents had access to.

On 10/19/23 at 10:36 AM, Surveyor #1 observed a staff member in a room across from the janitors closet on the [redacted] Unit. The staff member identified himself as the Housekeeping Director (HD). The surveyor interviewed the HD at that time

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F 689	Continued From page 57 regarding the unlocked janitors closet. The HD explained to the surveyor that the janitors closet door should be kept locked at all times because residents could enter the closet and ingest the toxic chemicals that were stored in the closet and they could also get the chemicals in their eyes. The HD specified to the surveyor during the interview that the janitors closet door should be locked at all times. On 10/19/23 at 10:41 AM, Surveyor #1 interviewed the staff member that was stationed at medication cart on [redacted] unit. The staff member identified herself and the Registered Nurse/Minimum Data Set Coordinator (RN/MDSC). The RN/MDSC stated that she was, "just helping out on the unit" but did not have any specific task that she was doing. The RN/MDSC explained to the surveyor that there was a Licensed Practical Nurse Manager/ Unit Manager (LPN/UM) however, she was out of the building today. The RN/MDSC stated that some confused residents wandered throughout the unit. She continued to explain that the residents that wandered were easily redirected and had the diagnoses of of dementia. On 10/19/23 at 11:10 AM, Surveyor #2 entered [redacted] hall unit and observed an unlocked janitor closet door. The surveyor observed one resident seated in a wheelchair by the janitor closet door at the time of the observation. The surveyor further observed that staff were present, walking by, but unaware that the door was unlocked and that the surveyor was in the janitor closet. The surveyor opened the door and observed chemicals attached to the wall. The chemicals were identified as NJ EX Order. 264b1 [redacted]. The window	F 689		

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shine cleaner was observed to have a non-child proof twist lid. The disinfectant cleaner and the bathroom cleaners' tops were open with tubes coming out of them.

On 10/19/23 at 11:15 AM, while Surveyor #2 was standing in the janitor closet, inspecting the area, a housekeeping staff member walked by and shut the door on the surveyor, leaving the surveyor in the unlocked closet. The housekeeping staff member did not turn a key at that time to lock the door and was unaware that the surveyor was in the janitor closet. The surveyor exited the closet and requested an interview with the gentleman who identified himself as a housekeeper/floor tech. The Housekeeper (HK) stated that the janitor's closet was used by the housekeeping staff to fill up the chemicals they used to clean the facility. The HK stated that the door was always locked. The surveyor asked if the door was currently locked, and the HK stated that he did not know because he wasn't in there today. At that time, the surveyor asked the HK to inspect the door to see if it was locked. The HK opened the door and stated, "No, but it is now." The surveyor asked the HK how he had locked the door, and the surveyor observed the HK take a key from his pocket and he proceeded to show the surveyor how to appropriately lock the door. The HK stated that it was important for the door to remain locked so no residents could open it and have contact with the chemicals. The HK further stated that some of the residents were somewhat confused and would congregate in the area because they sat at the tables across from the janitor's closet and could watch the television that was there. The HK told the surveyor that at times activities were conducted in the immediate vicinity of the janitor's closet.

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F 689	Continued From page 59 On 10/19/23 at 11:44 AM, the surveyor observed an unlocked treatment supply closet door on the [redacted] Unit across from the resident activities room which contained multiple bottles and items in non child proof containers such as 9 (nine) - 16 ounce (oz.) bottles of [redacted] solution, 5 (five) -8 (eight) oz. bottles of [redacted] solution, 25 count box of [redacted], 3 (three)-16 oz. jars of [redacted] creams, 8 (eight) bottles of [redacted] spray, 2 (two)-500 milliliter (mls) bottles [redacted] solutions, 4 (four)-tubes of 4 oz. [redacted] 3 (three)-3 oz. tubes of [redacted] gel, 6 (six) tubes of 1 (one) oz. [redacted] cream, and 1 box of 144 packets of [redacted] ointment. On 10/19/23 at 11:23 AM, Surveyor #2 interviewed Certified Nursing Aide (CNA) #1 who stated that the importance of the janitor closets being locked was because there were chemicals and substances in there and the facility did not want the residents to go into the closet and have contact with the chemicals and the substances. CNA#1 further stated that there were confused and ambulator residents who resided on the unit. On 10/19/23 at 11:32 AM, Surveyor #2 interviewed the RN/MDSC who stated that inside the janitor closets were mops, bags, and cleaners. The RN/MDSC told the surveyor that the doors to the janitor closets were locked because chemicals were stored in the closets and the doors were required to be locked due to resident safety. The RN/MDSC further stated that there were confused and ambulatory residents who resided on the units throughout the facility. The RN/MDSC stated, "That's why the doors are locked to protect the residents. The only people	F 689		

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who go into the room are the housekeeping staff." The RN/MDSC explained to the surveyor that because she was a nurse, she would not be able to enter the janitor closets without communicating to a housekeeping staff member first because the doors to the janitor's closets would be locked.

On 10/19/23 at 11:36 AM, Surveyor #2 interviewed the Regional/Director of Nursing (R/DON) who stated that there were three hallways in the facility, a skilled nursing unit, and two Long Term Care units. The R/DON was unsure of the number of janitor closets and treatment supply rooms in the building. She told the surveyor that she would imagine mops, pails, supplies, and disinfectants were stored in the janitor closets. The R/DON stated that the doors were locked so residents didn't go in. She stated, "We wouldn't want the residents to be in contact with dirty equipment or cleaning supplies." The surveyor asked why, and the R/DON further stated, "Because it would be a contamination issue for bacterial contamination. Surveyor #2 asked, "Would access to the chemicals be considered harmful?" The R/DON stated, "Yes." She further stated that there were confused and ambulatory residents residing in the facility.

On 10/19/23 at 11:47 AM, Surveyor #2 toured the C unit hallway and did not observe a janitor or treatment supply closet located in the area.

On 10/19/23 at 11:57 AM, Surveyor #1 interviewed Licensed Practical Nurse (LPN)#1 on the A Unit who stated that she had been employed for approximately 6 months. LPN#1 stated that the treatment supply room door on A unit should be secured and locked at all times for the safety of the residents. LPN#1 added that the

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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
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nurses, janitors and maintenance department had keys to the treatment supply room. She stated that it was important to assure the treatment supply room was locked at all times to protect the residents. She stated that there were medications, solutions, creams and gels that needed to be ordered by a physician that should be kept locked up so the resident didn't get into the supplies and hurt themselves.

On 10/19/23 at 12:25 PM, Surveyor #2 interviewed the Housekeeping Director (HD) who stated that the facility stored chemicals such as cleaning supplies, disinfectant, glass cleaner, and toilet bowl cleaner in the janitor closets. The HD told the surveyor that the janitor closets were locked, and the housekeeping department was responsible for locking them. The surveyor asked, "What's the purpose of keeping them locked?" The HD stated that the janitor closets were locked due to safety purposes because there were chemicals, sharp objects stored in them, and a resident could go into the area and drink the chemicals or spray other residents with them. The HD further stated that he tried to make rounds two or three times a day to make sure the doors were locked. The surveyor asked the HD if he checked the closets. The HD stated that he did first thing in the morning and identified that one was unlocked, but at that time he had not checked the second janitor closets. The HD explained that everyone was responsible to check and make sure the doors were locked. The HD further stated that the nurses had keys to the treatment storage rooms and the nursing staff was responsible for making sure those doors were locked. The HD stated that he was, "pretty sure" that there were confused and ambulatory residents in the area.

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F 689	Continued From page 62 On 10/19/23 at 01:43 PM, Surveyor #2 interviewed the I/DON who stated the janitor closets contained cleaning supplies. She further stated that the janitor closets should be kept secured for resident safety to prevent residents from accessing contents within the closets. The I/DON told the surveyor that the nursing treatment supply rooms were locked due to safety reason to prevent residents from accessing the contents within. The I/DON stated that she considered [NJ EX Order. 2] something that could hurt a resident who was not alert and oriented and items such as [NJ EX Order. 2] solution should kept under lock and key as well. The I/DON stated that there were residents who were confused and ambulatory on the unit, but most of the residents were wheelchair bound. On 10/19/23 at 01:48 PM, Surveyor #2 interviewed the facility's LNHA who stated that after the housekeeper went into the closet and removed items, the door should be locked and any items that they take with them should also be kept under supervision. The LNHA further stated the treatment supply rooms should not be unlocked, the items in the rooms were potentially hazardous and that was the purpose of keeping the doors locked. Surveyor #2 reviewed the medical record for Resident #44. Review of the resident's Admission Record (an Admission Summary) reflected the resident had resided at the facility for [NJ EX Order. 264b1] r and had diagnoses which included, but were not limited to, [NJ EX Order. 264b1]	F 689		

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NJ EX Order. 264b1

Review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ EX Order. 264b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ EX Order. 264b1 which indicated the resident had NJ EX Order. 264b [redacted]. A further review of the resident's MDS, Section NJ EX Order. 264b1, indicated that the resident had behaviors of NJ EX Order. 264b1 one to three days during the seven days look back period. Section [redacted]- Functional Status indicated that Resident #44 ambulated independently throughout the corridors of the facility and on the unit.

Review of the resident's Care Plan (CP), dated NJ EX Order. 264b1, reflected a focus area that the resident was at an NJ EX Order. 264b1 risk, as the resident liked to purposely NJ EX Order. 264b1 related to the diagnosis of NJ EX Order. 264b1. The goal of the resident's CP was that the resident's safety would be maintained through the review date. Interventions included to provide structured activities such as toileting, walking inside and outside with NJ EX Order. 264b1 strategies including NJ EX Order. 264b1, and NJ EX Order. 264b1.

On 10/25/23 at 10:12 AM, Surveyor #2 surveyor observed Resident #44 in their room. The resident was observed walking around his/her bed carrying NJ EX Order. 264b1 [redacted] all in their hands at the same time. The resident was well dressed and told the surveyor that he/she was able to take care of

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himself/herself. The resident was very pleasant and friendly and told the surveyor that he/she would love to take NJ EX Order. 264b1 and go shopping together because it would be a lot of fun. The resident was observed wearing a pair of well fitted shoes and was observed ambulating freely around their room.

On 10/20/23 at 12:15 PM, Surveyor #2 interviewed CNA#1 who stated that she was not the resident's current CNA but had cared for the resident in the past. CNA#1 stated that the resident was NJ EX Order. 264b1 with moments of NJ EX Order. 264b1 and utilized a NJ EX Order. 2 to ambulate throughout the facility. CNA#1 told the surveyor that the resident would ask why they were at the facility and say things like, "NJ EX Order. 264b1?" She explained that the resident would ask questions like that about once a week and the staff needed to monitor the resident because he/she was at risk for NJ EX Order. 264b1

On 10/25/23 at 10:18 AM, Surveyor #2 interviewed the resident's CNA#2 who stated that the resident was NJ EX Order. 264b1, with NJ EX Order. 264b1. CNA#2 told the surveyor that the resident was independent when it came to activities of daily living, however needed to be redirected. CNA#2 gave the example that the resident would NJ EX Orde in their NJ EX Order. 264b1 if the staff was not there to guide the resident to care for himself/herself independently. CNA#2 further stated that the resident would clean up their room, like they would if it was their own house. CNA#2 explained to the surveyor that at times the resident would have to be redirected back into their room because the resident would NJ EX Orde NJ EX Order. 264b1 of his/her surroundings at times and

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F 689	Continued From page 65 needed staff assistance. Surveyor #1 reviewed the medical record for Resident #46. According to the Admission Record, Resident #46 was admitted to the facility with the diagnoses that included but was not limited to [redacted] The quarterly MDS dated 09/19/2023, indicated that Resident #46 had scored a [redacted]) on the BIMS which indicated that the resident had NJ EX Order. 264b1. The MDS indicated that the resident independently ambulated and was able to perform self care. The MDS also indicated that the resident used a [redacted] (NJ EX Order. 264b1 [redacted]. Surveyor #1 reviewed Resident #46's CP, dated [redacted], which indicated that the resident was at risk for [redacted] related to (r/t) [redacted]. Interventions on the CP included the following: [redacted] in place on the [redacted] and revised CP indicated the wander-guard was now in place of the [redacted] The CP indicated that the the staff checks the [redacted] for placement and proper functioning. On 10/25/23 at 11:32 AM, Surveyor #1 observed Resident #46 sitting in the dayroom with other residents. The surveyor observed that the resident was wearing a NJ EX Order. 264b1 on the [redacted] The resident appeared [redacted]. The resident appeared clean, well dressed and was participating in activities.	F 689		

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On 10/25/23 at 11:46 AM, Surveyor #1 interviewed LPN#2 who stated that she was familiar with Resident #46 and decribed the resident as being very [redacted] and only [redacted]. LPN#2 stated that the resident had good and bad days, was able to independently able to walk throughout the unit and perform most acitivities of daily living for herself. LPN#2 stated that Resident #46 was not able to leave the building by himself/herself and was not exit seeking but wore a [redacted] to assure that he/she was kept safe.

Surveyor #2 reviewed the medical record for Resident #53.

Review of the resident's Admission Record indicated that the resident had diagnoses which included, but were not limited to, [redacted]

Review of the resident's quarterly MDS dated [redacted] indicated that the resident had a BIMS score of [redacted] which reflected the resident had [redacted]. A further review of the resident's MDS, Section [redacted] - Functional Status indicated that the resident was independently capable of walking throughout the facility with supervision.

Review of the resident's CP revised [redacted], reflected a focus area that the resident was an [redacted] the resident was disoriented to place, had [redacted], and [redacted] aimlessly. The goal of the CP was that the resident would not [redacted] facility [redacted]. Interventions included to

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F 689	Continued From page 67 provide the resident with programs and activities that would minimize the potential for NJ EX Order. 264b1. On 10/20/23 at 12:16 PM, Surveyor #2 observed Resident #53 walking independently throughout the [redacted] unit hallway. The resident was observed taking NJ EX Order. 264b1 and looking around the hallways. On 10/20/23 at 12:37 PM, Surveyor #2 observed Resident #53 NJ EX Order. 264b1 and independently around the main dining room area in the facility and back up and down the hallways of [redacted] unit. The resident was wearing a clothing protector in anticipation for lunch. The resident appeared NJ EX Order. 264b1 of his/her surroundings. At that time, the surveyor observed a staff member walk up to the resident, tell the resident that it was lunch time, and walk the resident down the hallway to his/her room. On 10/20/23 at 12:43 PM, Surveyor #2 made an additional observation of Resident #53 walk up to another resident in the main dining room area. The resident was NJ EX Order. 264b1 The alert and oriented resident who was eating their lunch told the resident his/her lunch was in their room. The surveyor observed a staff member re-direct the resident toward their room again. On 10/20/23 at 12:20 PM, Surveyor #2 interviewed CNA#3 who stated that she was the assigned CNA to the resident that day. CNA#3 further stated that the resident was NJ EX Order. 264b1 and could ambulate independently throughout the facility. Review of the facility NJ EX floor, floor plan (map), indicated that there were two treatment supply	F 689		

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closets and two janitor closets in the facility.

Review of the facility's undated Housekeeper Job Description/Competency/Evaluation indicated, "The primary purpose of the job position is to implement required housekeeping procedures in an efficient, cost effective manner meeting all federal, state, and local requirements while providing a safe environment for our residents." The Housekeepers Job Description/Competency/Evaluation further indicated, "Is involved with residents, personnel, visitors, government agencies/personnel, etc.., under all conditions and circumstances."

Review of the undated Director of Housekeeping (Housekeeping Director) Job Description indicated, "The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a clean, safe, comfortable manner. The Director of Housekeeping's Job Description further revealed Administrative Functions included, "Assume the administrative authority, responsibility, and accountability of directing the Housekeeping Department.

Review of the facility's Storage of Chemicals Policy and Procedure revised 01/2023 indicated, "All hazardous/toxic substances used in our facility will be stored in a secure location."

Review of the Storage of Treatment Policy and Procedure revised 12/2022, indicated, "The facility shall store treatment supplies in a safe,

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F 689	Continued From page 69 secure, and orderly manner .... The nursing staff shall be responsible for maintaining treatment supply storage and preparation areas in a clean, safe, and sanitary manner ... and Storage areas (including, but not limited to, drawers cabinets, rooms, refrigerators, carts and boxes) containing treatment supplies shall be locked when not in use, and trays and carts used to transport such items should not be left unattended if open or otherwise potentially available to others ..." NJAC 8:39-27.1(a)	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents reviewed a resident's [redacted]) and	F 711	" All residents are at risk to be affected by deficient practice. " The attending physician reviewed the [redacted] for Resident #6 on [redacted] and the [redacted] order was	12/4/23

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F 711	Continued From page 70 prescribed the correct medication to treat an NJ EX Order. 264b1 for 1 of 13 residents reviewed (Resident #6) and was evidenced by the following: According to the Admission Record, Resident #6 was admitted to the facility with the diagnoses which included, but were not limited to, NJ EX Order. 264b1. The annual Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated NJ EX Order. 264b1 indicated that Resident #6 was NJ EX Order. 264b1 and NJ EX Order. 264b1 assistance with activities of daily living. The MDS also indicated that Resident #6 had a history of NJ EX Order. 264b1), required assistance with toileting and was occasionally NJ EX Order. 264b1. On 10/19/23 at 10:10 AM during tour, the resident was observed sitting in the chair in NJ EX room getting equipment out of a bag to brush his/her hair. The resident was interviewed at that time and did not have any complaints. According to the laboratory results for a urinalysis and NJ EX Order. 264b1, dated NJ EX Order. 264b1, Resident #6 had a NJ EX Order. 264b1). The laboratory report also indicated that the resident was to be on NJ EX Order. 26 isolation. According to the NJ EX Order. 264b1 reported on the laboratory results, the organism NJ EX Order. was resistant to the NJ EX Order. 264b1 NJ EX Order. 264b1	F 711	changed accordingly. " All residents that are currently on NJ EX Order. 264b1 due to NJ EX Or will have a chart review to ensure a NJ EX Order. 264b1 were ordered and reviewed by attending physician. " All Nursing staff re-educated on facility policy for NJ EX Order. 264b1 Policy & Procedure & Surveillance for Infections. " DON/Designee will audit up to 2 resident charts new orders for Antibiotics weekly X4 weeks and then monthly X2 months to ensure compliance with facility policy. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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F 711	Continued From page 71 The Order Summary Sheet (OSS) reflected a physician's order (PO) dated [redacted] for [redacted] ablet by mouth one time a day for [redacted]. The surveyor reviewed Resident #6's medical records and the Medication Administration Record (MAR) indicated that Resident #6 was started on the [redacted] medication [redacted], for the [redacted] even though the organism was resistant to the medication. On 10/20/23 at 10:09 AM, the surveyor conducted an interview with the primary nurse for the [redacted] Unit. The nurse identified herself as a Licensed Practical Nurse (LPN) and stated that if the facility received a critical lab result such as [redacted] of the [redacted], the nurse would be responsible to notify the physician. She stated that the physicians have remote access to the electronic medical record (EMR) so they are able to review the [redacted] and [redacted]. She stated that if the physician's ordered a medication that the [redacted] was resistant to, then the nurse should question the physician to find what his/her rationale was for choosing that medication. The LPN reviewed Resident #6's [redacted] with the surveyor and confirmed that the organism [redacted] was resistant to the [redacted] that the physician ordered on [redacted] for [redacted]). On 10/20/23 at 10:24 AM, the surveyor interviewed the Licensed Practical Nurse Infection Preventionist (LPN/IP) who stated that	F 711		

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he had been employed in the position since NJ EX Order. 264b1. He explained that if a nurse discovered or suspected that a resident had an NJ EX Order. 264b1 (does not matter what kind) the nurse was to report it to the Unit Manager and the IP. He stated that after he was notified that the resident had an NJ EX Order. 264b1, he would investigate to see what NJ EX Order. 264b1 was and then add it to the NJ EX Order. 264b1 log. He would then utilize a guideline to see if the NJ EX Order. 264b1 was appropriate to use and to assure that the NJ EX Order. 264b1 was sensitive to the organism. The LPN/IP stated that he was not notified by the nurses that Resident # 6 was on NJ EX Order. 264b1. The LPN/IP confirmed that Resident #6 should have been put on the correct NJ EX Order. 264b1 that the NJ EX Order. 264b1 was NJ EX Order. 264b1 to.

On 10/20/23 at 11:00 AM, the surveyor interviewed the acting Director of Nursing (DON). The DON stated that there was no Unit Manager for the [redacted] Unit at this time. She stated that during the interim period other DONs from other facilities were covering the unit. She stated that if the nurse received a NJ EX Order. 264b1 that indicated that the resident had a NJ EX Order. 264b1 the nurse would call the physician to find out what he would recommend for treatment. If there were NJ EX Order. 264b1, the nurse would relay that to the physician. If the physician ordered an NJ EX Order. 264b1 that the NJ EX Order. 264b1 was NJ EX Order. 264b1 too, the nurse should then question the physician to see if he could order a medication that the NJ EX Order. 264b1 was NJ EX Order. 264b1 to. The DON stated that if the resident had NJ EX Order. 264b1, the information should be shared with the physician so that he could make the appropriate treatment decisions. The DON confirmed that Resident #6 should have been put on the appropriate NJ EX Order. 264b1 when they discovered that the resident had NJ EX Order. 264b1 of the

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The surveyor reviewed the Physician's Progress Note dated [redacted] at 19:42 (07:42 PM) for a follow up on laboratory result which indicated the following documentation: "Pt was seen in wheelchair today for follow-up lab results. Lab results [redacted] was + [redacted] and was started on [redacted] days. Patient doing well with [redacted] therapy. Nursing reports [redacted] in [redacted]. Patient denies [redacted].

On 10/20/23 at 01:44 PM, the surveyor telephone interviewed the Medical Director (MD) who stated that approximately [redacted], the physician assistant (PA) ordered the [redacted] for Resident #6. He explained that the Nurse Practitioner (NP) ordered the [redacted] and that it was not communicated to the NP what the [redacted] were. The MD stated that the "new" NP came to the facility and saw Resident #6 on [redacted] and documented that the resident was tolerating the [redacted] well. He confirmed that the NP should have reviewed [redacted] and ordered the appropriate [redacted] for the resident.

On 10/26/23 11:08 AM, the surveyor interviewed the Medical Director who stated that when a laboratory result comes from the lab, there was a section on the EMAR that it can be documented when a lab is reviewed. However, there were "clitches" in the EMR and if you "hit" the wrong button it would not document that the lab result was reviewed even though it was.

On 10/26/23 at 11:21 AM, the surveyor interviewed the LPN/IP who stated that if the

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resident had a NJ EX Order. 264b1 the nurse should immediately call the physician to determine what type of NJ EX Order. 264b1 treatment was to be initiated. He further stated that NJ EX Order. 264b1 treatment was based off a NJ EX Order. 264b1 which identified the type of NJ EX Order. 264b1 treatment appropriate to treat the NJ EX Order. 264b1. He stated that the lab results would have to be reviewed with the Nurse Practitioner or MD to prescribe the appropriate treatment. The surveyor asked the LPN/IP, "What if the doctor gave a PO for an NJ EX Order. 264b1 that was NJ EX Order. 264b1 to the NJ EX Order. 264b1?" and the IP stated that nurse should appropriately communicate what NJ EX Order. 264b1 treatment that was susceptible to fight the NJ EX Order. 264b1 based of the laboratory results. He added that if the physician gave an order for an inappropriate NJ EX Order. 264b1 treatment, the nurse who was reviewing the orders with the physician should intervene and educate the physician. The surveyor asked the LPN/IP, "How long after the resident is placed on an NJ EX Order. 264b1 should the physician follow up with the care of the resident?" and the LPN/IP stated that within 48 hours, it would be appropriate for the physician to check on the resident and their course of NJ EX Order. 264b1 treatment. When asked if the physician reviewed labs, the LPN/IP stated that the NP comes into the facility a couple times a week to review labs. The LPN/IP stated that the physician that reviewed the lab for the resident should have adequately reviewed the lab while at the facility and prescribed the appropriate NJ EX Order. 264b1 treatment for the resident. The LPN/IP further stated that it would be important for the resident to be treated with the correct medication, so they would not become further ill.

The surveyor reviewed the "Duties of the Medical

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F 711	Continued From page 75 Director" with a revised date of 06/2012 which indicated that the MD was to collaborate with the facilities leadership, staff and other practitioners and consultants to help develop, implement, and evaluate resident care policies and procedures that reflect current standards of practice and are consistent with state and federal law and regulation and assist in the implementation and monitoring of such policies. It also indicated that the MD was to interact with the physician's attending residents to review standard of care provided and intervene as necessary when problems with fare or standards of care are identified. A review of the facility's NJ EX Order. 264b1 Policy and Procedure revised 12/2022 indicated, "When a NJ EX Order. 264b1) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotics therapy should be started, continued, modified, or discontinued." The facility policy titled, "Surveillance for Infections" with a revised date of 01/2023 indicated that if there is a suspected infection the attending physician will determine if laboratory test are indicated and the treatment plan for the resident.	F 711		
F 812 SS=F	NJAC 8:39-27.1 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		12/4/23

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F 812	Continued From page 76 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation it was determined that the facility failed to: a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination, and c.) maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 10/19/23 at 09:59 AM, in the presence of the cook, two surveyors toured the kitchen and observed the following: 1. In a metal knife station on a food prep area, there was one white handled knife with a serrated blade with greasy marks on the blade and green debris on the handle. There was one red handled	F 812	" All residents are at risk to be affected by deficient practice. " The following immediate actions were taken in the kitchen: 1) Unclean knives removed from clean knife area and sanitized. 2) Large free standing soup pot debris cleaned. 3) Greasy debris on top of convection oven cleaned. 4) NJ EX Order 26401 base , container and blades sanitized and cleaned. 5) Coffee filters that were exposed were removed and placed in a closed bin. 6) Debris on Slicer removed and sanitized. 7) Cutting boards with scratches and smudges discarded. 8) Ice machine in kitchen sanitized and cleaned. 9) Pan on metal rack with debris removed and sanitized.	

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F 812	Continued From page 77 knife with a serrated blade with liquid on the blade. The cook acknowledged that the knives were not clean and that they should have been washed with soap and hot water and sanitized. The cook stated it was important to keep the knives clean to prevent cross contamination. 2. There was a large free standing soup pot with debris on the pouring rim and white and brown debris in the pot. The cook acknowledged the debris and stated the pot was not clean and that she would not have used it. 3. On the top convection oven, there was greasy debris on the inside doors and black and red debris on the oven floor. The cook acknowledged the debris and stated that it was from cooking and that it got cleaned weekly. The cook stated it was important to make sure the oven was clean to prevent contamination. 4. On a cook prep area, there was a Robot coupe base with the container next to the base and the blade resting inside of the container. There was clear liquid inside of the container and green debris on the outside of the container. There was tan debris on the metal rotator rod on the base. The cook stated that the container and blade were clean and that they were just washed. The surveyor inquired as to whether the liquid should have been in the container and the cook stated no, that it should have been dry and that it was important to make sure everything was clean and dry to prevent cross contamination. At 10:39 AM, the Food Services Director (FSD) arrived and joined the tour with the surveyors. 5. On the coffee station there was a stack of	F 812	10) Dietary Aide with hair sticking out of hair net was immediately inserviced and placed all his hair in the hair net. Larger hair nets immediately ordered. 11) All thawed-out meat , poultry and fish items that were delivered prior to 10/16 were discarded. Items delivered after were used immediately. Additional portable temporary freezers purchased for incoming order. Freezer technician arrived at the facility on 10/20 and repaired the freezer. " Food Service Director and all dietary staff re-inserviced on the facility policy for : 1) Food Storage Policy 2) Food Preparation and Services 3) Food Saftey □ General Personal Hygiene-Hairnets ,Beard Guards,& Head Covers . 4) Sanitation Standard Operating Procedure for Riverview Estates 5) Food Saftey-Food Storage-Use by & Expired Foods 6) Ice Machines and Ice Storage Chests 7) Ice Machine Cleaning/Sanitizing Procedure " LNHA/Designee will conduct a full kitchen audit with updated kitchen audit tool weekly X4 weeks and then monthly X2 months to ensure compliance with facility policies and that all equipment is working properly. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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exposed coffee filters resting on a bag of coffee filters. The FSD acknowledged the exposed coffee filters and stated that they were not stored correctly. She stated that it was important to store the coffee filters correctly to prevent contamination.

6. On a wheeled prep area there was a slicer covered with a clear plastic bag which the FSD stated meant that the slicer was clean. The FSD removed the bag and there was brown debris on the slicer and white debris on the base and the side of the slicer. The FSD acknowledged the debris and stated it should not have been there and that the slicer should have been clean and free from any type of food particles.

7. On a rack under the prep area were several cutting boards. There was one red cutting board with black smudges and scratches, one yellow cutting board with dark scratches, and one red cutting board with black smudges. The FSD acknowledged the smudges and scratches and stated that they should not have been there and that they should have been clean and free of any smudges or cracks. The FSD stated it was important to keep the cutting boards clean to prevent bacteria from forming.

During the tour at that time, the surveyor informed the FSD of the observations made prior to her arrival. The FSD stated it was important to make sure equipment was clean and dry for proper sanitization and to prevent food contamination.

8. In the ice machine, the surveyor wiped the inside cover with a white napkin and observed pink debris. The FSD stated the debris should not have been there and that it was important to keep

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the ice machine clean to prevent contamination.

9. On the metal clean pot storage rack, there was a six-inch third pan with green debris in the pan. The FSD stated it was food particles and that it should not have been there. The FSD returned the pan to the dishwashing area.

10. On the clean side of the dishwashing area, there was a dietary aide (DA) who stated he was sorting clean silverware. The DA was wearing a hairnet with the left side and the right side of his shoulder length hair exposed. The DA acknowledged he was not wearing the hairnet correctly and stated that it was not sanitary to wear the hairnet incorrectly and that hair could have gotten in the food.

During an interview with the surveyor at that time, the FSD acknowledged that the DA was not wearing the hairnet correctly and stated that hairnets should have been worn in the kitchen, at all times, and that the entire head should have been covered.

At 11:11 AM, the FSD escorted the surveyors to the basement refrigerator. In the walk-in refrigerator was a freezer. The freezer temperature gauge, mounted on the wall next to the outer door, read 28 degrees. The surveyors entered the freezer with the FSD and observed ice buildup on the left side of the fan unit with large pieces of ice resting on the rack below the unit. The FSD stated, "We are waiting on a part."

11. On a metal rack on the right side of the freezer there was: one box of jumbo franks containing two eight count packages of hot dogs marked use by 10/31/23 that were not frozen, soft

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to touch; one 10-pound ham in a box dated 10/16/23 that was not frozen, soft to touch; one 2.5 pound package of imitation crabmeat marked best by 5/20/25 that was not frozen, soft to touch; one open box containing three sealed clear bags and two tied plastic bags containing mozzarella cheese sticks, dated 4/28/22, that was not frozen, soft to touch; one box of chicken tender fritters, dated received on 10/9/23, that were not frozen, soft to touch; one box of breakfast turkey sausage links, dated 10/16/23, that were not frozen, soft to touch.

During an interview at that time, the FSD acknowledged that the food items were not frozen and stated that anything in the freezer should have been frozen solid. The FSD stated that she had noticed on 10/14/23, in the freezer, that some of the food items were "starting to thaw" and that the freezer temperature was going to 19 degrees. The FSD stated that she had called the Maintenance Director (MD) and that he looked at the freezer on 10/15/23 and chipped off the ice from the fan unit and the FSD was instructed to "give it time until the temp comes up." The FSD then corrected herself and stated that on 10/13/23 that the MD came and chipped off the ice from the fan unit and that on 10/14/23 she contacted the MD again when she noticed the temperatures were not in the negative anymore and that some food was thawing. The FSD stated that the MD reached out to his Regional MD and that she discussed the freezer with the MD again on 10/16/23 and 10/17/23 and was told that a part was being ordered for the compressor.

At 11:49 AM, the surveyors met with the FSD in the kitchen at the steam table. The FSD stated that the process for food prep was that the staff

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pulled the meat from the freezer the night before, labeled it, stored it in the refrigerator, prepped the meat the day of service, and then two hours prior to the meal the staff started cooking.

At 12:06 PM, along with the FSD, the surveyor continued the tour of the basement freezer and observed to following:

On a metal rack on the right side of the freezer there was: one box labeled deli turkey with two sealed packages of turkey with received sticked dated 10/16/23, that was not frozen, soft to touch; one box of breakfast turkey sausage links with received sticker dated 10/9/23, that was not frozen, soft to touch; one box fully cooked pork sausage patty with received sticker dated 10/2/23, that was not frozen, soft to touch; one box chicken tenderloin fritters with received sticker dated 10/16/23, that were not frozen, soft to touch.

During an interview with the surveyor at that time, the FSD acknowledged that the food items were not frozen and stated that if the food was in the freezer, that it should have been frozen. The FSD stated that if she had found thawed food in the freezer, that most of it was to be thrown away, but that the food items that came in on 10/16/23 were able to be used.

At 12:13 PM, the Regional Licensed Nursing Home Administrator (RLNHA) joined the surveyor and FSD in the basement refrigerator and observed the soft chicken fritters, then left the refrigerator.

On the same metal rack on the right side of the freezer there was: one box single sliced bacon

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with a received sticker dated 9/18/23, that was not frozen, soft to touch; one box single sliced bacon with a received sticker dated 9/25/23 that was not frozen, soft to touch; one box of crispy chicken breast filet with a received sticker dated 10/16/23, that was soft to touch with a hard center; one box of chicken breast filets with a received sticker dated 10/2/23 that was soft to touch with a hard center; one box of golden crispy portioned chicken breast filets with a received sticker dated 10/16/23 that were soft to touch with a hard center; one box of tilapia fillets with received sticker dated 8/28/23 that were soft to touch with a hard center; one box hamburger patties with received sticker dated 10/9/23, that were soft to touch with a hard center.

During an interview at that time, the FSD acknowledged the soft food items and stated that they were "thawed out," "starting to thaw," or "not fully frozen."

At 12:30 PM, the Licensed Nursing Home Administrator (LNHA) met with the surveyor and the FSD in the basement refrigerator. The LNHA asked the FSD when maintenance was notified of a problem with the freezer and the FSD stated on 10/13/23. The LNHA then left the area.

On the same metal rack on the right side of the freezer there was: one box dated 9/19/23 which contained one 10 pound log of ground beef marked best before or freeze by 10/12/23, that was soft to touch; one box deli turkey with a received sticker dated 10/9/23 that contained two turkey breasts that were soft to touch; one box dated 8/31/23 which contained four 10 pound logs of ground beef that were soft to touch with a hard center; one box of French toast with a

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received sticker dated 10/9/23 that was soft to touch; one box of charbroil pattie for Salisbury with a received sticker dated 10/16/23 that was soft to touch with a hard center.

During an interview with the surveyor at that time, the FSD acknowledged that the soft ground meat should not be used.

At 01:52 PM, two surveyors met with the Maintenance Director (MD) and observed him check the basement freezer temperature with an infrared thermometer which read 18.9 degrees. The thermometer mounted on the outside wall of the freezer read 26 degrees. The MD stated that the freezer was, "a little warm," and acknowledged that the temperature should have been 0 degrees. The MD stated that the maintenance department checked the refrigerator and freezer temperatures daily and if they were too busy then they would only get checked twice a week. The MD stated the last temperature check for the freezer was 09:00 AM this morning and that it was 26 degrees. The MD stated that he was first notified by the FSD that there was an issue with the freezer temperature on 10/17/23, that he came and checked it, and the temp was 30 degrees using the infrared thermometer and the mounted wall temperature reading was 2 degrees off. The MD stated that the facility used an electronic notification system to alert the maintenance department to any concerns and that he would have been notified via his cell phone right away with any work orders. The MD stated that he was verbally notified by the FSD on 10/17/23 and he assessed the freezer at that time. The MD stated he deiced the fans using his hands to remove the ice from the fan unit as well as a heat gun to melt the ice. He then stated that

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the temperature then started dropping on 10/17/23. The MD stated that he checked the freezer temperature again on 10/18/23 and the temperature read 24 degrees and that he then emailed the Chief of Operations (COO) for the technician to come out to assess the freezer. The MD stated that as of now that the technician has still not arrived but was due to visit today and that he verbally communicated with the COO about the freezer again today.

At 03:59 PM, the surveyors met in the conference room with the LNHA, the RLNHA and the Interim Director of Nursing and they were told of the kitchen concerns. The RLNHA stated, "I personally removed all those items from the freezer."

On 10/26/23 at 10:15 AM, the surveyor interviewed the FSD who stated that on 10/20/23 the contractor fixed the basement freezer and that the remaining frozen food items had been placed into two newly purchased box freezers. The basement freezer was kept empty until the proper temperature of negative 8 degrees was met on 10/21/23. She stated that the emergency order of meat came in on 10/21/23 and was immediately placed into the freezer. The FSD then stated that on 10/22/23 that the freezer was functioning properly and that they were in the process of placing the remaining food items from the box freezers back into the basement freezer.

At 10:20 AM, the surveyor interviewed the FSD who stated that she told the MD via his cell phone about her concern with the freezer temperature on 10/14/23 and that he came and removed ice from the fan unit. The FSD then stated that during the morning meeting on 10/16/23, that she let all

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the department heads know of her concerns over the weekend with the freezer temperature being 12 degrees and not a negative temperature. The FSD stated that on 10/17/23 that she spoke with the MD again about the temperature going up again and that he stated that, "he reached out to the regional to have the part ordered."

At 12:32 PM, the surveyor interviewed the MD who stated he was first notified about the basement freezer temperatures on 10/17/23 and that he deiced the condenser coil on the back of the fan unit at that time. He stated that when he checked it again on 10/18/23 that the temperature was rising again so he sent the email for the contractor to come out. The MD stated he did not work in the facility on the weekend of 10/14/23-10/15/23. The MD acknowledged that the technician did visit the facility on 10/20/23 and repaired the freezer at that time. The MD stated he had checked the temperature of the freezer daily since the repair and has had no issue.

On 10/26/23 at 01:13 PM, the surveyors met with the administration team to discuss the kitchen concerns again.

At 01:25 PM, the surveyor interviewed the LNHA who stated he was unsure when he was notified about the basement freezer issue and that he would look at his timeline. The LNHA acknowledged that the freezer temperature should not have been 28 degrees and that the freezer temperatures should have been maintained at a level to keep the frozen foods solid. The LNHA further stated that it was important to make sure the freezer kept food frozen to preserve the food over an extended amount of time.

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A review of the facility's "Food Prep Policy," revised 1/2023, revealed Policy: It the policy of the facility that meats, poultry and fish will be prepared and cooked in a manner that will ensure sanitary preparation.

A review of the facility's "Food Storage Policy," revised 1/2023, revealed Policy Statement: Food storage areas shall be maintained in a clean, safe, and sanitary manner. Policy Interpretation and Implementation: 4. Food shall be rotated as delivered and used in a "First In, First Out" method. Items will be dated on receipt to facilitate this procedure. 9. Frozen foods will be stored at 0 degrees F (Fahrenheit) or below at all times.

A review of the facility policy, "Food Preparation and Service," revised 5/2023, revealed Policy Statement: Food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Thawing Frozen food 1. E. 5 days labels must be used to defrost meats, 2 days to defrost, and 3 days to use. Must be discard after 5 days. 7. Dietary staff shall wear hair restraints (hair net, hat, beard restraints, etc.) so that hair does not contact food.

A review of the undated facility policy, "Food Safety-General Personal Hygiene-Hairnets, Beard Guards, & Head Covers," revealed, Policy Statement: Food service employees will follow department guidelines and proper procedures for hairnets, beard guards, and head covers to prevent any physical contamination of food or beverage within the department. Policy Interpretation and Implementation: 3. Hairnets must cover and contain all body of hair.

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A review of the undated facility documentation, "Sanitation Standard Operating Procedure for Riverview Estates," revealed, I.A. General equipment cleaning. All equipment, used for mixing, will be cleaned and sanitized after production. 1. Established cleaning procedures include: Food debris is removed from equipment ... Equipment parts are brushed where required and then rinsed with water to remove remaining food debris. Equipment/parts are inspected for cleanliness, and re-cleaned if necessary. II. C. Food processing operations. Food processing is performed under sanitary conditions to prevent direct and cross-contamination of ingredients. 8. Established personal hygiene procedures for employees processing products includes: All employees handling food ingredients will wear hairnets ...All employees will clean and sanitize hands, knives, scoops, etc., as necessary during processing to prevent contamination of finished products.

A review of the undated facility policy, "Food Safety-Food Storage-Use By & Expired Foods, revealed, Policy Interpretation and Implementation. 1. All food service workers will follow safe food handling practices and guidelines as it is stated for labeling and dating perishable items. 6. All expired items inside or out of original manufactures [sic] packaging will be discarded and will not be used further.

A review of the facility policy, "Ice Machines and Ice Storage Chests," revised 1/2012, revealed, Policy Statement: Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. Policy Interpretation and Implementation: 2. To help prevent contamination of ice machines,

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ice storage chests/containers or ice, staff shall follow these precautions: f. clean and sanitize the tray and ice scoop daily.

A review of the facility's undated ice machine Cleaning/Sanitizing Procedure documentation provided by the MD revealed, Preventive maintenance cleaning procedure: Step 8: while components are soaking, use ½ of the cleaner/water solution to clean all food zone surfaces of the ice machine and bin (or dispenser). Use a nylon brush or cloth to thoroughly clean the following ice machine areas: side walls, base (area above water trough), evaporator plastic parts-including top, bottom, and sides, bin or dispenser. Rinse all areas thoroughly with clean water ...Step 11: use ½ of the sanitizer/water solution to sanitize all food zone surfaces of the ice machine and bin ...pay particular attention to the following areas: side walls, base (area above water trough), evaporator plastic parts-including top, bottom, and sides, bin or dispenser. Do not rinse the sanitized areas.

A review of the facility documentation, "In-Service Training Report," dated 7/6/23, revealed a signature from the DA that confirmed his attendance at an in-service for Hairnet and Beard Restraints.

On 10/19/23 at 12:45 PM, the FSD provided the surveyor with the basement Refrigerator and Freezer temperature (temp) log for October 2023. The Freezer log temperatures were documented as follows on:
10/13/23 AM temp minus 16 degrees, PM temp minus 16 degrees;
10/14/23 AM temp minus 16 degrees, PM temp minus 16 degrees;

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10/15/23 AM temp minus 16 degrees, PM temp minus 16 degrees;
10/16/23 AM temp minus 16 degrees, PM temp minus 16 degrees;
10/17/23 AM temp minus 18 degrees, PM temp minus 16 degrees;
10/18/23 AM temp minus 16 degrees, PM temp minus 16 degrees;
10/19/23 AM temp minus 16 degrees.

On 10/19/23 at 02:12 PM, the MD provided the surveyor with email communication that was sent on 10/18/23 at 12:50 PM to the Director of Operations and the LNHA. The email discussed the temperature issues with the walk-in freezer and requested a contractor to assess the issue.

On 10/20/23 at 01:45 PM, the LNHA provided the surveyor with a copy of the service ticket for the service performed on the walk-in freezer and was documented that the freezer was "working ok."

On 10/26/23 at 10:35 AM, the FSD provided the surveyor with the basement Refrigerator and Freezer temperature log for October 2023. The Freezer log temperatures were documented as follows on:
10/21/23 AM temp minus 10 degrees, PM temp minus 9 degrees;
10/22/23 AM temp minus 11 degrees, PM temp minus 10 degrees;
10/23/23 AM temp minus 10 degrees, PM temp minus 12 degrees;
10/24/23 AM temp minus 11 degrees, PM temp minus 11 degrees;
10/25/23 AM temp minus 10 degrees, PM temp minus 11 degrees;
10/26/23 AM temp minus 5 degrees.

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F 812	Continued From page 90 NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		12/4/23

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F 880	Continued From page 91 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint NJ#: 168234 Based on observation, interview, review of medical records and review of pertinent facility documentation, it was determined that the facility staff failed to a.) provide a safe environment to prevent the potential spread of infection by not implementing transmission-based precautions	F 880	" All residents are at risk to be affected by deficient practice. " Transmission-based precautions were initiated for Resident #6 on [redacted]. " LPN that received the test results for Resident #6 was identified and immediately in-serviced on facility□s policy on NJ EX Order. 264b1	

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F 880	Continued From page 92 NJ EX Order. 264b1 used for persons suspected of having infections, diseases, or germs that are spread by touching the patient or items in the room, for a resident that had a NJ EX Order. 264b1 (Resident #6) 1 of 1 resident reviewed for TBP and b.) perform hand hygiene while assisting residents in the dining room for 1 of 1 dining rooms. This deficient practice was evidenced by the following: 1.) On 10/19/23 at 10:10 AM during tour, Resident #6 was observed sitting in the chair in NJ EX room getting equipment out of a bag to brush his/her hair. The resident was interviewed at that time and did not have any complaints. The surveyor did not observe any signage or notifications on the resident's door or in the resident's room that the resident was on transmission-based precautions. According to the Admission Record, Resident #6 was admitted to the facility with the diagnoses which included, but was not limited to, NJ EX Order. 264b1. The annual Minimum Data Set (MDS) an assessment tool that facilitated a resident's care, dated NJ EX Order. 264b1 indicated that Resident #6 was NJ EX Order. 264b1 and required NJ EX Order. 264b1 assistance with activities of daily living. The MDS also indicated that Resident #6 had a history of NJ EX Order. 264b1, required assistance with toileting, and was occasionally NJ EX Order. 264b1. According to the laboratory results for a urinalysis and NJ EX Order. 264b1 dated NJ EX Order. 264b1 Resident #6 had a NJ EX Order. 264b1	F 880	and Categories of Transmission-Based Precautions and importance of placing appropriate residents on proper precautions. " The infection preventionist was educated on NJ EX Order. 264b1 regarding the need to initiate transmission-based precautions for a resident with NJ EX Order. 264b1. " CNA assigned to dining hall on NJ EX Order. unit was identified and re-educated on facility policy for Handwashing/Hand Hygiene and importance of washing their hands when touching clean resident trays. " All nursing staff re-educated on facility policy for: A) NJ EX Order. 264b1 B) Categories of Transmission-Based Precautions C) "Handwashing/Hand Hygiene. " DON/Designee will review the chart of 1 resident with lab results that require isolation weekly X4 weeks and then monthly X2 months to ensure compliance with facility NJ EX Order. 264b1 and Categories of Transmission-Based Precautions policy. " DON/Designee will observe one meal pass weekly X4 weeks and then monthly X2 months to ensure compliance with facility Handwashing/Hand Hygiene" policy. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed	

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NJ EX Order. 264b1).

The laboratory report also indicated that the resident was to be on NJ EX Order. 264b1 isolation.

The Order Summary Sheet (OSS) reflected a physician's order (PO) dated NJ EX Order. 264b1 for NJ EX Order. 264b1 tablet by mouth NJ EX Order. 264b1 time a day for NJ EX Order. 264b1.

Review of the Medication Administration Record (MAR) indicated that Resident #6 was started on the NJ EX Order. 264b1 medication NJ EX Order. 264b1 for the NJ EX Order. 264b1 infection called NJ EX Order. 264b1

There was no documentation on the OSS that reflected a PO for the implementation of NJ EX Order. 264b1 precautions for NJ EX Order. 264b1

On 10/19/23 at 02:47 PM, the surveyor observed Resident #6's room and there was no signage posted on the door that indicated the resident was on TBP for NJ EX Order. 264b1

The surveyor reviewed the residents Care Plan (CP) and there was no documentation on the CP that the resident had NJ EX Order. 264b1 or that the resident was on NJ EX Order. 264b1.

On 10/20/23 at 09:40 AM, the surveyor observed Resident #6's room and there were no signage posted on the door that indicated the resident was on NJ EX Order. 264b1. The surveyor observed a Certified Nursing Assistant (CNA) coming out of the resident's room after providing resident care

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and was removing used cups and plates from the resident's bedside without gloves or a gown.

On 10/20/23 09:59 AM, the surveyor interviewed the primary care Certified Nursing Assistant (CNA) who stated that she had been employed in the facility through the agency and had been working on and off for the facility for approximately [redacted]. She stated that the resident required [redacted] assistance with care and that it depended on how his/her [redacted] was and if the resident was NJ EX Order. 264b1. The CNA stated that the resident's [redacted] affected how much she/he could perform. She stated that the resident had labile NJ EX Order. 264b1 [redacted]) and had NJ EX Order. 264b1 [redacted] to his/her NJ EX Order. 264b1. The CNA explained that the resident was currently being treated with NJ EX Order. 264b1. She stated that she was informed by the nursing staff that the resident had [redacted] but not informed as to what the [redacted] was. She continued to add that she usually wore gloves when she provided care, however that no personal protective equipment (PPE) was required to care for Resident #6. She stated that the Infection Preventionist (IP) usually placed signs on the resident's door and isolation bins outside a resident's room with personal protective equipment (PPE) such gloves mask, goggles and gowns that indicated if a resident had a [redacted] infection. She stated that Resident # 6 utilized the toilet in the morning to have a [redacted] and that family visited frequently.

On 10/20/23 at 10:09 AM, the surveyor conducted an interview with the primary nurse for the [redacted] Unit. The nurse identified herself as a Licensed Practical Nurse (LPN) and stated that she had

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been employed in the facility since NJ EX Order. 264b1. The LPN stated that Resident #6 required total care with aspects related to activities of daily living. She stated that Resident #6 was NJ EX Order to NJ EX Order. 264b1, but had periods of NJ EX Order and NJ EX Order. 264b1. She stated that during the day, Resident #6 had infrequent behaviors during the day. The LPN stated that Resident #6 was being treated with NJ EX Order. 264b1. She continued to explain that the resident's Care Plan should be updated to reflect that the resident had NJ EX Order. 264b1 and that the resident was on TBP. She stated that Resident #6 was on NJ EX Order 26 precautions for NJ EX Order L. She continued to explain that a resident with the diagnoses of NJ EX Order of the NJ EX Order was usually on NJ EX Order 2 t precautions and the staff would have to wear all PPE but only a gown when in NJ EX Order. 264b1. She confirmed that the resident should have had caution signs posted on the door to indicate that they should see the nurse before entering the room. She stated that it would be important for all staff and visitors to know if PPE was required before entering the room. She confirmed that the resident was not on NJ EX Order 26 precautions or isolation for the diagnoses of NJ EX Order. 264b1 and should have been.

On 10/20/23 at 10:24 AM, the surveyor interviewed the Licensed Practical Nurse Infection Preventionist (LPN/ IP) who stated that he had been employed in the position been since NJ EX Order. 264b1. He explained that if a nurse discovered or suspected that a resident had an NJ EX Order. 264b1 (does not matter what kind) the nurse was to report it to the Unit Manager and the IP. He stated that after he was notified that the resident had an NJ EX Order. 264b, he would investigate to

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see what [redacted] was and then add it to the NJ EX Order. 264b1 log. He would then utilize a guideline to see if the [redacted] was appropriate to use and to assure that the [redacted] was [redacted] to the [redacted] m. The IP stated that he was not notified by the nurses that Resident # 6 was on NJ EX Order. 264b1. He continued to explain that if he was made aware that the resident had [redacted] of the [redacted] he would have assured that the resident was put on [redacted] isolation (staff should wear PPE such gown, mask, gloves, eye protection) for someone on [redacted] precautions. He stated that there should be signs posted on the door that indicated that the staff and visitors should see the nurse before entering the resident's room. The IP stated it would be important that visitors and staff knew that the resident had a NJ EX Order. 264b1 so that they could wear the appropriate PPE. He stated that isolation bins containing PPE should have been put outside the resident's room. He stated the any contaminated laundry items should have been separated and washed separately to prevent cross contamination and that separate laundry bins and trash bins should have been inside the resident's room for the laundry and trash. He added that [redacted] was the type of contagious infection that it would be necessary for laundry and trash BINS to be placed in the room. The IP also stated that according to the documentation in the medical record that family was not notified that the resident had [redacted] urine. The IP confirmed that the resident should have been put on [redacted] isolation immediately after the resident was diagnosed with [redacted] and signs should have been posted on the resident's door that any visitors and staff needed to see the nurse before entering the resident's room.

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F 880	Continued From page 97 On 10/20/23 at 11:00 AM, the surveyor interviewed the acting Director of Nursing (DON). The DON stated that there was no Unit Manager for the [redacted] Unit at this time. She stated that during the interim period other DONs from other facilities were covering the unit. She stated that if the nurse received a NJ EX Order. 264b1 that indicated that the resident had a [redacted] the nurse would call the physician to find out what he would recommend for treatment. If there were sensitivities, the nurse would relay that to the physician. If the physician ordered an [redacted] that the organism was resistant too, the nurse should then question the physician to see if he could order a medication that the organism was [redacted] to. She continued to explain that if the organism was contagious then the nurse should follow Center for Disease (CDC) recommendations for TBP for that organism. The DON stated that if the resident had [redacted] of the [redacted] the information should be shared with the physician so that he could make the appropriate treatment decisions. The surveyor asked the DON if a resident should be put on contact precautions, and she stated that she would follow the CDC recommendations. The DON confirmed that Resident #6 should have been put on the appropriate [redacted] when they discovered that the resident had [redacted] of the [redacted]. The DON indicated that she did not know what PPE was supposed to be put in place when the resident was discovered that she had NJ EX Order. 264b1. But the resident should have been put on [redacted] precautions until she found out what the CDC recommended. On 10/20/23 at 01:44 PM, the surveyor interviewed the Medical Director (MD). stated	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

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F 880	Continued From page 98	F 880		

that the resident should have been put on [redacted] and isolated to prevent further transmission of [redacted].

The facility policy titled, "NJ EX Order. 264b1 [redacted]" with a revised date of 01/2023 indicated that the facility staff was to take the precautions needed for caring of residents known or suspected of having an infection or colonization, with a [redacted]. The policy indicated that when a resident was placed on [redacted]t precautions the facility would implement the following:
-Consult with the appropriate isolation policy.
-Provide isolation setup.
-A soiled linen hamper/refuse container is placed, when required, within the cubicle of the infected resident's area.
-Post the proper isolation signage on the resident's door.
-An explanation of the procedures and precautions was to be given to visitors.

The facility policy titled, "Categories of Transmission-Based Precautions" with a revised date of 01/2023 indicated that TBP shall be used when caring for residents who were documented or suspected to have communicable diseases or infections that can be transmitted to others.

2.) On 10/20/23 at 12:15 PM, the surveyor observed resident dining on the [redacted] unit. The surveyor observed a Certified Nursing Assistant (CNA) helping a resident set up their meal that the resident was already eating. The CNA was observed stirring the resident's coffee with a spoon that the un-sampled resident already touched and then the CNA was observed opening

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F 880	Continued From page 99	F 880		

the resident ice cream cup that he/she had also already the touched. The same CNA then without performing hand hygiene, went over to another un-sampled resident's tray and assisted that resident in cutting up that resident's meat with a fork and knife that that resident already handled. The CNA then left that resident failed to perform hand hygiene afterward and went over to the serving cart that contained resident liquids and pulled cleaned cups of the cart. The surveyor asked the CNA at that time what she should have done when going from one resident's tray to another resident's tray and then to the serving cart that all residents drink from and she stated that she should have performed hand hygiene after setting up each resident and before touching the serving cart that they serve drinks to all residents.

On 10/20/23 12:20 PM, the surveyor interviewed a Registered Nurse who identified herself as a DON (RN/DON) from another facility who was monitoring the [redacted] unit dining room. The surveyor asked the RN/DON what the CNA should have done after touching a resident's tray and then going to another resident's tray and the to the serving cart and she stated that the CNA should have performed hand hygiene to prevent any cross contamination.

On 10/30/2023 at 11:32, in the presence of the survey team the DON stated that she did not have any addition information to provide to the surveyor.

Reference: The Center for Disease Control (CDC); "Guidelines for Hand Hygiene in Healthcare Setting, "Vol [volume]. 51/No. RR-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING _____ B. WING _____	C 10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 100 (dated 10/25/02). Recommendations included but were not limited to the following: 1. Indications for hand washing and hand antiseptics: A). When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-microbial soap and water or an antimicrobial soap and water. C). Decontaminate hands before having direct contact with the patient. I.) Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. J.) Decontaminate hands after removing gloves. The facility policy titled, "Handwashing/Hand Hygiene: with a revised date of 01/2023 indicated that the facility considered that hand hygiene was the primary means to prevent the spread of infections. The policy also indicated that alcohol-based hand rub and soap and water would be used before and after assisting a resident with meals. NJAC 8:39-27.1 (a)	F 880		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030301 (Y1)	A. Building B. Wing (Y2)	12/29/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/04/2023	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
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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	
10/30/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
030301	A. Building B. Wing	12/29/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/30/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315448 Y1	A. Building B. Wing Y2	12/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580	Correction	ID Prefix F0610	Correction	ID Prefix F0656	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	12/04/2023	LSC	12/04/2023	LSC	12/04/2023
ID Prefix F0658	Correction	ID Prefix F0684	Correction	ID Prefix F0686	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	12/04/2023	LSC	12/04/2023	LSC	12/04/2023
ID Prefix F0689	Correction	ID Prefix F0711	Correction	ID Prefix F0812	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	12/04/2023	LSC	12/04/2023	LSC	12/04/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/04/2023	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?
10/30/2023	☐ YES ☐ NO

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
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Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	12/04/2023	LSC	12/04/2023	LSC	12/04/2023
ID Prefix F0686	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/04/2023	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	

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10/30/2023	☐ YES ☐ NO