STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaints#: NJ#158678, 158764, and FRE#163244 Survey Date: 8/23/24 Census: 186 Sample: 35 + 3 =38 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		9/25/24

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

Electronically Signed | 09/06/2024

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation and review of a resident's advance directives for one (1) of two (2) residents (Resident #25) reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #25.	F 578	Tag F 578 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident # 25 had their advanced directive and physician order clarified and corrected to show in the electronic health record. 2. How you will identify other residents having the potential to be affected by the	

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F 578	Continued From page 2 According to the Admission Record (a summary of important information about the resident) Resident #25 was admitted with diagnoses that included but were not limited to, [redacted], [redacted] and [redacted]. A comprehensive Minimum Data Set (MDS), an assessment tool to facilitate the management of care, dated [redacted], indicated the facility assessed the resident's [redacted] using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1). A Physician's Order (PO) dated [redacted] read, "[redacted]." The resident's paper chart included: a "[redacted]" sticker on the outside of the chart, and an Advance Directive for Health Care form completed prior to the resident's admission which indicated the resident wished to have a [redacted] and NJ Ex Order 26.4(b)(1)) code status. Additionally, in the paper chart was a another document [name] "[redacted]" signed by the Resident's Representative (RR), and physician in [redacted]. The Care Plan Evaluation progress notes, dated [redacted], documented Resident #25's NJ Ex Order 26.4(b)(1) was maintained. On 8/14/24 at 01:36 PM, the surveyor interviewed the U.S. FOIA (b) (6) about NJ Ex Order 26.4(b)(1). The [redacted] stated NJ Ex Order 26.4(b)(1) documentation would	F 578	same deficient practice and what corrective action will be taken: All residents with advanced directives have the potential to be affected by this deficient practice. All residents with advanced directives had their advanced directives and physician orders reviewed to match in the electronic health record. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: " New and Readmission orders and advanced directives were reviewed and updated to show accuracy in the medical record. " All new Advanced Directives will be checked quarterly by the social worker to ensure that the physician orders show in the medical record. " Nurse Supervisors, Unit Managers, Charge Nurses, and social workers were educated by the Director of Nursing or Designee to ensure that advanced directive and physician orders are matching in the medical record. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing or designee will audit 5 random charts with advanced directives weekly for 4 weeks and then monthly for 3 months. The results will be brought to a Quality Assurance and Performance Improvement meeting	

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F 578	Continued From page 3	F 578		

be in the resident's hybrid chart, there would be stickers on the paper chart to indicate the resident's [NJ Ex Order 26.4(b)(1)] and the resident's [NJ Ex Ord] would be documented in the electronic medical record (EMR).

The [U.S. FOIA (b) (6)] further explained in the EMR, the [NJ Ex Order 26.4b1] was documented on the dashboard (summary of important information about the resident) of the resident's EMR and included in the PO.

The [U.S. FOIA (b) (6)] in the presence of the surveyor reviewed Resident #25's hybrid chart.

The [U.S. FOIA (b) (6)] confirmed the hard copy chart indicated the resident's advance directive documentation indicated the resident had a [NJ Ex Ord]. The [U.S. FOIA (b) (6)] reviewed Resident #25's EMR including the care plan evaluation notes, the resident's dashboard, and PO summary. The [U.S. FOIA (b) (6)] confirmed there was no PO for [NJ Ex Order 26.4(b)(1)], and the dashboard documented the resident had a [NJ Ex Order 26.4(b)(1)] only. The [U.S. FOIA (b) (6)] stated she would have to follow up (f/u) to clarify the resident's advance directives and that besides nursing, the [U.S. FOIA (b)])was also responsible for advance directives.

On 8/14/24 at 01:52 PM, the surveyor interviewed the [U.S. FO] responsible for Resident #25. The [U.S. FO] stated upon admission advance directives for a resident were assessed, education was provided and the resident was offered to make advance directives. The [U.S. FO] stated a resident's advance directives would be communicated to nursing to f/u with the resident's physician for orders. The [U.S. FO] stated that long term care (LTC) residents'

quarterly.

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F 578	Continued From page 4	F 578		

advance directives were reviewed quarterly and annually to confirm advance directives and if they desired to make any changes. The surveyor reviewed with the [U.S. FO] regarding the concerns of the Resident #25's advance directives and there being no documentation of the resident's [NJ Ex Orde] in the PO and dashboard. The [U.S. FO] stated she would have to review and would provide further information. The [U.S. FO] further stated if resident is [NJ Ex Orde] it should be clarified to reflect resident is [NJ Ex Order]

On 8/15/24 at 10:44 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated the [U.S. FO] followed up with the RR to clarify Resident #25's advance directive. The [U.S. FOIA (b)(6)] stated the resident's [NJ Ex Orde] was updated to include [NJ Ex Orde] and that when the resident was re-admitted in [NJ Ex Orde] that the [NJ Ex Orde] order was not re-entered in the EMR, it was missed.

On 8/15/24 at 11:05 AM, the [U.S. FO] informed the surveyor that she spoke to the RR who confirmed the resident desired to be NJ Ex Order 26.4(b)(1). The [U.S. FO] stated the PO for NJ Ex Order 26.4(b)(1) was ordered, NJ Ex Order 26.4(b)(1) stickers placed on the chart. The [U.S. FO] acknowledged there should have been a NJ Ex Order 26.4(b)(1) indicated on the EMR and was not sure exactly what happened. The surveyor was asked about the process of reviewing NJ Ex Order 26.4(b)(1) during quarterly reviews and who was responsible for checking advance directives. The [U.S. FO] replied that the [U.S. FO] and nursing were responsible for reviewing advance directives. She further stated for quarterly reviews, "I try to double check everything" and would document in note if resident/RR wanted to make any changes.

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F 578	Continued From page 5 On 8/21/24 at 01:03 PM, the surveyor informed the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)), and U.S. FOIA (b) (6)) of the above concerns. On 8/22/24 at 11:07 AM, the U.S. FOIA (b) (6) , and U.S. FOIA met with the survey team. The U.S. FOIA (b) stated the NJ Ex Order 26.4(b)(1) was corrected immediately. The U.S. FOIA (b) further explained that when the resident was re-admitted to facility NJ Ex Order 26.4(b) the order did not get transcribed when the resident returned to the facility. A review of the facility provided policy titled, "Advance Care Planning" with a last revised date of Nov 2023 read under Procedure: "...2. Upon admission, the presence of an existing Advance Directive, POLST [Physician Orders for Life-Sustaining Treatment], or DNR order will be determined by nursing staff/SW/physician ...7. At least quarterly, or if there is a significant change in the resident's/patient's medical condition or as otherwise needed, the resident/patient (and if the resident/patient agrees, the resident's/RR) will be invited to participate in reviewing the resident's/patient's Advance Directive during the quarterly Interdisciplinary Care Plan process ..." N.J.A.C. 8:39-9.6	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		9/25/24

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F 607	Continued From page 6 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for two (2) of five (5) [redacted] licensed staff reviewed, (Staff #8 and #10). This deficient practice was evidenced by the following:	F 607	Tag F 607 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Staff # 8 and Staff # 10 had their licenses verified and background checks completed. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	

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F 607	Continued From page 7 On 8/22/24, the surveyor reviewed ten randomly selected new employee files. The review for license verification for two of the NJ Ex Order 26.4b1 employees revealed the following: 1. Staff #8, an U.S. FOIA (b) (6) hired NJ Ex Order 26.4. The surveyor was unable to locate a license verification in the employee file. There was no documented evidence that Staff #8's license was verified prior to the date of hire (doh). 2. Staff #10, a U.S. FOIA (b) (6)), hired NJ Ex Order 26.4, had a New Jersey Division Consumer Affairs license verification printout that was un-dated. The file also contained a background screening and license verification performed by an outside company. The printout from the outside contractor revealed the following information: Report Run Date 8/20/24, Date Last Checked 8/20/24, Retrieved on 8/20/24. The verification was completed after the staff member was hired. There was no documented evidence that Staff #10's license was verified prior to the doh. On 8/22/24 at 12:40 PM, the U.S. FOIA (b) (6) provided an Employee File Check List (undated) to the survey team. The surveyor reviewed the check list. The check list revealed spaces for Criminal Background Check and License Verification. On 8/23/24 at 11:26 AM, the surveyor in the presence of the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) . The surveyor notified the facility management of the concern that there was	F 607	All residents have the potential to be affected by this deficient practice. All hired staff with licenses will have licenses verified prior to hire. All new hires will have background checks completed prior to hire. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: A checklist was provided to the Human Resources Director to ensure that all license verification and background checks will be done prior to hire. Human Resources was educated by the administrator on the importance of license verification and background checks for new employees prior to hire. Human Resources will send an email to the Administrator and Director of Nursing stating all paperwork has been complete and employee is cleared to start working. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator or designee will audit 2 new employee charts weekly for 4 weeks and then monthly for 3 months. Results will be brought to the quality assurance and performance improvement meeting which will be held quarterly.	

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F 607	Continued From page 8	F 607		

no license verification for Staff#8 on file. The surveyor also notified the facility management that the background check and license verification for Staff#10 was dated 8/22/24 and a license verification for the same [U.S. FOIA] was undated. The [U.S. FOIA (b)] stated that the license verification for the [U.S. FOIA (b)] would be at the corporate HR office.

On that same date and time, the [U.S. FOIA (b)] stated that a license verification was done for Staff#10. That same time, the surveyor showed the [U.S. FOIA (b)] a copy of the verification that had no date when it was accessed and a copy of the background check that was dated 8/22/24.

A review of the facility provided copy of the [U.S. FOIA (b)] license to the survey team coordinator during the entrance conference revealed that the copy was undated. The [U.S. FOIA (b) (6)] copy of license did not reflect if the license was verified prior to doh.

On 8/23/24 at 12:37 PM, the surveyor in the presence of the survey team interviewed the [U.S. FO] [redacted]. The surveyor asked if the facility has a policy for conducting background checks and license verification upon hiring new employees. The [U.S. FOIA (b) (6)] stated there was no policy that she was aware of, and that she just knew what to do as facility's practice. The surveyor asked what the purpose for conducting these checks (criminal background check and license verification). The [U.S. FOIA (b) (6)] stated that something could be a red flag on a criminal background investigation.

The facility did not provide any further pertinent information.

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F 607	Continued From page 9 NJAC 8:39-43.15(a, b)	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for one (1) of 38 residents, Resident #111, reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 8/14/24 at 10:56 AM, the surveyor observed an NJ Exec Order 26.4b1) sign posted outside the door of the resident. Both the U.S. FOIA (b) (6)) and the surveyor inside the resident's room observed Resident #111 with NJ Ex Order 26.4(b)(1) via the NJ Ex Order 26.4(b)(1) attached to a NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) At that same time, the U.S. FOIA confirmed that the resident had NJ Ex Order 26.4(b)(1) and stated that the NJ Ex Order 26.4(b)(1) had a date of NJ Ex Order 26.4 which indicated that the NJ Ex Order 2 was changed on that date. The surveyor reviewed the hybrid (combination of	F 641	Tag F641 Accuracy of Assessments 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #111□s Quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of NJ Ex Order 26.4 has been modified and corrected to reflect NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All current residents who receive oxygen therapy via trach collar and/or tracheostomy/laryngeal care and/or respiratory treatments via trach collar have the potential to be affected by the deficient practice. A review of current residents who receive oxygen therapy via trach collar, and/or tracheostomy/laryngeal care, and/or respiratory treatments via trach have had their MDS assessments for the last 90 days reviewed to ensure their MDS	10/1/24

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F 641	Continued From page 10 paper and electronic) medical records of Resident #111 and revealed: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted], [redacted], [redacted]), and [redacted]. The most recent quarterly MDS with an assessment reference date (ARD) of [redacted], under Section [redacted], reflected on [redacted] showed that the resident was coded for [redacted] which indicated that the resident's [redacted] was [redacted]. Section [redacted], Procedures, and Programs reflected that the resident did not receive [redacted], or [redacted] while at the facility. A review of the [redacted] Order Summary Report (OSR) revealed the following Physician's Orders (PO): 1. PO dated [redacted] for [redacted]) one time a day related (r/t) to [redacted]. 2. PO dated [redacted] for [redacted]	F 641	assessments have been coded accurately. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The [redacted] has been re-educated by the Regional MDS Consultant on the Resident Assessment Instrument (RAI) requirements for coding the MDS accurately for residents with physician orders who receive oxygen therapy via trach collar, and/or tracheostomy/laryngeal care, and/or respiratory treatments via trach under section O Special Treatments, Procedures, and Programs. The MDS/RN or designee will run a monthly report in the electronic health record system to identify residents with physician orders for oxygen therapy via trach collar, tracheostomy/laryngeal care, and/or respiratory treatments via trach to ensure accuracy of the MDS assessment. This report will be run monthly x 3 months and then reviewed by the Quality Assessment and Assurance (QAA) Committee to determine the need for additional review. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The MDSC/RN or designee will conduct monthly audits x 3 months to ensure the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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F 641	Continued From page 11 (NJ Ex Order 26.4(b)(1) h two times a day r/t NJ Ex Order 26. 3. PO dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1) . Monitor NJ Ex Order 26.4(b)(1)) every shift. Notify US FOIA if NJ Ex Order 26.NJ less than or equal to NJ Ex Ord . 4. PO dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) care every shift to maintain NJ Ex Order 26.4(b)(1) every shift. Further review of the hybrid medical records showed that the above PO were transcribed to the electronic Medical Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) for NJ Ex Order 26.4(b)(1) and were signed by nurses as administered and provided. On 8/21/24 at 9:28 AM The surveyor interviewed the U.S. FOIA (b) (6) The U.S. FOIA (b) (6) informed the surveyor that the information reflected in the MDS was gathered from the assessment, nursing notes, consultation notes, orders, eMAR, and eTAR of the resident. On that same date and time, the U.S. FOIA (b) (6) stated that she was familiar with Resident #111 and that the NJ Ex was a recent order. The surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. The U.S. FOIA (b) (6) stated that she would have to check the resident's records and get back to the surveyor about why the MDS for ARD NJ Ex Order 26.4 did not capture the resident's NJ Ex O NJ Ex Order and NJ Ex Order 26.4(b)(1) and treatment in Section NJ Ex On 8/21/24 at 11:15 AM, the U.S. FOIA (b) (6) informed the surveyor that after checking the medical	F 641	coding accuracy of MDS section O for residents who receive oxygen therapy via trach collar, tracheostomy/laryngeal care, and/or respiratory treatments via trach. The results of these audits will be presented at the Quarterly Quality Assessment Performance Improvement (QAPI) Committee meeting for review to ensure facility compliance and the deficient practice will not recur.. Date of Compliance: 10/07/2024	

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F 641	Continued From page 12	F 641		

records of the resident, she found out that the nurses were signing the electronic eTAR for [redacted] for the whole month for [redacted] and NJ Ex Order 26.4(b)(1) care every shift which should have been captured in the section [redacted] of MDS. She further stated that the MDS for ARD [redacted] will be modified to reflect the resident's care. The U.S. FOIA (b) (6) also provided a copy of the Section RAI (Resident Assessment Instrument) manual and the [redacted] eTAR.

On 8/21/24 at 12:58 PM, the survey team met with the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted]), and [redacted]). The surveyor notified the facility management of the above findings and concerns.

On 8/22/24 at 11:07 AM, the survey team met with the [redacted] U.S. FOIA (b) (6) [redacted], and [redacted] The [redacted] stated that the MDS concern was modified and corrected by the [redacted], and the [redacted] was educated.

A review of the provided CMS's (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual dated [redacted] that was provided by the [redacted] showed:
O0110: Special Treatments, Procedures, and Programs
[redacted]: Code continuous or intermittent [redacted], etc., delivered to a resident to [redacted] in this item....
Check if [redacted] was continuously delivered for 14 hours or greater per day...
[redacted] care: ...This item includes [redacted] care.

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F 641	Continued From page 13 On 8/23/24 at 12:51 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) for an Exit Conference and there was no additional information provided by the facility management.	F 641		
F 658 SS=D	NJAC 8:39-11.1, 11.2(e)(1) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to promptly notify the physician of a medication being consistently not administered to a resident due to limits on the physician's order (hold parameter), document the physician's notification, and the physician's response. This deficient practice was identified for one (1) of 38 residents (Resident #190) reviewed, according to the standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential	F 658	Tag F658 Services Provided Meet Professional Standards 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #190 is no longer a resident at the facility 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents that have medications with heart rate or blood pressure holding parameters have the potential to be affected by this deficient practice. The following corrective actions were taken: A comprehensive audit was conducted to identify medications that were consistently being held. The attending physician or his/her delegate was notified for those	9/25/24

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F 658	Continued From page 14 physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The surveyor reviewed the closed medical record of Resident #190 and revealed: The resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted]). According to the resident's electronic Medication Administration Record (eMAR), the resident had and order for and was administered NJ Ex Order 26.4(b)(1) [redacted] (a medication (med) that is used to NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) [redacted] one tablet one time a day scheduled at 9:00 AM. The NJ Ex Order 26.4(b)(1) order had a limitation	F 658	medications that were identified, and their recommendations were documented in the resident's medical record. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Director of Nursing or designee has in-serviced all licensed nursing staff regarding the facility's policy on medication holds and timely physician notification. The systemic change will be that a Medication Administration Audit Report will be run weekly on each unit by the Unit Manager or designee. If a medication is being consistently held due to heart rate or blood pressure holding parameters, the physician will be notified. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing or his/her designee will conduct weekly random audits of 5 residents x 4 weeks, then monthly x 3 months to ensure that medications which are consistently being held due to parameters are identified, the physician is notified in a timely manner, and the physician's response is documented in the resident's medical record. The results of these audits will be reported to the quarterly Quality Assurance Performance Improvement (QAPI) Committee for evaluation. Date of Compliance: 10/07/2024	

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commonly known as a hold parameter, (instructions to not give the med if NJ Ex Order 26.4(b)(1) was NJ Exec Order 26.4b1). The hold parameter reflected an indicated range to not give the med if the resident's NJ Ex Order 26.4(b)(1) is less than NJ Ex O or a NJ Ex Order 26.4(b)(1).

Further review of the resident's eMAR revealed:
-for the month of NJ Ex Order 26.4(b)(1) the resident did not receive NJ Ex Order 26.4(b)(1) fifteen (15) times out of thirty days.
-for NJ Ex Order 26.4(b)(the resident did not receive NJ Ex Order 26.4(b)(1) nine (9) times out of twenty-two (22) days.
On the days the resident did not receive the NJ Ex Order 26.4(b)(1) the eMAR reflected that it was not given due to the resident's NJ Ex or NJ Ex O being NJ Exec Order 26.4b1.

Further review of the resident's electronic medical record (EMR), there was no documented evidence that the physician (MD) was informed of the NJ Ex Order 26.4(b)(1) being held frequently. There was no documented evidence that the U.S. FOIA (b) (6)) identified the irregularity of med being held frequently as identified on the above findings.

On 8/20/24 at 9:20 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The surveyor asked the U.S. FOIA what he would expect from nursing staff if a med was held multiple times and what documentation, and any other procedures should there be. The U.S. FOIA stated he would expect the staff to contact the US FOIA if there was a pattern of holding meds. He further stated he would not expect the staff to contact the US FOIA if the med was only held one or two times or if US FOIA had

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previously been notified and they wished to continue the med as is. The surveyor asked if fifteen (15) times in one month would be considered enough to notify the [US FOIA]. The [U.S. FOIA] stated "yes," he would expect the med nurse to inform the charge nurse to follow up with the [US FOIA]. The surveyor asked the [U.S. FOIA] for the facility policy for holding meds and [US FOIA] notification.

On 8/20/24 at 10:44 AM, the surveyor interviewed the U.S. FOIA (b) (6)) on the [NJ Exec Order 26.4b1] unit. The surveyor asked the [U.S. FOIA] what the procedure was if a med was held due to parameter. The [U.S. FOIA] stated she would document in eMAR, and if it was more than once or was a pattern she would notify charge nurse to contact the [US FOIA]. She further stated that the [US FOIA] would make final decision for any med changes. The [U.S. FOIA] also stated that she would document a note in the record as well about contacting the [US FOIA] or having the charge nurse call the [US FOIA].

On 8/20/24 at 10:48 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] of [NJ Exec]. [U.S. FOIA (b) (6)] stated that she would call the [US FOIA] after at least two instances of the med being held. [U.S. FOIA (b) (6)] further stated that they check every morning with the morning report for meds that were held.

A review of the facility's Medication Holds and Physician Notification Policy dated January 2024 that was provided by the [US FOIA (b)] revealed: Section II. Policy: To ensure the safe and effective administration of meds by establishing clear guidelines for holding meds based on defined parameters and ensuring timely communication with MD when necessary. Section III. Procedure: 2. Physician Notification:

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F 658	Continued From page 17 For med holds in accordance with the MD orders: The MD or prescribing practitioner should be notified if a trend of meds being held is identified with the potential for adverse effect on the resident's health. The facility will document the date and time of MD notification, and any recommendations or orders received in the resident's medical record. 3. CP's Monthly Med Regimen Review (MRR): the CP will review each resident's med regimen monthly, including any documented med holds. On 8/21/24 at 01:08 PM the survey team met with the U.S. FOIA (b) (6) the U.S. FOIA (b) and the U.S. FOIA (b) (6)) to discuss concerns. The surveyor notified the U.S. FOIA of a concern with Resident #190's NJ Ex Order 26.4(b)(1) being held frequently with no documentation of any U.S FOIA notification. There was no further pertinent information provided by the facility.	F 658		
F 684 SS=D	NJ 8:39-11.2 (b) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		10/1/24

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F 684	Continued From page 18 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) follow the physician's order (PO) with regard to NJ Ex Order 26.4(b)(1) protocol, b.) clarify the PO regarding NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) orders, and c.) ensure staff followed protocol for accurate and timely documentation for one (1) of three (3) residents, Resident #58, reviewed for care and treatment of NJ Ex and NJ Ex Order 26.4(b)(1) protocol according to facility's policies and standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and	F 684	Tag F684 Quality of Care 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #58□s NJ Ex Order 26.4(b)(1) log, medication administration record (eMAR), and progress notes were reviewed. A.) The physician was notified that the physician□s orders (PO) regarding NJ Ex Order 26.4(b)(1) protocol were not followed on NJ Ex Order 26.4(b)(B.) The physician clarified the NJ Ex Order 26.4(b)(1) coverage orders to check the resident's NJ Ex Order 26.4(b)(1) before the NJ Ex Order 26.4(b)(1) is administered. The timing of the resident's NJ Ex Order 26.4(b)(1) checks were adjusted accordingly. C.) All nursing staff were immediately in-serviced regarding accurate and timely documentation of the NJ Ex Order 26.4(b)(1) protocol. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents with a PO for hypoglycemic protocol have the potential to be affected by this deficient practice. The following corrective actions were taken: A.) All licensed nursing staff were in-serviced by the Assistant Director of Nursing regarding the hypoglycemic protocol; B.) A comprehensive audit was conducted on all residents with tube feeding (TF) and insulin sliding coverage orders to identify inaccuracies regarding insulin timing -no other cases were identified; and C.) All licensed nursing staff were in-serviced by	

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F 684	Continued From page 19 restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/14/24 at 10:49 AM, the surveyor observed Resident # 58 lying on the bed with the [redacted] at the bedside. The surveyor observed there was a [redacted]. The [redacted] informed the surveyor that he provided morning care to the resident and waiting for another [redacted] to help him with the [redacted] The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #58. The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted] According to the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted], revealed in Section [redacted] that the resident had [redacted] for [redacted]	F 684	the Assistant Director of Nursing regarding accurate and timely documentation of the Hypoglycemic protocol. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The systemic change will be that the 24-Hour Report will be monitored to ensure that: a.) any residents with hypoglycemic events will have the hypoglycemic protocol followed; b.) any resident with TF orders and insulin sliding coverage orders will have the timing of the insulin administration adjusted accordingly; and c.) any residents with hypoglycemic events will have the hypoglycemic protocol documented accurately and timely. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing or designee will conduct weekly random audits of 5 residents with orders for hypoglycemic protocol x 4 weeks, then monthly x 3 months to ensure that the hypoglycemic protocol was followed for any hypoglycemic events; and to ensure the blood sugar was correctly documented for any episode of hypoglycemia. The Director of Nursing or designee will conduct weekly random audits of 2 residents with orders for TF and orders for insulin sliding coverage x 4 weeks, then	

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F 684	Continued From page 20 NJ Ex Order 26.4(b)(1). Section NJ Ex Order 26.4(b)(1) Status revealed that the resident with NJ Ex O Section N Medications showed that the resident received NJ Ex Order 26.4(b)(1) during the seven-day lookback period. A review of the NJ Ex Order 26.4(b)(1) Order Summary Report revealed the following: -PO dated NJ Ex Order 26.4(b)(1) order four times a day NJ Ex Order 26.4(b)(1) via NJ Ex O prior to NJ Ex Order 26.4(b)(1). -PO dated NJ Ex Order 26.4(b)(1)) via NJ Ex Order 26.4(b)(1) once daily with NJ Ex Order 26.4(b)(1) one time a day for monitoring. [the order was discontinued (d/c) on NJ Ex Order 26.4] -PO dated NJ Ex Order 26.4(b)(1) as per NJ Ex Order 26 If NJ Ex Order 26.4(b)(1) less than NJ Ex call US FOIA (b)(6)); NJ Ex Order 26.4(NJ Ex Order 26. NJ Ex Order 26.4(NJ Ex Order 26; NJ Ex Order 26.4(NJ Ex Order 26. NJ Ex Order 26.4(NJ Ex Order 26 more than NJ Ex O call US FOIA NJ Ex Order 26.4(b)(1) before meals and at bedtime related (r/t) to NJ Ex Order 26.4(b)(1) without complications. -PO dated NJ Ex Order 26.4 If NJ Ex Order 26.4(b)(1) is less than NJ Ex Order 26.4(b)(1)) (whether NJ Ex Order 26.4(b)(1) or not) or less than NJ Ex Order 26.4(b)(1) initiate tx (treatment) for NJ Ex Order 26.4(b)(1) administer approx. (approximately) NJ Ex Order 26.4(b)(1) found in any one of the following: ½ cup juice, ½ cup applesauce, 1 cup milk as needed (PRN) for NJ Ex Order 26.4(b)(1) symptoms after administration-wait	F 684	monthly x 3 months to ensure that the timing of the insulin administration is ordered appropriately. The results of these audits will be reported to the quarterly Quality Assurance Performance Improvement (QAPI) Committee for evaluation.	

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F 684	Continued From page 21 15 minutes & re-check [NJ Ex O] -PO dated [NJ Ex Order 26.4(b)(1)] Emergency kit [NJ Ex Orde] [NJ Ex Order 26.4(b)(1)] PRN for [NJ Ex Order 26.4(b)(1)] symptoms if unable [NJ Ex Order 26.4(b)(1)] [NJ Ex] is less than [NJ Ex Order 26.4(b)(1)] or less than [NJ Ex Order 26.4(b)(1)], administer [NJ Ex Order 26.4(b)(1)] immediately. Recheck [NJ Ex] in 15 min (minutes). If no response, may repeat x 1. Contact [US FOO] for continuing orders. A review of the above orders showed that they were transcribed into the [NJ Ex Order 26.4(b)(1)] electronic Medication Administration Record (eMAR). Further review of the [NJ Ex Order 26.4(b)(1)] eMAR revealed the following: - the [NJ Ex Order 26.4(b)(1)] 4 x/day plotted at 1 AM, 9 AM, 1 PM, and 7 PM vs the order for [NJ Ex Order 26.4(b)] before meals and bedtime plotted for 8:30 AM, 9:00 AM, 1 PM, and 7 PM and the results of [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4] at 8 AM was [NJ Ex] and [NJ Ex Order 26.4] at 5:30 PM was [NJ Ex Order 26.4(b)] -On [NJ Ex Order 26.4] at 0800 (8 AM) the [NJ Ex] was [NJ Ex] The PO PRN for the [NJ Ex Order 26.4(b)(1)] Emergency kit and PRN for [NJ Ex Order 26.4(b)(1)] less than [NJ Ex Order 26.4(b)] were blank for the date [NJ Ex Order 26.4(b)] There was no documented evidence that the PRN orders for [NJ Ex Order 26.4(b)(1)] protocol were followed or why it was not followed for [NJ Ex] below [NJ Ex Order 26.4(b)] which was [NJ Ex Order 26.4(b)] on [NJ Ex Order 26.4(b)] -On [NJ Ex Order 26.4] at 1730 (5:30 PM) the [NJ Ex] was [NJ Ex] The PO PRN for the [NJ Ex Order 26.4(b)(1)] Emergency kit and PRN for [NJ Ex Order 26.4(b)(1)] less than [NJ Ex Order 26.4(b)] were blank for the date [NJ Ex Order 26.4].	F 684		

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F 684	Continued From page 22 There was no documented evidence that the PRN orders for NJ Ex Order 26.4(b)(1) protocol were followed or why it was not followed for NJ Ex below NJ Ex Order 26.4(b) which was NJ Ex Order 26.4(b) on NJ Ex Order 26.4(A review of the BS Summary under NJ Ex Order 26.4(and Vitals Summary of Resident #58 showed and included the following: NJ Ex Order 26.4 at 9:20 PM NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4 at 6:24 PM NJ Ex Order 26.4(b NJ Ex Order 26.4 at 12:02 PM NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4 at 5:30 PM NJ Ex Order 26.4(b NJ Ex Order 26.4 at 8:50 AM NJ Ex Order 26.4(b NJ Ex Order 26.4 at 8:53 AM NJ Ex Order 26.4(b)(NJ Ex Order 26.4 at 8:31 AM NJ Ex Order 26.4(b NJ Ex Order 26.4 at 8:26 AM NJ Ex Order 26.4(b On 8/20/24 at 8:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) in the NJ Exec Order 26 nursing station. The U.S. FOIA (b) (6) showed the eMAR for NJ Ex Order 26.4(b)(1) and the surveyor notified of the above findings and concerns regarding the NJ Ex Order 26.4(b)(1) 4 x/day plotted at 1 AM, 9 AM, 1 PM, and 7 PM vs the order for NJ Ex Order 26.4(b) NJ Exec Order 26.4b1 before meals and bedtime plotted for 8:30 AM, 9:00 AM, 1 PM, and 7 PM and the results of NJ Exec Order 26.4b1 for NJ Ex Order 26.4 at 8 AM was NJ Ex Order 26.4(b) and NJ Ex Order 26.4 at 5:30 PM was NJ Ex Order 26.4(b) and there was no documented evidence that the PO for PRN NJ Ex Order 26.4(b)(1) protocol was followed. On that same date and time, the U.S. FOIA (b) (6) informed the surveyor that the order for NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) should be coordinated and the order should have been clarified so the 7 PM NJ Ex Orde should be adjusted for the 5:30 PM NJ Ex Order 26.4(b)(1) order for NJ Ex Order 26.4(b)(She further stated that the nurses should have	F 684		

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followed the PO for the [NJ Ex Order 26.4(b)(1] kit to administer the PRN [NJ Ex Order 26.4(b)(1)], signed the eMAR, rechecked the [NJ Ex O] documented it in the medical records, and notified the physician as ordered and documented also in the progress notes (PN). The [U.S. FOIA (b) (6)] confirmed that if the PRN [NJ Ex Order 26] eMAR was blank it means that the PRN [NJ Ex Order 26.4(b)(1)] protocol orders were not administered or provided.

On 8/20/24 at 12:39 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) regarding the above findings and concerns. The LPN stated that the order for the [NJ Ex Order 26.4(b)(1)] should correspond to the [NJ Ex Order 26.4(b)] order when it was being given. She further stated that the orders should have been called and clarified with the [US FOIA]

On 8/20/24 at 01:50 PM, the surveyor called and spoke to LPN#2 in the presence of the survey team. The LPN informed the surveyor that she recognized and knew the resident, she stated that she was a [NJ Exec Order 26.4b1] of the facility at 3-11 shift. The surveyor notified the LPN of the above findings and concerns regarding the timing of the [NJ Exec Order 26.4b1], the [NJ Ex Order 26.4(b)(1)] order, the [NJ Ex Order 26.4(b)(1] kit order, and other [NJ Ex Order 26.4(b)(1)] protocol orders. The LPN stated that she does not give the [NJ Ex Order 2] without the resident receiving the [NJ Ex Order 26.4(b)(1)]. The surveyor then asked the LPN if she did not give the [NJ Ex Order 2] without [NJ Ex Order 26.4(b)(1)] and how she administered [NJ Ex Order 2] for the 5:30 PM [NJ Ex Order 26.4(b)(1)] when the [NJ Ex Orde] on her shift was at 7 PM. LPN#2 responded that she gives the [NJ Ex Order 2] for 5:30 PM at a later time after the 7 PM [NJ Ex Order 2] The surveyor then asked the LPN, how about the 9 PM [NJ Ex Order 2] would that be too close for the 7 PM [NJ Ex Order 2]

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if she administered NJ Ex Order 2 at 7 PM and should that be clarified with the physician instead. The LPN had no response.

On that same date and time, the surveyor notified LPN#2 of the above findings and concerns that on NJ Ex Order 26.4 at 5:30 PM, her initial showed on that date the NJ Exec Order 26.4b1 was NJ Ex Order 26.4(b, and there was no documentation that she administered the NJ Ex Order 26.4(b)(kit and other NJ Ex Order 26.4(b)(1) protocol orders. The LPN stated that "the NJ Ex result of NJ Ex Order 26.4(b)(1) was probably a typo because there is no such thing as NJ Ex Or The LPN was not able to state what the NJ Exec Order 26.4b1 results then if NJ Ex Order 26.4(b was a typo error and why it was not corrected on that same date and time.

On 8/21/24 at 8:44 AM, the U.S. FOIA (b) (6)) showed a handwritten explanation of LPN#2 that the NJ Ex Order 26.4(b result on NJ Ex Order 26.4 at 5:30 PM was a typo error and it should have been NJ Ex O The U.S. FOIA also showed a copy NJ Ex Order 26.4 eMAR that the 8/13/24 at 5:30 PM result was now NJ Ex Order 26.4(b)(1) The surveyor then asked the U.S. FOIA how they were able to change the NJ Ex Order 26.4(b to NJ Ex Order 26.4(b)(1 in the eMAR. The U.S. FOIA stated that LPN#2 was able to go back to eMAR and change it and they can change the records after eight days. The U.S. FOIA acknowledged that the changes in the eMAR were done after the surveyor's inquiry.

On 8/21/24 at 10:20 AM, the surveyor in the presence of another surveyor interviewed LPN#1 regarding the NJ Ex Order 26.4(b)(1) eMAR and the NJ Ex on NJ Ex Order 26.4 at 8:31 AM NJ Ex Order 26.4(b and at 8:53 AM it was NJ Ex Order 26.4(b)(Surveyors and LPN#2 checked the eMAR and observed no documented evidence that the PRN NJ Ex Order 26.4(b)(1) protocol was followed

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and no PN as to why it was not followed.

At that same time, the surveyor asked LPN#1 why it was not followed the PO for PRN NJ Ex Order 26.4(b)(1) protocol, the LPN stated "Probably" after checking the NJ Ex when it was NJ Ex Order 26.4(b), she provided the order for NJ Ex Order 26.4(b)(1) and then rechecked the NJ Ex after 15 minutes and it was "okay." The surveyor then asked why when she rechecked it as shown in the NJ Ex Summary, at 8:53 AM it was still NJ Ex Order 26.4(b)(and the PO for PRN NJ Ex Order 26.4(b)(1) protocol was not administered or provided. The LPN had no response.

Furthermore, LPN#1 stated that if she administered the NJ Ex Order 26.4(b)(or the PRN medications for NJ Ex Order 26.4(b)(1) protocol it should have been documented and if she called the physician, it should be in the PN. The LPN acknowledged that there were no documented evidence that the US FOIA was called and the PRN NJ Ex Order 26.4(b)(1) protocols were administered.

On 8/21/24 at 12:58 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b and U.S. FOIA (b) (6)). The surveyor notified the facility management of the above findings and concerns.

On 8/22/24 at 11:07 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , and U.S. FOIA (b) (6 The U.S. FOIA stated that LPN#1 wrote a handwritten statement that when the nurse rechecked the NJ Ex on NJ Ex Order 26.4 it was NJ Ex Order 26.4(b and that the nurse entered the results in error. The U.S. FOIA stated that the documentation in the PRN NJ Ex Order 26.4(b)(1) orders on NJ Ex Order 26.4 was entered

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F 684	Continued From page 26 after the surveyor's inquiry. U.S. FOIA stated that the NJ Ex Order 26.4(b)(1) protocol in service was provided to the staff. The U.S. FOIA acknowledged that the change in NJ Ex Order 26.4(b)(1) eMAR to include the PRN NJ Ex Order 26.4(b)(1) protocol orders were signed after the surveyor's inquiry which was after 14 days. A review of the facility's Physician Services Policy with a revised date of January 2024 that was provided by the U.S. FOIA revealed: III. Notification The resident's Attending Physician may be notified in the following circumstances: -In the event of an acute change of condition (ACOC). ACOC is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. -In accordance with previously established Physician orders, care plans, or facility policies. A review of the facility's Retention of Medical Records Policy that was provided by the U.S. FOIA with a reviewed date of Feb 2024 showed: Medical records shall be retained by the facility in accordance with current applicable laws. On 8/23/24 at 12:51 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-3.2(a,b), 11.2(b), 27.1(1)	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		10/7/24

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F 686	Continued From page 27 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain infection control practices to reduce the risk of infection during a NJ Ex Order 26.4(b)(1)) treatment and perform a NJ Ex [redacted] risk assessment quarterly for one (1) of four (4) residents (Resident #131) and b.) ensure that comprehensive assessment was done and documented to reflect the NJ Ex Or [redacted] of one (1) of four (4) residents reviewed for NJ Ex Order 26.4(b) (Resident #164) according to standards of clinical practice and facility policy. The deficient practice was evidenced by the following: Reference: National Pressure Injury Advisory Panel's Pressure Injury Prevention Points included the following: Risk Assessment Consider bedfast and chairfast individuals to be at risk for development of pressure injury. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for	F 686	Tag F686 Treatment/svcs to Prevent/Heal Pressure Ulcer 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #131 has had an updated NJ Ex Order 26.4(b)(1)) risk assessment (NJ Ex Order 26.4(b)(1)) completed. Resident #131's NJ Ex Order 26.4(b)(1) was evaluated by the Nurse Practitioner NJ Ex Order 26.4b1 any signs/symptoms of NJ Ex Order 26.4(b) LPN #1 was immediately re-educated on the correct infection control practices to follow when completing a NJ Ex Order 26.4b1 and passed a competency observation by the Infection Preventionist (IP) nurse. Resident #164 no longer resides in the facility. Resident #164 had a NJ Ex Order 26. [redacted] ordered and applied on NJ Ex Order 2 to the NJ Ex Order 26.4(b)(1). 2. How you will identify other residents having the potential to be affected by the same deficient practice and what	

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F 686	Continued From page 28 pressure injury as soon as possible (but within 8 hours after admission). Refine the assessment by including these additional risk factors. Fragile skin Existing pressure injury of any stage, including those ulcers that have healed or are closed Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use Pain in areas of the body exposed to pressure Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: Acute care ... Every shift Long term care ... Weekly for 4 weeks, then quarterly Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. 1. On 8/14/24 at 12:01 PM, the surveyor observed Resident #131 lying in bed on NJ Ex Order [redacted]. The surveyor attempted to interview Resident #131 but the resident did not respond to the surveyor. A review of Resident #131's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) an NJ Ex Order 26.4(b)(1) [redacted]	F 686	corrective action will be taken: All residents who are at risk for skin breakdown have the potential to be affected by the deficient practice. A comprehensive review of current residents at risk for PU has been conducted and have had a quarterly PU risk assessment (Braden scale) completed if none noted in the medical record. A comprehensive review of current residents with new treatment orders for wounds in the past 30 days has been conducted and none were found to be without a wound assessment. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Assistant Director of Nursing (ADON) or designee completed education/in-servicing for licensed nursing staff on the following: a. Accurate wound assessment and documentation to be completed in the medical record. b. Completion of the Braden scale to be done on admission, re-admission, with a significant change in condition and quarterly. c. How to complete a wound treatment with emphasis on adherence to Infection Control Standards and the facility policy titled “Dressing Change”. The ADON or designee has completed wound treatment competency observations for licensed nursing staff to ensure they adhere to Infection Control principles when completing a wound	

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F 686	Continued From page 29 NJ Ex Order 26.4(b)(1)). A review of Resident #131's Physician Order (PO) Set included the following order: NJ Ex Order 26.4(b)(1)) Apply to NJ Ex Order 26.4(b)(1) every day shift for NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)). NJ Ex O . Apply NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). Cover with NJ Ex Order 26.4(b)(1)), then cover with NJ Ex Order 26.4(b)(1) daily and prn (as needed) with an order date of NJ Ex Order 26.4(On 8/15/24 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) regarding Resident #131's NJ Ex O. LPN#1 stated that Resident #131 had a NJ Exec Order 26.4(b)(1) that had ordered to place on NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). LPN #1 stated that it was from NJ Exec Order 26.4 and had it in the past. On 8/19/24 at 9:30 AM, the surveyor interviewed the third floor U.S. FOIA (b) (6)) regarding the NJ Ex Order 26.4(b)(1) assessment. The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(b)(1) was not done routinely and that it was done on admission and if a resident acquired a NJ Ex O She then stated that it was an assessment in the computer and that it was not part of the quarterly assessment. She then added that it used to be but for some reason it was stopped. On 8/19/24 at 9:47 AM, the surveyor observed LPN #1 perform the NJ Ex treatment for Resident #131 who wore the appropriate personal protective equipment which included a NJ Ex Order and	F 686	treatment. The systemic change will be that The Director of Nursing (DON) or designee will run a report in the electronic medical record on a monthly basis to identify residents with new wound treatment orders to ensure that they have a wound assessment documented in the resident's chart. The policy titled Wound Care/Pressure Ulcer Prevention has been updated to include completion of the Braden Risk Assessment on admission/re-admission, quarterly and with a significant change in condition. The Dressing change policy has been updated in the required documentation section an accurate assessment of the wound. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing (DON) or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of 10 residents to ensure they have an updated Braden scale completed quarterly. The ADON or designee will conduct treatment observations weekly x 4 weeks, then monthly x 3 months of 5 licensed nursing staff to ensure that Infection Control Standards are being followed during wound treatments. The DON or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of residents with new treatment orders to ensure that they have a wound	

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F 686	Continued From page 30 gloves. After LPN #1 appropriately cleansed the [redacted] and [redacted], LPN #1 took the [redacted] tube in her hand and squeezed the container to apply the [redacted] directly on Resident #131's [redacted] LPN #1 did not change her gloves after cleaning the [redacted] and before applying the [redacted] The tip of the tube did not touch the resident. LPN #1 then removed her gloves and performed hand hygiene with an alcohol based handrub. LPN #1 applied a new pair of gloves and picked up the same [redacted] tube and squeezed a small amount of the [redacted] onto a small square piece of [redacted] and placed it on Resident #131's [redacted]. LPN #1 then finished the treatment (tx) and wiped the [redacted] tube with a disinfectant wipe and put it in the tx cart. After the tx was complete, the surveyor asked LPN #1 why she applied the [redacted] directly from the tube. LPN #1 stated that she was told that she could squeeze it that way. She added that she could have put it in a cup and use an applicator. The surveyor then asked LPN #1 if she should have changed her gloves and performed hand hygiene after cleaning the wound and before application of the [redacted] LPN #1 stated that she should have done hand hygiene before applying the [redacted] A review of Resident #131's electronic record revealed that Resident #131 had a [redacted] performed on Admission, [redacted] and after Resident #131 developed a [redacted]. There was no documented evidence that a [redacted] was done quarterly to assess the risk for [redacted] The [redacted] was done after	F 686	assessment documented in their chart. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	

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the [redacted] had developed.

A review of Resident #131's most recent last three quarterly Minimum Data Set's (qMDS), an assessment tool used to facilitate the management of care, which were prior to the development of the [redacted] reflected the following under section [redacted]:
Determination of [redacted] Risk
B. Formal assessment instrument/tool (e.g. [redacted], or other)-No
C. Clinical assessment-No

Further review of the above qMDS revealed that there were no assessments done to determine the resident's risk for developing a [redacted]

On 8/19/24 at 10:24 AM, the surveyor interviewed the [redacted] regarding [redacted] treatment. The [redacted] stated that after cleaning the [redacted] gloves should be removed, hand washing should be done and then new gloves applied before the [redacted] should be applied. The [redacted] stated that the [redacted] or [redacted] should be placed into a small cup and use a tongue depressor to apply it.

On 8/21/24 at 12:59 PM, in the presence of the survey team, the surveyor notified the [redacted], [redacted] and [redacted] the concern that the LPN did not change her gloves and perform hand hygiene after cleaning the [redacted] and before applying the [redacted] and brought the multiuse tube and squeezed it directly on the resident and did not put the [redacted] in a medicine cup and apply it with an applicator during Resident #131's [redacted]

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F 686	Continued From page 32 On 8/21/24 at 01:05 PM, the surveyor reviewed the facility provided incident report/investigation for Resident #131's newly identified [NJ Ex] which was dated [NJ Ex Order 26.4]. There was a document attached which included the following: NJ Ex Order 26.4(b)(1) and management quality improvement tool Process for all [NJ Ex Order 26.4] (Ongoing) [NJ Ex Order 26.4(b)] Risk assessment (NJ Ex Order 26.4(b)(1)) is completed: weekly after admission for a total of 4 weeks; Quarterly; With a change in condition (including a new [NJ Ex Order 26]) The staff member marked yes for this section. On 8/22/24 at 9:41 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the [NJ Ex Order 26.4] Scale. The [U.S. FOIA] stated that the [NJ Ex Order 26.] Scale was done on admission and a significant change. The surveyor asked the [U.S. FOIA] the reason a quarterly [NJ Ex Order 26.] Scale was not done any longer. The [U.S. FOIA] stated that he was at the facility since [NJ Ex Order 26.4(b)(1)] and that maybe before he was at the facility it was done quarterly but that a quarterly was not done now. On 8/22/24 at 9:50 AM, the surveyor asked the [U.S. FOIA] about the [NJ Ex Order 26.4(b)(1)] Prevention and Management Quality Improvement Tool. The [U.S. FOIA] stated that the form was outdated. He added that the person that filled out the form was the person that did the incident report. The [U.S. FOIA] stated that he thought that the person marked yes to show that the risk assessment was done that day. The [U.S. FOIA] stated that it was no longer policy to do the assessment quarterly. The surveyor asked the [U.S. FOIA] what the purpose of the [NJ Ex Order 26.]	F 686		

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Scale was. The [U.S. FOIA] stated that it was to look for the risk of [NJ Ex Order 26.4(b)(1)].

On 8/22/24 at 11:26 AM, in the presence of the survey team, [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], the [U.S. FOIA] stated that at that time he did not have any information about the [NJ Exec] tx.

On 8/22/24 at 12:05 PM, the surveyor interviewed the MDS/Registered Nurse (MDS/RN #1) and MDS/RN #2 regarding the risk assessment for [NJ Ex O]. The MDS/RN #1 stated that she was not sure if the [NJ Ex Order 26.] scale was done quarterly and that it would be the nurse on the unit that would do it.

On 8/22/24 at 12:55 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] the concern that Resident #131 did not have a quarterly [NJ Ex] risk assessment.

On 8/23/24 at 9:12 AM, in the presence of the survey team, the [U.S. FOIA] stated that he was providing the surveyor with the quarterly MDS which was an assessment. The surveyor asked the [U.S. FOIA] where the MDS nurse obtained the information for the MDS assessment. The [U.S. FOIA] stated that would be a question for the MDS nurse and that he was told MDS was an assessment for [NJ Exec C]. The [U.S. FOIA] then added that he performed a competency with the LPN after the concern of the [NJ Ex] tx was received. The surveyor asked the [U.S. FOIA] if the LPN should have performed hand hygiene prior to application of the [NJ Ex Order 26.4(b)(1)] and should have used a different method to apply the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] stated "yes."

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F 686	Continued From page 34 On 8/23/24 at 11:28 AM, in the presence of the survey team, U.S. FOIA (b) [redacted] and U.S. F[redacted] the U.S. FOIA (b) [redacted] stated that the NJ Ex Order 26.4(b)(1) [redacted] Scale was done on admission and any significant change and that it was addressed in the MDS. She added that Resident #131 had a NJ Ex Order 26.4(b)(1) [redacted] Scale assessment when the NJ Ex Order 26.4(b)(1) [redacted] was noted, "we followed our policy." A review of the facility provided policy titled, "Dressing Change" with a revised date of Mar (March) 2024, included the following: Clean the wound per the PO 1. Clean the wound from the center outward using a circular motion or vertical strokes. Use a clean gauze or swab and discard after each use. ... 2. Remove gloves and wash hands and don a new pair of gloves. Wound tx as ordered by the physician 1. Treat the wound as ordered by the physician by applying medicated ointments etc. 2. Apply the ointment directly to the wound site using cotton-tipped applicator. DO NOT apply the ointment directly to the dressing and place it over the wound. 3. Begin to apply the ointment at the center or top of the wound and apply the ointment outward in a circular or vertical motion. 4. Use the applicator only once and discard into the moisture-proof bag. Select another applicator for additional ointment application if necessary .... A review of the facility provided policy titled, "Pressure Ulcer Prevention" with a reviewed date of April 2024 included the following: II. Policy ...Residents will also be assessed for risk of	F 686		

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development of PU. Interventions to eliminate or minimize risk factors will be introduced at the earliest possible time. Our goal will be to prevent facility acquired PU unless the resident's clinical condition clearly demonstrates that they are unavoidable.
IV. Risk Assessment
The Braden Scale will be the standard assessment scale ...The Braden Scale will be completed on admission, and whenever there is a significant change in condition.
V. Turning and Repositioning
Turning and repositioning will be determined based on risk assessment.
2. On 8/14/24 at 11:14 AM, the surveyor observed Resident #164 resting in bed with their eyes closed. The resident was NJ Ex Order 26.4(b)(1) to the surveyor's greeting.

The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #164.

The AR documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)

A comprehensive MDS dated NJ Ex Order 26.4, indicated under Section NJ Ex Order 26.4(b)(1), that the resident had NJ Ex Order 26.4(b)(1) and was receiving NJ Ex Order 26.4(b)(1) care.

A review of PO included a NJ Ex Order 26.4(b) order dated NJ Ex Order 26.4 that read, 'NJ Ex Order 26.4(b)(1) Apply to NJ Ex every day shift for NJ Ex Order 26 care NJ Ex Order 26.4(b)(1)) with NJ Ex Order NJ Ex Order 26. Apply NJ Ex Order 26.4(b)(1)

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NJ Ex Order 26.4(b)(1) that prepares NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1)) to NJ Ex O then apply NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) . Cover with NJ Ex Order 26.4(b)(1) with NJ Ex Orde then cover with NJ Ex Order 26.4(b)(1) and prn."

A PO dated NJ Ex Order 26.4(b read "WEEKLY NJ Ex Orde NJ Ex Order 26.4(b)(1) ; NJ Ex Order 26.4 ; NJ Ex Order 26.4(b)(1) every day shift every Fri [Friday]."

A review of the electronic Treatment Administration Record (eTAR) for NJ Ex Order 26.4(b)(1) revealed for the NJ Exec Order 26.4b1 assessment entry on NJ Ex Order 26.4 a 'NJ E was documented by the nurse indicating that the resident had a NJ Ex Order 26.4(b .

A review of progress notes and assessments revealed there was no NJ Ex Order 26.4(b)(1) documentation.

A review of the NJ Exec Order consultant notes revealed there was no note found on NJ Ex Order 26.4 or after to indicate an assessment of the resident's NJ Ex Order 26.

On 8/19/24 at 12:42 PM, the surveyor interviewed LPN #2 who had cared for the resident. LPN #2 confirmed that the resident NJ Ex Order 26.4(b)(1) which were being treated. LPN #2 stated the resident had a NJ Ex Order 26.4(b)(1) which was being treated with NJ Ex Order 26.4(b)(1) tx. LPN #2 stated weekly NJ Ex Order 26.4(b)(1) were performed and documented in the eTAR. If there was any NJ Ex Order 26.4(b)(1) any incident report would be completed, the resident representative, and the physician would be notified. Additionally, the

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resident would be seen by the [NJ Exec Order] care consultant who visited the facility weekly.

The surveyor asked LPN #2 if the [NJ Ex Order 26.4(b)(1)] consultant evaluated Resident #164's and any [NJ Exec Order] assessment documentation. LPN #2 stated that the resident was seen by the [NJ Ex Order 26.] consultant after the [NJ Ex Order 26.4(b)(1)] was identified. LPN #2 in the presence of the surveyor reviewed the hybrid medical record and could not find a [NJ Ex Order 26.4(b)(1)] consultant note for after [NJ Ex Order 26.4]. LPN #2 stated the [NJ Ex Order 26.4(b)(1)] consultant would send their visit notes to the facility and would have to follow up with the consultant.

On 8/19/24 at 01:18 PM, the [U.S. FOIA] provided the surveyor with the [NJ Ex Order 26.4(b)(1)] consultant's [NJ Ex Or] note for Resident #164, dated [NJ Ex Order 26.4].

A review of the [NJ Ex Order 26.4(b)(1)] note revealed there was no [NJ Ex Order 26] assessment and no documentation of the resident having a [NJ Ex Or] to the [NJ Ex Order 26.4(b)] area.

The surveyor reviewed the facility's policy titled, "Wound Care," with a review dated of April 2024. The policy did not further address wound and skin assessments completed by nurses.

On 8/21/24 at 01:03 PM, the surveyor informed the [U.S. FOIA (b)] [U.S. FOIA (b)] and [U.S. FOIA (b)] of concerns there was no [NJ Ex Order 26] assessment documentation for Resident #164's [NJ Ex Order 26.4(b)(1)]. The surveyor requested any additional policies related to [NJ Ex Or].

On 8/22/24 at 11:07 AM, the survey team met

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F 686	Continued From page 38 with the [redacted], and [redacted]. The [redacted] stated an incident report for NJ Ex Order 26.4(b)(1) was completed on [redacted] when the [redacted] was identified and included an assessment of the [redacted]. The surveyor discussed with the [redacted] if there was any documentation in report of a description and measurement of the resident's [redacted] and if the incident report was part of the resident's medical record. The [redacted] replied that the incident report documented the resident [redacted] as being '[redacted]' and an '[redacted]'. There was no additional response or documentation provided. On 8/23/24 at 10:30 AM, the surveyor requested from the [redacted] for any additional policy related to [redacted] and [redacted] assessments other than the "[redacted] Care" policy already provided to the survey team. There was no additional information provided by the facility. NJAC 8:39-27.1 (e)	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review	F 689	Tag F689 Free of Accident	10/1/24

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F 689	Continued From page 39 and review of other pertinent facility provided documentation, the facility failed to ensure a NJ Ex [redacted] assessment was done quarterly in accordance with their facility policy for one (1) of four (4) residents reviewed for accidents. The deficient practice was evidenced by the following: On 8/19/24 at 9:13 AM, the surveyor observed Resident #161 asleep in a NJ Ex Order 26.4(b)(1) bed. A review of Resident #131's Admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4([redacted] . A review of Resident #161's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected under Section NJ Ex Order 26.4(b)(1) indicated that the resident had NJ Ex Ord [redacted] since admission/entry or reentry or prior assessment. The MDS does not include a question about NJ Ex Or [redacted] and a NJ Ex Order 26 assessment being done. On 8/19/24 at 10:53 AM, the surveyor asked the U.S. FOIA (b) (6)) for any incidents from the last NJ Exec Order 26.4b1 for Resident #161. On 8/21/24 at 8:26 AM, the surveyor reviewed the facility provided investigation that was for an NJ Ex Order 26.4(b)(1) which occurred on NJ Ex Order 26.4(b)(1	F 689	Hazards/Supervision/Devices 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #161 has had a quarterly NJ Ex O [redacted] Assessment completed, with no change noted in the NJ Ex Order 26 assessment score. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All current residents who are at risk for falls have the potential to be affected by the deficient practice. A review of all current residents who are at risk for falls has been conducted and have had a quarterly fall risk assessment completed if not current. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Assistant Director of Nursing (ADON) has provided licensed nursing staff with education on the policy of completing the fall risk assessment on admission, re-admission, quarterly and with a significant change. The fall risk assessment will be scheduled for residents at risk for falls quarterly with their quarterly Minimum Data Set (MDS) assessment to ensure that any changes in the fall risk assessment score are addressed by the Interdisciplinary Care Team and the resident plan of care is updated accordingly.	

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F 689	Continued From page 40 A review of Resident #161's electronic medical record revealed that Resident #161 had a NJ Ex Order 26 assessment done on admission in NJ Ex Order 26.4(b)(1), readmission in NJ Ex Order 26.4(b)(1) and when the NJ Ex O occurred on NJ Ex Order 26.4(b)(1). There was no documented evidence that a quarterly NJ Ex Order 26.4 assessment was done. On 8/22/24 at 12:00 PM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding NJ Ex O assessment. The U.S. FOIA stated that the charge nurse did the assessment and that it was done on admission, a change of status and when a NJ Ex occurred. On 8/22/24 at 12:02 PM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding NJ Ex O assessment. The U.S. FOIA (b) (6) stated that the NJ Ex O assessment was not done quarterly. She added that it was done on admission, when a NJ Ex occurred and a NJ Exec Order 26.4b1. On 8/22/24 at 12:05 PM, the surveyor interviewed the MDS/Registered Nurse (MDS/RN #1) and MDS/RN #2 regarding the NJ Ex Order 26 assessment. MDS/RN #1 stated that the information for NJ Exec O was obtained from the nurse's notes and that the NJ Ex Order 26 assessment was done on admission and when a resident had a NJ Ex O She added that she was not sure if it was done quarterly and that it would be done by the nurse on the unit. On 8/22/24 at 12:55 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) the concern that	F 689	4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The ADON or designee will conduct weekly random audits of 10 residents at risk for falls weekly x 4 weeks, then monthly x 3 months to ensure they have quarterly fall risk assessments completed. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	

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F 689	Continued From page 41 Resident #161 did not have a quarterly [NJ Ex Order 26] assessment. On 8/23/24 at 9:12 AM, in the presence of the survey team, the [U.S. FOIA] stated that he was providing Resident #161's MDS which was the assessment that included the [NJ Ex Order 26] which was done quarterly. The surveyor reviewed the provided MDS and there was no indication on the MDS that a [NJ Ex Order 26] assessment was included. On 8/23/24 at 11:28 AM, in the presence of the survey team, [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], the [U.S. FOIA (b) (6)] stated that the [NJ Ex] assessment was done on admission and significant [NJ Exec Order 26.4b1]. She added that Resident #161 had a [NJ Ex] and had an assessment, "we followed our policy." A review of the facility provided policy titled, "Fall Prevention" with a revised date of September 2024, included the following: II. Policy The purpose of the profile is to identify residents at risk for falls. It is the goal that once the risk is identified preventive measures can be implemented to reduce and/or eliminate incidents. III. Procedure Upon admission each resident is to be evaluated for fall risk based upon history of falls, diagnosis, hospital records, fall assessment score, and actual attempts upon admission to get up unassisted. A resident at risk will have approaches developed for prevention of falls by admitting nurse. All risks and approaches should be reevaluated by the IDC (interdisciplinary) team and addressed on the care plan. Thereafter it shall be reevaluated quarterly ...	F 689		

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	315010	A. BUILDING _____ B. WING _____	C 08/23/2024

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F 689	Continued From page 42 N.J.A.C. 8:39-27.1 (a)	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to administer NJ Ex Order 26.4(b)(1) per Physician's order (PO). This deficient practice was identified for one (1) of three (3) residents (Resident #48) reviewed for NJ Exec Order 26.4b1 via NJ Ex Order 26.4(b)(1)) and was evidenced by the following:	F 693	Tag F693 Tube Feeding Managment/Restore Eating Skills 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #48□s NJ Ex Order 26.4(b)(1) was immediately corrected and set to the rate per the physician□s order. Resident #48□s physician was notified and came in	9/27/24

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F 693	Continued From page 43 On 8/14/24 at 10:49 AM, the surveyor entered Resident #48's room and observed the resident sitting in their wheelchair (w/c), and [redacted]. The surveyor observed that the resident had a [redacted] attached to a [redacted], and [redacted] at a rate of NJ Ex Order 26.4(b)(1)). On 8/15/24 at 12:36 PM, the surveyor observed the resident in their room, sitting in their w/c and a visitor was sitting next to them. The surveyor further observed a [redacted] connected to a [redacted], and [redacted] at a rate of [redacted]. Later on, the [redacted] was verified with second surveyor. The surveyor reviewed the medical record for Resident #48. According to the Admission Record or face sheet (admission summary), the resident was admitted to facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted]), [redacted], and [redacted] . According to the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of "[redacted] which	F 693	to evaluate the resident who had [redacted] related to the incorrect [redacted]. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All current residents who receive tube feedings (nutrition through a flexible tube inserted into the stomach) via a pump have the potential to be affected by the deficient practice. A review of current residents who receive tube feeding via pump has been conducted and none were found to have incorrect tube feeding rates. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: A new order has been created and added to all residents who receive tube feedings via pump in the electronic medical record (EMAR) for the licensed nurse to check the physician□s order every shift and verify that the tube feeding is set at the correct rate. The Assistant Director of Nursing (ADON) or designee has completed in-services with licensed nursing staff on the importance of checking physician orders to ensure that residents receiving tube feedings via pump are set at the correct rate during their assigned shift even if they did not initiate the tube feeding. The ADON has also educated licensed nursing staff on the new order that is in place on the EMAR for residents with tube	

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F 693	Continued From page 44 indicated the resident was NJ Ex Order 26.4(b)(1) [redacted] A review of the Quarterly NJ Ex Order 26.4(b)(1) Assessment note dated NJ Ex Order 26.4(b)(1), revealed that the NJ Ex Order 26.4(indicated the resident's NJ Ex Order 2 was NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) over the past year, and the NJ Ex O would be slightly lowered. Additionally, the NJ Ex Order 26.4(recommended NJ Ex change from "NJ Ex Order 26.4(b)(1) " to "NJ Ex Order 26.4(b)(1) ." The Order Summary Report revealed a PO dated NJ Ex Order 26.4 for the following: NJ Ex Order 26.4(b)(1) one time a day NJ Ex Order 26.4(b)(1) [redacted] per hour= NJ Ex Order 26.4(with a start date NJ Ex Order 26.4(b) The above PO for NJ Ex Order 26.4(b)(1) was transcribed to the NJ Ex Or and NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) indicated that Resident #48 had received NJ Ex at NJ Ex Order 26.4(and was signed by the nurses. A review of the Care Plan ([CP] a document that summarizes a person's health condition, specific care needs and health condition) included a focus for: Receiving NJ Ex Order 26.4(b)(1) to meet NJ Ex Order 26.4(& NJ Ex Order 26.4(b)(needs. Interventions included to Administer NJ Ex Order 26.4 as ordered. Further review of the CP revealed a focus for: Resident with NJ Ex Order 26.4(b)(1) as main source of NJ Ex Order 26.4(b)(1). It documented " ... NJ Ex Order 26.4 - NJ Ex Order 26.4(b)(1) reduced ..." During an interview with the surveyor on 8/15/24 at 01:33 PM, the U.S. FOIA (b) (6) [redacted] explained the process	F 693	feedings via pump that the nurse will be required to check the physician order every shift to verify the tube feeding pump is set at the correct rate. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing (DON) or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of residents who receive tube feedings via pump to ensure the pump is set at the rate ordered by the physician. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	

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F 693	Continued From page 45	F 693		

of [redacted] that he would check the PO first to see what type of [redacted] and the rate that was ordered for the resident. The [redacted] further stated, "it was important to check PO to make sure that you do not NJ Exec Order 26.4b1 or at wrong rate." The surveyor presented their concerns about the [redacted] rate that was observed on Resident #48's [redacted] to the [redacted]. The [redacted] further acknowledged that it was not acceptable that the resident was receiving the [redacted] at wrong rate, and he would call and inform the physician and the [redacted]

On 8/15/24 at 01:39 PM, the U.S. FOIA (b) (6) [redacted]) accompanied the surveyor to Resident #48's room, and observed the [redacted] at [redacted]. The [redacted] reviewed the PO in presence of the surveyor and stated, "the [redacted] is at [redacted], which was created by [redacted] on [redacted]" and the [redacted] was usually [redacted] by the overnight nurse. The [redacted] acknowledged that the rate on the [redacted] was a mistake and that it was not changed when the new orders were put in on [redacted].

A review of the facility provided "Enteral Feeding" policy, reviewed on January 2024, did not specify nurse's responsibility for residents who are receiving TF and following the PO.

A review of the undated facility provided "Job Description" for Position: LPN" document revealed under Duties and Responsibilities: 1.) Provides nursing care according to physician instructions ...."

On 8/19/24 at 01:49 PM, the survey team met with U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6)), and [redacted]

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F 693	Continued From page 46 U.S. FOIA (b) (6)). The surveyor notified the facility management of the above findings. On 8/23/24 at 9:12 AM, the U.S. FOIA informed the survey team that the physician was notified of the resident receiving the NJ Ex at the wrong rate. The U.S. FOIA provided the physician's progress note (PPN). The surveyor reviewed the PPN which was dated NJ Ex Order 26.4 at 21:22 (9:22 PM) and under assessment, the physician documented "Apparently no adverse reaction for NJ Ex Order 26.4(b)(1) ." NJAC 8:39-27.1(a)	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary NJ Ex Order 26.4(b)(1) care and services of residents that were receiving NJ Ex Order 26.4 according to the standard of clinical	F 695	Tag F695 Respiratory/Tracheostomy Care and Suctioning 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice An NJ Ex Order 26.4 in Use sign has been placed on the doorway of resident #66□s room. Resident #66 immediately had the NJ Ex Orde	10/4/24

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F 695	Continued From page 47 practice and facility's policy and procedure, specifically a.) the posting of cautionary and safety signs indicating the use of NJ Ex Order 26. were utilized for residents that received NJ Ex Order 26. , b.) that NJ Ex Order 26.4(b)(1) equipment were stored in accordance with facility policy and infection control measures for one (1) of two (2) residents reviewed for NJ Ex Order 26.4(b)(1) care (Resident #66), c.) administer NJ Ex Order 26.4(b)(1) according to the physician's order for one (1) of two (2) residents, Resident #111, reviewed for NJ Ex Order 26.4(b)(1) care, and d.) ensure staff followed the appropriate hand hygiene and use of personal protective equipment (PPE) protocol during NJ Ex Order 26.4(b)(1) care for one (1) of one (1) of resident, Resident #111, reviewed for NJ Ex Order 26.4(b)(1) (including NJ Ex Order 26.4(b) care) care. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical	F 695	NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1) replaced and dated. The NJ Ex Order in resident #66□s room that was connected to the NJ Ex Order 26.4(b)(1) unit was immediately removed and replaced with a new NJ Ex Order 26.4(b)(1), dated and placed in a new plastic storage bag. The Oxygen Administration Policy has been updated to include how to store the NJ Exec Order 26.4b1 when not in use. Resident #111□s NJ Ex Order 26.4(b)(1) was immediately set at NJ Ex Order 26.4(b)(1) according to the physician order. Resident #111 has been monitored and has had no NJ Ex Order 26.4b1 . LPN #1 was immediately re-educated on hand hygiene, NJ Exec Order 26.4b1 precautions and NJ Exec Order 26.4b1 care. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who utilize oxygen therapy and/or require tracheostomy/laryngeal care, and/or have enhanced barrier precautions in place have the potential by this deficient practice. Current residents who utilize oxygen therapy have had Oxygen in Use signs placed on the doorway of their room and all oxygen tubing and humidification bottles have been checked for current dates and are being stored properly. Current residents who utilize oxygen therapy have had their physician□s orders checked for the correct liter flow per	

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F 695	Continued From page 48 nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Reference: National Institutes of Health defines oxygen (O2) as a colorless, odorless and tasteless gas. It will support life. It is noncombustible, but will actively support the burning of combustible materials. Some materials that will not burn in air will burn in O2. Materials that burn in air will burn more vigorously in O2. 1. On 8/15/24 at 12:11 PM, the surveyor observed Resident #66 seated in a wheelchair in the dining room eating lunch. The surveyor observed Resident #66 was receiving [redacted] via a [redacted] at [redacted], that was connected to a [redacted]. The [redacted] was not dated. On 8/15/24 at 12:29 PM, the surveyor entered Resident #66's room and observed Resident #66's [redacted] at the bedside. The surveyor observed a [redacted] that was connected to the [redacted] that was dated [redacted]. The [redacted] was laying on top of the [redacted]. The [redacted] was not placed in the clear plastic bag that was connected to the [redacted]. The surveyor observed that Resident #66's entrance to their room did not have an [redacted] in use sign. On 8/15/24 at 12:30 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) regarding	F 695	minute (LPM) and receiving the correct LPM as ordered. Current residents who require tracheostomy/laryngeal care and/or enhanced barrier precautions have been monitored for signs/symptoms of infection and none have been identified. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Assistant Director of Nursing (ADON) or designee has in-serviced nursing staff on the updated policy of placing Oxygen in Use signs on the doorway of residents who utilize oxygen therapy and the proper dating and storage of oxygen tubing and humidification bottles. The ADON or designee has in-serviced licensed nursing staff on the correct procedure to follow when providing tracheostomy/laryngeal care, hand hygiene and enhanced barrier precautions. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing (DON) or designee will conduct weekly random audits x 4 weeks, then monthly x 3 months of 5 residents who utilize oxygen therapy to ensure they have and Oxygen in Use sign on their doorway, their oxygen tubing and humidification bottle has a	

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F 695	Continued From page 49 the process for NJ Ex C The LPN stated that the NJ Ex [redacted] should be dated and that it was changed once a week. The LPN stated that when the NJ Ex [redacted] was not in use that it would be placed in a plastic bag. The surveyor asked NJ Ex C LPN if a resident that received NJ Ex should have a sign that indicated NJ Ex in use. The LPN stated that there should be a sign. The surveyor then asked the LPN to view Resident #66's NJ Ex Order 26.4(b)(1) that was on the NJ Ex Order 26.4(b)(1). The LPN confirmed that the NJ Ex Order 26.4(b)(1) was placed on top of the NJ Ex Order 26.4(b)(1) and not in the clear plastic bag. The LPN stated that the NJ Ex Order 26.4(b)(1) [redacted] had done that when the NJ Ex Orde just got the resident out of bed and that the NJ Ex Order 2 should have been placed in the clear plastic bag. LPN#1 stated that she would discard the NJ Ex Order 2 and get a new one. On that same date and time, the surveyor then asked LPN#1 to observe Resident #66 in the dining room. The LPN confirmed that the NJ Ex [redacted] that Resident #66 had on was not dated and that it should have been dated. The LPN added that sometimes they write on the NJ Ex Order 2 but that it should be written on a piece of tape. On 8/15/24 at 12:36 PM, the surveyor interviewed Charge Nurse/Licensed Practical Nurse #1 (CN/LPN#1) in the 3rd floor regarding the process for NJ Ex C CN/LPN#1 stated that the NJ Ex Order 26.4(b)(1 should be dated and in a bag plastic when not in use. The surveyor asked CN/LPN#1 if there should be a sign on the resident's door. CN/LPN#1 stated that there should be a sign. On 8/15/24 at 12:44 PM, CN/LPN#1 stated that the facility was not a smoking facility, so they did not have to put up the NJ Ex in use sign.	F 695	current date, is being stored properly and is set at the correct LPM as ordered by the physician. The DON or designee will conduct tracheostomy/laryngeal care observations of 2 residents weekly x 4 weeks, then monthly x 3 months to ensure care, hand hygiene and enhanced barrier precautions are being followed and completed properly. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	

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F 695	Continued From page 50 On 8/15/24 at 01:01 PM, the U.S. FOIA (b) (6) [redacted]) stated that the facility was a non smoking facility and that they did not have to put up [NJ Ex] in use signs. He added that he believed the signs were for a smoking facility. On 8/21/24 at 12:58 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b)] U.S. FOIA (b) (6) [redacted]) and [U.S. FOIA (b) (6)] [redacted] the concern that Resident #66's [NJ Ex Order 26.4(b)(1)] that was in use was not dated, the [NJ Ex Order 26.4(b)(1)] that was not being used by the resident was not placed in a plastic bag and there was no [NJ Ex] in use sign posted outside the room. On 8/22/24 at 11:18 AM, in the presence of the survey team, [U.S. FOIA (b)] [U.S. FOIA (b)] U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted], the [U.S. FOIA (b)] stated that the resident had a care plan for non compliance and a history of removing the [NJ Ex O] The [U.S. FOIA (b)] stated that it was possible that the resident placed the [NJ Ex Order 26.4(b)(1)] on the [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b)] stated that he did not know why the other [NJ Ex Order 2] was not dated. The surveyor asked if the resident needed assistance to transfer from the bed to a wheelchair. The [U.S. FOIA (b)] stated that the resident was supposed to be helped by the [US FOIA (b)] and that the [US FOIA (b)] placed it [NJ Ex Order 26.4(b)(1)] on the [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b)] stated that according to NFPA (National Fire Protection Association) 101 that in a nonsmoking facility it was not required to have signage outside [NJ Ex] storage rooms and resident rooms that had [NJ Ex] in use. The [U.S. FOIA (b)] provided the survey with a printout of a NFPA regulation.	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A review of the facility provided printout included the following:
NFPA 101 19.7.4 Smoking.
Smoking regulations shall be adopted and shall include not less than the following provisions:
(1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or O2 is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.

The above NFPA 101 Smoking information revealed that there was no reference regarding NJ Ex [redacted] in use sign.

On 8/22/24 at 12:59 PM in the presence of the survey team, the U.S. FOIA (b) [redacted] the U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6) and U.S. FOIA (b) (6) [redacted] the U.S. FOIA (b) [redacted] stated that NJ Ex [redacted] in use signs were specific to NJ Ex Order 26.4(b) [redacted] and that as far as he knew there was no issue during previous surveys.

A review of the facility provided policy titled, "Oxygen Administration" with a revised date of April 2024, included the following:
7. Equipment Maintenance:
Date and initial tubing and humidifiers when started each week.
The policy did not include how to store the O2 tubing when not in use.

2. On 8/14/24 at 10:40 AM, the surveyor interviewed CN/LPN#2 who informed the surveyor that residents on NJ Ex Order 26.4(b)(1)

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NJ Ex Order 26.4(b)(1)) were those residents with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) further stated that Resident #111 had a NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1).

On 8/14/24 at 10:56 AM, the surveyor observed an NJ Ex Order 26.4(b)(1) sign posted outside the door of the resident. Both LPN#2 and the surveyor inside the resident's room observed Resident #111 with NJ Ex Order 26.4(b)(1) via the NJ Ex Order 26.4(b)(1), attached to a NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1).

At that same time, LPN#2 confirmed that the resident had NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) and stated that the NJ Ex Order 26.4(b)(1) had a date of NJ Ex Order 26.4(b)(1) which indicated that the NJ Ex Order 26.4(b)(1) was changed on that date.

The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #111 and revealed:
The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1).

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NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)

The most recent quarterly MDS with an assessment reference date (ARD) of NJ Ex Order 26.4, under Section NJ Ex Order 26.4(b)(1), reflected on NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and showed that the resident was coded for number NJ Exec Or which indicated that the resident's NJ Ex Order 26.4(b)

A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed the following physician's orders (PO):
-PO dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) with humidification every shift for NJ Ex Order 26.4(b)(1)) Administer NJ Ex O via NJ Ex Order 26.4(b)(1). Monitor NJ Ex Order 26.4(b)(1)) every shift. Notify US FOR if NJ Ex Order 26.4(b) less than or equal to NJ Ex Orde
-PO dated NJ Ex Order 26.4(for NJ Ex Order 26.4(b)(1) care every shift to maintain NJ Ex Order 26.4(b)(1) every shift.
-PO dated NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) every shift to maintain NJ Ex Order 26.4(b)(1) every shift.

Further review of the hybrid medical records showed that the above orders were transcribed to the electronic Treatment Administration Record (eTAR) for NJ Ex Order 26.4(b)(1) and were signed by nurses as administered and provided.

On 8/15/24 at 8:29 AM, LPN#2 informed the surveyor that she would NJ Exec Order 2 and provide NJ Ex Orde care for the resident. Inside the resident's room, both the surveyor and the LPN observed the

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resident's [NJ Ex] was at [NJ Ex Order 26.4(b)(1)]. The LPN stated that the resident's [NJ Ex] should be set at [NJ] and not [NJ Ex Order 2]. She further stated that she wanted to correct what she said to the surveyor yesterday (8/14/24) that the resident's [NJ Ex] order was [NJ Ex Order 2]. The LPN also stated that she did not know why the [NJ Ex] was at [NJ Ex Order 2] yesterday and "now" at [NJ Ex Order 26.] The LPN immediately adjusted the setup of [NJ Ex] to [NJ Ex Order 2] and stated that the order was at [NJ Ex Order 26.]

On that same date and time, the surveyor observed LPN#2 pull the curtain for privacy with gloves, open the nightstand table, and stated she was looking for the [NJ Ex Order 26.4(b)(1)]. The LPN found the [NJ Ex Order 26.4(b)(1)] on top of the [NJ Ex Order 26.] machine, the [NJ Ex Order 26.4(b)(1)] was inside a plastic and placed the [NJ Ex Order 26.4(b)(1)] (still inside the bag) near the resident's pillow, then pulled the curtain, removed gloves, donned (put on) a new pair of gloves without performing hand hygiene. The LPN with gloves, pulled the curtain again for privacy, took [NJ Ex Order 26.4(b)(1)] near the [NJ Ex Order 26.] , and [NJ Ex C] it with [NJ Ex Order 26.4(b)(1)]). The LPN did not remove gloves that were used in touching the resident's immediate environment. The LPN with the same gloves, cleansed the [NJ Ex Order 26.4(b)(1)], and the surrounding area. The LPN doffed off (removed) gloves, performed hand hygiene with the use of alcohol base hand rubbed (ABHR) inside the resident's room, donned gloves, and [NJ Ex Order 26.4(b)(1] the resident. The LPN [NJ Ex Order 26.4(b)(1] the resident [NJ Ex] and the LPN stated that there were [NJ Ex Order 26.4(b)(1)] After [NJ Ex Order 26.4(b)(1)] the resident, the LPN removed gloves, performed hand hygiene with the use of ABHR, immediately went outside the resident's room without removing the [NJ Ex Order 2] and took the NJ Ex Order 26.4(b)(1)

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NJ Ex Order 26.4(b)(1) Inside the resident's room, the LPN donned a new pair of gloves without performing hand hygiene and checked the resident's NJ Ex Order 26. The LPN after checking the NJ Ex Order 26, removed gloves, went to the resident's toilet room, placed the NJ Ex Order 26 machine on top of the sink and the LPN performed handwashing for 55 seconds, dried hands with a paper towel, took another paper towel and took the NJ Ex Order 26.4(b)(1) outside the room without removing gown that was used for NJ Ex Order 26.4(b)(1) the resident. Then the LPN returned to the resident's room with the same gown.

At that time, the surveyor asked LPN#2 about the observation of hand hygiene and PPE use. The LPN stated that she should have performed hand hygiene after removing gloves and prior to donning gloves. She further stated that she should have removed the gown inside the room before exiting the room because the gown was contaminated during NJ Ex Order 26.4(b)(1)

On 8/15/24 at 11:22 AM, the surveyor interviewed the U.S. FOIA (b) (6) The U.S. FOIA (b) informed the surveyor that she was responsible for the facility staff's education regarding infection control that included hand hygiene and PPE use. The surveyor notified the U.S. FOIA (b) of the above findings regarding the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) concerns.

On that same date and time, the U.S. FOIA (b) informed the surveyor that LPN#2 should have performed hand hygiene after the direct contact of the LPN's hand with gloves in the immediate environment of the resident's curtain and nightstand table drawer, in between use of gloves [before and after gloves donning and doffing]. The U.S. FOIA (b) stated that the

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F 695	Continued From page 56 LPN should have removed the gown and other PPE when exiting the resident's room. The [U.S. FOIA (b)] also stated that the LPN should have used a sterile [NJ Ex Order 26.4b1] and a new [NJ Ex Order 26.4b1] at that time. On 8/21/24 at 12:58 PM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] The surveyor notified the facility management of the above findings and concerns. On 8/22/24 at 11:07 AM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] also stated that the facility did multiple in-services to address the concerns and findings of the surveyor with regard to Resident #111. A review of the facility's Oxygen Administration Policy with a revised date of April 2024 that was provided by the [U.S. FOIA (b)] revealed: II. Policy: O2 will be administered as per the MD (medical doctor) order to aid in breathing. III. Procedure: 1. Check MD Order .... On 8/23/24 at 12:51 PM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a)	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F 697		9/27/24

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F 697	Continued From page 57 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure: a.) that the Physician's Order (PO) for [redacted] was clarified according to the appropriate [redacted] for one (1) of two (2) residents, Resident #111, and b.) the PO for as needed [redacted] medications were separated according to indications for two (2) of two (2) residents, Residents #111 and #164, reviewed for NJ Ex Order 26.4(b)(1) according to standards of clinical practice and facility policy. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 697	Tag F697 Pain Management 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice For Resident #111: The physician's order for NJ Ex Order 26.4(b)(1) was clarified to specify the appropriate [redacted] medication based on the resident's [redacted]. The as needed (PRN) orders for [redacted] and [redacted] were separated according to their indications. It was clarified with the physician that [redacted] is indicated for [redacted] to [redacted] and [redacted] is indicated for [redacted] The PRN order for [redacted] was further clarified to separate the indications for [redacted] and [redacted]. The orders were adjusted accordingly. For Resident #164, the PRN order for NJ Ex Order 26.4(b)(1) was clarified to separate the indications for [redacted] and [redacted] Resident #164 is no longer a resident at the facility. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who receive PRN pain medications have the potential to be affected by the same deficient practice. The Director of Nursing or designee conducted a comprehensive review of all current resident physician orders to	

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F 697	Continued From page 58 "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 8/14/24 at 10:40 AM, the surveyor interviewed the U.S. FOIA (b) (6) who informed the surveyor that Resident #111 was in NJ Ex Order 26.4(b)(1). On 8/14/24 at 10:56 AM, the surveyor observed an NJ Ex Order 26.4(b)(1)) sign posted outside the door of the resident. Both Licensed Practical Nurse #1 (LPN#1) and the surveyor inside the resident's room observed Resident #111 with NJ Ex Order 26.4(b)(1) with a NJ Ex Order 2 attached to a NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) at NJ Ex Order 2). The LPN also stated that the resident was recently admitted for NJ Ex Order 26.4 care. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #111 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)	F 697	identify any PRN pain medications with multiple indications, overlapping indications, or unclear pain level guidelines. All identified concerns were clarified with the attending physician, and the orders were updated accordingly. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Director of Nursing or designee in-serviced all licensed nursing staff on the Pain Management Policy with emphasis on clarifying orders for PRN pain medications with multiple or overlapping indications. A 24-Hour chart check will be implemented for reviewing and clarifying physician orders for pain management, ensuring that all orders are clear, complete, and consistent with current standards of practice. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing or designee will conduct random audits of 10 residents' medical records weekly x 4, then monthly x 3 months to ensure that physician orders for pain management are clear without with overlapping or multiple indications. The results of these audits will be reported to the quarterly Quality Assurance Performance Improvement (QAPI) Committee for evaluation.	

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NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)

The most recent quarterly MDS with an assessment reference date (ARD) of NJ Ex Order 26.4, under Section NJ Ex Order 26.4(b)(1), reflected on NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and showed that the resident was coded for NJ Ex Order 26.4 which indicated that the resident's NJ Ex Order 26.4(b) was NJ Ex Order 26.4(b)(1).

A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed the following PO:
-PO dated NJ Ex Order 26.4 for [name of NJ Ex Order 26.4] NJ Ex Order 26.4 evaluation and treatment.
-PO dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) give two tablets (tab) via NJ Ex Order 2) every six hours (hrs) as needed (PRN) for NJ Ex Ord do not exceed NJ Ex Order 2 of NJ Ex Order 26.4(b)(1) from all sources in 24 hrs.
-PO dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) every four hrs PRN for NJ Ex Order 26.4(b)(1)). May repeat in 30 min (minutes) if the first dose is ineffective (NJ Ex Ord .

On 8/20/24 at 8:50 AM, the surveyor interviewed the U.S. FOIA (b)(6). The surveyor notified the U.S. FOIA (b)(6) of the above findings and concerns. The U.S. FOIA (b) (6) informed the surveyor that the resident was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), and it was the NJ Ex Order 26.4 nurse who recommended the PRN NJ Ex Order 26.4(b)(1) The U.S. FOIA (b)(6) stated that the PRN

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NJ Ex Order 26. and NJ Ex Order 26.4(b)(should have been clarified with the doctor for medications (meds) sequencing to determine which med to administer first according to NJ Ex Order 26.4(b)(. She further stated that the PRN NJ Ex Order 26. should be for NJ Ex Order 26.4(b) and the PRN NJ Ex Order 26.4(b)(should be for NJ Ex Order 26.4(b)(1)

On that same date and time, the U.S. FOIA (b) (6) stated that the order for PRN NJ Ex Order 26.4(b)(should have been separated, one for PRN NJ Ex Ord and one for PRN NJ Ex Order She further stated that she would call the doctor and clarify the orders.

On 8/20/24 at 02:19 PM, the U.S. FOIA (b) (6) stated that the facility had no policy with regard to the sequencing of meds.

On 8/21/24 at 12:58 PM, the survey team met with the U.S. FOIA (b) (6) , U.S. FOIA (b) an U.S. FOIA (b) (6) The surveyor notified the facility management of the above findings and concerns.

On 8/22/24 at 11:07 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , and U.S. FOIA (b) (6) U.S. FOIA (b) also stated that the facility did multiple in-services to address the concerns and findings of the surveyor with regard to Resident #111.

A review of the facility's Pain Management Policy with a reviewed date of April 2024 that was provided by the U.S. FOIA revealed:
II. Policy: it is the policy of the facility to provide a uniform method of assessing and documenting our residents' complaints of pain and effectively

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treat residents with both chronic and/or acute pain ...
III. Procedure: all residents will be assessed for pain on admission and readmission and as needed thereafter.
IV. Purpose:
-to reduce pain and perception of pain.
-to reassess pain relief and pain intensity at a regular interval ...
V. Resident Rights:
1. Residents have the right to understand their options for pharmacologic and non-pharmacologic pain control strategies.
2. Residents may describe verbally or nonverbally the pain, location, and characteristics of the pain ...

On 8/23/24 at 12:51 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) for an Exit Conference and there was no additional information provided by the facility management.
2. On 8/14/24 at 11:14 AM, the surveyor observed Resident #164 resting in bed with their eyes closed. The resident was NJ Ex Order 26.4(b)(1) to the surveyor's greeting.

On 8/15/24 at 01:31 PM, the surveyor interviewed LPN#2 who was assigned to care for the resident. LPN#2 confirmed that the resident was receiving NJ Exec Order 26.4b1 care and was NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 The LPN further stated the resident was to be kept comfortable and there were no reported concerns.

The surveyor reviewed the hybrid medical records of Resident #164.

The AR documented that the resident had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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F 697	Continued From page 62 diagnoses that included but were not limited to, [redacted] and [redacted] A PO dated [redacted] read, "[redacted] eval [evaluation] & care by [redacted] Agency Name]" A PO dated [redacted] read, "[redacted] Give [redacted] by mouth every 4 hours PRN for [redacted] administer [redacted] A review of the electronic Medication Administration Record (eMAR) for [redacted] revealed the resident received [redacted] nine times for [redacted] The numerical [redacted] scale documented ranged from [redacted] to [redacted] On 8/21/24 at 01:03 PM, the surveyor informed the [redacted] the [redacted] and the [redacted] of the concern for the [redacted] having the two indications for [redacted] and [redacted] The facility to review to provide additional information. On 8/22/24 at 11:07 AM, the survey team met with the [redacted] the [redacted] the [redacted] the [redacted] and the [redacted]. The [redacted] stated nursing staff were provided in-service education about clarifying and entering orders for medication with multiple PRN indications separately. The [redacted] added that the facility followed up with the [redacted] agency as the [redacted] nurse had written the recommendation for [redacted] as it was carried out. The [redacted] acknowledged that the order should have been carried out by the nurse at the time of order entry. NJAC 8:39-27.1 (a)	F 697		

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F 728	Continued From page 63	F 728		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent	F 728		9/25/24

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F 728	Continued From page 64 as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a.) a non-certified Nurse Aide (NA) did not continue to work as an NA after the specified 120 days for one (1) of two (2) NAs reviewed, (NA #1) and b.) there was a delineated policy and/or program in place for the hiring of non-certified NAs. This deficient practice was evidenced by the following: Reference: State of New Jersey (NJ) Department of Health memo dated April 21, 2023, sent to Nursing Homes included the following: On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP (Nurse Aide Training and Competency Evaluation Program) and completed the first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6,	F 728	Tag F 728 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Correct school verification was immediately obtained and verified for Nurses Aide # 1. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. All nurses' aides will have school verification prior to hire. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: A checklist has been provided to the Human Resources Director to ensure that all Nurses' aides have a school verification prior to hire. U.S. FOIA (b) (6) [redacted] was educated by the administrator to verify the school enrollment for nurses' aides and ensuring that nurses aides are not employed for longer than 120 days. The administrator or designee will review new nurse aide applicant charts prior to their date of hire to ensure that school verification is obtained and documented in their employee record/chart. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	

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F 728	Continued From page 65 2022). Facilities are advised as follows: II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 8/14/24, at 01:11 PM, the U.S. FOIA (b) (6) [redacted]) provided the survey team of the facility's list of new hires form from the last recertification survey to 8/14/22 that was requested by the survey Team Coordinator (TC) during the facility entrance conference. The surveyor randomly chose ten new hire employee files to review and requested the files from the LNHA that included NA#1. On 8/20/24, the surveyor reviewed the employee file for NA #1 provided by the [redacted]. The file revealed the following: -had a date of hire of [redacted]. -a Certificate of Completion for a Certified Home Health Aide issued [redacted](undated). -a signed job description for a Certified Nursing Aide (CNA). -a duplicate result report that reflected that NA #1 passed a skill test that was a manual skill portion of the NJ CNA competency exam. -the cover of the employee file folder, under "job title" reflected CNA. The file did not show any proof of school enrolment or completion, or successful completion of state approved 90 hours of training.	F 728	Administrator or designee will audit 2 nurse aide charts weekly for 4 weeks and then monthly for 3 months. Results will be brought to the quality assurance and performance improvement meeting which will be held quarterly	

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F 728	Continued From page 66	F 728		

On 8/21/24 at 12:02 PM, the surveyor in the presence of the survey team interviewed the U.S. FOIA (b) (6)). The surveyor asked for documentation for NA #1 showing that they are currently enrolled in school and successful completion of 90 hours of state approved training. The surveyor also requested any policy for hiring or on boarding for NA's and/or new employees.

On 8/22/24 at 12:37 PM, the U.S. FOIA provided documents to the survey team and revealed:
-a timecard report for NA #1 for the dates of NJ Ex Order 26.4 through NJ Ex Order 26.4 which reflected dates NA #1 worked in the facility which were NJ Ex Orde .
-an undated appointment confirmation for NA #1 to take an exam for NJ CNA.

On that same date and time, the U.S. FOIA stated that NA #1 was finishing up her training today and she was NJ Exec Order 26.4b1 in school when she was hired. She further stated that NA #1 finished classes in NJ Exec Order 26.4b1. The U.S. FOIA also stated that she did not know the Certificate in the file was for a Home Health Aide not a CNA. The U.S. FOIA (b) (6) provided an Employee File Check List to the survey team and stated that there was no policy for hiring or on boarding.

On 8/23/24 at 9:50 AM, the U.S. FOIA provided to the survey team an undated document that was a copy of a Certificate of Completion of a CNA program of 90 total hours for NA #1. The U.S. FOIA stated that the "school made a mistake and sent the wrong certificate" referring to the previous certificate that was in NA #1's file. The new certificate reflected an "issued date" of NJ Ex Order 26.4 .

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F 728	Continued From page 67 On 8/23/24 at 11:26 AM, the survey team met with the facility administrative team consisting of the [redacted] the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6) The surveyor team discussed the concern with NA #1's verification of school and training prior to hire. On 8/23/24 at 12:25 PM, the survey team met with the [redacted] and [redacted] for any responses to concerns. The [redacted] stated clarifying the school verification, the skills test means she was in school. The facility has no other pertinent information to offer. N.J.A.C. 8:39-43.1	F 728		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		9/23/24

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F 757	Continued From page 68 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of thirty-six (38) residents reviewed, (Resident #147). The deficient practice was evidenced by the following: On 8/15/24 at 11:18 AM, the surveyor observed Resident #147 in a wheelchair in hallway. The resident agreed to speak with the surveyor. During the brief interview, the resident stated they were NJ Ex Order 26.4(b)(1) at the facility and was here because of a NJ Ex Order 26.4(b)(1). The surveyor asked if the resident has any NJ Ex Or or other complaints. The resident did not state anything specific but did refer to some NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(at times. The surveyor reviewed Resident #147's electronic medical record (EMR) which revealed the following: A review of Resident #147's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)	F 757	Tag F757 Drug Regimen is Free From Unnecessary Drugs 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Resident #147□s physician was notified about the resident complaint of NJ Ex Order 26.4(b)(and changed the time of the NJ Ex Order 26.4(b)(1) medication to bedtime (9 PM) and ordered a NJ Ex Order 26.4(b)(1) consult to address the diagnosis of NJ Ex Order 26.4(b)(1) versus NJ Ex Order 26.4(b)(1). On 8/24/24 resident #147 was evaluated by her physician and diagnosed with NJ Ex Order 26.4(b)(1) . Resident #147 was discharged to home on NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents with a physician□s order for Ropinirole have the potential to be affected by the deficient practice. A review of current residents who reside in the facility has been completed and no residents were identified with a physician□s order for Ropinirole. 3. What measures will be put into place or what systemic changes you will make to	

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F 757	Continued From page 69 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)). Resident #147's Medicare 5-day Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4, reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify NJ Exec Order 26.4b1, score of NJ Ex out of 15, which indicated that Resident #147 was NJ Ex Order 26.4(b)(1) The resident's list of medication (med) reflected a Physician's order (PO) for NJ Ex Order 26.4(b)(1) tablets, once a day, scheduled to be given in the morning at 9:00 AM. The order reflected a diagnosis of NJ Ex Order 26.4(b)(1). The surveyor reviewed the manufacturer's package insert for Ropinirole. The package insert reflects Federal Drug Administration approved indications for use of the med. FDA indications reflected were treatment of NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) The recommended dose for NJ Ex Order 26.4(b)(1) is NJ Ex Order 26 3 times a day up to a maximum (max) of NJ Ex Order 26 total per day. The recommended dose for NJ Exec O is NJ Ex Order 26 once per day, 1 to 3 hours before bedtime, increasing to a max of NJ Ex Orde per day. Further review of the Resident #147's EMR did not reveal a diagnosis of NJ Ex Order 26.4(b)(1) or NJ Ex Orde A diagnosis of NJ Exec Order 26.4b1 was reflected in the EMR. Review of the Physician's Progress Notes (PN) in the EMR did not reveal any documentation that reflected a statement of using NJ Ex Order 26.4(b)(1) outside of the manufacturer's	F 757	ensure the deficient practice will not recur: The Director of Nursing (DON) or designee has educated nurse managers, supervisors and charge nurses on the manufacturer□s guidelines for indication when an order for Ropinirole is received and to notify the physician if the diagnosis is not restless leg syndrome or Parkinson□s Disease so the risk versus benefit can be reviewed and documented. The systemic change will be that a monthly report will be run in the electronic health record (EMAR) to identify physician□s orders for Ropinirole to ensure that the appropriate diagnosis of restless leg syndrome or Parkinson□s Disease is in place or that the risk versus benefit is documented by the physician in the medical record. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will conduct weekly audits x 4, then monthly audits of residents who have a physician□s order for Ropinirole medication to ensure that the appropriate diagnosis of restless leg syndrome or Parkinson□s Disease is in place or that the risk versus benefit is documented by the physician in the medical record. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement	

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F 757	Continued From page 70 indication or a statement of benefit versus risk to the resident for using NJ Ex Order 26.4(b)(1) for other NJ Ex Order 26 . On 8/19/24 at 11:34 AM, the surveyor interviewed the U.S. FOIA (b) (6) on the unit where Resident #147 resides. The U.S. FOIA (b) (6) stated that Resident #147's US FOIA (b)(6) usually visits on the weekends. On 8/19/24 at 11:38 AM, the surveyor interviewed the resident while in bed. The resident stated they NJ Ex Order 26.4(b)(1), with NJ Ex Order 26.4(b)(1) like NJ Ex Order 26 and NJ Ex Or in bed. On 8/19/24 at 11:39 AM, the surveyor notified the U.S. FOIA (b) (6) of Resident #147's statements of NJ Ex Or and NJ Ex Order 26.4(b)(1) On 8/20/24 at 01:23 PM, the surveyor documented attempts to reach Resident #147's US FOIA by telephone. They surveyor attempted three (3) times, at 12:53 PM, 01:16 PM, 01:17 PM and reached a recording each time. On 8/21/24 at 9:45 AM, the surveyor attempted to reach the US FOIA by telephone and reached a recording. Unable to reach US FOIA for an interview. On 8/21/24 at 01:08 PM the surveyor in the presence of the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) . The surveyor asked the U.S. FOIA to provide any information for the use of NJ Ex Order 26.4(b)(1) for Resident #147 including any record of diagnosis, indications, or benefit versus risk.	F 757	(QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	

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F 757	Continued From page 71 On 8/22/24 at 11:07 AM, the survey team met with the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)). The U.S. FOIA stated that Resident #147 was taking NJ Ex Order 26.4(b)(1) in the hospital and was ordered for NJ Ex Order 26.4(b)(1). The U.S. FOIA also stated the med was ordered as an "as needed" order from the hospital and the US FOIA changed it to a routine order and for other NJ Ex Order 26.4(b)(1) as a diagnosis code was difficult to find for NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that other could mean NJ Ex Order 26.4(b)(1) On 8/23/24 at 9:14 AM, the U.S. FOIA provided a nursing PN dated NJ Ex Order 26.4 that reflected communication with Resident #147's US FOIA The U.S. FOIA stated that the US FOIA stated that he was not a NJ Ex Order 26.4(b)(1) and cannot diagnose NJ Ex Order 26.4(b)(1) The nursing PN the U.S. FOIA provided reflected a discussion between the U.S. FOIA and US FOIA The PN reflected that the US FOIA stated NJ Ex Order 26.4(b)(1) may present as "NJ Ex Order 26.4(b)(1)." The PN reflected that he wanted a follow up with a NJ Ex Order 26.4(b)(1), continue the med at the current dose and change the administration time to 9:00 PM. The facility provided no further pertinent information as of 8/23/24 at 12:52 PM.	F 757		
F 761 SS=D	N.J.A.C. 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		10/1/24

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F 761	Continued From page 72 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on two (2) of three (3) floors. This deficient practice was evidenced by the following: On 8/19/24 at 10:25 AM, the surveyor conducted the Medication Storage and Labeling task. The surveyor inspected a medication (med) cart located on the third-floor north unit in the presence of Licensed Practical Nurse #1 (LPN#1) assigned to that med cart. The surveyor observed	F 761	Tag F761 Label/Store Drugs and Biologicals 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice No residents were identified to be affected by the deficient practice of improper drug storage. The 9 medications found loose in the bottom of the drawer on the 3rd floor North medication cart were immediately removed and disposed by Licensed Practical Nurse (LPN) #1. The 2 medications found in the bottom of the drawer in the 2nd floor South medication	

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F 761	Continued From page 73 nine (9) medications (meds) of various sizes, shapes and colors located on the bottom of the second drawer of the med cart. The surveyor showed the loose meds to the LPN and asked if those meds should be there. The LPN stated "no," there should not be any loose meds. The surveyor observed the LPN dispose of the loose meds. The surveyor inspected a med cart located on the second-floor south unit in the presence of LPN#2 assigned that med cart. The surveyor observed two (2) meds, white in color, on the bottom of the second drawer of the med cart. The surveyor showed the loose meds to the LPN and asked if those meds should be there. The LPN stated "no," they should remain in packaging until used. They surveyor observed the LPN dispose of the loose meds. On 8/21/24 at 01:08 PM, the surveyor, in the presence of the survey team, informed the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)). The surveyor asked the U.S. FOIA if there should be any loose med in the med carts. The U.S. FOIA stated, "no," there should not be. The surveyor requested the facility policy for Medication Storage. On 8/22/24 at 11:07 AM, the U.S. FOIA provided the facility policy for Medication Storage, with a revised date of August 2024, to the survey team. A review of the facility's Medication Storage Policy with a revised date of August 2024 revealed: Section II. Purpose: To ensure the safe and secure storage of all meds and biologicals, preventing unauthorized access, maintaining med	F 761	cart were immediately removed and disposed by LPN #2. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who receive medications have the potential to be affected by the deficient practice. All medication carts in the facility were inspected and no other loose medication(s) was found in the bottom of the drawers in the carts. LPN #1 & LPN #2 were educated on the facility Medication Storage Policy. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: A new procedure has been added to the night shift (11PM to 7AM) to remove the cards that the medications are dispensed in from the pharmacy and check the bottom of the drawers for any loose medications found have been removed and properly disposed of daily. The Assistant Director of Nursing (ADON) has conducted in-servicing with licensed nursing staff on the facility policy for Medication Storage with emphasis on checking the bottom of the drawers in the medication carts for loose pills and disposing of them as soon as possible. The ADON has also educated the licensed nursing staff on the new procedure for 11-7 shift to check sign off that the carts have been inspected for loose medications.	

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F 761	Continued From page 74 integrity, and promoting patient safety. Section III. Scope: This policy applies to all meds and biologicals stored within the facility, including those in med rooms, carts, boxes, and refrigerators. Section IV. Policy: 1. Secure Storage: Line 3- Med storage areas must be kept clean and sanitary. 2. Labeling: Line 1- All meds and biologicals must be labeled in accordance with currently accepted professional principles... 6. Medication Carts: Line 2- Meds on carts must be organized and labeled clearly. On 8/23/24 at 10:59 AM, the U.S. FOIA provided to the survey team, a U.S. FOIA (b) (6)) unit inspection report for Unit 2 North, dated 7/23/24. A review of the U.S. FOIA unit inspection report reflected, under the section Additional Comments, Unit Comment. "Please remove loose pills from bottom of med drawers." On 8/23/24 at 12:51 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , U.S. FOIA (b) for an Exit Conference. There was no additional information provided by facility.	F 761	4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing (DON) or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months of three medication carts to ensure no medications are found loose in the bottom of the drawers in the carts. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	
F 804 SS=D	NJAC 8:39-29.4(a)(f-h) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804		10/2/24

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F 804	Continued From page 75 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure palatable and appetizing temperature of food for one (1) lunch meal observed on one (1) of four (4) nursing units (Third floor unit). This deficient practice was evidenced by the following: Reference: "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines" N.J.A.C. 8:24-3.5 Limitation of growth of organisms of public health concern (f) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under (g) below, potentially hazardous food shall be maintained: 1. At 135°F or above, except that roasts cooked to safe cooking temperatures or reheated as specified under N.J.A.C. 8:24-3.4(g)5 may be held at a temperature of 130°F; or 2. At refrigeration temperatures. On 8/19/24 at 10:38 AM, the surveyor held a Resident Council meeting with four residents (Resident #94, #98, #122 and #159). Two of the four residents complained that the hot food was cold by time the food got to the floor. The residents thought it was related to staffing and that not everyone got their tray timely. The residents stated that they brought their concerns	F 804	Tag F 804 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice No residents were affected by this deficient practice. A sample test tray was determined to be under 135 degrees Fahrenheit during serving time. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The deficient practice had the potential to affect residents who eat meals provided by the facility. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Administrator or designee conducted in-services for licensed and certified nursing staff on the timeliness of meal pass. The US FOIA (b)(6) was educated to do sample test trays to determine if meals are being served at palatable temperatures. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Food Service Director/Designee will conduct test tray audits for all three meals	

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F 804	Continued From page 76 to the monthly food meetings but that there was no change. On 8/21/24 at 11:20 AM, during the food tray line, the surveyor, in the presence of another surveyor, asked the U.S. FOIA (b) (6)) to place an extra tray on the food cart that was going to the third floor unit to be tested. The surveyor asked the U.S. FOIA if he had done test trays to check the temperature on the unit. The U.S. FOIA stated that he did one or two trays a week. On 8/21/24 at 11:28 AM, in the presence of another surveyor, the surveyor observed the first cart that was going to the third floor unit was completed with the residents trays and one extra test tray and the U.S. FOIA placed a clear plastic bag over the open metal tray cart. The U.S. FOIA then took the tray cart to the unit. The surveyor, in the presence of another surveyor, asked the U.S. FOIA about his thermometer. The U.S. FOIA stated that he had calibrated the thermometer about an hour ago to 32 degrees using the ice method. The surveyor observed that one of the two elevators had a sign that the elevator was not working. On 8/21/24 at 11:32 AM, in the presence of another surveyor, the surveyor observed the U.S. FOIA went on the elevator with the tray cart. On 8/21/24 at 11:35 AM, in the presence of another surveyor, the surveyor observed the U.S. FOIA arrived on the third floor unit with the lunch cart. While waiting for the lunch trays to be passed out by the unit staff, the surveyor, in the presence of another surveyor, asked the U.S. FOIA if he received complaints about the food not being served hot. The U.S. FOIA stated that he did not receive any complaints "in a long time" because there was a	F 804	for hot food on a weekly basis for one month and then monthly for 2 months to assist with determining gaps in the process for achieving meal tray temperatures that are safe and appetizing. If an appropriate temperature is not achieved a plan of correction will be implemented immediately. The Food Service Director will present the weekly test tray audits at the next quarterly Quality assurance and performance improvement meeting for follow-up and to determine if additional oversight of this area is required.	

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palate that kept the plate hot.

On 8/21/24 at 11:38 AM, in the presence of another surveyor, the surveyor observed a unit staff member remove the clear plastic bag from the lunch tray cart and she and one other staff member started to pass the trays. The surveyor observed that during the passing of the trays three additional staff at different times joined the initial two staff members pass trays. The surveyor observed that when a staff member took off a tray from the cart that they had to take the empty cup and pour the desired beverage into the cup before bringing the tray to each resident.

On 8/21/24 at 11:50 AM, in the presence of another surveyor, the surveyor observed a staff member take the last resident tray off the cart and as the tray was being removed, the surveyor notified the U.S. FOIA to take the temperatures of the food on the extra test tray. In the presence of another surveyor, the surveyor observed the U.S. FOIA obtain the following temperatures from the sample tray:
Chicken 128.3 degrees in one part and then 130 degrees in another part
Spinach 118 degrees
Corn on the cob 129 degrees
Watermelon (cut in small pieces) 54.9 degrees

At that time, the surveyor, in the presence of another surveyor, asked the U.S. FOIA what he expected the temperatures to be. The U.S. FOIA stated that hot food should be between 130 and 135. He added that he would expect it to be more than that but that it should at least be that. The U.S. FOIA stated that the cold should be in the 50's but no more than 60. He added that considering the time the staff took to pass the trays was a factor. He

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added that he expected the last tray to be passed 15 to 20 minutes from the time it left the kitchen. The [U.S. FOIA] stated that it should take three minutes to come up to the unit, three to five minutes waiting for passing to start and be passed in the range of 10 minutes.

Furthermore, the surveyor, in the presence of another surveyor asked the [U.S. FOIA] how he performed test trays. The [U.S. FOIA] stated that he did the test tray downstairs in the kitchen, that he would leave a tray in his office and test it five to 10 minutes later. The surveyor in the presence of another surveyor asked the [U.S. FOIA] if the temperature of the hot food was acceptable. The [U.S. FOIA] stated that he would expect it to be hotter.

On 8/21/24 at 12:59 PM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] the concern regarding the lunch tray temperatures and the temperatures that were taken on each item.

On 8/22/24 at 11:21 AM, in the presence of the survey team, [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], the [U.S. FOIA (b)] stated that food had to be served at a palatable temperature. He added that he had interviewed residents after the lunch meal and the residents were extremely happy with the meal. The [U.S. FOIA (b)] provided the surveyor with a printout of the Dining Order Report, which had the residents listed for the lunch cart that was observed the previous day. The Dining Order Information had 21 residents listed in order by room number.

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F 804	Continued From page 79 A review of the facility provided printout included the following handwritten and signed by the [U.S. FOIA (b) (6)] I interviewed: Unsampled Resident (listed as #6 on the dining order)-Lunch was delicious today. I loved the corn. It was hot and tasty. Resident #122 (listed as #3 on the dining order)-The lunch was really good today. [I ([U.S. FOIA (b) (6)] asked if it was warm) Resident replied yes. Unsampled Resident (listed as #5 on the dining order)-Lunch was real tasty today. It was warm. The chicken breast and corn and spinach were really warm and good. Unsampled Resident (listed as #2 on the dining order)-Lunch was really nice. I ate my entire plate. It was nice and hot. A review of the undated facility provided policy titled, "Timely Meal Service" included the following: Policy: Food will be delivered promptly to ensure safe, palatable and high-quality food served at the proper temperature. Procedure: 1. Nursing staff will notify the food and nutrition services department in writing of individuals who wish to eat in their rooms so food can be delivered to the correct location. 2. Meals will be placed in the delivery cart in sequence to achieve the most effective service. Each meal will be identified by the meal identification (ID) card/ticket with the individual's name, room number and physician ordered diet. 3. Food and nutrition services staff will notify the appropriate staff as each cart is ready for delivery. Food and nutrition services staff will deliver the carts to the Units. Nursing or food and	F 804		

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F 804	Continued From page 80 nutrition services staff will return the carts to the kitchen after meal service per facility policy. 4. Meals will be distributed promptly with supervision as needed by nursing staff. Staff should check each name and room number to verify correct information and check items on the plate or tray against the meal ID card/ticket to assure accuracy. 5. Food will be served at acceptable temperatures (hot foods hot and cold foods cold) as discerned by the patients/residents and customary practice. 6. Food will be delivered as per truck delivery schedule. N.J.A.C. 8:39-17.4(a)(2);(g)	F 804		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population	F 838		9/25/24

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considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an

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F 838	Continued From page 82 all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on the interview and review of facility documentation, it was determined that the facility failed to ensure that facility wide assessment included the resources required to establish policies and procedures for the management of staffing contingency plan and linen and/or supplies in order to meet the requirements and needs of all residents in the facility. This failure had the potential to affect all 186 residents who currently live in the facility. This deficient practice was evidenced by the following: During the entrance conference on 8/14/24 at 9:50 AM, Surveyor #1 (S#1) requested from the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) a copy of the Facility Assessment (FA). Both the U.S. FOIA (b) and U.S. FOIA stated that the facility's census (the number of residents currently under the care of a specific facility) was 186. A review of the facility's "Facility Assessment" with a date of August 24 (2024). The submitted FA of the U.S. FOIA (b) on 8/15/24 at 9:05 AM did not include information about the facility's contingency plan for staffing and information about information on addressing the resident's need for supplies for linens. On 8/19/24 at 10:38 AM, Resident #122 informed S#2 during the Resident Council meeting that at times there was a shortage of linen and towel supplies. The resident was unable to further elaborate on the concern.	F 838	Tag F 838 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice The facility Assessment has been updated to include procedures for contingency staffing and a linen supply par. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. The facility assessment has been updated to include a contingency staffing plan as well as a linen supply par. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The administrator educated the U.S. FOIA (b) (6) , U.S. FOIA (b) (6), and U.S. FOIA (b) (6) on the Facility Assessment regulation and the updated memo from Centers for Medicare and Medicaid services Ref: QSO-24-13-NH on the requirements of a staffing contingency plan and proper resources for the residents. If new resources are needed, they will be added to the facility assessment. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The facility assessment will be reviewed by the administrator or designee, monthly	

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ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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F 838	Continued From page 83 On 8/22/24 at 9:21 AM, the surveyor interviewed the U.S. FOIA (b) regarding FA. The U.S. FOIA (b) informed the surveyor that he was aware of the updates and new memo from CMS (Centers for Medicare and Medicaid Services) about the FA with an effective date of 8/08/24. The surveyor asked the U.S. FOIA (b) what the facility's process for FA was. The U.S. FOIA (b) stated that the facility utilizes a tool [name] wherein the interdisciplinary team (IDT) which includes the NJ Ex Order 26.4(b)(1), NJ Ex Order Corporate nurses, and the IDT meets quarterly. He further stated that "my understanding," of the FA was on how the facility handles the facility's staffing, environmental needs, and acuities. The U.S. FOIA (b) also stated that "I would think so, there will be a number to follow or a grid," for staffing of the facility. He further stated that the facility followed the New Jersey (NJ) Mandated law for staffing, and that should be in their FA. The U.S. FOIA (b) acknowledged that the FA should address the needs of the residents in the facility. On that same date and time, the surveyor notified the U.S. FOIA (b) of the concern that the previously submitted FA did not include information about the NJ Mandated staffing law, the contingency plan for staffing, and the grid that the facility should follow. At that same time, the U.S. FOIA (b) reviewed the previously provided FA copy. The U.S. FOIA (b) stated and showed page 21 (total pages 40) and revealed: A.1. Function-Sufficiency Analysis Summary: 1. Staffing and scheduling systems. Each department utilizes a staffing system and staffing patterns that are directly correlated to the resident population and resident care requirements in the	F 838	for the first 3 months. The results of the review will be brought to the Quality Assurance and performance Improvement meeting which is held quarterly.	

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facility.

The surveyor then asked the U.S. FOIA (b) how the above information correlates to NJ mandated law for staffing. The U.S. FOIA (b) then further reviewed the FA paper and stated some documents were missing in the previously provided FA and would get back to the surveyor.

On 8/22/24 at 9:41 AM, the U.S. FOIA (b) provided additional documents that included the staffing plan for direct care staff plan were 1:8 ratio Days (total licensed or certified), 1:10 ratio Evening, and 1:14 ratio Nights. The U.S. FOIA (b) stated that the ratio was derived from the NJ Mandated law for staffing.

A review of the provided documents did not include the Staffing Contingency Plan and grid for supplying linens to address the needs of the residents at the facility.

On that same date and time, the surveyor asked the U.S. FOIA (b) does the facility had a plan for maximizing the recruitment and retention of direct care staff. The U.S. FOIA (b) stated by following the mandated law. The surveyor also asked does the facility assessment includes a contingency plan that was informed by the FA. The U.S. FOIA (b) stated he would get back to the surveyor.

On 8/22/24 at 12:55 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , and U.S. FOIA (b) (6) . The surveyor notified the facility management of the above findings and concerns.

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F 838	Continued From page 85 On 8/23/24 at 8:31 AM, the [NJ Ex Order 2] provided a copy of the Staffing Contingency Plan. The [NJ Ex Order 2] acknowledged that the Staffing Contingency Plan was done after the surveyor's inquiry. On 8/23/24 at 12:51 PM, the survey team met with the [U.S. FOIA (b)] [U.S. FOIA (b)] [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26] for an Exit Conference. The facility management did not provide additional information. NJAC 8:39-5.1(a)	F 838		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/25/24

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F 880	Continued From page 86 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 87 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of NJ Ex Order 26.4(b)(1)) practices for four (4) of nine (9) staff (two Recreation Staff, one US FOIA (b)(6) , and one US FOIA (b)(6)) and b.) follow appropriate NJ Ex Order 26.4(b)(1) control practices to prevent the potential NJ Ex Order 26.4(b)(1) for two (2) of two (2) rooms observed during laundry area tour in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC guidelines dated 4/02/24,	F 880	Tag: F 880 - Infection Prevention and Control 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice 1) Recreation Staff #1 (RS#1), RS#2 and U.S. FOIA (b) (6)) were immediately in serviced by Infection Preventionist/Registered Nurse (IP/RN) on appropriate handwashing/hand hygiene protocol and use of Personal Protective Equipment (PPE) during dining room activities and patient care. Competency handwashing observation performed by IP/RN for RS#1, RS#2, CNA. Resident #163 wheelchair handles were cleaned and sanitized. 2) Laundry Staff #1 (LS#1) and LS#2 were immediately in-serviced by IP/RN on Infection Control Practices to prevent the potential spread of infection while doing Laundry with emphasis on keeping working areas clean at all time and staff personal effects are to be stored secure and safe from contact with all work areas, surfaces and linens/garments in the washroom and folding area. Laundry Washing and Drying Procedures were reviewed with LS#1 and LS#2 by Director of Environmental Services. Laundry Area was immediately cleaned, personal effects removed from working areas, working surfaces cleaned and	

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F 880	Continued From page 88 Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) included information for EBP when to use PPE (personal protective equipment) during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing ... Providing hygiene Changing linens ... Device care or use: central line, urinary catheter, ... Implementation When implementing Contact Precautions or EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of a gown and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room ... Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education Provide education to residents and visitors ... 1. On 8/14/24 at 11:56 AM, the surveyor observed lunch at the[NJ Exec Order 26.4b1]) dining room with a total of 12 residents assisted by Recreation Staff #1 (RS#1) and RS#2 with residents'[NJ Ex Order 2] [redacted]	F 880	disinfected. 3) Hospice Certified Home Health Aide (CHHA) □ Hospice agency was immediately notified of the CHHA wearing gloves in the hallway and improper disposal of linens from the room of resident #164 on[NJ Ex Order 26.4(b)(1)] [redacted] After the CHHA disposal of plastic bag of linens in the soiled utility room, the door handle to soiled utility room was cleaned and disinfected. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient hand hygiene, PPE use, and Laundry Washing/Drying/Infection Control Management practice. 1)Recreation Staff and CNA staff have been educated by IP/RN on handwashing procedure and gloves use while assisting residents in the dining room. 2)Laundry Staff have been educated by IP/RN and Director of Environmental Services on Infection Control Policies and Laundry Washing and Drying Procedure which includes keeping work areas and folding areas clean and free of personal effects. 3)[US FOIA (b)(6] was re-educated by Hospice Agency on handwashing, PPE use and EBP precautions. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: IP/Designee has re-educated Recreation	

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F 880	Continued From page 89 [NJ Ex Order 26.4(b)] Both RS#1 and #2 donned (applied) a pair of gloves without performing hand hygiene and distributed disinfecting wipes to all residents. Both Recreation Staff collected the used disinfecting wipes from the residents. On that same date and time, RS#1 did not perform hand hygiene after she discarded the used disinfecting wipes, and removed her used gloves. RS#1 immediately checked by touching the folded green tablecloth at the separate table inside the dining room, then sat down at the back of the dining room. At that same time, RS#2 did not perform hand hygiene after she discarded the used disinfecting wipes, and removed her used gloves. RS#2 immediately wheeled Resident #163's wheelchair to the table without performing hand hygiene. During an interview, RS#1 acknowledged that she should have washed her hands after removing used gloves. During an interview, RS#2 stated that "I forgot" to perform hand hygiene after removing gloves and prior to touching the resident. Later, the surveyor observed the [US FOIA (b)(6)] [redacted]) enter the [NJ Exec O] dining room and perform handwash, scrub her hands with soap for four seconds, then proceed to wash her hands under the stream of running water, used a paper towel to dry hands, and discarded used paper towels in the garbage receptacle. During an interview, the [US FOIA (b)] informed the surveyor that she should scrub her hands for at least 20 seconds. The surveyor asked the [US FOIA (b)] if she scrubbed her hands for at least 20 seconds, and	F 880	Staff, Nursing Staff, CHHA on Handwashing, PPE use and EBP Precaution Practices. IP has re-educated [U.S. FOIA (b) (6)] [redacted] and Laundry Staff on following appropriate Infection Practices in the Laundry Area, as per: -Policy for Laundry Washing and Drying Procedures, -Infection Control Management Policy. IP/ or Designee will conduct quarterly, and as needed, competencies/ observations of Recreation Staff, Nursing Staff, Hospice Aids on hand hygiene and PPE use, specifically when assisting residents in dining room, when providing care for residents on EBP precautions in compliance with Centers for Disease Control and Prevention (CDC) Guidelines and Facility Policies. Director of Environmental Services/ or Designee will conduct weekly deep cleaning of the Laundry Area 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 1) IP/ or Designee will conduct observation of 5 Nursing Staff and 2 Recreation Staff weekly x 4 weeks, then monthly x 3 months on performing hand hygiene and PPE use while assisting residents in dining room. 2) IP/or Designee will conduct observation of 2 CHHA weekly x 4 weeks, then monthly x 3 months while providing care for hospice patients. 3) Director of Environmental Services/ or Designee will conduct weekly audits x 4	

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F 880	Continued From page 90 the [redacted] stated, "I think so." The surveyor then notified the [redacted] of the above observation. Afterward, the [redacted] assisted the other residents at the dining table by repositioning them on the table and the [redacted] washed her hands again. The surveyor observed the [redacted] scrubbed her hands for nine seconds. On 8/15/24 at 11:22 AM, the surveyor interviewed the [redacted] The [redacted] informed the surveyor that she was responsible for the facility staff's education about infection control including hand hygiene and PPE use and competencies. The surveyor then notified the [redacted] of the above findings regarding RS#1 and #2 and [redacted] hand hygiene and gloves use during dining observation on 8/14/24 at lunch in the 2NW dining room. On that same date and time, the [redacted] informed the surveyor that she was made aware yesterday by the [redacted]) of what had happened because the [redacted] was at the dining room at that time when the surveyor observed both the Recreation Staff. The [redacted] stated that the two Recreation staff were educated again regarding hand hygiene. The [redacted] further stated that the [redacted] will also be educated. At that time, the surveyor asked the [redacted] what should have happened. The [redacted] stated that the Recreation Staff should have washed their hands before and after removing gloves. She further stated that the [redacted] should have washed her hands outside the stream of running water for at least 20 seconds, the 20 seconds should be the scrubbing of hands and not the entire	F 880	weeks, then monthly x 3 months of the following laundry area: - room with washers and clean linen folding table, - - room inside the laundry area used for storage of clean folded linens that would be delivered to the unit - room for the clean personal clothing of the residents and for the donated clothes and shoes (labeled Podiatrist room) to ensure appropriate Infection Control Practices to prevent the potential spread of infection are being followed in accordance with CDC guidelines and facility policies. 4) The IP/ or Designee will document the audit results and report those findings quarterly during the facility Quality Assurance and Performance Improvement (QAPI) meeting. The QAPI committee will assess and modify the action plan as needed to ensure continued compliance. -	

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handwashing process.

2. On 8/20/24 at 8:18 AM, the surveyor toured the laundry area on the ground floor. The surveyor interviewed Laundry Staff #1 (LS#1) inside the laundry room. LS#1 informed the surveyor that she was assigned to the linens and LS#2 was assigned to the personal clothing of the residents who were currently in the other room. There was a pen, paper, and a crumpled paper towel on top of a clipboard, a personal tumbler, two bottles of water, a used surgical mask, a box of opened gloves, an open snack, and a personal cellphone on top of the table where LS#1 was observed folding the blanket that came out of the dryer. The personal cell phone was near the folded blankets on the same table.

Later, LS#1 informed the surveyor that the folding table was considered a clean area. The surveyor then asked LS#1 if the table was considered clean, and why there were multiple personal items on top of the table where she actively folded blankets. LS#1 stated that the surgical mask was hers and it was a used mask, the water tumbler, two bottles of water, and the cell phone were her items. She further stated that there was no other place to put them which was why it was on top of the clean folding table. LS#1 confirmed the open snacks were hers and she was eating them at that time. The folded clean blankets were uncovered.

On that same date and time, the surveyor observed a heavy accumulation of whitish color substances on top of the four washers, on the floor near the washers and the surrounding area of the laundry room, and there was equipment that blew air directly into the area where LS#1

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was folding blankets. LS#1 stated that the whitish substances was accumulation of dust and lint. LS#1 informed the surveyor that the equipment that blew air was the blower that was being used by housekeeping for drying floors and was being used as a fan in the laundry room. LS#1 stated that there was no air circulating and at times it got hot inside the laundry room which was why it was being used as a fan.

At that same time, the surveyor observed there was another room inside the laundry area and LS#1 stated that was the room for clean folded linens that would be delivered to the unit. The room for clean folded linens was observed with pieces of paper on the floor and dust. LS#1 was unable to state if there was accountability for cleaning the laundry area and when was the last time it was cleaned.

On 8/20/24 at 8:31 AM, the surveyor and LS#2 both went inside a room named "[NJ Exec Order 26.4b1]" and LS#2 stated that was the room for the clean personal clothing of the residents and for the donated clothes and shoes. LS#2 informed the surveyor that she was the assigned laundry staff for personal clothing. The surveyor observed a folding table where LS#2 was folding clothes at that time. The surveyor observed keys that were used by LS#2 in opening the room that she took from her uniform pocket. On top of the folding table also were two coffee makers, on top of the coffee maker was a cup with a straw. LS#2 stated that the folding table was considered a clean area. LS#2 stated that the coffee makers had been there for a long time, and she does not use them. LS#2 had no answer when asked why it was placed on top of the folding table where there were clean clothes.

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F 880	Continued From page 93 On 8/20/24 at 9:15 AM, the surveyor notified the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) of the above findings and concerns in the laundry area. The U.S. FOIA (b) stated that he would take care of the concerns. On 8/21/24 at 12:58 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) and U.S. FOIA (b) (6) The surveyor notified the facility management of the above findings and concerns regarding dining and laundry observations. A review of Policy: Laundry Washing and Drying Procedures dated June 2024 that was provided by the U.S. FOIA (b) revealed: Policy: To establish procedures and protocols for the proper and efficient laundering of soiled linen articles. All linens and personal clothing are processed under Standard Precautions protocols and considered infectious. Note: Staff personal effects (i.e., refreshments such as water, soda, coffee; purses, cellphones, keys, etc.) are to be secured safe from contact with work surfaces and linens/garments in the washroom and folding area. A review of the facility's Policy: Infection Control Management dated June 2024 that was provided by the U.S. FOIA (b) showed: Purpose: To effectively provide processes and cleaning supplies to maintain surfaces from harmful germs, viruses, etc. Procedure: Note: Staff shall be informed that personal effects (cell phones, refreshments, purses, lunch bags/boxes, food items, etc.) are not allowed: ...	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 94	F 880		

Personal effects shall be stored secure and safe from all work areas and surfaces.

3. On 8/14/24 at 10:55 AM, during tour on a unit, the surveyor observed the door to the room of Resident #164 had a [redacted] signage. [redacted] indicated that PPE such as gloves and [redacted] should be worn while providing [redacted] activating with a resident to reduce the [redacted] of [redacted]. The surveyor observed a [redacted] agency's [redacted]) exit the room of Resident #164. The [redacted] was wearing disposable gloves and carried in one hand a plastic bag of linens. The [redacted] walked down the hallway to the soiled utility room, then opened the door of the room with her gloved hands. The [redacted] disposed of the bag of linens in the soiled utility room, removed her gloves, disposed them in the room, closed the soiled utility room, and proceeded to walk back down the hallway.

The surveyor interviewed the [redacted] who stated gloves should not be worn in the hallway upon exiting a room. The surveyor informed the [redacted] of the above observations. The [redacted] replied that she removed her gloves when throwing out the soiled linen and acknowledged she should have not worn the gloves in the hallway after exiting the resident's room.

On 8/14/24 at 11:03 AM, the surveyor interviewed the [redacted]) about glove use in hallway. The [redacted] stated gloves should not be worn in the hallway especially when exiting a resident's room. The surveyor informed the [redacted] of the observation of the [redacted] The [redacted] replied the [redacted] should not have worn gloves in the hallway and would talk with her.

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	315010	A. BUILDING _____ B. WING _____	C 08/23/2024

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F 880	Continued From page 95 On 8/21/24 at 01:03 PM, the surveyor informed the U.S. FOIA (b) and the U.S. FOIA about the observed concern with U.S. FOIA (b) (6) On 8/22/24 at 11:07 AM, the U.S. FOIA (b) (6), and U.S. FOIA met with survey team. The U.S. FOIA (b) stated the facility had communicated with the hospice agency about the concerns and that the U.S. FOIA (b) (6) who came to the facility were re-educated about hand hygiene and glove use. A review of the facility's policy titled "Enhanced Barrier Precautions (EBP)" with a updated date of 4/12/2024, under Procedure read: " ...Soiled linen and trash bins will be placed inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room ..." On 8/23/24 at 12:51 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) U.S. FOIA (b) (6), U.S. FOIA (b), and U.S. FOIA (b) for an Exit Conference and there was no additional information provided by the facility management.	F 880		
F 944 SS=E	N.J.A.C. 8:39-19.4(a)(1,2),m,n QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.	F 944		10/2/24

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F 944	Continued From page 96 This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI (quality assurance and performance improvement) program for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. This deficient practice was evidenced by the following: On 8/22/24 the surveyor reviewed the annual in-service education hours for five randomly selected CNA files, which were provided by the facility. The Employee In-service Record showed the following: CNA#1 had a hire date of [redacted]. According to the "Topic" on the Inservice Record and Certificates of Completion, CNA #1 did not have QAPI training. CNA#2 had a hire date of [redacted] According to the "Topic" on the Inservice Record and Certificates of Completion, CNA #2 did not have QAPI training. CNA#3 had a hire date of [redacted]. According to the "Topic" on the Inservice Record and Certificates of Completion, CNA #3 did not have QAPI training. CNA#4 had a hire date of [redacted]. According to the "Topic" on the Inservice Record and Certificates of Completion, CNA #4 did not have QAPI	F 944	Tag F944 QAPI Training 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice No residents were identified to have been affected by the deficient practice. Certified Nurse Assistant (CNA) #1, CNA #2, CNA #3, CNA #4, and CNA #5 were provided with mandatory Quality Assurance Performance Improvement (QAPI) training. CNA #6, CNA #7, CNA #8 and the [redacted] were also provided with mandatory QAPI training. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who reside in the facility have the potential to be affected by the deficient practice. The [redacted]) was re-educated by the Licensed Nursing Home Administrator (LHNA) on the requirement of providing all nursing staff the mandatory QAPI training. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The ADON or designee will provide all facility nursing staff with the required mandatory QAPI training. This training will be provided upon hire and on an annual basis. The LHNA or designee will review and sign off on the New Jersey Mandatory	

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F 944	Continued From page 97 training. CNA#5 had a hire date of [NJ Ex Order 2]. According to the "Topic" on the Inservice Record and Certificates of Completion, CNA #5 did not have QAPI training. On 8/22/24 at 01:07 PM, the surveyor in the presence of another surveyor interviewed the U.S. FOIA (b) (6)). The [U.S. FOIA (b)] stated she started at the facility 02/01/24 and her responsibilities included but were not limited to collaboration with the U.S. FOIA (b) (6)) and perform in-service education to the staff. The [U.S. FOIA (b)] confirmed that she was the only person who was responsible for staff education. The [U.S. FOIA (b)] stated there was a hybrid system for monthly education, they were scheduled on-line courses and some in-person group education. The surveyor asked the [U.S. FOIA (b)] about the 12-hour competency for CNAs. The [U.S. FOIA (b)] stated that she can only speak to the education provided from February 2024 to present and can not say what was earlier as the previous [U.S. FOIA (b)] was responsible. The [U.S. FOIA (b)] stated she was only made aware of using the [US FOIA (b)] date of hire as an "anniversary date" for [US FOIA (b)] education. During the interview with the [U.S. FOIA (b) (6)] the [U.S. FOIA] provided the surveyor with education competencies for five CNAs that were previously requested. On 8/22/24 at 01:17 PM, the surveyor in the presence of other surveyors interviewed the [U.S. FOIA (b)] The [U.S. FOIA] was asked if the competencies that were just provided everything for those 5 CNAs. The [U.S. FOIA] stated that he cannot confirm what was being provided as complete proof of mandatory in-services as the [U.S. FOIA (b)] was not responsible for it.	F 944	CNA and Nurse Education Requirement checklist that is kept in the staff education file to ensure compliance for mandatory QAPI training. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The LHNA or designee will conduct audits weekly x 4 weeks, then monthly x 3 months of 5 staff mandatory education records to ensure that QAPI training has been completed. The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement (QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.	

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F 944	Continued From page 98	F 944		

On 8/22/24 at 01:31 PM, the survey team asked the U.S. FOIA (b) to provide everything she had for annual mandatory education to the team.

On 8/23/24 at 10:07 AM, the surveyor in the presence of the survey team interviewed the U.S. FOIA (b) (6) The survey team asked if there was a list of mandatory in-services. The U.S. FOIA (b) provided a list of education protocols. The U.S. FOIA (b) stated that the U.S. FOIA (b) (6) and the U.S. FOIA have a list for QAPI education and the U.S. FOIA (b) (6)) has a list for infection control education.

The surveyor reviewed the list titled "NJ (New Jersey) Mandatory CNA and Nurse Education Requirements" (undated) that was provided by the U.S. FOIA (b) (6 The list reflected on line 15. QAPI, with a notation of "mandatory for CNA renewal."

On 8/23/24 at 10:14 AM, the survey team interviewed the U.S. FOIA in the presence of the U.S. FOIA (b) (6)). The U.S. FOIA confirmed the NJ mandatory education list provided by the U.S. FOIA (b) (6 The surveyor asked if the U.S. FOIA does QAPI education. The U.S. FOIA stated he could not provide a formal sign in sheet for QAPI education and confirmed responsibility for QAPI education.

On 8/23/24 at 10:20 AM, the survey team interviewed the U.S. FOIA (b) who confirmed the NJ mandatory education list provided by the U.S. FOIA (b) (6 The U.S. FOIA (b) could not provide sign in sheets for QAPI education.

On 8/23/24 at 10:25 AM, the surveyor in the presence of another surveyor interviewed CNA#6

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F 944	Continued From page 99 who stated she worked at the facility for [redacted]. The surveyor asked CNA#6 if she got any education on QAPI. The CNA stated she was unsure as there are many different in-services. On 8/23/24 at 10:33 AM, The surveyor in the presence of another surveyor interviewed CNA#7 who stated she worked at the facility for [redacted]. The surveyor asked CNA#7 if she got any education on QAPI. The CNA stated she was unsure. The CNA asked the surveyors what was QAPI about. On 8/23/24 at 10:45 AM, The surveyor in the presence of another surveyor interviewed CNA#8 who stated she worked at the facility for [redacted]. The surveyor asked CNA#8 if she got any education on QAPI. The CNA stated she had many different in-services but was not sure if that was one. On 8/23/24 at 10:54 AM, The surveyor in the presence of another surveyor interviewed the U.S. FOIA (b) (6)) who was also a CNA. The surveyor asked the [redacted] if she got any education on QAPI. The [redacted] stated she did not know. On 8/23/24 at 12:51 PM, the survey team met with the [redacted] for an Exit Conference. There was no additional information provided by facility management. N.J.A.C 8:39-33.1	F 944		
F 946 SS=E	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics.	F 946		10/1/24

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F 946	Continued From page 100 The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's Compliance and Ethics training for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. This deficient practice was evidenced by the following: On 8/22/24, the surveyor reviewed the annual in-service education hours for five randomly selected CNA files, which were provided by the facility. The Employee In-service Record showed the following: CNA#1 had a hire date of NJ Ex Order 26. . According to the the Inservice Record and Certificates of Completion, CNA #1 did not have Compliance and Ethics training. CNA#2 had a hire date of NJ Ex Order 26. . According to the Inservice Record and Certificates of	F 946	Tag F946 Compliance and Ethics Training 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice No residents were identified to have been affected by the deficient practice. Certified Nurse Assistant (CNA) #1, CNA #2, CNA #3, CNA #4, and CNA #5 were provided with mandatory Compliance and Ethics training. CNA #6, CNA #7, CNA #8 and the US FOIA (b)(6) were also provided with mandatory Compliance and Ethics training. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who reside in the facility have the potential to be affected by the deficient practice. The U.S. FOIA (b) (6)) was re-educated by the Licensed Nursing Home Administrator (LHNA) on the	

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F 946	Continued From page 101	F 946		

Completion, CNA #2 did not have Compliance and Ethics training.

CNA#3 had a hire date of [redacted]. According to the Inservice Record and Certificates of Completion, CNA #3 did not have Compliance and Ethics training.

CNA#4 had a hire date of [redacted]. According to the Inservice Record and Certificates of Completion, CNA #4 did not have Compliance and Ethics training.

CNA#5 had a hire date of [redacted]. According to the Inservice Record and Certificates of Completion, CNA #5 did not have Compliance and Ethics training.

On 8/22/24 at 01:07 PM, the surveyor in the presence of another surveyor interviewed the [redacted]). The [redacted] stated she started at the facility 02/01/24 and her responsibilities included but were not limited to collaboration with the [redacted] and perform in-service education to the staff. The [redacted] confirmed that she was the only person who is responsible for staff education. The [redacted] stated there was a hybrid system for monthly education, they were scheduled on-line courses and some in-person group education. The surveyor asked the [redacted] about the 12-hour competency for CNAs. The [redacted] stated that she can only speak to the education provided from February 2024 to present and can not say what was earlier as the previous [redacted] was responsible. The [redacted] stated she was only made aware of using the [redacted] date of hire as an "anniversary date" for [redacted] education. During the interview with the [redacted] The [redacted] provided the

requirement of providing all nursing staff the mandatory Compliance and Ethics training.

3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur:
The ADON or designee will provide all facility nursing staff with the required mandatory Compliance and Ethics training. This training will be provided upon hire and then on an annual basis.
Compliance and Ethics training was added to the New Jersey Mandatory CNA and Nurse Education Requirement checklist that is used to track staff completion and kept in the staff education file.
The LHNA or designee will review and sign off on the New Jersey Mandatory CNA and Nurse Education Requirement checklist to ensure compliance for mandatory Compliance and Ethics training.

4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:
The LHNA or designee will conduct audits weekly x 4 weeks, then monthly x 3 months of 5 staff mandatory education records to ensure that Compliance and Ethics training has been completed.
The results of these audits will be presented at the Quarterly Quality Assurance Performance Improvement

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F 946	Continued From page 102	F 946		

surveyor with education competencies for five CNAs that were previously requested.

On 8/22/24 at 01:17 PM, the surveyor in the presence of other surveyors interviewed the [redacted]. The [redacted] was asked if the competencies that were just provided everything for those 5 CNAs. The [redacted] stated that he cannot confirm what is being provided as complete proof of mandatory in-services as the [redacted] was not responsible for it.

On 8/22/24 at 01:31 PM, the survey team asked the [redacted] to provide everything she had for annual mandatory education to the team.

On 8/23/24 at 10:07 AM, the surveyor in the presence of the survey team interviewed the [redacted]. The survey team asked if there was a list of mandatory in-services. The [redacted] provided a list of education protocols. The [redacted] stated that other topics like ethics could be done by an outside contractor the facility used.

The surveyor reviewed the list titled "NJ (New Jersey) Mandatory CNA and Nurse Education Requirements" (undated) that was provided by the [redacted]. The list did not reflect any Compliance or Ethics requirements.

On 8/23/24 at 10:14 AM, the survey team interviewed the [redacted] in the presence of the [redacted]). The [redacted] confirmed the NJ mandatory education list provided by the [redacted]. The surveyor asked if the [redacted] does Compliance and Ethics Training education. The [redacted] stated that Ethics education was done annually. The [redacted] stated that there were posters by the time clock that reference

(QAPI) committee meeting for review to ensure facility compliance and that the deficient practice will not recur.

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Ethics and he could not provide any sign in sheets.

On 8/23/24 at 10:20 AM, the survey team interviewed the U.S. FOIA (b) (6) who confirmed the NJ mandatory education list provided by the U.S. FOIA (b) (6

On 8/23/24 at 10:25 AM, the surveyor in the presence of another surveyor interviewed CNA#6 who stated she worked at the facility for NJ Exec The surveyor asked CNA#6 if she got any education on Ethics and Compliance. The CNA stated she was unsure as there are many different in-services.

On 8/23/24 at 10:33 AM, The surveyor in the presence of another surveyor interviewed CNA#7 who stated she worked at the facility for NJ Exec Order 26. The surveyor asked CNA#7 if she got any education on Ethics and Compliance. The CNA stated she was unsure what that topic was.

On 8/23/24 at 10:45 AM, The surveyor in the presence of another surveyor interviewed CNA#8 who stated she worked at the facility for NJ Exec Order 26. The surveyor asked CNA#8 if she got any education on Ethics and Compliance. The CNA stated she had many different in-services but could not recall exactly if one was ethics.

On 8/23/24 at 10:54 AM, The surveyor in the presence of another surveyor interviewed the U.S. FOIA (b) (6)) who was also a CNA. The surveyor asked the U.S. FO if she got any education on Ethics and Compliance. The U.S. FO stated she was not sure.

On 8/23/24 at 12:51 PM, the survey team met

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F 946	Continued From page 104 with the [redacted] and [redacted] for an Exit Conference. There was no additional information provided by facility.	F 946		

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S 000	Initial Comments Complaint#: NJ#158764 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	Tag S 560 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice A review of resident care records for the time periods 7/28/24-8/10/24 and 10/02/2022-11/05/2022 was conducted. No complaints or grievances related to resident care on the day shift were discovered. This indicates that no residents were adversely affected by the deficient practice. 2. How you will identify other residents having the potential to be affected by the	10/1/24

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

Electronically Signed | 09/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32003	A. BUILDING: _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTEF	225 W JERSEY STREET ELIZABETH, NJ 07202

(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 1 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: To prevent recurrence of the staffing shortage, the facility has implemented the following measures: Education & Accountability: The Staffing Coordinator has received thorough re-education by the Director of Nursing on The State of New Jersey Department of Health requirement on the minimum ratio of one Certified Nurse Aide (CNA) to every eight residents for day shift. Proactive Staffing: The Staffing Coordinator will conduct daily assessments of staffing needs to proactively identify and address potential shortages. Contingency Plan: In event of a CNA shortage where the ratio of one CNA to every eight residents on day shift will not being met, a multi-pronged plan is in place: " The nurse manager/supervisors will recruit CNA from previous or upcoming shift, " Staffing coordinator and nursing management have the authority to utilize agency companies for staffing support, and " The CNA unit clerk may be reassigned to assist with providing direct resident care. Recruitment: The facility is actively recruiting new employees. Strategies include offering referral and sign-on	

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S 560	Continued From page 2 (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for a 5 week period beginning 10/02/2022 and ending11/05/2022 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for residents on 15 of 35 day shifts as follows: -10/02/22 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs. -10/05/22 had 20 CNAs for 169 residents on the day shift, required at least 21 CNAs. -10/06/22 had 18 CNAs for 169 residents on the day shift, required at least 21 CNAs. -10/08/22 had 19 CNAs for 169 residents on the day shift, required at least 21 CNAs. -10/13/22 had 19 CNAs for 169 residents on the	S 560	bonuses, utilizing online advertisements, and recruiting candidates from local CNA training programs. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator, Director of Nursing, or their designee will be responsible for conducting audits. Weekly CNA staffing schedule audits will be conducted for 4 weeks to establish immediate compliance. Audits will then transition to monthly for 3 months to ensure sustained compliance. Audit findings and any corrective actions taken will be reviewed during quarterly Quality Assurance and Performance Improvement (QAPI) meetings to ensure continuous monitoring and prevent recurrence.	

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S 560	Continued From page 3	S 560		

day shift, required at least 21 CNAs.
-10/15/22 had 20 CNAs for 166 residents on the day shift, required at least 21 CNAs.

-10/16/22 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-10/21/22 had 19 CNAs for 161 residents on the day shift, required at least 20 CNAs.
-10/22/22 had 19 CNAs for 166 residents on the day shift, required at least 21 CNAs.

-10/23/22 had 19 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-10/24/22 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-10/25/22 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs.
-10/28/22 had 20 CNAs for 170 residents on the day shift, required at least 21 CNAs.

-10/30/22 had 20 CNAs for 168 residents on the day shift, required at least 21 CNAs.
-11/05/22 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs.

2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 7/28/2024 and ending 8/10/2024 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for residents on 11 of 14 day shifts as follows:

-07/29/24 had 21 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-07/30/24 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-08/01/24 had 19 CNAs for 180 residents on the day shift, required at least 22 CNAs.

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S 560	Continued From page 4 -08/02/24 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs. -08/03/24 had 21 CNAs for 188 residents on the day shift, required at least 23 CNAs -08/04/24 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs. -08/05/24 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -08/06/24 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -08/08/24 had 20 CNAs for 187 residents on the day shift, required at least 23 CNAs. -08/09/24 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs. -08/10/24 had 19 CNAs for 192 residents on the day shift, required at least 24 CNAs. On 8/23/24 at 12:51 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and Regional Registered Nurse Consultant for an Exit Conference. There was no additional information provided by facility.	S 560		
S2905	8:39-43.1(a)(2) Certification of Nurse Aides (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey: 2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or	S2905		9/27/24

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S2905	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that one (1) of two (2) non-certified Nurse Aides (NA) reviewed were enrolled in an approved nurse aide training course during their employment with the facility, reviewed during the Sufficient and Competent Nurse Staffing task, (NA #1). This deficient practice was evidenced by: On 8/14/24, at 01:11 PM, the Licensed Nursing Home Administrator (LNHA) provided the survey team of the facility's list for Certified Nursing Aides (CNAs), NAs, and Nurses with their date of hire (doh) and license numbers listed that was requested by the survey Team Coordinator (TC) during the facility entrance conference. A review of the staff list provided by the LNHA revealed that NA#1's employee file did not show any proof of school enrollment or completion and/or successful completion of state approved 90 hours of training. On 8/21/24 at 12:02 PM, the surveyor in the presence of the survey team interviewed the Human Resources Director (HRD). The surveyor asked for documentation for NA #1 showing that they were currently enrolled in school and successful completion of 90 hours of state approved training. The surveyor also requested any policy for hiring or on boarding for NA's and new employees.	S2905	Tag S2905 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice Correct school verification was immediately obtained and verified for Nurses Aide # 1. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. All nurses aides will have school verification prior to hire. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: A checklist was provided to the Human Resources Director to ensure that all Nurses aides have a school verification prior to hire. Human resources Director was educated by the administrator to verifying the school enrollment for nurses aides and ensuring that nurses aides are not employed for longer than 120 days. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator or designee will audit 2 nurses aide charts weekly for 4 weeks and then monthly for 3 months. Results will be	

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S2905	Continued From page 6 On 8/22/24 at 12:37 PM, the HRD provided documents to the survey team. The documents included a timecard report for NA #1 for the dates of NJ Ex Order 26.4b1 and an undated appointment confirmation for NA #1 to take an exam for NJ CNA. The HR director stated that NA #1 was finishing up her training today and she was not enrolled in school when she was hired. She further stated that NA #1 finished classes in NJ Ex Order 26.4b1. The HRD also stated that she did not know the Certificate in the file was for a Home Health Aide not a CNA. The HRD provided an Employee File Check List to the survey team and stated that there was no policy for hiring or on boarding. On 8/23/24 at 9:50 AM, the HRD provided to the survey team an undated document that was a copy of a Certificate of Completion of a CNA program of 90 total hours for NA #1 after the surveyor's inquiry. The HRD stated that the "school made a mistake and sent the wrong certificate" referring to the previous certificate that was in NA #1's file. On 8/23/24 at 11:26 AM, the survey team met with the LNHA, the Director of Nursing (DON), Regional Registered Nurse Consultant (RRNC), and the Infection Preventionist. The surveyor team discussed the concern with NA #1's. On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, IP, RRNC for an Exit Conference. There was no additional information provided by facility management.	S2905	brought to the quality assurance and performance improvement meeting which will be held quarterly	

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
315010 Y1	A. Building B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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	F0578	Correction	ID Prefix	F0607	Correction	ID Prefix	F0641	Correction
Reg. #	483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. #	483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. #	483.20(g)	Completed
LSC		09/25/2024	LSC		09/25/2024	LSC		10/01/2024
ID Prefix	F0658	Correction	ID Prefix	F0684	Correction	ID Prefix	F0686	Correction
Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(b)(1)(i)(ii)	Completed
LSC		09/25/2024	LSC		10/01/2024	LSC		10/07/2024
ID Prefix	F0689	Correction	ID Prefix	F0693	Correction	ID Prefix	F0695	Correction
Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.25(g)(4)(5)	Completed	Reg. #	483.25(i)	Completed
LSC		10/01/2024	LSC		09/27/2024	LSC		10/04/2024
ID Prefix	F0697	Correction	ID Prefix	F0728	Correction	ID Prefix	F0757	Correction
Reg. #	483.25(k)	Completed	Reg. #	483.35(d)(1)-(3)	Completed	Reg. #	483.45(d)(1)-(6)	Completed
LSC		09/27/2024	LSC		09/25/2024	LSC		09/23/2024
ID Prefix	F0761	Correction	ID Prefix	F0804	Correction	ID Prefix	F0838	Correction
Reg. #	483.45(g)(h)(1)(2)	Completed	Reg. #	483.60(d)(1)(2)	Completed	Reg. #	483.70(e)(1)-(3)	Completed
LSC		10/01/2024	LSC		10/02/2024	LSC		09/25/2024

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315010 Y1	A. Building B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix F0944	Correction	ID Prefix F0946	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.95(d)	Completed	Reg. # 483.95(f)(1)(2)	Completed
LSC	09/25/2024	LSC	10/02/2024	LSC	10/01/2024

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?
8/23/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
32003	A. Building B. Wing	10/11/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/01/2024	ID Prefix S2905 Reg. # 8:39-43.1(a)(2) LSC	Correction Completed 09/27/2024	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	
8/23/2024	☐ 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
	315010	A. BUILDING **01** B. WING _____	**08/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	**225 W JERSEY STREET** **ELIZABETH, NJ 07202**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/21/2024 and 08/22/2024, Elmora Hills Health and Rehab. Center was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The facility is a 3-story building that was built in 90's. It is composed of Type II protected construction. The facility is divided into 9- smoke zones. The 350 KW diesel generator does 100 % of the building. The facility has 200 certified beds. At the time of the survey the census was 186.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document	K 311	Tag K 311	9/12/24

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

Electronically Signed | 09/06/2024

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ELMORA HILLS HEALTH & REHABILITATION CENTER	**225 W JERSEY STREET** **ELIZABETH, NJ 07202**

(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 311	Continued From page 1 review on 8/21/2024 and 8/22/2024 in the presence of facility management, it was determined that the facility failed to ensure that 11 of 14 exit access (leading into stairwells) stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction in accordance with NFPA 101: 2012 edition, Section 19.3.1. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility provided lay-out on 8/21/2024, revealed the facility was a three-story (3) building with a lower level. Observations starting at approximately 9:00 AM on 8/21/2024 and continued on 8/22/2024 in the presence of the facility's U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted], revealed 11 of 14 exit access doors leading into exit stairwells did not close to provide positive latching as follows: On 8/21/2024: 1) At approximately 10:16 AM, the lower level stairwell exit access door #002 (near the elevator mechanical room) did not positive latch into its frame. 2) At approximately 11:06 AM, the 3rd floor stairwell exit access door #302 (near Resident room #301) did not positive latch into its frame. 3) At approximately 11:20 AM, the 3rd floor stairwell exit access door #303 (near the "Bridge" walkway) did not positive latch into its frame. This test was repeated two additional times with the same results. 4) At approximately 11:21 AM, the 3rd floor	K 311	1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice All 11 out of 14 exit access doors that were found to not provide a positive latch were corrected and ensured to have a positive latch into their frames as required to maintain the exit stairwells 1 ¿ hour fire rated construction and to prevent fire, smoke, and poisonous gases to enter the exit stairwells in the event of a fire. No residents had negative outcomes related to the findings. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. All exit doors were inspected and ensured to have a positive latch when in the closed position. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Maintenance Department was re-educated about maintaining the 1 ¿ hour fire rated construction on stairway corridor exit access doors. 14 Fire exit doors will be inspected monthly by the Maintenance Director or designee. 4. How the corrective action will be monitored to ensure the deficient practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING **01** B. WING _____	**08/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	**225 W JERSEY STREET** **ELIZABETH, NJ 07202**

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K 311	Continued From page 2 stairwell exit access door #304 (near Elevator #3) when tested did not positive latch into its frame. This test was repeated two additional times with the same results. 5) At approximately 11:23 AM, on the 3rd floor stairwell exit access door #301 (near Elevators #1 and #2) did not positive latch into its frame. This test was repeated two additional times with the same results. On 8/22/2024: 6) At approximately 9:06 AM, the 2nd floor stairwell exit access door #202 (near Resident room #201) did not positive latch into its frame. 7) At approximately 9:35 AM, the 2nd floor stairwell exit access door #203 (near Elevator #3) did not positive latch into its frame. This test was repeated two additional times with the same results. 8) At approximately 10:03 AM, the 2nd floor stairwell exit access door #201 (near Elevators #1 and #2) did not positive latch into its frame. This test was repeated two additional times with the same results. 9) At approximately 10:38 AM, the 1st floor stairwell exit access door #103 (near Elevator #3) did not positive latch into its frame. This test was repeated two additional times with the same results. 10) At approximately 10:48 AM, the 1st. floor stairwell exit access door #106 (in the Residents Dining room) did not positive latch into its frame. 11) At approximately 11:19 AM, the 1st floor	K 311	will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director or designee will monitor the stairway corridor exit access doors weekly for 4 weeks, then monthly to ensure a positive latch into their frames as required to maintain the 1.5 hour fire rated construction. The maintenance director will report the findings to the quality assurance and performance improvement meeting quarterly for 2 quarters.	

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	315010	A. BUILDING **01** B. WING _____	**08/23/2024**

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K 311	Continued From page 3 stairwell exit access door #101 (near Elevators #1 and #2) did not positive latch into its frame. This test was repeated two additional times with the same results. The [redacted] and [redacted] confirmed the findings at the time of observations. The [redacted] and [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 8/22/2024 at approximately 01:30 PM.	K 311		
K 351 SS=E	NJAC 8:39- 31.2(e) Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 351		9/11/24

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K 351	Continued From page 4 Based on observation, interview, and document review on 8/21/2024 and 8/22/2024 in the presence of facility management, it was determined that the facility failed to install fire sprinklers as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101: 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and NFPA 13: 2010 Edition. This deficient practice had the potential to affect limited residents and was evidenced by the following: A review of the facility provided lay-out on 8/21/2024, revealed the facility was a three-story (3) building and a lower level. Observations starting at approximately 9:00 AM on 8/21/2024 and continued on 8/22/2024 in the presence of the facility's U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), revealed the following locations failed to provide fire sprinkler coverage as follows: 1) On 8/21/2024 at approximately 10:08 AM, the surveyor observed inside the stairwell (next to the Electrical room) lower level, a 12-foot by 6-foot 9-inch area with no fire sprinkler coverage. In an interview at the time, the U.S. FO [redacted] confirmed there was no fire sprinkler coverage in the area. The Code requires fire sprinkler coverage inside stairwells at the top landing, bottom landing and every other floor in between. 2) On 8/22/2024 at approximately 10:10 AM, the surveyor observed inside the second floor North Unit, a 4-foot 5-inch by 4-foot 5-inch housekeeping closet with no fire sprinkler	K 351	Tag K 351 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice The two areas identified with no fire sprinkler coverage were visited by a certified fire sprinkler company to install new sprinklers to the affected areas. Certified sprinkler company completed the new installation of sprinkler heads on 9/11/2024. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The maintenance department was educated on NFPA 13 Standards for installation of Sprinkler systems by the administrator to ensure protection with sprinklers in all areas. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director or designee will inspect all areas that require sprinkler coverage weekly for 4 weeks, then monthly for 3 months. Audit results will be brought to the Quality Assurance and Performance improvement committee quarterly meeting.	

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	315010	A. BUILDING **01** B. WING _____	**08/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 351	Continued From page 5 coverage. In an interview at the time, the [U.S. FO redacted] confirmed there was no fire sprinkler coverage in the area. The [U.S. FOIA (b) (6) redacted] [U.S. FO redacted] and [U.S. FO redacted] were informed of the deficient practice during the Life Safety Code survey exit on 8/22/2024 at approximately 01:30 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review on 8/21/2024 and 8/22/2024 in the	K 353	Tag K 353 1.What corrective actions(s) will be	9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 6 presence of facility management, it was determined that the facility failed to maintain fire system sprinkler heads free of debris (loading) in accordance with NFPA 25: 2011 Edition. This deficient practice had the potential to affect limited residents and was evidenced by the following: On 8/21/2024 during the survey entrance at approximately 8:35 AM, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building and a lower level. Observations starting at approximately 9:00 AM on 8/21/2024 in the presence of the facility U.S. FOI revealed the following: On 8/21/2024: 1) At approximately 9:20 AM, the surveyor observed on the lower level, a 17-foot by 8-foot 4-inch room adjacent to the Central Supply area with two (2) up-rite sprinkler heads that were covered with a sprayed on fire proofing material. 2) At approximately 9:30 AM, the surveyor observed on the inside the lower level, a 23-foot by 5-foot Mattress Storage room two (2) up-rite sprinkler heads that were covered with a sprayed on fire proofing material. The U.S. FO confirmed the findings at the time of observations.	K 353	accomplished for those residents affected by the deficient practice Sprinkler heads that were found with debris were cleaned and inspected by a certified fire sprinkler company to be operational and in good working order. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: Maintenance Department was educated by administrator on NFPA 25: 2011 edition on standard for inspection, testing, and maintain of water-based fire protection systems. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director or designee will inspect 4 random sprinkler heads weekly for 4 weeks and then monthly for 2 months to ensure that all sprinkler heads are clear from debris. Audit results will be brought to a Quality assurance and performance improvement meeting quarterly.	

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K 353	Continued From page 7 The U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FO were informed of the deficient practice during the Life Safety Code survey exit on 8/22/2024 at approximately 01:30 PM. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 8/21/2024 and 8/22/2024 in the presence of facility management, it was determined that the facility failed to 1) replace one (1) of 37 portable fire extinguishers observed with evidence of corrosion and rust on the bottom of the metal cylinder and 2) install portable fire extinguishers no higher than 5-feet high for nine (9) of 37 fire extinguishers in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations starting at approximately 9:00 AM on 8/21/2024 and continued on 8/22/2024 in the presence of the facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6)	K 355	Tag K 355 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice A fire extinguisher found to have rust on the bottom of metal cylinder was removed from service immediately and replaced with a spare fire extinguisher. 9 fire extinguishers were identified to be mounted above 5-feet high. They were all lowered and mounted no more than 5-feet high as per NFPA 101: 2012 edition section 19.3.5.12, 9.7.4.1, and NFPA 10: 2010 edition, sections 6.1, 6.1.3.8.1, and 6.1.3.8.3. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be	9/12/24

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K 355	Continued From page 8 (U.S. FOIA revealed the following: On 8/21/2024: Lower level: 1) At approximately 9:15 AM, the ABC-Type fire extinguisher near the Social workers office was mounted too high and had evidence of corrosion and rust on the bottom of the extinguisher. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 3-inches to the center of the pressure indicator gauge. On the 3rd floor: 2) At approximately 10:37 AM, the ABC-Type fire extinguisher near the smoke doors next to resident room #318 was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 4-inches to the center of the pressure indicator gauge. 3) At approximately 11:01 AM, the ABC-Type fire extinguisher to the left of resident room #304 was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 4-inches to the center of the pressure indicator gauge. On 8/22/2024: 4) At approximately 8:39 AM, the ABC-Type fire extinguisher to the right of resident room #215 was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 3-inches to the center of the pressure indicator gauge. 5) At approximately 8:42 AM, the ABC-Type fire extinguisher to the left of resident room #204 was mounted too high. The surveyor observed, measured and recorded	K 355	affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur: The Maintenance department was educated on NFPA 101: 2012 edition section 19.3.5.12, 9.7.4.1, and NFPA 10: 2010 edition, sections 6.1, 6.1.3.8.1, and 6.1.3.8.3. on the maximum height mount of a portable fire extinguisher. The Maintenance Director or designee will inspect each fire extinguisher monthly for signs of rust and corrosion. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director designee will inspect 5 fire extinguishers for their mounted height and for rust and corrosion. This will be done weekly for 4 weeks, then monthly for 2 months and quarterly thereafter. Inspection results will be brought to the quality assurance and performance improvement meeting each quarter.	

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K 355	Continued From page 9 the fire extinguisher was mounted 5-foot 4-inches to the center of the pressure indicator gauge. 6) At approximately 9:31 AM, the ABC-Type fire extinguisher to the left of the Staff Lounge was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 6-inches to the center of the pressure indicator gauge. 7) At approximately 10:02 AM, the ABC-Type fire extinguisher near stairwell door #201 was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 5-inches to the center of the pressure indicator gauge. On the 1st floor: 8) At approximately 11:00 AM, the ABC-Type fire extinguisher next to the Dietary Staff bathroom was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5'- 6-1/2" to the center of the pressure indicator gauge. 9) At approximately 11:10 AM, the ABC-Type fire extinguisher across from elevators #1 and #2 was mounted too high. The surveyor observed, measured and recorded the fire extinguisher was mounted 5-foot 3-3/4-inches to the center of the pressure indicator gauge. The U.S. FO and U.S. FO confirmed the findings at the time of observations. The U.S. FOIA (b) (6) U.S. FO and U.S. FO were informed of the deficient practice during the Life Safety Code survey exit on 8/22/2024 at approximately 01:30	K 355		

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K 355	Continued From page 10 PM. NJAC 8:39 -31.1 (c), 31.2 (e) NFPA 10	K 355		

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
315010 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	09/12/2024	LSC K0351	09/11/2024	LSC K0353	09/11/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0355	09/12/2024	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	
8/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO