STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING _____ B. WING _____	C 05/17/2023

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N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #'s NJ00159512 and NJ00163437 Survey Date: 5/17/23 Census: 70 Sample: 18 + 3 closed records + 9 = 30 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 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 # NJ00163437 Based on observation, the interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to: a) ensure there was a physician's order and physician documentation regarding discharge for one (1) of three (3) closed medical records reviewed for discharge (Resident #117) and b) ensure a physician's order for a diet order of NJ Exec. Order 26:4.b.1 for one (1) of five (5) residents were followed during Medication Pass Observation of Resident#1. This deficient practice was evidenced by the	F 658	I. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #117. It was identified that human error was related to the primary physician□s change of practice right after resident□s discharge. Facility administrator contacted the head of the physician group and Policy on Physicians role on resident□s discharge was reviewed. Resident #117 discharge order, summary and documentation were completed by	6/15/23

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

Electronically Signed | 06/01/2023

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F 658	Continued From page 1 following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/04/23 at 01:27 PM, the surveyor reviewed the closed medical record for Resident #117 and revealed the following: The Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; [redacted]	F 658	the head of the physician group. Resident #117 no longer resides in the facility as of [redacted]. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #1. It was identified that human error was the main cause of the incident. The staff identified was immediately rein-serviced on the importance of following the physician order, and of following the guideline of [redacted] program. Resident #1 was reeducated on the importance of following her prescribed [redacted] order. The drinking cup was also removed and replaced with a new cup of water with the right [redacted]. No negative outcomes were identified on the deficient practices. II. Audits were conducted by the facility Administrator or designee on all residents discharged within the last 6 months, and all residents with thickened liquids order. These individuals could have been potentially affected by the deficient practice. An initial audit done 5/18/23 found no other similar incidents. III. Policy review of physician□s role on	

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F 658	Continued From page 2 and[redacted]	F 658	resident□s discharge, and the importance of writing Discharge Summary and order, will be conducted to all physicians, Medical records personnel, and nursing staff by facility Administrator and/or designee. A re-inservice on the importance of following the physician order, particularly on thickened liquids, will be conducted by the Staff Development Coordinator or designee, to all nursing staff. IV. To ensure that the solutions are sustained, the performance of identified Staff who were responsible for the deficient practice, shall be observed and monitored by the Staff Development Coordinator weekly for 4 weeks, then monthly for 3 months. A random audit of 4 charts, conducted by the Director of Social Work or Designee, will be conducted to review physician's discharge orders and discharge summary compliance, monthly for 6 months. A random audit of 4 charts will be conducted by the facility Staff Development Coordinator or designee, on nursing compliance with physician□s orders, weekly for 4 weeks, then monthly for 3 months. Results and data of the audits with be shared with the QAPI committee during the next 3 quarterly meetings. Final	

[redacted]

The Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], showed that the resident was discharged to the community (which includes private home/apt, board/care, assisted living, group home).

A review of a Progress Note (PN) dated [redacted] showed a note written by nursing staff which included the following: Resident was discharged from the facility at approximately 02:45 PM, discharge papers with medication scripts were handed over to resident's responsible party.

Further review of the electronic PNs showed a note written by the physician that included Resident #117's history and physical (H&P). The H&P did not include information about a plan for discharge. There was no other documentation written by a physician in the PN's.

The Order Summary Report (OSR) dated [redacted], did not include a physician's order for discharge. A review of a copy of prescriptions written by the physician dated [redacted] did not include a physician's order for discharge.

On 5/11/23 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) via phone, regarding the process of a resident's discharge. LPN #1 stated that the physician would usually write an order for discharge in the electronic medical record or would give a verbal order to the nurse and that the nurse would place the order in the electronic medical record.

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F 658	Continued From page 3 On 5/11/23 at 11:32 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process of a resident's discharge and a physician's order for discharge. The DON stated that there would be a physician's order for discharge and that it would be in the order section of the electronic medical record. The surveyor then asked the DON if Resident #117 should have had a physician's order for discharge in the electronic medical record. The DON stated that there should be a physician's order for discharge. On 5/11/23 at 01:39 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Admissions and Marketing/Assistant Administrator (DoAM/AA) and DON, the findings that Resident #117's medical record did not include a physician's discharge order and physician's documentation regarding discharge. On 5/16/23 at 12:58 PM, in the presence of the survey team, DoAM/AA and DON, the LNHA confirmed that there was no physician's order for discharge for Resident #117 prior to surveyor inquiry. The surveyor asked the LNHA if there should have been a physician's order for discharge. The LNHA stated that there should have been a physician's order for discharge. She added that an order could be in the electronic medical record, or it could be handwritten and uploaded to the electronic medical record. On 5/17/23 at 12:01 PM, the DoAM/AA provided the survey team a Clinical Physician Order which included the following: Discharge to ALF (Assisted Living Facility). A review of the document indicated the note was created after	F 658	results of the audit will be presented at the 3rd quarterly QAPI meeting.	

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F 658	Continued From page 4	F 658		

surveyor inquiry on 5/16/23.

2. On 5/05/23, at 8:53 AM, the surveyor began the Medication Observation Pass for Resident #1. LPN #2 began to prepare the medication for the resident.

At that time, the surveyor observed an order on the electronic Medication Administration Record (eMAR) that indicated the resident had a NJ Exec Orde [redacted]

On 5/05/23 at 9:10 AM, LPN #2 confirmed with the surveyor that she was ready to administer the medications to Resident #1.

On 5/05/23 at 9:11 AM, during the medication pass observation for Resident #1, the LPN stated she had pre-prepared the resident's NJ Exec Orde [redacted] that morning.

At that time, LPN #2 identified the liquid that was in a covered Styrofoam cup on the resident's sink was the liquid she had prepared that morning.

At that time, Resident #1 stated she added a tea bag in the Styrofoam cup. The surveyor observed the LPN was about to administer the medications to the resident.

At that time, the surveyor stopped the medication pass for Resident #1 to check the liquid in the cup. LPN #2 removed the Styrofoam cup from the resident's room.

At that time, the surveyor and LPN #2 reviewed the liquid within the Styrofoam cup. The LPN informed the surveyor that the liquid in the Styrofoam cup was not NJ Exec Order 26.4b1.

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The surveyor reviewed the medical records for Resident #1.

The AR reflected the resident was admitted with medical diagnoses that included, NJ Exec Order 26.4b1 [redacted]

The quarterly MDS dated NJ Exec Order 26 [redacted], reflected the resident had a brief interview for mental status (BIMS) score of NJ Exe [redacted] out of 15, which indicated the resident had a NJ Exec Order 26.4b1. Further review of the MDS under section K 0510 Nutrition approaches under subsection C. Mechanically altered diet - require change in texture of food or liquids (e.g., puree food, thickened liquids) indicated NJ Exec Ord [redacted]

The OSR reflected the dietary order for NJ Exec Order 26.4b1 [redacted] with a start date of NJ Exec Order 26.4b [redacted]. Further review of the order summary report revealed an NJ Exec Order 26.4b1 [redacted] recommendation: NJ Exec Order 26.4b1 [redacted] Patient can be provided with regular NJ Exec [redacted] in between meals ONLY upon request and as tolerated. Adequate NJ Exec O [redacted] care and positioning OOB (out of bed) in wheelchair ONLY when provided with NJ Exec Order 26.4b1 with DIRECT SUPERVISION. Maintain NJ Exec Order 26.4b1 precautions at all times and continue to monitor for NJ Exec Order 26.4b1 [redacted]. "Medications to be provided with NJ Exec Order 26.4b1".

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On 5/05/23 at 10:53 AM, during a follow up interview with the surveyor, LPN #2 informed the surveyor that she prepared a NJ Exec Order 26.4b1 because she had an order for it. LPN #2 stated she used two (2) packets in a nine-ounce cup not filled to the brim and poured it into the Styrofoam cup. LPN #2 stated she was not sure why the liquid in Resident #1's room was not NJ Exec Orde [redacted] The LPN #2 informed the surveyor that she did add ice into the resident's cup, and it may have changed the consistency. LPN #2 stated she should have double checked after mixing the liquid before placing the Styrofoam cup into the resident's room.

On 5/10/23 at 12:04 PM, in the presence of the survey team, the DON, the LNHA and the DoAM/AA, the surveyor discussed the findings regarding the failure to follow the physicians order for NJ Exec Order 26.4b1 for Resident #1.

On 5/11/23 at 12:07 PM, during an interview with the surveyor, the Rehabilitation Director (RD) stated Resident #1 was referred because the resident wanted an upgrade on their diet. The RD explained an upgrade/advance meant a less restrictive diet.

On 5/11/23 at 12:08 PM, the surveyor and the RD reviewed the NJ Exec Order 26.4b1 [redacted] Evaluation and Plan of Treatment. The evaluation reflected diagnoses that included NJ Exec Order 26.4b1 [redacted]

At that time, the RD stated that Resident #1's NJ Exec O [redacted] recommended NJ Exec Order 26.4b1 with adequate NJ Exec Order [redacted] care and distant supervision. The RD clarified that medication must be

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F 658	Continued From page 7 administered with NJ Exec Order 26.4b1. On 5/11/23 at 01:05 PM, the DON stated the resident was given instruction for NJ Exec Order 26.4b1 and in between meals. The DON also stated he had consulted with the consultant pharmacist and was told since the resident had order for NJ Exec Order 26.4b1 the nurse should have been able to administer the medication with NJ Exec Order 26.4b1 The DON stated he would further research the order that indicated medication to be provided with NJ Exec Order 26.4b1 The DON informed the surveyors that education was given to LPN #2. A review of the facility provided policy titled, "Discharge Policy & Procedure" dated 2/15/23, included the following: POLICY It is the policy of this facility that residents will be assessed for their discharge goals, preferences and care needs to meet their goals. The assessment information will be used to develop a comprehensive discharge care plan ...The care plan will be developed by the interdisciplinary team (IDT), including the resident's physician ... OBJECTIVE OF THE DISCHARGE PLAN FACILITY POLICY The objective of the discharge plan policy and procedure is to provide a framework for the completion of relevant documents by the IDT and the residents and representative that will inform the discharge process and assist the resident to reach their discharge goals. The policy did not include information regarding physician order or documentation. A review of the facility provided policy titled,	F 658		

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"Discharge Planning-Physician's Responsibility" dated 12/11/2020, included the following:
I. POLICY: It is the policy of ....that the medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition, including transfer and discharge.
II. STATEMENT: Physician involvement in nursing facilities is essential to the delivery of quality long-term care. Attending physicians should lead the clinical decision-making for patients under their care ...
III. Process and Procedure:
...C. Physician responsibilities
Physicians are responsible for deciding whether the patient is safe for discharge, creating the discharge plan in conjunction with the rest of the team, and communicating instructions to the discharge nurse or designated discharge personnel ...
To facilitate a patient's safe discharge from an inpatient unit, physicians should:
a. Determine that the patient is medically stable and ready for discharge from the treating facility ...
Physician responsibilities may include:
...Provide appropriate documentation and other information that may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual;
Give all orders needed at the time or prior to discharge from the facility ...

A review of the facility policy provided, Operational Manual, subject: Speech Therapy Policy revised/ reviewed 3/15/21 included under Procedure, B. The areas addressed by Speech

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F 658	Continued From page 9 therapist include, but are not limited to: 7. Diet consistency/textures A review of the facility policy provided, Nursing Policy Manual, subject Medication Administration dated 7/08 included under Policy: Medications are administered by licensed nurses per physician order, following all regulations and best practices. No further information was provided. NJAC 8:39-17.4 (a) 1(e), 27.1 (a)	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The	F 661		6/15/23

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F 661	Continued From page 10 post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Complaint # NJ00163437 Based on interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to document a discharge summary which included a recapitulation of the resident's stay and a final summary of the resident's status for one (1) of three (3) closed records reviewed for discharge (Resident #117). This deficient practice was evidenced by the following: On 5/04/23 at 01:27 PM, the surveyor reviewed the closed medical record for Resident #117 and revealed the following: The Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; [redacted] The Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], showed that the resident was discharged to the	F 661	I. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #117. It was identified that human error was related to the primary physician□s change of practice right after resident□s discharge. Facility administrator contacted the head of the physician group and Policy on Physicians role on resident□s discharge including discharge summary documentation was reviewed. Resident #117 discharge summary and documentation, which includes recapitulation of the residen's stay and the final status of the resident, were completed by the head of the physician group. Resident #117 no longer resides in the facility as of [redacted] No negative outcomes were identified on the deficient practice. II. An audit will be conducted on all residents discharged within the last 6 months by the Director of Social Work or designee. This	

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F 661	Continued From page 11 community (which includes private home/apt, board/care, assisted living, group home). A review of a Progress Note dated [redacted] showed a note written by nursing staff which included the following: Resident was discharged from the facility at approximately 2:45 PM, discharge papers with medication scripts were handed over to resident's responsible party. The Transfer/Discharge Report included Resident #117's diagnoses, last vital signs (included the date but not a time) and the date and time of discharge. The Transfer/Discharge Report did not include where Resident #117 was discharged to, a recapitulation of the resident's stay and the final status of the resident. The medical record revealed that there was no documented discharge summary which included the recapitulation of the resident's stay and a final summary of the resident's status. On 5/11/23 at 01:39 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Admissions and Marketing/Assistant Administrator (DoAM/AA) and Director of Nursing (DON), the findings that Resident #117's medical record did not include a discharge summary. On 5/16/23 at 12:48 PM, in the presence of the survey team, LNHA and DON, the DoAM/AA stated that Resident #117's physician left the medical practice and had not written a note but that another physician wrote a late entry. On 5/16/23 at 12:58 PM, in the presence of the survey team, DoAM/AA and DON, the LNHA	F 661	group of residents can potentially be affected by the deficient practice. An initial audit done 5/18/23 found no other similar incidents. III. Policy review of physician□s role on resident□s discharge including discharge summary documentation, will be conducted to all physicians, Medical records personnel, and nursing staff by Director of Social Work or designee. IV. To ensure that the solutions are sustained, performance of the identified phsyician group who was responsible for the deficient practice, shall be observed and monitored by the Medcial Record Officer monthly for 3 months A random audit of 4 charts will be conducted by the Director of Social Work or designee on physician□s resident discharge□s role compliance, monthly for 6 months. Results and data of the audits with be shared with the QAPI committee during the next 3 quarterly meetings. Final results of the audit will be presented at the 3rd quarterly QAPI meeting.	

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confirmed that there was not a discharge summary written for Resident #117 until after surveyor inquiry. The surveyor then asked the LNHA if there should have been a discharge summary. The LNHA stated that there should have been a discharge summary.

On 5/17/23 at 12:01 PM, the DoAM/AA provided the survey team a late entry Medical Progress Note which included a medical discharge summary. A review of the document indicated the note was created on [redacted] after surveyor inquiry.

A review of the facility provided policy titled, "Discharge Policy & Procedure" dated 2/15/23, included the following:
(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new environment.
The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care and any post-discharge medical and non-medical services ...
8. Discharge Summary
a. A discharge summary will be completed upon discharge to include:
a. A recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports)
b. A final summary of resident status
c. Medication reconciliation

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d. A post-discharge plan of care developed with the resident and resident representative.
i. Location/Agency/Facility where resident will reside.
ii. Arrangements for care, medications and services post-discharge.
iii. Arrangements for follow-up communication post-discharge.

A review of the facility provided policy titled, "Discharge Planning-Physician's Responsibility" dated 12/11/2020, included the following:
I. Policy: It is the policy of ....that the medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition, including transfer and discharge ...
III. Process and Procedure:
...C. Physician responsibilities
Physicians are responsible for deciding whether the patient is safe for discharge, creating the discharge plan in conjunction with the rest of the team, and communicating instructions to the discharge nurse or designated discharge personnel ...
To facilitate a patient's safe discharge from an inpatient unit, physicians should:
a. Determine that the patient is medically stable and ready for discharge from the treating facility ...
Physician responsibilities may include:
...Provide appropriate documentation and other information that may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual; ...
Provide pertinent medical discharge information within 30 days of discharge or transfer of the

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F 661	Continued From page 14 patient. N.J.A.C. 8:39-35.2(d)(16)	F 661		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to maintain the necessary [NJ Exec Order 26.4b1] care and services for residents who were receiving [NJ Exec Order 26.4b1] treatment according to standards of practice. This deficient practice was identified for three (3) of three (3) residents (Resident #10, #31, and #120) reviewed for [NJ Exec Order 26.4b1] care. This deficient practice was evidenced by the following: 1. On 5/02/23 at 10:06 AM, the surveyor observed Resident #10 seated in a wheelchair in their room. The surveyor observed a [NJ Exec Order 26] [NJ Exec Order 26.4b1] attached to an [NJ Exec Order 26.4b1] in Resident #10's room. The [NJ Exec Order 26.4b1] was in a clear plastic bag and was dated [NJ Exec Order 26].	F 695	I. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #10. It was identified that human error was the main cause of the incident. The staff identified was immediately re-inserviced on the importance of signing given PRN orders, following facility policy on [NJ Exec Order 2] set up change, storing and dating, and initiating [NJ Exec Order 26.4b1] Care Plan. The [NJ Exec Order 26.4b1] of resident #10 was immediately changed and dated on [NJ Exec Orde]. An order for [NJ Exe] set up schedule change has been obtained from the physician and plotted on the resident's TAR. Resident's Care Plan has also been updated to include PRN [NJ Exe] use and [NJ Exec] set up change schedule as part of the	6/15/23

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F 695	Continued From page 15 On that same date and time, the surveyor interviewed Resident #10. Resident #10 stated that he/she would use the [redacted] at night and that he/she had a NJ Exec Order 26.4b1 after he/she had [redacted]. Resident #10 then added that he/she tried not to use it [redacted] the during day. The surveyor reviewed the medical records of Resident #10. The resident's Admission Record (AR; or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Exec Order 26.4b1 [redacted]. A review of the [redacted] Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's NJ Exec Order 26.4b1 The QMDS did not indicate that the resident was on [redacted]. The Order Summary Report (OSR) dated [redacted], revealed an order for NJ Exec Order 26.4b1 via [redacted] as needed for NJ Exec Order 26.4b1 Further review of the OSR showed that there was no order for [redacted] change. The resident's personalized care plan did not reflect that the resident was on [redacted] and there were no interventions for [redacted] care for the use of PRN (as needed) [redacted]	F 695	interventions. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #31. It was identified that human error was the main cause of the incident. The staff identified was immediately re-inserviced on the facility Respiratory policy which includes suction machine set up change, storing and dating, and disposal of used equipment. The entire NJ Exec Order 26.4b1 set up for resident #31 was removed from the room and changed with a new one. An order for NJ Exec Order 26.4b1 set up schedule change has been obtained from the physician and plotted on the resident's TAR. Resident's Care Plan has also been updated to include NJ Exec Order 26.4b1 set up change schedule as part of the interventions. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #120. It was identified that human error was the main cause of the incident. The staff identified was immediately re-inserviced on the importance of signing given PRN orders, following facility policy on [redacted] set up change, storing and dating, and initiating [redacted] Care Plan. Resident #120 no longer resides in the facility as of [redacted]. No negative outcomes were identified on the deficient practices.	

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F 695	Continued From page 16 On 5/03/23 at 02:10 PM, the surveyor interviewed Licensed Practical Nurse#1 (LPN #1) regarding the process for storing and changing [NJ Exec Order 26.4b]. LPN #1 stated that the 11-7 staff change the [NJ Exec Order 26.4b] once a week and put it in a bag and label it with the date. At that same time, the surveyor showed LPN #1 the picture of Resident #10's [NJ Exec Order 26.4b] that was observed on [NJ Exec Order 26.4b]. LPN #1 confirmed that the [NJ Exec Order 26.4b] should have been changed on [NJ Exec Order 26.4b]. The surveyor asked LPN #1 if the staff documented when the [NJ Exec Order 26.4b] had been changed. LPN #1 stated that she was not sure if it was documented. She further stated that there was no order on her shift (7-3) but that she would check if there was an order on the other shift. On 5/08/23 at 11:18 AM, the surveyor interviewed the Infection Preventionist (IP) regarding the process for storing and changing [NJ Exec Order 26.4b]. The IP stated that the [NJ Exec Order 26.4b] should be changed every week on the 11-7 shift and that when it was not in use that the [NJ Exec Order 26.4b] should be in a plastic bag. She added that there should be an order and that it was documented in the electronic Treatment Administration Record (eTAR). On 5/10/23 at 12:38 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Admissions and Marketing/Assistant Administrator (DoAM/AA) and Director of Nursing (DON), the findings about the [NJ Exec Order 26.4b1]. On 5/11/23 at 01:14 PM, in the presence of the survey team, LNHA and DoAM/AA, the DON stated that Resident #10 had a PRN order for [NJ Ex]	F 695	II. Audits will be conducted by the Director of Nursing or designee on all current residents with orders for oxygen use, suctioning and/or having suction machine at bedside. This group of residents has the potential to be affected by the deficient practice. An initial audit done 5/18/23 found no other similar incidents. III. Staff Development Coordinator or designee will conduct an in-service to all nursing staff on the importance of signing given PRN orders; facility policy on oxygen set up change, storing and dating, and initiating Respiratory Care Plan; Respiratory policy which includes suction machine set up change, storing and dating, and disposal of used equipment. The facility policy on Respiratory care will also be updated to include oxygen set up change and dating schedule orders, be reflected on the resident□s Treatment Administration Record. IV. To ensure that the solutions are sustained, the performance of all identified Staff who were responsible for the deficient practice, shall be observed and monitored by the Staff Development Coordinator weekly for 4 weeks, then monthly for 3 months.	

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F 695	Continued From page 17 and that the next change was to be done on NJ Exec Order 2[illegible] but that the nurse acknowledged that they forgot. The DON added that changing the NJ E[illegible] was a standard of practice and that the order had not been in the eTAR but that the facility was going to change the policy to reflect changing the NJ Exec Order 26.4b in the eTAR and in the careplan. A review of the facility provided policy titled, "Oxygen Use" with a revised date of 8/08 included the following: 4. Nasal cannula, mask, tubing, humidifier bottles are all single resident use items and are changed and dated weekly and only used for one resident. 2. On 5/02/23 at 10:28 AM, the surveyor observed in Resident #31's room, a NJ Exec Order 2[illegible] that contained a disposable NJ Exec Order 26[illegible] that had NJ Exec Order 26.4b1 in it. Attached to the NJ Exec Order 26[illegible] was a NJ Exec Order 26.4b1 attached to the other end of the NJ Exec Orde[illegible]. The NJ Exec Order 26.4b1 was laid on the top of the dresser. There was no protective covering over the NJ Exec Order 26.4b[illegible] to keep it clean. There was a NJ Exec Or[illegible], next to the NJ Exec Order 26.4b1, which was dated NJ Exec Order 26.[illegible] On that same day at 11:50 AM, the surveyor interviewed Resident #31 who was seated in a wheelchair in their room. Resident #31 stated that he/she had NJ Exec Order 26.4b1 and had been in the hospital recently and had NJ Exec Order 26.4b1 that was being NJ Exec Order 26.4b1. Resident #31 was not sure when was the last time the NJ Exec Order 26.4b1 was used.	F 695	An audit will be conducted by the Director of Nursing or designee on the compliance of deficient practices by reviewing records of all current residents and future admissions with orders for oxygen use, suctioning and/or having suction machine at bedside weekly for 4 weeks, then monthly for 3 months. Results and data of the audits will be shared with the QAPI committee during the next 3 quarterly meetings. Final results of the audit will be presented at the 3rd quarterly QAPI meeting.	

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F 695	Continued From page 18 The surveyor reviewed the medical records of Resident #31 and showed the following: The resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted]. The NJ Exec Order 26 QMDS revealed a BIMS score of NJ Ex out of 15, which indicated that the resident's NJ Exec Order 26.4b1. The OSR dated NJ Exec Order 26, revealed an order for NJ Exec Order 26.4b1 at bed s NJ Exec Order 26.4b1 resident as needed for NJ Exec Order 26.4b1. On 5/03/23 at 02:16 PM, the surveyor interviewed the LPN #1 regarding the process for the NJ Exec Order 2 equipment. LPN #1 stated that the equipment should be in a bag and if it is used the disposable portion should be discarded. She added that a new setup should be available for use. The surveyor asked LPN #1 the reason Resident #31 had the NJ Exec Order 26.4b1 at bedside. LPN #1 stated that Resident #31 was on NJ Exec Order 26.4b1 and that was the reason the NJ Exec Order 26.4b1 was at the resident's bedside. The surveyor then showed LPN #1 a picture of the observed NJ Exec Order 26.4b1 and disposable equipment. LPN #1 confirmed that the used disposable NJ Exec Order 26 equipment should not have been left there and that it should have been discarded.	F 695		

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F 695	Continued From page 19 On 5/08/23 at 11:19 AM, the surveyor interviewed the IP regarding the process for the [NJ Exec. Order 2] machine equipment. The IP stated that the disposable [NJ Exec Order 2] equipment could be used for a week. She further stated that the [NJ Exec Order 26.4b1] should be stored in a plastic bag. On 5/10/23 at 12:39 PM, in the presence of the survey team, the surveyor notified the LNHA, DoAM/AA and DON the above findings about the improper storage of the disposable [NJ Exec Order 2] equipment. On 5/11/23 at 01:16 PM, in the presence of the survey team, LNHA and DoAM/AA, the DON stated that Resident #31 had been transferred to the hospital on [NJ Exec Order 25] and the resident came back to that room on [NJ Exec Order 25]. The DON further stated that when the resident came back to the room a new [NJ Exec Order 2] machine and equipment was brought to the room and the nurse forgot to take out the old machine and used disposable [NJ Exec Order 2] equipment. At that same time, the surveyor asked the DON what the process was for the disposable [NJ Exec Order 2] equipment after it was used. The DON stated that the [NJ Exec Order 26.4b1] should be discarded right away [after use]. He added that it should all be in a bag and when not being used. A review of the facility provided policy titled, "Suctioning" with a revised date of 10/94, included the following: PURPOSE: To provide guidelines to help prevent nosocomial infections associated with suctioning and to decrease the spread of infections. PROCEDURE:	F 695		

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...8. If using a multi-use bottle of sterile distilled water for source of water for flushing, mark bottle with resident's name, date, and your initials. Discard twenty-four (24) hours after opening or if contamination is suspected ....
MISCELLANEOUS:
...11. When suction equipment is designated for a particular resident for extended use, suction connecting tubing and suction collecting canister need not be discarded on a regular schedule, but should be cleaned and flushed as necessary when secretions are present. If the suction connecting tubing becomes visibly soiled with secretions that will not flush, new tubing may be attached. The suction collection canister should be emptied and cleaned daily and changed or decontaminated as necessary.
12. ...Disposable suction collecting canisters must be discarded after single resident use.
The policy did not contain information about suction yankauer tip.

3. On 5/02/23 at 11:16 AM, the surveyor observed Resident#120 laying on the bed with the head of the bed elevated. The surveyor observed that the resident had [NJ Exec] in use at [NJ Exec Order 26.4b1] attached to an [NJ Exec Order 26] with a [NJ Exec Order 26.4b1]

At that same time, the resident stated that he/she had [NJ Exec Order 26] and started on [NJ Exec Order 26] when he/she was hospitalized. The resident was not aware of how much [NJ Exec] he/she should be on and stated [NJ] "

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included [NJ Exec Order 26.4b1]

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NJ Exec Order 26.4b1 [redacted]

The [redacted] Comprehensive MDS (CMDS) revealed a BIMS score of [redacted] out of 15 which indicated that the resident's NJ Exec Order 26.4b1 [redacted]. The CMDS reflected that the resident was on [redacted]

A review of the [redacted] and [redacted] OSR revealed that there was an order dated [redacted] for [redacted] at [redacted]. There was no order for care of [redacted].

The above order for PRN [redacted] was transcribed to the [redacted] and [redacted] eTAR. The [redacted] eTAR showed that the PRN [redacted] was signed as administered by the nurse on [redacted] at 0000 (midnight). The [redacted] eTAR reflected that there were no nurses' signatures that showed that the PRN [redacted] was administered.

A review of the Progress Notes (PN) revealed that nurses documented on the following dates and times that the resident was on [redacted] use via [redacted]

[redacted] at 04:32 (4:32 AM)
[redacted] at 18:47 (6:47 PM)
[redacted] at 20:58 (8:58 PM)
[redacted] at 04:40 (4:40 AM)
[redacted] at 13:16 (01:16 PM)
[redacted] at 21:11 (9:11 PM)

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F 695	Continued From page 22 [redacted] at 05:52 (5:52 AM) The personalized care plan did not reflect that the resident was on [redacted] and there were no interventions for [redacted] care for the use of PRN [redacted] On 5/05/23 at 8:59 AM, the surveyor observed the resident seated on the bed with [redacted] On 5/05/23 at 9:01 AM, the surveyor interviewed the assigned Certified Nursing Aide (CNA). The CNA informed the surveyor that it was the nurse's responsibility to take care of Resident #120's [redacted] She further stated that the resident was on continuous [redacted] since the resident was admitted to the facility because the resident was [redacted] On 5/05/23 at 9:48 AM, the surveyor interviewed Licensed Practical Nurse#2 (LPN#2). LPN#2 informed the surveyor that the staff nurse initiates the baseline care plan, and the nursing supervisors review and revise the care plan. LPN#2 stated that the [redacted] care plan should be part of the baseline care plan and care plan should include [redacted] care "like" how often the [redacted] to be changed, "which in the facility, is once a week at 11-7 shift on a Saturday." On that same date and time, LPN#2 stated that for residents with an order for PRN or routine [redacted], the nurse must sign in the electronic Medication Administration Record (eMAR) or eTAR that it was administered and provided. She further stated that the care for [redacted] and change of [redacted] must be signed in the eTAR. At that time, LPN#2 informed the surveyor that	F 695		

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F 695	Continued From page 23 Resident #120 was NJ Exec Order 26.4b1 LPN#2 stated that the resident required total assistance with activities of daily living (ADL), with NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. She further stated that the resident was on NJ Exe since admission at NJ Exec Orde. LPN#2 acknowledged that on NJ Exec Order 2 she was the assigned nurse of the resident and that the resident was on NJ Exec but was unable to remember if she noticed that the NJ Exe was at NJ Exec Orde at that time. LPN#2 further stated that "you're maybe right," about the NJ Exec Order 26.4b1 of the resident at NJ Exec Orde. She indicated that a family member visited on that day and "probably," changed the amount of NJ Exec In addition, LPN#2 stated that she should have signed the eTAR when the PRN NJ Exe was administered and that there should have been a care plan for NJ Exe, and an order for NJ Exec Order 26.4b1 care and changes according to the facility practice and policy. On 5/10/23 at 12:32 PM, the survey team met with the LNHA, DON, and DoAM/AA and were made aware of the above findings. On 5/11/23 at 01:03 PM, the survey team met with the LNHA, DON, and DoAM/AA. The DON informed the surveyor that according to LPN#2 on NJ Exec Order 2 the religious representative and a family member visited the resident and LPN#2 was not sure who changed it to NJ Exec Orde Furthermore, the DON stated that there was no care plan and accountability for the nurse to change the NJ Exec Order 26.4b1. The DON further stated that the electronic medical record for the care	F 695		

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plan did not have a pre-set [NJ Exe] care plan and that he was not aware of how to modify it for him to be able to add [NJ Exe] as part of the care plan. He acknowledged that there should be an order for [NJ Exec Order 26.4b1] and a change in the eTAR.

A review of the facility's Care Plan: Baseline and Comprehensive Policy dated 02/23/21 that was provided by the DON included that the facility will develop and implement a baseline care plan, followed by a comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

A review of the facility's Oxygen Use Policy revised 8/08 that was provided by the DON included that patients will be assessed for the need for respiratory services as part of the nursing assessment process; oxygen delivery via nasal cannula or mask will observe universal (standard) precautions; nasal cannula/mask/tubing/humidifier bottles are all single resident use items and are changed and dated weekly and only used for one resident; monitor resident for the effectiveness of oxygen administration and document in the medical record; and when oxygen is no longer required by the resident, dispose of all tubing, cannula, humidifiers, and clean/disinfect equipment.

On 5/17/23 at 12:03 PM, the survey team met with the LNHA, DoAM/AA, and DON, and there was no additional information provided by the facility team.

NJAC 8:39-11.2 (e)(1)(2)

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide pharmaceutical services in accordance	F 755	I. An Apparent Cause Analysis was	6/15/23

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F 755	Continued From page 26 with professional standards to ensure a) expired medications were removed from the electronic emergency (back-up) supply for 1 (one) of 1 (one) back up machine, b) prescription medication for unsampled Resident #267 was removed from active inventory after being discontinued on October 2022, c) prescription medications were labeled, dispensed, and accounted, for 1 (one) of 2 (two) medication rooms inspected and 1 (one) of 3 (three) medication carts inspected. 21 CFR 1306.24(b) If the prescription is filled at a central fill pharmacy, the central fill pharmacy shall affix to the package a label showing the retail pharmacy name and address and a unique identifier, (i.e. the central fill pharmacy's DEA registration number) indicating that the prescription was filled at the central fill pharmacy, in addition to the information required under paragraph (a) of this section. 21 CFR 205.50(a)(3) a) Facilities. All facilities at which prescription drugs are stored, warehoused, handled, held, offered, marketed, or displayed shall: Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in immediate or sealed, secondary containers that have been opened ... The deficient practice was evidenced by the following: 1. On 5/05/23 at 12:31 PM, the surveyor and the Registered Nurse/Unit Manager (RN/UM) entered the medication room for the [redacted]	F 755	conducted to determine the cause of the deficient practice. Identified causes were human error and deficient pharmacy policy and processes. Facility administrator meets with the pharmacy provider leadership to update and change their existing policies and processes on Medication back up, storing and accountability. Administration also met with the Consultant Pharmacist to discuss the policies and policies as stated above. Medications identified were immediately removed and disposed of appropriately. No negative outcomes were identified on the deficient practice. II. An audit will be conducted on the entire medication back up supplies located in the Stat-Safe and Med Rooms. All residents have the potential to be affected by the deficient practice. An initial audit done 5/18/23 found no other similar incidents. III. Facility Administrator or designee will meet with the pharmacy provider leadership and the Consultant Pharmacist to review current Pharmacy policies and processes, and correct the identified deficient practices.	

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F 755	Continued From page 27 NJ Exec Ord Located within the same medication room was the electronic back-up machine. At that time, the RN/UM stated that the supervisors on all shifts were responsible to monitor the inventory and did not have a written accounting that the task was being completed. On 5/05/23 at 12:37 PM, the RN/UM, in the presence of the surveyor began the cycle count for the back-up machine. The back-up machine had locked drawers that opened once the nurse entered their credentials. Each drawer contained several medications. On 5/05/23 at 12:53 PM, the surveyor, in the presence of the RN/UM observed two Ciprofloxacin (antibiotic medication used to treat various bacterial infections) 200 milligram (mg)/100 milliliter (ml) 5 % dextrose (D5W) injection, USP. The medication was labeled with an expiration date of 01/31/23. On 5/04/23 at 12:56 PM, the RN/UM confirmed the two Ciprofloxacin for injection were expired since 01/31/23. A review of the PAR (minimum and maximum quantity limits that was set for a certain medication) of the Ciprofloxacin D5W 200 mg/100 reflected a quantity of 2 (two). At that time, during an interview with the surveyor, the RN/UM stated expired medications should not have been contained within the electronic back-up machine. The RN/UM stated expired medications would not have been effective to treat the resident.	F 755	Facility Staff Development Coordinator or designee will do an in-service/ training to all nursing staff on the updated and/or revised pharmacy policies and processes. IV. To ensure that the solutions are sustained, the performance of identified Staff: Pharmacy Provider and Consultant Pharmacist, who were responsible for the deficient practice, shall be observed and monitored by the facility Administrator or designee on the effectiveness of the new pharmacy policies and processes in meeting the standard of practice on CFR(s): 483.45(a)(b)(1)-(3), monthly for 6 months. The Director of Nursing or designee will do an audit on the pharmacy inventory records on back up medications monthly for 6 months, and will do a random audit on all Med Rooms, weekly for 4 weeks, then monthly for 3 months. Results and data of the audits will be shared with the QAPI committee during the next 3 quarterly meeting. Fianl results of the audit will be presented at the 3rd quarterly QAPI meeting.	

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At that time, the RN/UM stated, "I recognize that we do not have an audit list and that could have helped with the accountability." The RN/UM stated she would remove the expired medications, notify the pharmacy to pick up, replace the medication and inform the Director of Nursing (DON).

2. On 5/11/23 at 9:34 AM, the surveyor in the presence of the Registered Nurse#1 (RN#1) began the unit inspection for the medication room for the NJ Exec Order 26.4b1

On 5/11/23 at 9:48 AM, the surveyor, in the presence of RN #1, observed a bottle of NJ Exec Order 26.4b1 labeled for unsampled Resident #267 commingled with the over the counter (OTC; house stock) medications.

At that time, RN#1 could not explain why the labeled medication bottle for Resident #267 dated NJ Exec Order 26.4b was in the same medication cabinet commingled with the OTC medications.

The surveyor reviewed the medical records for Unsampled Resident #267.

The Admission Record (AR; face sheet; admission summary) for Unsampled Resident #267 reflected the resident was admitted with diagnoses that included acute on NJ Exec Order 26.4b1

The Clinical Physician Orders for Unsampled Resident #267 reflected that NJ Exec Order 26.4b1 had a start date of NJ Exec Order 26.4b and an end date of

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F 755	Continued From page 29 NJ Exec Order 26.4b	F 755		

A review of the Census List for Unsampled Resident #267 revealed the resident was discharged to the hospital on NJ Exec Order 26.4b

On 5/11/23 at 9:56 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated discontinued medications should have been returned to the pharmacy provider for the resident to receive credit.

On 5/11/23 at 10:02 AM, the LPN/UM stated the discontinued medication should have been separated from all the OTC medications in active inventory to avoid medication errors, "We can't use someone else's medications and resident should receive the credit."

3. On 5/11/23 at 10:02 AM, the surveyor in the presence of RN#1 continued the inspection of the medication room and observed the following:
-three sealed bottles of Lactulose with no pharmacy provider label
-one box of Ondansetron (medication used to treat nausea and vomiting) 4 mg, quantity of thirty tablets with pharmacy provider label.

At that time, during an interview with the surveyor, the RN/UM stated the pharmacy should not have sent prescription medications without a label. We do not know who the medications were indicated for, and this is not safe for the residents.

On 5/11/23 at 10:22 AM, the surveyor began the medication cart inspection for the A and B wing (unit 1) in the presence of the Licensed Practical Nurse (LPN).

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On 5/11/23 at 10:31 AM, the surveyor observed an unlabeled box of Ondansetron 4 mg Oral Disintegrating tablets that contained 23.

At that time, during an interview with the surveyor, the LPN stated that prescription back-up medications were also known as house stock. She further informed the surveyor that the Ondansetron was a house stock medication that they used.

At that time, the LPN/UM explained the process for removal of back-up medications, "we take out the dose of what we need for the resident." The LPN stated "we should" not have an unlabeled medication in our active inventory because medication error and drug diversion could occur. The LPN informed the surveyor that she would immediately remove the medication from the medication cart and give it to the RN/UM.

On 5/11/23 at 01:05 PM, in the presence of the survey team, the DON, the Licensed Nursing Home Administrator (LNHA) and the Administrator in Training (AIT), the surveyor discussed the concerns regarding the expired medication, unlabeled medications and discontinued medication.

At that time, the LNHA stated she followed up with the pharmacy provider. She stated that the pharmacy provider assured her that the expired medication would not show as available and would not be dispensed from the electronic back-up machine.

At that time, the LNHA, presented an electronic mail (email) correspondence between her and the

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provider pharmacy. The email reflected that the electronic back-up machine was checked for outdated medications monthly and inventoried every 90 days. The individual tasked with the responsibility to was terminated in March. The correspondence further revealed that the expired medication in the machine was automatically quarantined and unavailable for removal.

The LNHA acknowledged that the expired Ciprofloxacin D5W from 01/31/23 should have been removed.

On 5/16/23 at 01:23 PM, the DON presented an email correspondence between him and the pharmacy provider. The email reflected that the Lactulose was a back-up supply and was labeled with the location on a different medication room. The pharmacy provider acknowledged that a unit dose medication would be best for the back-up supply and the bottles would be replaced with the unit dose medication.

At that time, the DON and the LNHA stated that the medication that belonged on the back-up supply should have been in the same medication room and that they should have been informed. Both acknowledged it should not have been in a separate unit.

On 5/17/23 at 11:40 AM, during a follow up interview with the surveyor, in the presence of the survey team, the DON stated that the previous medical director had ordered Ondansetron from a different pharmacy provider on 11/12/21 as a house stock. The DON stated the Ondansetron should not have been there. It should have been returned to the pharmacy or discarded. It was missed by nursing, the supervising nurses, and

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F 755	Continued From page 32 the consultant pharmacist (CP). On 5/17/23 at 11:54 AM, during an interview with the surveyor, in the presence of the survey team, the DON, LNHA and AIT, the CP stated that the "unlabeled medications in a different unit from the back-up machine commingled with active OTC inventory was not inappropriate". The CP also stated the discharged resident's medication should have been removed and was overlooked. A review of facility policy provided; Medication Storage revised/reviewed 8/01/22 included under Policy: It is the policy that back up medication shall be kept in the [name redacted] provided by [name redacted]. A review of facility policy provided, Medication Storage in the Facility 2023 Edition included under section 13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without closures are immediately removed from stock, disposed of according to the procedures for medication destruction and reordered from the pharmacy, if current order exits [exists]. NJAC 8:39-29.4 (c) (f) (g) (h)	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		6/15/23

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F 756	Continued From page 33 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of the facility provided documents, it was determined that the facility failed to: a) follow up and act upon the Consultant Pharmacist's (CP's) recommendations for one (1) of 18 residents reviewed for Medication Record Review (MRR),	F 756	I. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #118. It was identified that human error was the main	

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F 756	Continued From page 34 Resident #118 and b) identify medication irregularity during the monthly MRR of the CP for one (1) of five (5) residents reviewed for unnecessary medications, Resident#120. This deficient practice was evidenced by the following: 1. On 5/02/23 at 11:08 AM, the surveyor observed Resident #118 seated in a wheelchair inside their room while watching television. The surveyor reviewed Resident #118's medical records. The Admission Record (AR or face sheet; an admission summary) showed that the resident was admitted to the facility with diagnoses that included NJ Exec Order 26.4b1 [redacted]. The Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [redacted] showed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's NJ Exec Order 26.4b1 [redacted]. The [redacted] and [redacted] electronic Medication Administration Record (eMAR) revealed a physician order (PO) dated [redacted] for [redacted] to give one tablet by	F 756	cause of the incident. The staff identified was immediately re-inserviced on the importance of clarifying unclear pharmacy recommendation with the Consultant Pharmacist, and making sure that Consultant Pharmacist recommendations are relayed to the physician. Resident #118 primary physician was contacted immediately, and the CP recommendation was relayed. Resident #118 no longer resides in the facility as of [redacted]. An Apparent Cause Analysis was conducted to determine the cause of the deficient practice for resident #120. It was identified that human error was the main cause of the incident. The staff identified was immediately re-inserviced on the importance of sequencing multiple PRN pain medications. Resident #120 primary physician was contacted immediately to review current medication orders. Physician order was obtained with the proper sequencing of multiple PRN NJ Exec Order 26.4b1 for same indication, including the clarification of indication for NJ Exec Order 26.4b1 [redacted]. Resident #120 no longer resides in the facility as of [redacted]. No negative outcomes were identified on the deficient practices.	

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F 756	Continued From page 35 mouth every eight (8) hours (hrs) as needed (PRN) for NJ Exec Order 26.4b1 [redacted] According to the NJ Exec Order 26.[redacted] CP MRR for Resident#118, the CP recommended to change the PRN NJ Exec Order 26.4b1 [redacted] to be given if NJ Exec Order 26.4b1 [redacted] and obtain an order to check NJ Exec O[redacted] every 8 hrs to determine if the order should be administered. Further review of the medical records and the eMAR showed that the above recommendation to change the parameter of NJ Exec Order 26.4b1 [redacted] was followed and was transcribed to NJ Exec Order 26.4b1 [redacted] eMAR. The recommendation to obtain an order to check NJ Exec O[redacted] every 8 hrs was not followed. On 5/05/23 at 9:48 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN informed the surveyor that the CP comes once a month to review the MRR of residents at the facility, and reports are submitted via email to the Director of Nursing (DON), and then the DON will give it to the Registered Nurse/Supervisor (RN/S) to follow up the recommendations and call the doctor. On 5/10/23 at 12:32 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Admissions & Marketing/Assistant Administrator (DoAM/AA), and DON and were made aware of the above findings. On 5/11/23 at 8:56 AM, the surveyor interviewed the RN/S in the presence of the survey team. The RN/S informed the surveyor that it was the facility's practice, policy, and procedure that the	F 756	II. Audits will be conducted on all Consultant Pharmacist recommendations done for the last 6 months, and all current residents with multiple PRN pain medications. All residents have to potential to be affected by the deficient practice. An initial audit done 5/18/23 found no other similar incidents. III. A re-inservice will be conducted by the Staff Development Coordinator or designee on the importance of clarifying unclear pharmacy recommendation with the Consultant Pharmacist, and making sure that Consultant Pharmacist recommendations are relayed to the physician, to all nursing staff. A re-inservice will be conducted by the Staff Development Coordinator or designee on the importance of sequencing multiple PRN pain medications, to all facility nursing staff and Hospice staff. IV. To ensure that the solutions are sustained, the performances of all identified Staff who were responsible for the deficient practice, shall be observed and monitored by the Staff Development Coordinator weekly for 4 weeks, then monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING _____ B. WING _____	C 05/17/2023

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F 756	Continued From page 36 CP review resident's MRR every first week of the month, then a couple of days the written reports were sent via email to the DON. The RN/S stated that the DON will provide a copy to the RN/S, then the RN/S initiate to act upon the CP's recommendations, if it was not completed, it will then be delegated to the nurses in the unit and/or to the afternoon Nursing Supervisor. The RN/S further stated that the following day if the CP's recommendations were not completed, the RN/S will continue to follow up on the remaining recommendations that were not done. At that same time, the surveyor showed and notified the RN/S of the [NJ Exec Order 2] CP's recommendation to obtain an order for [NJ Exec Or] every 8 hrs was not followed. The RN/S stated that she was not sure who took care of the recommendations and why the recommendation for Resident #118 was not followed. On 5/11/23 at 01:03 PM, the survey team met with the LNHA, DoAM/AA, and the DON. The DON stated that he investigated what had happened and why the CP's recommendation on [NJ Exec Order 2] was not followed. The DON further stated that it was the Registered Nurse (RN) who followed up on the CP's recommendation for a [NJ Exec Order 26.4b] order for [NJ Exec O] and the reason why the RN did not follow the recommendation to obtain an order for every 8 hrs to check [NJ Exec O] because all residents in the [NJ Exec Order 26.4] where the resident was located had a standing order for vital signs check every shift. On that same date and time, the surveyor asked the DON what time every shift was plotted and the every 8 hrs plotted in the eMAR. The DON stated that every shift has no specific time and	F 756	A random audit of 2 charts on CP recommendations compliance, and proper sequencing of multiple PRN medications for same indication, will be conducted by the facility Staff Development Coordinator or designee, on the deficient practices compliance weekly for 4 weeks, then monthly for 3 months. Results and data of the audits with be shared with the QAPI committee during the next 3 quarterly meetings. Final results of the audit will be presented at the 3rd quarterly QAPI meeting.	

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F 756	Continued From page 37	F 756		

"usually" vital signs are checked during the first med pass at 8:00 AM for the 7-3 shift and 4:00 PM for the 3-11 shift. The DON further stated that every 8 hrs means it is 6:00 AM, 2:00 PM, and 10:00 PM. In addition, the DON stated that the RN should have called the doctor and obtained an order for every 8 hrs. Furthermore, the DON acknowledged that the CP's recommendation was not clear and should have been clarified as well.

2. On 5/02/23 at 11:16 AM, the surveyor observed Resident#120 laying on the bed with the head of the bed elevated. The resident informed the surveyor that he/she had a NJ Exec Order 26.4b1 and with NJ Exec Order 26.4b1 that nurse administers NJ Exec Order 26.4b1. The resident further stated that he/she was satisfied with their NJ Exec O regimen.

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included NJ Exec Order 26.4b1

The NJ Exec Order 26 Comprehensive MDS (CMDS) revealed a BIMS score of NJ Ex out of 15 which indicated that the resident's NJ Exec Order 26.4b1 The CMDS reflected that the resident received PRN NJ Exec Order 26.4b1, with occasionally NJ Exec Order 26.4b1 .

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F 756	Continued From page 38	F 756		

A review of the [NJ Exec O] and [NJ Exec Order 26.4b1] eMAR revealed the following orders:

1. PO dated [NJ Exec Order 2] at 1751 (5:51 PM) for [NJ Exec Order 26.4b1] to give 2 (two) tabs by mouth for a total of [NJ Exec Order 2] every 4 (four) hrs PRN for [NJ Exec Order 26.4b].
2. PO dated [NJ Exec Order 2] at 1530 (3:30 PM) for [NJ Exec Order 26.4b1] to give one tab by mouth every 4 hrs PRN for [NJ Exec Order 26.4b1]
3. PO dated [NJ Exec Order 2] at 1015 (10:15 AM) for [NJ Exec Order 26.4b1], give [NJ Exec Order 26] by mouth every 3 (three) hrs PRN for [NJ Exec O]. The order for [NJ Exec Order 26.4b1] was updated on [NJ Exec Order 2] at 0645 (6:45 AM) to give [NJ Exec Order 26] by mouth every 4 hrs PRN for [NJ Exec O].

Furthermore, the above orders for PRN pain medications for [NJ Exec O] and [NJ Exec Order 26.4b1] showed that the PRN [NJ Exec Order 26.4b1] was administered on [NJ Exec Order 2] and [NJ Exec Order 2] and the PRN [NJ Exec Order 26.4b] was administered on [NJ Exec Order 2], [NJ Exec Order 2], [NJ Exec Order 2], and [NJ Exec Order 2].

A review of the [NJ Exec Order 2] MRR of the CP showed that there were no recommendations comments. In addition, the [NJ Exec Order 2] at 1842 (6:42 PM) Progress Notes of CP in the electronic medical record revealed that MRR was completed.

On 5/05/23 at 9:48 AM, the surveyor interviewed the LPN. The LPN stated that the resident was able to make needs known to staff, was [NJ Exec Order 26.4b1], and was on [NJ Exec Order 26.4b1] regimens as standing order and PRN. The LPN further stated that the physician and the

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F 756	Continued From page 39	F 756		

responsible party were aware of the resident's condition.

At that same time, the LPN informed the surveyor that there were times when the CNA will have to call the nurse to assess the resident because the resident NJ Exec Order 26.4b1 . The LPN stated that even during morning rounds, the LPN noticed that the resident with a NJ Exec Order 26.4b1 and PRN NJ Exec Order 26.4b1 being offered and the resident will decline.

On that same date and time, the surveyor notified the LPN of the findings with regard to PRN NJ Exec O [redacted] NJ Exec Order 26.4b1 with no indication of what to administer. The LPN stated that there should be a proper sequencing of PRN NJ Exec O medications and it was "probably" an oversight on their part. She further stated that the CP should have "pick up" the irregularity and reported it to CP's monthly MRR. The LPN indicated that she will call the physician regarding the PRN NJ Exec Order 26.4b1

On 5/10/23 at 12:32 PM, the survey team met with the LNHA, DON, DoAM/AA and were made aware of the above findings.

On 5/11/23 at 8:56 AM, the surveyor interviewed the RN/S. The RN/S informed the surveyor that residents with multiple PRN orders for NJ Exec O [redacted] should have a sequenced order for NJ Exec Order 26.4b1 and it was the nurse's responsibility to clarify and obtain that order from the physician according to the facility's practice and policy. The RN/S stated that it was also the CP's responsibility to identify those irregularities and document and report it in the written MRR. She further stated that the nurse

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F 756	Continued From page 40 and the CP should have identified those sequencing irregularities for PRN [NJ Exec Order 26.4b1] [redacted] A review of the facility's Medication Regimen Review (MRR) Policy that was provided by the LNHA with a revised date of January 2018 included that the CP performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. MRR also involves reporting findings with recommendations for improvement. MRR activities include but are not limited to evaluating medication orders to determine that the resident's orders represent optimal therapy for that individual that includes PRN orders that include indications for use. Recommendations are acted upon and documented by the facility staff and/or the prescriber. On 5/17/23 at 12:10 PM, the LNHA provided her phone with CP on the other line to discuss the PRN Morphine findings in the presence of the survey team. The CP stated that "you are right, the [NJ Exec. Order 26:4.b] [redacted] should have been clarified and identified" in the 5/02/23 MRR. The CP further stated that the nurse should have identified the irregularities as well.	F 756		
F 812 SS=D	NJAC 8:39-29.3 (a)(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 approved or considered satisfactory by federal,	F 812		6/15/23

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F 812	Continued From page 41 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, interview, and review of pertinent facility documents, it was determined that the facility failed to: a) properly label and date the opened bulk dry food items and b) maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a foodborne illness. This deficient practice was evidenced by the following: On 5/03/23 at 12:33 PM, during the second day tour of the kitchen, the surveyor and General Manager/Food Service (GM/FS) observed the following in the basement food storage area: 1. In the basement#1 refrigerator, the surveyor observed four (4) crates of 4oz (ounces) whole milk, one gallon of 2% milk, four boxes of individual creamers, six (6) crates of 2% 4oz milk. The inside bottom floor of basement#1 refrigerator had dried and liquid white substance residue covering almost half of the refrigerator.	F 812	I. An apparent cause analysis was conducted to determine the cause of the deficient practices and was found to be human error. Re-inservicing of dietary staff was conducted regarding both the milk refrigerator and labelling and storage of bulk dry items. Floor of milk refrigerator was immediately cleaned and sanitized. Staff was re-inserviced on cleaning of refrigerators weekly and as needed in case of a spill/leak. Bulk sugar and flour bins were cleaned and opened bags of bulk sugar and flour were disposed of. Staff was re-inserviced on the correct procedures for cleaning storage bins as well as proper storage and labeling/dating of open bulk bags of dry goods including flour, sugar, rice, etc. II.	

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F 812	Continued From page 42 During an interview, the GM/FS informed the surveyor that the white substance was milk. The GM/FS stated that the refrigerator should be cleaned once a week and maintained to be clean. He further stated that there was no accountability log for the weekly cleaning of the basement#1 refrigerator. 2. In the dry storage room, the surveyor observed the unlabeled covered bin with black plastic inside with noticeable white and brown substances around it and papers at the bottom of the container. In addition, inside the container were two (2) opened bulky bags of sugar and flour with no date opened and a use-by date. At that time, the GM/FS informed the surveyor that as per facility policy and protocol, all opened food items must have a label, date opened, and use-by date. Furthermore, the GM/FS picked up and showed to the surveyor labels that were on the bottom of the container which revealed that three (3) out of four (4) labels that fell off were for the flour with dates: 4/15/21 (date open) and use by 6/25/21, 9/23/21 (date open) and use by 11/23/21, and 4/11/23 (date open) and use by 7/11/23. The other label was for the sugar with dates: 4/13/21 (date open) with use by 7/13/21. Furthermore, the GM/FS stated that the bag of sugar and flour contained 50 lbs (pounds) each and both had approximately 25 lbs remaining in each bag. He further stated that he did not know why the bag of sugar had no appropriate label. He acknowledged that the container of sugar and flour was not clean, with dust and residues of both flour and sugar visibly seen because of the black plastic.	F 812	All residents have the potential to be affected by the deficient practice. III. Sanitation and Infection Control Policies were updated to reflect these changes. Dining service staff were re-inserviced on cleaning and sanitizing of refrigerators. Refrigerator cleaning log was implemented. General Manager or Designee will conduct weekly audits on refrigerator cleanliness for 2 months. New storage bins were purchased and implemented to store flour and sugar separately with date labels on outside of container. Policies were updated to reflect these changes (Food Safety Product Labeling and Dating Guidelines) Dining service staff were re-inserviced on storage, labeling and dating of all products including bulk dry storage items. General Manager or Designee will conduct weekly audits on cleaning of storage bins, labeling and dating of all products including bulk dry storage items General Manager will conduct monthly food safety audit. IV. To ensure that the solutions are sustained, the performance of all identified Staff who were responsible for	

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F 812	Continued From page 43 On 5/05/23 at 10:05 AM, the surveyor interviewed the GM/FS. The GM/FS informed the surveyor that according to their previous policy about the bulk items and following the 2017 Food Code, bulk sugar and other bulk food items once opened, should have an open date and use by date because, after two years, the sugar crystallized. The GM/FS stated that opened bulk flour and sugar should have been placed in a separate covered container with a label outside the container. On that same date and time, the GM/FS stated that in the process of receiving the delivery of milk every Monday, the Executive Chef (EC) who receives delivery should remove the old milk stock, clean and sanitize the reach in refrigerator (basement#1 refrigerator), check the new delivered milk temperature, then store the newly delivered milk. He further stated that it was a "major oversight for me." A review of the undated facility's Bulk Product Procedure Policy that was provided by GM/FS included that all bulk products must have a receiving date upon delivery; once the product is open, it must be transferred in a clean and sanitized container labeled with product name, date opened, use by date (follow manufacturer's guideline), and employee initials; and products: bulk flour, bulk sugar, bulk rice, and bulk thickener. A review of the undated facility's Cold Storage Refrigeration and Freezers Cleaning and Sanitizing Policy that was provided by the GM/FS included that the reach-in Refrigerator and Freezer are weekly.	F 812	the deficient practice, shall be observed and monitored by the General Manager weekly for 4 weeks, then monthly for 3 months. Results and data of the audits will be shared with the QAPI committee during the next 3 quarterly meetings. Final results of the audit will be presented at the 3rd quarterly QAPI meeting.	

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F 812	Continued From page 44 On 5/10/23 at 12:32 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing, and Assistant Administrator and were made aware of the above findings. NJAC 8:39-17.2(g)	F 812		

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	031804	A. BUILDING: _____ B. WING _____	C 05/17/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 1 out of 14 Day Shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S560-Mandatory Access to Care I. No residents were found to have been affected by the deficient practice. An apparent cause analysis was performed to determine the cause of the deficient practice. It was determined that a last minute call-out resulted in the deficient practice. Re-inservice of nursing supervisors regarding the patient care ratios was conducted to reiterate the importance of filling call-outs for the oncoming shift. There were no negative outcomes identified.	6/15/23

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

Electronically Signed | 06/01/23

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 4/16/2023 to 4/22/2023, and 4/23/2023 to 4/29/2023, the staffing to resident ratios that did not meet the minimum requirement of one (1) CNA to eight (8) residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -4/17/23 had 8 CNAs for 69 residents on the day shift, required 9 CNAs. On 5/17/2023 at 9:42 AM the surveyor interviewed the Staffing Coordinator (SC) regarding staffing. The SC acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs.	S 560	II. All residents have the potential to be affected by the deficient practice. III. Staffing Coordinator and Nursing Supervisors were re-educated regarding the importance to comply with the required minimum direct care to staff ratios as mandated by the State of New Jersey. Schedule done for entire month and reviewed weekly and daily and by shift to manage any last-minute staff call-outs. Staffing agreements maintained with 9-agencies. Facility updated list of certified nursing assistants, per shift, willing to work overtime. Facility updated list of nurses, per shift, willing to work as certified nursing assistants. Staffing Coordinator is also a Certified Nursing Assistant and will work as a CNA if needed. Actively recruit LPN students doing their clinical rotation in our facility to work temporarily as CNA□s while awaiting their LPN exam results. Reviewed and revised open position advertisements and increased sign-on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031804	A. BUILDING: _____ B. WING _____	C 05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2	S 560	bonus to attract additional candidates. IV. Daily meeting between DON/designee and Staffing Coordinator/designee to review nursing schedule for projected compliance with ratios. DON will perform an audit of staffing schedules 5x per 1 week, then 2x per week for 4 weeks. Results of audit will be presented to the QAPI committee.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315419	A. Building B. Wing	6/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/15/2023	ID Prefix F0661 Reg. # 483.21(c)(2)(i)-(iv) LSC	Correction Completed 06/15/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/17/2023	☐ 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
315419 Y1	A. Building B. Wing Y2	6/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658	Correction	ID Prefix F0661	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25(i)	Completed
LSC	06/15/2023	LSC	06/15/2023	LSC	06/15/2023
ID Prefix F0755	Correction	ID Prefix F0756	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	06/15/2023	LSC	06/15/2023	LSC	06/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/17/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
031804	A. Building B. Wing	6/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

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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 06/15/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	**111 FINDERNE AVENUE** **BRIDGEWATER, NJ 08807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 05/03/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/03/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy NJ Eastern Star is a one-story building with basement that was built in 1957 with an addition constructed in 2015, it is composed of Type II 111 protected construction. The facility is divided into four - smoke zones. The generators do 100 % of the building as per the Maintenance Director. The current occupied beds are 72 of 82.	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced	K 281		6/15/23

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

Electronically Signed | 06/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 281	Continued From page 1 by: Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switches in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 72 residents. Findings include: An observation on 05/03/23 at 01:53 PM and at 02:13 PM revealed emergency lighting was not present at the emergency generator transfer switches located in the electrical rooms on the lower level in each building. The Maintenance Director who was present at the time of the observation confirmed the emergency lighting was not present. NJAC 8:39-31.2(e)	K 281	I. No residents in the facility were affected by the deficient practice II. The facility acknowledges that all residents have the potential to be affected by the deficient practice III. A licensed and qualified electrical company was hired by the Director of Maintenance and security to install emergency, battery back-up lighting in each of the 2 emergency generator switchgear areas of the facility. This work was completed on May 5th, 2023. Each area was tested for proper operation by the Director of Maintenance and Security. The Annex building Emergency Generator Switch Gear room and the Emergency Generator switch gear in the Maintenance store room locations were added to the Computerized Maintenance Management System (CMMS) checklist associated with Preventive Maintenance work order #PM0038 titled Monthly EXIT and Flood Light Battery Back Up Check to ensure that they are captured on the prescribed monthly frequency. Director of Maintenance or Designee will perform Monthly Exit and Flood Light Battery Back Up Check. Those performing the task of the PM have been in-serviced on the 2 additional locations that were added to the checklist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

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K 281	Continued From page 2	K 281	These completed work orders will be entered into the CMMS to provide proof for audit. IV. Monthly audits of Exit and Flood Light Battery Back-up Check in the two affected areas will be added as a standing agenda item at the next QAPI meeting and presented at quarterly QAPI meetings by Maintenance Director or Designee.	
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a manual fire alarm box was located within 60 inches of the rear exit door in accordance with NFPA 72 (National Fire Alarm and Signaling Code) 17.14.6. This deficient practice had the potential to affect 72 residents.	K 342	I. No residents in the facility were affected by the deficient practice II. The facility acknowledges that all	6/15/23

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	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	**111 FINDERNE AVENUE** **BRIDGEWATER, NJ 08807**

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K 342	Continued From page 3 Findings include: An observation on 05/03/23 at 02:21 PM revealed there was not a manual fire alarm box located within 60 inches of the rear exit door. The nearest manual fire alarm box was located 30 feet from the exit in the dining room at the exit. At the time of the observation, the Maintenance Director confirmed a manual fire alarm box was not located within 60 inches of the rear exit door. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 342	residents have the potential to be affected by the deficient practice III. The Director of Maintenance and Security hired the facility Fire Equipment company to install a manual fire alarm box within 60 of the affected door. This installation was completed on May 23rd, 2023. The new equipment was tested by the installing technician as well as by the Director of Maintenance and Security and subsequently placed into service. This manual fire pull box was added to the master list of facility equipment and will become part of the Annual Fire Alarm System inspection performed by vendor which is entered as a work order in the Computerized Maintenance Management System (CMMS)system. Vendor is contracted to perform an Annual Fire Alarm System Inspection to ensure that all required fire pull stations are operating properly. IV. Vendor's report will be submitted to Director of Maintenance or Designee annually upon completion. Results of this Annual Fire Alarm Inspection will be added as a standing agenda item at quarterly QAPI meetings and results will be presented by the Director of Maintenance or Designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

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K 761	Continued From page 4	K 761		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 72 residents. Findings include: An observation of the facility's fire doors on 05/03/23 from 12:45 PM to 02:21 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The Maintenance Director was present at the time of the observation and confirmed the fire	K 761	I. No residents in the facility were affected by the deficient practice II. The facility acknowledges that all residents have the potential to be affected by the deficient practice III. Inspection stickers received on May 30th,2023 and implemented. PM Work order # PM0060 was created by the Director of Maintenance and Security titled Annual 11-point Fire door check to address the inspections of the facility fire doors. A checklist was created by the Director of	6/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	**111 FINDERNE AVENUE** **BRIDGEWATER, NJ 08807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 5 doors were not inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	Maintenance to encompass the 11-point check for each door and linked to the previously mentioned work order to account for each facility fire door. This check will be performed by the Director of Maintenance or Designee annually. Maintenance Staff in-serviced on Annual 11-point Fire Door Check. PM Work order# PM0060 will be entered into the CMMS by the Director of Maintenance or Designee to act as proof for audit. IV. Director of Maintenance or Designee will present the audit of Fire Doors at the next QAPI Committee meeting and annually thereafter.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		6/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 6 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that the three - year load bank test was completed on the emergency generators in accordance with NFPA 110 (2010 edition) section 4.9.1 This deficient practice had the potential to affect all 72 residents. Findings include: A review of documents on 05/03/23 at 10:48 AM revealed that the three - year load bank test was not completed on the emergency generators. The Maintenance Director confirmed that the three - year load bank test was not completed on either generator. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	I. No residents in the facility were affected by the deficient practice II. The facility acknowledges that all residents have the potential to be affected by the deficient practice III. The Director of Maintenance and Security contracted with the facility Emergency Generator service company to perform a 4-hour continuous, under load test for each of the 2 facility emergency generators. The tests were performed, and the record of the passing results are maintained for annual review. This was scheduled and completed on May	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING **2A** B. WING _____	**05/17/2023**

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K 918	Continued From page 7	K 918	10th,2023. The Director of Maintenance and Security created a recurring Annual work order #PM0063 in the CMMS titled 36-month Emergency Generator Load Bank Test to ensure that the required 36-month frequency of this testing requirement is fulfilled. These frequency dates will be communicated at quarterly QAPI meetings. These completed work orders will be entered into the CMMS by the Director of Maintenance and Security for proof of audit purposes. IV. Results of the testing performed on 5/10/23 will be presented at the next QAPI meeting. The 36- month Emergency Generator Load Bank Test results will be discussed annually at QAPI Committee meeting as a standing agenda item.	

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
315419 Y1	A. Building 2A - NJ EASTERN STAR MAIN & ADDITION B. Wing Y2	6/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	06/15/2023	LSC K0342	06/15/2023	LSC K0761	06/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	06/15/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO