STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

(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 not 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		
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information	E 033		12/5/22

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

Electronically Signed | 11/11/2022

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

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E 033	Continued From page 1 about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on review of the Emergency Preparedness Policies and Procedures and interview with administrative staff, it was determined that the facility's communication plan did not include a system which ensured the continuity of care for residents. This deficient practice would affect all residents and was evidenced by the following: On 10/04/22 at 10:37 AM, the surveyor began review of the facility's Emergency Preparedness Policies and Procedure manual which did not include a method for sharing medical information/documentation for the residents under the facility's care with other health providers during an emergency. On 10/06/22 at 10:57 AM, the surveyor interviewed the U.S. FOIA (b)(6) who was currently	E 033	1. Immediate Action a. The facility emergency preparedness plan was revised to include methods for communication in accordance with federal, state, and local laws b. The staff was immediately educated on methods for communication the facility emergency preparedness communication plan 2. Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice 3. Systemic changes a. The revised facility emergency preparedness plan was placed into effect and strategically placed throughout the	

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E 033	Continued From page 2 overseeing the [redacted] and the facility, who stated that the Regional Maintenance Director was in charge of the facility's Emergency Preparedness Program. The U.S. FOIA (b)(6) stated he was not in the building today, but provided the surveyor with their contact number. On 10/06/22 at 11:50 AM, the surveyor conducted a phone interview with the U.S. FOIA (b)(6) [redacted] who confirmed he was in charge of the facility's Emergency Preparedness program which he started overseeing a month ago. At this time, the surveyor requested documentation of the facility's communication plan that included a system to ensure the continuity of care for residents during an emergency. On 10/06/22 at 2:48 PM, the surveyor in the presence of the U.S. FOIA (b)(6) [redacted] requested documentation of the facility's communication plan that included a system to ensure the continuity of care for residents during an emergency. On 10/11/22 at 10:54 AM, the [redacted] provided the surveyor with additional Emergency Preparedness documents which did not include the facility's communication plan for a system to ensure the continuity of care for residents during an emergency. On 10/12/22 at 12:40 PM, the U.S. FOIA (b)(6) [redacted] confirmed that the facility had no additional documentation to provide. N.J.A.C. 8:39-31.2(e)	E 033	facility in designated locations 4. Quality assurance monitoring a. The facility Director of Maintenance will audit the facility emergency preparedness plan annually to ensure compliance with federal, state and local laws. The audit findings will be reported to the facility QAPI committee annually. The first of which will take place in December 2022.	

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E 034	Continued From page 3	E 034		
E 034 SS=F	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on review of the Emergency	E 034	1. Immediate Action	12/5/22

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E 034	Continued From page 4 Preparedness Policies and Procedures and interview with administrative staff, it was determined that the facility's communication plan did not include a system to provide information regarding the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. This deficient practice would affect all residents and was evidenced by the following: On 10/04/22 at 10:37 AM, the surveyor began review of the facility's Emergency Preparedness Policies and Procedure manual which did not include a system to provide information regarding the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. On 10/06/22 at 10:57 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who was currently overseeing the U.S. FOIA (b)(6) and the facility, who stated the Regional Maintenance Director was in charge of the facility's Emergency Preparedness Program. The U.S. FOIA (b)(6) stated he was not in the building today but provided the surveyor with their contact number. On 10/06/22 at 11:50 AM, the surveyor conducted a phone interview with the U.S. FOIA (b)(6) who confirmed he was in charge of the facility's Emergency Preparedness program which he started overseeing a month ago. At this time, the surveyor requested documentation of the facility's communication plan that included a system to provide information regarding the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction.	E 034	a. The facility revised the emergency preparedness plan to include the facility' occupancy needs and its ability to provide assistance to the authority having jurisdiction, the incident command center or designee b. The staff was immediately educated on the revised emergency preparedness plan 2. Identification of Others a. All residents residing in the facility have the ability to be affected by the deficient practice 3. Systemic Changes b. The revised facility emergency preparedness plan was placed into effect and strategically placed throughout the facility in designated locations 4. Quality assurance monitoring b. The facility Director of Maintenance will audit the facility emergency preparedness plan annually to ensure compliance with federal, state and local laws. The audit findings will be reported to the facility QAPI committee annually.	

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E 034	Continued From page 5 On 10/06/22 at 2:48 PM, the surveyor in the presence of the U.S. FOIA (b)(6), the facility's U.S. FOIA (b)(6) [redacted], requested documentation of the facility's communication plan that included a system to provide information regarding the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. On 10/11/22 at 10:54 AM, the U.S. FOIA (b)(6) provided the surveyor with additional Emergency Preparedness documents which included an email dated 10/11/22, but did not provide documentation of the facility's communication plan for a system to provide information regarding the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction . On 10/12/22 at 12:40 PM, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) confirmed that the facility had no additional documentation to provide.	E 034		
E 037 SS=F	N.J.A.C. 8:39-31.2(e) EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54,	E 037		12/5/22

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E 037	Continued From page 6 Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and	E 037		

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E 037	Continued From page 7	E 037		

others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in

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E 037	Continued From page 8	E 037		

case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of

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E 037	Continued From page 9	E 037		

alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide

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E 037	Continued From page 10 emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of the Emergency Preparedness Program binder and interviews with administrative staff it was determined that the facility failed to provide emergency preparedness training to all new and existing staff annually. This deficient practice affected all residents and was evidenced by the following: On 10/04/22 at 10:37 AM, the surveyor began review of the facility's Emergency Preparedness Policies and Procedure manual which did not include evidence that the facility was providing emergency preparedness training to all new and existing staff annually. On 10/06/22 at 10:57 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who was currently overseeing the LNHA and the facility, who stated that the Regional Maintenance Director was in charge of the facility's Emergency Preparedness Program. The U.S. FOIA (b)(6) stated he was not in the building today but provided the surveyor with their contact number. On 10/06/22 at 11:50 AM, the surveyor conducted a phone interview with the U.S. FOIA (b)(6) who confirmed he was in charge of the facility's Emergency Preparedness program. The U.S. FOIA (b)(6) stated he had been at this facility for one month and had not conducted any staff training on Emergency Preparedness, but he planned to train in the future. At this time, the surveyor requested documentation for all new and existing staff	E 037	1. Immediate Action a. The facility revised the training of the facility emergency preparedness plan to comply with federal, state and local laws b. Staff was immediately educated on the revised emergency preparedness training program 2. Identification of Others a. All residents residing in the facility have the potential to be affected by this deficient practice 3. Systemic Changes b. The facility developed an emergency preparedness training schedule to comply with federal, local and state regulations c. The revised facility emergency preparedness plan includes: • Initial training on emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role • Annual training on emergency preparedness plan • Maintain documentation of all emergency preparedness training • Educate staff if emergency preparedness plan is significantly updated 4. Quality assurance monitoring a. The facility educator will audit employee education records monthly to ensure compliance with the facility	

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E 037	Continued From page 11 training for Emergency Preparedness. On 10/06/22 at 2:48 PM, the surveyor in the presence of the U.S. FOIA (b)(6), the facility's U.S. FOIA (b)(6) requested evidence that all new and existing staff were trained on Emergency Preparedness. On 10/11/22 at 10:54 AM, the U.S. FOIA (b)(6) provided the surveyor with additional Emergency Preparedness documents which did not include evidence that all new and existing staff were trained on Emergency Preparedness. On 10/12/22 at 12:40 PM, the U.S. FOIA (b)(6) confirmed that the facility had no additional documentation to provide. N.J.A.C. 8:39-31.2(e)	E 037	emergency preparedness training schedule monthly on an ongoing basis. Audit findings will be reported to the QAPI committee on a monthly basis. The first of which will take place in December 2022.The QAPI committee will review audit findings and make further recommendations as needed	
F 000	INITIAL COMMENTS COMPLAINT #: NJ00152936, NJ00155999, NJ00156357 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Survey Date: 10/12/22 Census: 103 Sample: 19 + 46 = 65	F 000		

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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.

The following Immediate Jeopardy (IJ) situations were identified for F600, F835, F880, F886 and F888.

During a Standard Survey conducted on 9/21/22 through 10/12/22, the survey team identified the following:

F600 s/s L

The survey team identified that an IJ situation began on Ex Order 26.4B1 after a resident was Ex Order 26.4B1 Ex Order 26.4B1 by another resident in the facility and the alleged Ex Order 26.4B1 was not monitored to prevent further abuse to the other residents on the unit.

The NJ Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 09/28/22, including the Immediate Jeopardy Templates.

The Facility failed to:

-Ensure vulnerable residents were free from Ex Order 26.4B1.

-Ensure vulnerable residents were protected from a Ex Order 26.4B1
On 09/29/22, the NJ Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy.

On 10/03/22, the NJ Department of Health

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F 000	Continued From page 13	F 000		

conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 09/29/22.

F835 s/s L

The survey team identified that an IJ situation began on [redacted] after the [redacted] was unable to provide the survey team with requested policies, procedures and documentation required to conduct the survey.

The NJ Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 09/28/22, including the Immediate Jeopardy Templates.

The Facility failed to:

-Ensure policies, procedures and systems were developed and implemented to ensure immediate action was taken to ensure the facility operated in a manner to ensure the facility residents attained or maintained the highest practicable physical, mental and psychosocial well-being of each resident.

-Ensure that a resident was free of [redacted].

-Maintained an effective infection control program that limited the spread of [redacted]

On 09/29/22, the NJ Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy.

On 10/04/22, the NJ Department of Health

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F 000	Continued From page 14	F 000		

conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 09/29/22.

F880 s/s L

The survey team identified that an IJ situation began on EX Order 26.4B1 after the facility did not perform contact tracing when two residents EX Order 26.4B1

The NJ Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 09/23/22, including the Immediate Jeopardy Templates.

The Facility failed to:

- to ensure a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of NJ Ex Order 26.4b1.

On 09/27/22, the NJ Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy.

On 10/03/22, the NJ Department of Health conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 09/27/22.

F886 s/s L

The survey team identified that an IJ situation began on 09/20/22 after the facility failed to conduct immediate resident and staff testing after a resident tested positive for NJ Ex Order 26.4b1

The NJ Department of Health sent a Notice of

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F 000	Continued From page 15 Determination of Immediate Jeopardy to the Facility Administrator on 09/23/22, including the Immediate Jeopardy Templates. The Facility failed to: - Conduct immediate resident and staff testing upon the identification of a single NJ Ex Order 26.4b1 staff or resident result. On 09/27/22, the NJ Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy. On 10/03/22, the NJ Department of Health conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 09/27/22. F888 s/s L The survey team identified that an IJ situation began on NJ Ex Order 26.4b1 after a staff member, who was NJ Ex Order 26.4b1 without a qualifying exemption proceeded to work forty-seven shifts from the start of the facility outbreak of NJ Ex Order 26.4b1 which began on EX Order 26.4B1 The NJ Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 10/11/22, including the Immediate Jeopardy Templates. The Facility failed to: - Ensure all staff were up to date with NJ Ex Order 26.4b1 and/or be granted a qualifying exemption during a NJ Ex Order 26.4b1 were not permitted to work in the facility placed all	F 000		

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F 000	Continued From page 16 residents and staff at risk for contracting a contagious deadly disease. On 10/12/22, the NJ Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy. On 10/12/22, the NJ Department of Health conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 10/12/22. The Facility continued to remain out of compliance on 10/12/22 for actual harm that is not IJ, and no actual harm with he potential for more than minimal harm that is not IJ.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		12/5/22

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F 550	Continued From page 17 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of documentation, it was determined that the facility failed to promote dignity by failing to ensure: a.) a resident who required assistance at meals and foods in bowls was provided , and b.) a resident was provided with priviacy during dressing. This deficient practice occurred for 2 of 19 residents reviewed (Resident #7) and (Resident #54) and was evidenced by the following: a.) During observation of the lunch meal on 09/23/22 at 12:30 PM, the surveyor observed Resident #7 seated at a table eating lunch. Resident #7 EX Order 26.4B1 and was observed picking up the food with his/her Ex Order 26.4B1 . Two staff	F 550	1. Immediate Action: a. Resident #7's care plan and sigma tasks were reviewed and revised to address current care needs b. Resident #7 received an NJ Exec Order 26.4b1 with recommendation for NJ Ex Order 26.4b1 c. Resident #54's care plan and sigma tasks were reviewed and revised to address current care needs d. Resident #54's room was deep cleaned, all dirty linen was removed e. Facility policy was reviewed to ensure compliance with federal regulations. f. Staff received immediate education on residents' rights	

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F 550	Continued From page 18 members (TNA #1 and CNA #2) were observed in the dayroom assisting the residents. The surveyor observed TNA #1 who poured the remaining food from Resident #7's shirt on their plate and was about to serve the resident the food collected when the surveyor stopped her and asked her to call the kitchen for more food. On 09/23/22 at 1:43 PM, during an interview with the surveyor, TNA #1 stated that Resident #7 was always "Ex Order 26.4B1" during meals and would Ex Order 26.4B1 Ex Order 26.4B1 . She stated that resident #7 should be presented with Ex Order 26.4B1 Ex Order 26.4B1. She could not comment on why the process was not being followed today. On 09/23/22 the surveyor reviewed Resident #7's medical record. According to the Admission Face Sheet, Resident #7 was admitted to the facility with diagnoses which included but not limited to Ex Order 26.4B1 Ex Order 26.4B1 . The Quarterly Minimum Data Set (MDS) dated Ex Order 26.4B1 indicated Resident #7 was Ex Order 26.4B1 Ex Order 26.4B1, Resident #7 received a score of " " for Ex Order 26.4B1 for daily decision-making problems. The MDS also indicated Resident #7 required Ex Order 26.4B1 A review of the Physician Order Sheet Ex Order 26.4B1 indicated that Resident #7 was on a Ex Order 2 Ex Order 26.4B1 with instructions to provide Ex Order 2 in a bowl. On 09/23/22 at 2:00 PM, the surveyor interviewed CNA #2 who was sitting at the same table where Resident #7 Ex Order 26.4B1 CNA #2 expressed her	F 550	2. Identification of Others All residents residing in the facility have the potential to be affected by the deficient practice. 3. Systemic Changes A Licensed Nurse will be present in the dining room to oversee meal service. The nurse will monitor meal service to ensure that resident's rights are protected, and residents received the necessary dining assistance. Resident's demonstrating a change or need for increased assistance will be referred the interdisciplinary team for review and consults as needed. The facility Incontinence policy and procedure has been reviewed and revised to include scheduled incontinence rounds. Staff has been Inservice on the revised policy. A daily walking rounds policy has been written and unit managers/designees will conduct walking rounds to observe resident condition and ensure timely intervention is provided with consideration for resident s' care needs, privacy and dignity The facility grievance policy has been reviewed and revised. Resident grievances wlll be recorded in the grievance log. The social worker will maintain a grievance log which will be reviewed by the interdisciplinary team at daily clinical meeting to ensure appropriate grievance resolution 4. Quality Assurance Monitoring The director of social services will conduct weekly quality assurance audits of the grievance log weekly x 6 months. The	

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F 550	Continued From page 19 frustration over the lack of oversight and follow up. She stated that the Ex Order 26.4B1 and Ex Order 26.4B1 for Resident #7. CNA #2 stated she and other staff reported the behavior several times and nothing had been done about it. The surveyor reviewed Resident #7's Plan of care and could not find any directive written for the direct care staff to follow during meals. On 10/04/22 at 8:30 AM, the surveyor returned to the locked unit to observe the breakfast meal. The surveyor observed Resident #7 in bed. The bed was Ex Order 26.4B1 Ex Order 26.4B1. The resident was on a Ex Order 26.4B1 There was no staff in the room to assist the resident with the breakfast meal. Resident #7 Ex Order 26.4B1 The surveyor left the room and alerted a staff who then entered the room and removed the tray from the resident. On 10/04/22 at 9:30 AM, the surveyor interviewed the CNA #3 assigned to Resident #7 regarding how the resident's needs were communicated to staff. CNA #3 stated in the morning they received report for new residents only. CNA #3 acknowledged that she did not receive any report from the nurse that morning. The surveyor then asked the CNA if there was a care card, or system to follow while providing care, she stated that prior to the transition to electronic medical records, the care cards were in the patient's room and were easily accessible. On 10/04/22 at 10:10 AM, the surveyor then interviewed the Unit Manager (RN #1) in charge of the Ex Order 26 Unit. RN #1 confirmed that she did not give report to the CNA's. RN #1 stated she	F 550	audit results will be reported to the quality assurance and performance improvement committee monthly. The unit manager will conduct quality assurance audits of unit rounds weekly X 6 months. The audit results will be reported to the quality assurance and performance improvement committee monthly. The Quality assurance and performance improvement committee will meet monthly. The first of which will take place in December 2022.	

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F 550	Continued From page 20	F 550		

was here to help and did not have much knowledge of the resident's needs on the [redacted] Unit.

The surveyor further reviewed the medical record and noted there was no referral for [redacted] to provide guidance and assistance with the above concerns.

A review of Resident #7's Care Plan initiated [redacted] had a Focus for Nutrition.
Etiology: I have a nutritional problem related to nutrition, need for [redacted]).
The goals: I will receive adequate nutrition to maintain fairly stable weight.
Interventions implemented: We will monitor and encourage your oral intake.
We will honor your preferences and offer substitutions within your dietary restrictions.

During the two above observations, Resident #7 was not provided with [redacted] nor being assisted by staff. It was only on [redacted] after the surveyor brought it to the staff's attention, that Resident #7 was provided with assistance during meals.

On 10/05/22 at 11:00 AM, the surveyor interviewed the [redacted]) regarding the observed meal experience. The [redacted] stated that she was not aware that Resident #7 had been eating with [redacted] until [redacted] when she observed the same. The [redacted] stated that if she were made aware she would have referred Resident #7 to [redacted] for evaluation.

On 10/06/22 at 8:45 AM, the surveyor observed

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CNA #3 assist Resident #7 with the breakfast meal. CNA #3 stated she had been trained to assist with meals but was not aware that eating with NJ Ex Order 26.4b1 considered a dignity issue.

During a follow up interview on 10/06/22 at 2:29 PM, the U.S. FOIA (b) stated Temporary Nursing Assistants (TNAs) and CNAs knew what needed to be done for each resident in the care guide that was transitioned to the electronic medical record. The U.S. FOIA (b) also stated during orientation and at least once a year, information regarding assisting resident with meals was reviewed in training and they do quarterly in-services on Activities of Daily Living (ADLs). The U.S. FOIA (b) further stated her expectations were for staff to be sitting down during a meal, talking and trying to encourage a resident to eat and assist residents with meals as needed.

On 10/11/22 at 8:51 AM, CNA# 3 revealed that Resident #7 Ex Order 26.4B1 and liked to grab objects. When allowed to feed himself/herself, Resident #7 would spill all the food on the tray and on their clothing. The U.S. FOIA (b)(6)) and the U.S. FOIA (b) informed the survey team last week that Resident #7 had to NJ Ex Order 26 .

b. On 09/21/22, the surveyor toured the Ex Order 26.4 locked unit assigned to residents with NJ Ex Order 26.4b1 The surveyor observed Resident #54 seated in a wheelchair in the hallway. A Ex Order 26.4B1 permeated in the hallway while approaching Resident #54's room. The surveyor entered the room and observed the linen which included the EX Order 26.4B1 pad, and the Ex Order 26.4B1 Ex Order 26.4B1 . Some clothing was observed on the radiator in the room.

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A review of Resident #54's medical record revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26.4B1 Ex Order 26.4B1.

The Annual MDS, a resident assessment tool used by the facility to prioritize care dated Ex Order 26.4B1 revealed that Resident #54 was Ex Order 26.4B1. Resident #54 scored Ex out of 15 on the Brief Interview for Mental Status (BIMS). Section E of the MDS which addressed behavior indicated that Resident #54 had EX Order 26.4B1. Section E 0600 impact on behavior subpart c was coded as NJ Ex Order 26.4b1 in the living environment.

On 09/22/22 at 9:55 AM, the surveyor observed Resident #54 sitting in the hallway Ex Order 26.4B1 Resident #54 had on a Ex Order 26.4B1. The surveyor observed several staff Ex Order 26.4B1 in the hallway entering and exiting other resident's room. No staff approached and asked if Resident #54 needed assistance. At 10:00 AM, the surveyor observed a staff member walking toward Resident #54 with some clothing in her hands. The staff greeted the resident and proceeded to dress Resident #54 in the hallway.

On 09/22/22 at 1:06 PM, the surveyor interviewed TNA #1 assigned to Resident #54. TNA #1 stated that Resident #54 was self-sufficient with care, was Ex Order 26.4B1 Ex Order 26.4B1 and changed himself/herself. Resident #54 would Ex Order 26.4B1 and Ex Order 26.4B1, sometimes would Ex Order 26.4B1

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F 550	Continued From page 23 and placed them on the vent in the room to dry. On 09/23/22 at 10:47 AM, the surveyor interviewed the Behavior Aid (BA #1) regarding Resident #54 observed Ex Order 26.4B1 in the hallway. The BA stated when she reported to the Ex Order 26 locked unit around 9:00 AM and almost every day, Resident #54 would be Ex Order 26.4B1 [redacted]. BA #1 revealed that she was not trained to provide care, however she would assist when they were short-handed. BA #1 stated that the proper way would be to escort Resident #54 to the room and assist with dressing. When asked for the rationale, she added for privacy. BA #1 stated, "I know for sure you have to have the resident in the room". She could not comment why she did not escort Resident #54 to the room. The administrative staff was made aware of the above incident on 10/11/22 and again on 10/12/22. On 10/12/22 at 2:00 PM, the corporate liaison told the survey team that she identified that the facility had some concerns that needed to be addressed and told the survey team that the facility did not have any additional information to provide. A review of the facility's undated policy for Resident Rights indicated under policy statement, "Employees shall treat all residents with kindness, respect and dignity." N.J.A.C. 8:39-4.1(a)12	F 550		
F 559 SS=E	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his	F 559		12/5/22

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AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

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F 559	Continued From page 24 or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and other pertinent facility documentation, it was determined that the facility failed to a.) notify in writing of residents' room changes for Ex Order 26.4B1 Ex Order 26.4B1 residents and b.) develop facility policy for room changes in accordance with federal and state regulations. This deficient practice was identified for 2 of 3 residents reviewed for room changes (Resident #10 and #47) and was evidenced by the following: On 09/26/22 at 2:52 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated the process for a resident room change was the nurse or nurse's aide would inform her the resident's room needed to be changed. The U.S. FOIA stated if a room was available, she talked to the resident directly as well as the roommate and then let the U.S. FOIA (b)(6)) know a room would be changed. At this time, the surveyor requested a list of resident room changes from the past two months.	F 559	1. Immediate action a. Resident #10 and their representative was provided a written explanation of the room change that occurred on EX Order 26.4B1 Resident #35 and their representative was provided a written explanation of the room change that occurred on EX Order 26.4B1 Resident #47 and their representative was provided a written explanation of the room change that occurred on EX Order 26.4B1 b. Staff received immediate education on choosing/being notified of room/roommate changes 2. Identification of Others a. All residents having a room/roommate change have the potential to be affected by the deficient practice 3. Systemic Changes • The facility policy on room and roommate changes was revised and written to ensure compliance with federal	

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F 559	Continued From page 25 On 09/27/22 at 12:35 PM, the surveyor re-interviewed the U.S. FOIA (b)(6) regarding the resident room change procedure, who confirmed that she would speak to the resident and roommate if there was a request for a room change. Then she spoke with the U.S. FOIA (b)(6) or the U.S. FOIA (b)(6) regarding the situation and the need or request for a room change. The U.S. FOIA (b)(6) stated she called the resident's family to notify of the room change and documented in the electronic Medical Record (eMR) a Progress Note for why the room was changed. The U.S. FOIA (b)(6) confirmed she did not notify residents or their representatives in writing about a room change. The U.S. FOIA (b)(6) stated that some residents had been moved due to their COVID-19 outbreak response to mitigate the spread of the virus, which would be a temporary move. At this time, the surveyor and the U.S. FOIA (b)(6) reviewed the Admission, Discharge, Transfer Activity Detail Report from Ex Order 26.4B1. The surveyor asked the Ex Order 26.4B1 to provide the reason for the room changes for Resident #10 on Ex Order 26.4B1 Resident #35 on Ex Order 26.4B1, and Resident #47 on Ex Order 26.4B1. The U.S. FOIA (b)(6) looked in the Progress Notes for each resident and stated the following: For Resident #10, the U.S. FOIA (b)(6) confirmed that there were no Progress Notes for this resident regarding the room change. The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) was responsible for this room change and she thought the resident's room was changed because they were initially on a locked nursing unit which was not an appropriate placement for the resident. For Resident #35, there was a Progress Note dated NJ Ex Order 26.4b1 that the resident Ex Order 26.4B1	F 559	regulations. Staff was educated on the revised facility policy. • All resident room/ roommate changes will be reviewed at the daily clinical meeting to ensure compliance with facility policy. • Resident requests and preferences will be considered and honored whenever possible. Resident will be educated and reason and rationale for room change will be provided. 4. Quality assurance monitoring The director of social service/designee will audit resident room/roommate changes to ensure compliance with facility policy on a weekly basis X 6 months. Negative audit findings will be corrected immediately. Audit finding will be reported to the QAPI committee monthly. The QAPI committee will review audit findings for further recommendations.	

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Continued From page 26

Ex Order 26.4B1 so was moved.

For Resident #47, the U.S. FOIA confirmed there were no Progress Notes for the resident regarding the room change. The U.S. FOIA stated she was not involved in this room change and she thought the resident's room was changed because they were initially on a locked nursing unit which was not an appropriate placement for the resident.

The U.S. FOIA informed the surveyor since the U.S. FOIA (b) started at the facility in Ex Order 26.4B1 the U.S. FOIA (b) had been looking at the residents who were on the locked nursing unit and if the resident needed to be there. The U.S. FOIA stated that both Resident #10 and #47 NJ Ex Order 26.4b1 so they did not need to be on that unit, so the facility was in the process of moving these residents as rooms became available. The U.S. FOIA confirmed she did not notify in writing the resident or their representative of these changes.

The surveyor reviewed the medical record for Resident #10.

A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in Ex Order 26.4B1 with diagnoses which included Ex Order 26.4B1

A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated Ex Order 26.4B1, reflected a brief interview for mental status (BIMS) score NJ Ex Order 26.4b1 with a Ex Order 26.4B1 with Ex Order 26.4B1.

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F 559	Continued From page 27	F 559		

There was no documentation regarding the resident's room change or that the resident or their representative was notified in writing.

The surveyor reviewed the medical record for Resident #47.

A review of the Resident Face Sheet reflected the resident was admitted to the facility in Ex Order 26.4B1 of Ex Order 26 with diagnoses which included Ex Order 26.4B1 Ex Order 26.4B1

A review of the most recent annual MDS dated [redacted] reflected a BIMS score of unable to be determined with Ex Order 26.4B1 Ex Order 26.4B1 .

There was no documentation regarding the resident's room change or that the resident or their representative was notified in writing.

On 10/06/22 at 12:59 PM, the surveyor interviewed the U.S. FOIA (b)(regarding the facility's process for room changes. The U.S. FOIA (stated if a room change was requested, staff notified social services and admission departments. The U.S. FOIA (notified the resident or their representative, and when the facility received the okay for the change, the resident was moved. The resident's representative was notified by the U.S. FOIA (via telephone and documented in the Progress Notes. The U.S. FOIA (stated resident representatives received only a telephone call and residents were verbally spoken to, no one received anything in writing.

On 10/12/22 at 9:07 AM, the U.S. FOIA (b)(6) who was overseeing the facility's U.S. FOIA (b)(6) and the

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F 559	Continued From page 28 facility, confirmed there was no documentation for the room changes as well as nothing provided in writing to the resident or their representative regarding the room changes for both residents. A review of the facility's "Room Change Policy and Procedure" dated effective 01/24/14 and reviewed 01/20/22, included the Social Worker will...give the resident, designated representative/family member notification prior to changing room...provide notice to designated representative, legal guardian and/or family member of the need or intent to transfer the resident to another room...will document room changes and transfers in the resident's medical record. The policy did not indicate the notice to residents and their representatives must be in writing. N.J.A.C. 8:39-4.1(a)(13)	F 559		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		12/5/22

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F 584	Continued From page 29 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to maintain a clean and sanitary environment in the shower room on 1 of 3 units (second floor unit) and was evidenced by the following: On 09/21/22 at 11:55 AM, the surveyor in the presence of two other surveyors were touring the second floor of the facility. The surveyors entered the resident shower room and observed the following: Shower labeled C1 had a visibly stained blanket	F 584	1. Immediate action a. Shower room C1, soiled linen and blanket were removed, a new shower curtain was hung, grout was deep cleaned, chipped surfaces were repaired b. Shower room C2, soiled linen and blanket were removed, a new shower curtain was hung, grout was deep cleaned, chipped surfaces were repaired c. Shower rooms C1 and C2 were deep cleaned d. Staff was immediately educated on safe, clean, comfortable homelike	

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F 584	Continued From page 30 being used as a shower curtain and tied in a knot on the shower rod. The blanket was wet and lying on the base of the shower. The grout on the floor was blackened. There was an area below the shower handrail which was blackened and chipped. Shower labeled C2 had visibly darkened grout below the shower chair. There was an area below the shower handrail which was blackened and chipped. There was a blanket being utilized as a shower curtain. There was a dried washcloth left on the shower chair rail. On 09/21/22 at 12:04 PM, the surveyor asked the EX Order 26.4B1 floor US FOIA (b)(6) to join the surveyors in inspecting the shower room. The U.S. FOIA (b)(6) observed both shower rooms. The US FOIA (b)(6) stated that both showers were used daily. She further stated she had recently started at the facility and had not had a chance to inspect the showers yet. The U.S. FOIA (b)(6) acknowledged C1 "looks like it needs quite a bit of attention, it is mucky" and it was stained as well. She commented that C2 should not have a washcloth drying on the shower chair rail. She further stated C2 was "gross". The US FOIA (b)(6) stated that the nursing staff was responsible to "sanitize" the showers before the next use. She stated she would find out who the appropriate people were to get the showers clean. On 09/21/22 at 12:10 PM, during an interview with the surveyor, the EX Order 26.4B1 floor Certified Nursing Assistant (CNA) confirmed that she had used the shower room twice so far that day. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on	F 584	environment. 2. Identification of Others a. All residents using the shower room have the potential to be affected by the deficient 3. Systemic Changes " Unit manager /designee will make walking unit rounds daily to monitor the physical plant to include shower rooms. Negative physical plant findings will be recorded in the maintenance log which is monitored daily by the Director of Maintenance and reviewed weekly by the facility administrator to assure compliance. Rooms requiring additional housekeeping services have been identified and placed on more frequent daily housekeeping schedule. The Director of Environmental Services will round on the unit daily to inspect and insure a clean homelike environment. " A facility policy was written for weekly environmental and maintenance rounds. A weekly environmental and maintenance rounding audit tool was implemented to assure a clean, safe, homelike environment, which will be completed by the Unit Manager/designee, Directors of Environmental Services and Maintenance. " Photographic evidence of shower rooms has been provided to support that the changes have been made. 4. Quality Monitoring The unit manager/designee will report audit findings weekly. Audit results will be reported to the quality assurance performance improvement committee monthly X 6 months. The first which will	

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F 584	Continued From page 31 10/12/22, the facility had no additional information to provide. A review of the facility provided, "Certified Nursing Assistant" job description undated, included but was not limited to Purpose of Job Position: provide each of your assigned residents with routine daily nursing care and services ...., Personal Nursing Care Functions: assist residents with bath functions, Safety and Sanitation: keep floors dry ...notify housekeeping if equipment needs cleaning ...report hazardous conditions and equipment to management or nursing supervisor immediately. A review of the facility provided, "Environmental Services-Cleaning Resident Rooms", undated included but was not limited to Purpose: to provide guidelines for cleaning and disinfecting residents' rooms and environmental surfaces to break the chain of infection., General Guidelines: 2. All environments/areas (.....shower rooms) ....will be disinfected (or cleaned) daily and when surfaces are visibly soiled. 3. when there is an outbreak, residents' rooms....will be disinfected and/or cleaned more often. Definitions: cleaning: removal of visible soil from surfaces through the physical action of scrubbing with a surfactant or detergent and water. N.J.A.C. 8:39-31.4(a)(b); 31.8(e)	F 584	take place in December 2022.	
F 600 SS=L	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		12/5/22

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F 600	Continued From page 32 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined the facility failed to ensure vulnerable residents were: a.) free from Ex Order 26.4B1, and b.) protected from Ex Order 26.4B1 from staff. This deficient practice occurred for 3 of 6 residents reviewed for abuse (Resident #10, Resident #56, and Resident #63) and was evidenced by the following: Part A On 08/10/22, multiple staff members observed on the locked nursing unit, Resident #63, a Ex Order 26.4B1 exit Resident #10's room. Resident #10 had Ex Order 26.4B1 and was NJ Ex Order 26.4b1 on staff for Activities of Daily Living (ADLs). Resident #63 was reported to be Ex Order 26.4B1 Ex Order 26.4B1 Ex Order 26.4B1 Certified Nursing Aide (CNA #1) reported this observation Ex Order 26.4B1" and reported it to a Licensed Practical Nurse (LPN #1). CNA #1, LPN #1, and Behavioral Aide (BA #1) entered Resident #10's room and observed the bed curtain was open, the resident was lying in bed with the	F 600	I: Immediate Action: " On 9/28/22 the facility team, including Administrator and DON, immediately reviewed the Abuse and Neglect Policy and Procedure and an addendum was done on 9/29/22 to reflect National sex offender background check prior to acceptance into center to ensure appropriate admissions and that patients with a sexual offence history would not be admitted to the building. " On 9/28/22 In services on Abuse and neglect, including sexual abuse and Peggy□s law, facility wide were initiated. In services being done by DON or designee. " On 9/28/22 the facility reported the Ex Order 26.4B1 allegation involving resident #63 and resident #10 to the Police, report was completed, report # Ex Order 26.4B1 " On 9/28/22 the facility completed the reportable form AAS 45 and reported the	

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F 600	Continued From page 33 blanket pulled down, their Ex Order 26.4B1 Ex Order 26.4B1 and their Ex Order 26.4B1 Ex Order 26.4B1 Resident #10 was reported to be Ex Order 26.4B1 saying, Ex Order 26.4B1 LPN #1 reported the incident to the U.S. FOIA (b)(6) who both failed to investigate and report the situation. Resident #10 remained on the locked nursing unit for two weeks with Resident #63, until Resident #10's room was changed on Ex Order 26.4B1 by the U.S. FOIA (b), since the resident reportedly did not need to be on a locked unit. Resident #63 remained on the locked unit with no additional monitoring and was free to roam around the unit and into other resident rooms. An interview with the U.S. FOIA (b)(6) revealed that the facility observed Resident #63 exit Resident #10's room on video surveillance footage, that was unable to be provided to the survey team. The U.S. FOIA (b)(6) stated that Resident #63 was only in Resident #10's room for six to seven minutes, and upon interview, Resident #63 stated he/she was in Resident #10's bathroom by mistake, the U.S. FOIA (b)(6) stated that was determined as plausible since LPN #1 was at some point inside Resident #10's room while administering medication and did not observe Resident #63. The U.S. FOIA (b)(6) concluded that no abuse had occurred, therefore, no investigation was required. The facility's failure to ensure all residents were free from abuse including Ex Order 26.4B1, and physical by failing to investigate the abuse, reporting to the appropriate authorities, and implementing interventions regarding an allegation of Ex Order 26.4B1 to Resident #10 by Resident #63, after staff and administration	F 600	Ex Order 26.4B1 allegation involving resident #63 and resident #10 to DOH. " On 9/28/22 the facility reassessed the resident to determine appropriate level of care for resident #63 who is a Ex Order 26.4B1 and he was found inappropriate for a continued stay in this facility. The resident was transferred to another center on NJ Exec Order 26.4b1 for a more appropriate environment. " On 9/28/22 resident #10 was assessed for any NJ Ex Order 26.4b1 r/t incident on NJ Exec Order 26.4b1 none noted. NJ Ex Order 26.4b1 ssessment completed on NJ Exec Order 26.4b1 " On 9/29/22 a Ex Order 26.4B1) was done on resident #10, Ex Order 26.4B1 Ex Order 26.4B1 " On 9/29/22 physician of resident #10 was notified of incident on Ex Order 26.4B1 " On 9/28/22 resident #10 was evaluated by the Ex Order 26.4B1 and found Ex Order 26.4B1 " On 9/29/22 care plan of resident #10 was updated to reflect monitoring for any NJ Ex Order 26.4b1 ges.	

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F 600	Continued From page 34 confirmed Resident #63, who was a Ex Order 26.4B1 Ex Order 26.4B1 was observed exiting Resident #10's room, posed a serious and immediate threat for abuse which can cause serious physical and emotional harm, impairment, or death that resulted in an Immediate Jeopardy (IJ) situation that began on Ex Order 26.4B1, after Resident #63 was observed exiting Resident #10's room, and Resident #63 continued to remain on the locked unit for 15 days with no monitoring. The facility administration was notified of the IJ on 09/28/22 at 2:55 PM. The facility submitted an acceptable Removal Plan (RP) on 09/29/22 at 2:25 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/03/22. During an interview on 09/26/22 at 1:43 PM, Temporary Nursing Aide (TNA #1) informed the surveyor (#1) that she had concerns about an event that occurred on the Ex Order 2 -floor locked nursing unit involving Resident #10 who had Ex Order 26.4B1 . TNA #1 stated she observed Resident #63 exit Resident #10's room with their Ex Order 26.4B1 . When TNA #1 went to check Resident #10, the resident was observed in bed with their Ex Order 26.4B1 twisted and opened on one side with Ex Order 26.4B1 . The resident was reportedly saying " Ex Order 26.4B1 " and Ex Order 26.4B . TNA #1 stated Resident #10's assigned aide, CNA #1 was not at the facility today, but she could corroborate the incident as well as BA #1. TNA #1 stated LPN #1 was informed of the incident. On 09/27/22 at 8:38 AM, the surveyor re-interviewed TNA #1 who stated Resident #63 was NJ Ex Order 26.4b1 from staff for Activities of Daily Living (ADLs),	F 600	" On 9/29/22 social worker initiated PHQ9 assessments(Patient Health Assessment-9), to assess for Ex Order 26.4B1 for all residents on the locked unit. PHQ9 (Patient Health Assessment-9), to assess for Depression interviews ongoing. " On 9/29/22 social worker-initiated Trauma risk assessments for all residents on the locked unit. Trauma risk assessments ongoing. " On 9/29/22 care plans of residents on the locked unit were updated to reflect monitoring for any mood or behavior changes. " On 9/28/22 the Admissions office initiated the process to check the sex registry for all current patients for any other potential patients with sexual offence history. " On 9/28/22 Regional administrator updated the Admissions policy to reflect National sex offender background check prior to acceptance into center to ensure appropriate admissions of residents without any sexual offence history. II. Identification of Others: All residents have the potential of being affected when the proper protocols and policies are not followed for properly screening admissions for any sex offence history and for properly investigating and reporting sexual abuse allegation. III. Systemic changes:	

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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F 600	Continued From page 35 while Resident #10 had the mindset of a Ex Order 26.4B1 Ex Order 26.4B1 and required NJ Ex Order 26.4b1 from staff for ADLs. When Resident #63 was observed leaving Resident #10's room with Ex Order 26.4B1 Ex Order 26.4B1 and staff observed Resident #10 in bed with their Ex Order 26.4B1 Ex Order 26.4B1, LPN #1 told staff not to touch the resident. The U.S. FOIA (b) had come to the floor and asked questions but she did not take a formal statement from TNA #1 or have TNA #1 sign a formal statement. TNA #1 reported the U.S. FOIA (b) informed staff she would move Resident #10's room, but the resident was not moved until two weeks later. There was no monitoring of Resident #63 who still had access to all the residents in the locked unit. TNA #1 stated the U.S. FOIA (b)(6) was aware of this incident, and the police never came to the facility and Resident #10 was never sent to the hospital to be examined for possible Ex Order 26. TNA #1 stated she had the date of when the incident occurred with a photo of the nursing staff sheet from that day. On 09/27/22 at 9:00 AM, the surveyor interviewed CNA #1 who confirmed she was Resident #10's aide on the date in question, and stated she had clearly recalled observing Resident #10 in bed in their hospital type gown with a blanket covering them, watching television with their bed curtain in the open position prior to her taking a morning break. CNA #1 stated that upon her return from her break, around 9:00 AM or 10:00 AM, she stated she observed Resident #63 exiting Resident #10's room and he/she appeared Ex Order 26.4B1 Ex Order 26.4B1 CNA #1 went into Resident #10's room and observed their roommate (Resident #56) who was lying in the first bed, and was alert but in their	F 600	On 9/28/22 All departments were In services on Abuse and neglect, including sexual abuse and Peggy□s law, and proper and timely investigation and reporting facility wide were initiated. In services being done by DON or designee and completed by 10/5/22. On 9/28/22 admissions team were in serviced on the new policy for screening admissions for any sex offence history and verbalized understanding. In service done by Regional Administrator. On 10/11/22 facility initiated a Trigger Call to provide support, analysis, and direction to facility by regional team, sign placed on all nursing units□ staff will have to call Administrator, DON or designee with any significant incident/accident event, including any and all allegations of neglect and abuse immediately, upon discovery of event. Facility wrote and implemented a grievance policy that addresses updating families on outcomes of grievances Regional LNHA will participate on trigger calls and review reportable events at the time they occur IV. QA Monitoring A tracker for incident/accidents and reportable event was instituted. All accident /incident investigations will be brought to the morning meeting on the next day for Interdisciplinary team review. The tracker will be reviewed by the DON weekly. Admissions will conduct an audit on all admitted residents to ensure the screening was done for any sexual offense history on a weekly basis x 6	

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F 600	Continued From page 36 Ex Order 26.4B1" and was unable to be interviewed. CNA #1 stated she then observed Resident #10's curtain was now drawn closed as if someone was in there with them, and she knew the resident was unable to close the curtain themselves. When CNA #1 opened the curtain, Resident #10's sheet was pulled off of them, Ex Order 26.4B1 Ex Order 26.4B1, their Ex Order 26.4B1 Ex Order 26.4B1, and their face looked Ex Order 26.4B1. When CNA #1 asked Resident #10 what Resident #63 did to them, they were Ex Order 26.4B1 asking for Ex Order 26.4B1 and said "[he/she] Ex Order 26.4B1 [him/her]". CNA #1 reported the incident to LPN #1 who was US FOIA (b)(6) and LPN #1 assessed the resident in the presence of multiple aides. CNA #1 stated after that, she went to see Resident #63 to ask what they did, but she Ex Order 26.4B1 and that was all she needed to see since there was Ex Order 26.4 in Resident #10's Ex Order 26. CNA #1 stated LPN #1 called downstairs, and it took twenty minutes for the U.S. FOIA (b and U.S. FOIA (b)(6 to come to the floor. The U.S. FOIA (b and U.S. FOIA (b)(6 were back and forth between Resident #10 and #63's rooms. Resident #10 was assessed by LPN #1 but never sent to the hospital for an evaluation and the police were not called, and LPN #1 told me to "clean [Resident #10] up" which "I was not comfortable doing." CNA #1 stated she asked U.S. FOIA (b)(6 what the facility was doing and if they needed her to write a statement and the U.S. FOIA (b)(6 responded to CNA #1 to "let him handle it." CNA #1 stated Resident #63 was a Ex Order 26.4B1 and did not receive "special monitoring". CNA #1 stated that Resident #63 usually stayed in his/her room, which was another reason that seeing them exiting out of Resident #10's room Ex Order 26.4B1 CNA #1 stated Resident #63 was able to self-propel in their wheelchair as well as get out	F 600	months. All findings will be reviewed at the Quality Assurance meeting x 3 quarters V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee Avant Rehabilitation and Care Center-Removal of IJ F600L- B I: Immediate Action: " On 9/24/22 CNA #2 was sent home by the DON, not to return to work pending investigation. " On 9/30/22 the facility team, including Administrator, DON and regional team, immediately reviewed the Abuse and Neglect Policy and Procedure, no revisions done. " On 9/30/22 In services on Abuse and neglect were initiated by the DON and Supervisor with the staff who were working at the time on the Ex Orde floor and might have witnessed the altercation on NJ Ex Order 26.4b1 " On 9/26/22 the facility completed the reportable form AAS 45 and reported the altercation incident from NJ Ex Order 26.4b1 involving resident #56 to DOH via phone. On 9/30/22 the facility sent the reportable AAS 45 regarding the altercation incident from NJ Ex Order 26.4b1 via fax. " On 9/30/22 resident #56 was assessed for any NJ Ex Order 26.4b1 r/t incident on NJ Ex Order 26.4b1	

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F 600	Continued From page 37 of their wheelchair. CNA #1 stated "I still haven't written a statement" and confirmed that no one has asked her to write one. On 09/27/22 at 9:22 AM, the surveyor accessed the United States Department of Ex Order 26.4B1 and confirmed Resident #63 was a Ex Order 26.4B1 for a victim under Ex Order 26.4B1 The surveyor reviewed the medical record for Resident #63 which revealed the following: Resident #63's Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included, but were not limited to; Ex Order 26.4B1 . The most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26.4B1 reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated a Ex Order 26.4B1 . The resident's Comprehensive Care Plan (CP) included a focus area dated effective Ex Order 26.4B1 , for at risk for Ex Order 26.4B1 . Interventions included to bring to activities that you enjoy; to arrange phone calls or video chats with your family; to ensure you have activities of your choosing available; and to provide you with tools you need to do your favorite activity if applicable. The care plan failed to include the resident's Ex Order 26.4B1 .	F 600	none noted. NJ Ex Order 26.4b1 . " On 9/29/22 a NJ Exec Order 26.4b1 was done on resident #56, NJ Exec Order 26.4b1 observed. " On 9/30/22 physician of resident #56 was notified of incident on NJ Ex Order 26.4b . " On 9/30/22 request was made for the NJ Exec Order 26.4b1 to evaluate resident #56 " On 9/29/22 care plan of resident #56 was updated to reflect monitoring for any NJ Ex Order 26.4b1 . " On 9/29/22 social worker completed PHQ9 assessments(Patient Health Assessment-9), to assess for Depression for all residents on the locked unit. " On 9/29/22 social worker initiated Trauma risk assessments for all residents on the locked unit. Trauma risk assessments ongoing. " On 9/29/22 care plans of residents on the locked unit were updated to reflect monitoring for any mood or behavior changes. " On 9/30/22 the social worker interviewed another alert and oriented resident on CNA #2	

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F 600	Continued From page 38 A review of the all Progress Notes did not include the incident with Resident #10. The surveyor reviewed the medical record for Resident #10 which revealed the following: A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included; Ex Order 26.4B1 [redacted] A review of the most recent annual MDS, dated Ex Order 26.4B1, reflected a BIMS score NJ Ex Order 26.4b1 determined with a Ex Order 26.4B1 [redacted]. A review of the resident's CP included a focus area dated effective Ex Order 26.4B1, for ADL Function/ [Rehabilitation] Potential. Interventions included to provide NJ Ex Order 26.4b1 for bathing, bed mobility, dressing, eating, personal hygiene, toilet use, transfer with a Ex Order 26.4B1 of two people from bed to chair and chair to bed, and turn and reposition. The care plan did not include the incident with Resident #63. A review of the Progress Notes did not include documentation regarding the incident with Resident #63. On 09/27/22 at 9:57 AM, the surveyor interviewed TNA #2 who stated about Ex Order months ago, she observed Resident #63 exit Resident #10's room and was told Ex Order 26.4B1 Resident #10. TNA #2 stated that Resident #63 should not have been in Resident #10's room. TNA #2 stated LPN #1	F 600	" On 9/29/22 the U.S. FOIA (b)(6) was educated by the Regional Administrator on Abuse Policy and Procedure, Investigations and reporting. " On 9/30/22 the U.S. FOIA (b)(6) was given disciplinary notice by the Regional Administrator regarding failure to determine the reportable status of the altercation incident on NJ Exec Order 26.4, delay in reporting, no interventions put in place. II. Identification of Others: All residents have the potential of being affected when the proper protocols and policies are not followed for properly investigating and reporting abuse. III. Systemic changes: On 9/28/22 In services on Abuse and neglect, including sexual abuse and Peggy□s law, and proper and timely investigation and reporting facility wide were initiated. In services were done by DON or designee and completed by 10/5/22. On 10/11/22 facility initiated a Trigger Call to provide support, analysis and direction to facility by regional team, sign placed on all nursing units□ staff will have to call Administrator, DON or designee with any significant incident/accident event, including any and all allegations of neglect and abuse immediately, upon discovery of event. Facility wrote and implemented a grievance policy that addresses updating families on outcomes of grievances	

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F 600	Continued From page 39 was informed of the incident which occurred either the Ex Order 26.4B1 ; it was Ex Order 2 months ago. TNA #2 confirmed that there was no monitoring completed for Resident #63. On 09/27/22 at 10:30 AM, the surveyor interviewed TNA #3 who stated Resident #63 could be Ex Order 26.4B1 with other residents such as trying to Ex Order 26.4B1 TNA #3 stated she only witnessed it happen one time, and that the wandering resident had only made it to Resident #63's door before the aide then redirected the resident, and told Resident #63 that they were not allowed into the other resident's room. TNA #3 stated that she felt it was not safe for any resident in general to be alone in the room of resident of the Ex Order 26.4B1 and that Resident #63 had not done anything in particular that she had been aware of to make her feel extra concerned about it. TNA #3 when asked, stated she was unaware of Resident #63 ever being inside another resident's room. On 09/27/22 at 10:38 AM, TNA #1 informed the surveyor that her cell phone battery was dead and she needed to charge the phone first to provide the surveyor with the information regarding the date of the incident. On 09/27/22 at 10:46 AM, the surveyor interviewed the U.S. FOIA (b) who stated she had worked at the facility since 08/01/22, and was in charge of investigations. The U.S. FOIA (b) stated the facility investigated Ex Order 2, anything EX Order 26.4B1 , Ex Order 2 tears, any kind of abuse including physical, verbal, and misappropriation of property. The U.S. FOIA (b) stated the process for an investigation was to collect statements from all staff who saw the	F 600	Regional LNHA will participate on trigger calls and review reportable events at the time they occur IV. QA Monitoring A tracker for incident/accidents and reportable event was instituted. All accident /incident investigations will be brought to the morning meeting on the next day for Interdisciplinary team review. The tracker will be reviewed by the DON weekly. All findings will be reviewed at the Quality Assurance meeting x 3 quarters V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee	

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resident or took care of the resident; interview the resident if able to, even if the resident was confused. Then the facility notified the family or representative and the physician. The [redacted] stated that abuse and/or neglect was investigated with the [redacted], and abuse was reported to the New Jersey Department of Health (NJDOH). At that time, the [redacted] provided the surveyor with all investigations and incidents, which totaled [redacted] that the facility conducted from [redacted] through the present. The [redacted] stated the facility was searching for additional investigations, and "if they could find any", they would give them to the surveyor.

On 09/27/22 at 11:02 AM, the surveyor reviewed the [redacted] investigations provided by the [redacted]. None of which did included the incident alleged by staff that occurred between Resident #10 and Resident #63.

On 09/27/22 at 11:09 AM, the [redacted] stated and confirmed that the surveyor had all of the facility investigations. The [redacted], upon inquiry, stated that he did not keep any "soft files", but then stated "there may be one or two reportables (mandatory facility reporting)" and he would check.

On 09/27/22 at 11:23 AM, the surveyor attempted to interview Resident #10's [redacted] via telephone, however, the [redacted] did not answer. The surveyor left a message to call back.

On 09/27/22 at 11:25 AM, the surveyor attempted to interview Resident #10's Emergency Contact via telephone, but the number was not in working service.

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F 600	Continued From page 41 On 09/27/22 at 12:10 PM, the U.S. FOIA (b)(6) confirmed that the surveyor had been provided with all investigations, incidents, and grievances from the past three months. This did not include any investigation regarding the alleged incident between Resident #10 and Resident #63. On 09/27/22 at 12:12 PM, the surveyor attempted to interview LPN #1 via telephone, but there was no answer. The surveyor left a message to call back. On 09/27/22 at 12:14 PM, the surveyor called the Ex Order 2 again on the telephone, and there was no answer. On 09/27/22 at 12:34 PM, the surveyor attempted to interview Resident #63 who Ex Order 26.4B1 Ex Order 26.4B1 and stated that he/she was Ex Order 26.4B1, and mostly stayed in bed. On 09/27/22 at 12:35 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated she was the only social worker at the facility. The U.S. FOIA stated she was involved in the grievance process as well as room changes. If a resident wanted a room change she would speak to the U.S. FOIA (b)(6) and change their room if one was available. The U.S. FOIA (b stated she would document in the electronic medical record (eMR) under Progress Notes as to why a room change was occurring. When asked why Resident #10 changed their room on Ex Order 26.4B1, the U.S. FOIA responded she was not involved in that room change but thought it was because Resident #10 was not appropriately placed on a locked unit. The U.S. FOIA (b stated Resident #10 was a Ex Order 26.4B1 Ex Order 26.4B1 and was	F 600		

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Ex Order 26.4B1 . The U.S. FOIA stated the resident spent time in the dayroom, had NJ Ex Order 26.4b1 , and had NJ Ex Order 26.4b1 with the NJ Ex Order 26.4b1 . The U.S. FOIA confirmed the room change was not documented in the eMR.

On 09/27/22 at 1:31 PM, the surveyor attempted to interview Resident #10 in the presence of CNA #1, but was unable to tell the surveyor their NJ Ex Order 2 The resident was Ex Order 26.4B1 on the television, and holding a Ex Order 26.4B1 and kept pointing to the surveyor's manilla folder saying Ex Order 26.4B1 and Ex Order 26.4 Ex Order 26.4B1

On 09/27/22 at 1:34 PM, the surveyor attempted to interview Resident #10's previous roommate, Resident #56. When asked about Resident #10, Resident #56 stated he/she really liked that roommate who wasNJ Ex Order 26.4b1 . The surveyor asked if Resident #10 ever had visitors, and Resident #56 stated that Resident #10 left something here and he/she wanted it returned to them. At that time, Resident #56 went to the empty bed that Resident #10 had previously occupied and provided the surveyor with a Ex Order 26.4B1 When the surveyor opened the Ex Order 26. the Ex Order 26 was written to Resident #63's name from [name redacted], an unknown person.

On 09/27/22 at 1:41 PM, the surveyor showed LPN #2 the Ex Order 26.4B1 , and she could not speak to why Resident #63's Ex Order 2 would have been inside Resident #10's previous room. LPN #2 confirmed that was not Resident #63's room, and could not speak to if Resident #63 had ever been inside Resident #10's room.

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On 09/27/22 at 1:49 PM, the surveyor accompanied by a U.S. FOIA (b)(6) interviewed Resident #63 in their Ex Order 26.4B1. Resident #63 looked at the Ex Order 26.4B1 and confirmed it was theirs. Resident #63 did not speak to why the Ex Order 26.4B1 was in Resident #10's former room, and told the surveyor that they could keep the Ex Order 26.4B1

On 09/27/22 at 2:23 PM, TNA #1 informed the surveyor that she was able to retrieve the nurse staffing reports and reviewed the nursing staff reports from Ex Order 26.4B1 TNA #1 confirmed the incident had occurred on Ex Order 26.4B1.

On 09/27/22 at 2:23 PM, the U.S. FOIA (b)(6 presented the surveyor team with an undated document entitled "Summary of Events". The document included the following"

On [no date] I received a call from unit [unnamed unit] a staff member [unnamed] was yelling in the hall. When I arrived I saw staff outside [Resident #63's] room and when asked the nurse [unnamed] what was going on that a patient had just come out of [Resident #10's] room who was [Ex Order 26.4B1] patient. The report continued that the nurse [unnamed] and I immediately went into both Resident A [Resident #63] and Resident B's [Resident #10] rooms. Resident #10 was Ex Order 26.4B1 and we spoke with the resident for a few minutes, then spoke to Resident #63 who stated that he/she was Ex Order 26.4B1 and went into Resident #10's room to use the bathroom and when realized it was the wrong bathroom he/she was Ex Order 26.4B1. There were a couple of staff members [unnamed] expressing themselves about the resident's [Resident #63's] history, and I

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pulled staff aside and educated them on the importance of "HIPAA" (HIPAA; Heath Insurance Portability and Accountability Act; a law created to protect patient "health" information) and staff [unnamed] were concerned [Resident #63] was in [Resident #10's] room. We reviewed the camera footage [no date or time] and observed Resident #63 was in Resident #10's room for 6-7 minutes. The report continued that Resident #63 entered Resident #10's room at 9:43 AM after [LPN #1] walked away from her medication cart and we could see LPN #1 came back to her cart 1.5 minutes later that was outside of Resident #10's room and she went into the room [unnamed room] and gave medications to the patients [unnamed] and left the room. Then "[He/she]" moved on from that room towards Resident Room [redacted] and as she was walking away, Resident #63 came out of Resident #10's room. Since LPN #1 was in the room and Resident #63 was in the bathroom, that was why we did not see [Resident #63 in the room]. The timeline and event details supported [Resident #63] went into the bathroom and left as suggested. Met with all staff on sensitivity, behavior, and "HIPAA". State Agency [name redacted] came to the facility after an anonymous call, and she had nothing further to share because wrong date and wrong time [date and time not included], furthermore no detail on anything. We went over the situation from that day, shared our video footage/pictures from video and timeline. She spoke with some staff [unnamed] and suggested she was closing the case and left.

In addition to the statement, there were three dark grainy pictures of surveillance video on an unidentifiable nursing unit. The first picture revealed a nursing unit hallway with a medication

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cart, a grainy picture of an unidentifiable resident self-propelling in a wheelchair into a resident room, and another person possibly in a wheelchair behind the medication cart. Viewing the picture, the sex of the people or the room could not be determined. The picture was undated and the time stamp was "EX Order 26.4B1 (S)". The second picture was a grainy picture of a nursing unit hallway with the only identifiable object being a medication cart, and an unidentifiable person. There was no date and the timestamp only included EX Order 26.4B1. The third grainy picture showed a nursing unit hallway with an unidentifiable nurse at a medication cart, a possible staff member walking up the hallway towards the nurse and the rest of the picture was unidentifiable. There picture was undated, and the timestamp indicated "EX Order 26.4B1. The packet also contained Resident #10's admission record Face Sheet dated generated by the U.S. FOIA (b)(6) on Ex Order 26.4B1, and Resident #63's admission record Face Sheet dated generated by the U.S. FOIA (b)(6)

On 09/27/22 at 2:23 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated "he found" the undated "Summary of Events", "stuck in a drawer" in his desk even though he previously informed the surveyors earlier that he kept no "soft files", and he confirmed that the surveyors had been provided all the investigations since he had been at the facility. The U.S. FOIA (b)(6) stated this event was "immediately" dismissed, there was "no concern". When asked why there was no concern, the U.S. FOIA (b)(6) stated it was no concern because Resident #63 "immediately" came out of the room. According to the undated "Summary of Events" Resident #63 was in Resident #10's room for 6-7 minutes. The EX Order 26.4B1 stated that the event could

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have occurred on NJ Ex Order 26.4b1 because that was "my statement to self" not provided to the surveyors. The U.S. FOIA (b)(6) continued, there were staff a CNA, maybe an activity aide, do not recall the names saying Resident #63 was a Ex Order 26.4B1 who came to this facility from our sister facility. The U.S. FOIA (b)(6) stated he did not know if Resident #63 was a Ex Order 26.4B1 but has a history of their background as a Ex Order 26.4B1. The U.S. FOIA (b)(6) confirmed staff was upset, but he never followed up on it. The U.S. FOIA (b)(6) also stated that the Ex Order 26.4B1 Ex Order 26.4B1 status was not followed up on. The U.S. FOIA (b)(6) stated that staff members refused to write statements and he did not memorialize that. The U.S. FOIA (b)(6) stated the first picture was Resident #63 entering Resident #10's room, the second picture was the nurse in Resident #10's room, and the third picture was Resident #63 exiting Resident #10's room (that could not be corroborated by the photos provided by the U.S. FOIA (b)(6)

On 09/27/22 at 2:37 PM, the surveyor asked the U.S. FOIA (b) if she was aware of any allegations of Ex Order 26.4B1 abuse at the facility. The U.S. FOIA (b) responded she was out of the office on NJ Ex Order 26.4b1 and was informed by the U.S. FOIA (b) and U.S. FOIA (b)(6) on Ex Order 26.4B1, that Resident #63 went into Resident #10's room, and based on video surveillance footage, "there was no need to take it any further". The U.S. FOIA (b) continued she was under the impression everything had been taken care of. When asked if the incident would be a concern, the U.S. FOIA (b) responded, "definitely a huge concern" no resident should be discussed regarding, "HIPAA". At this time, the surveyor reviewed the facility's abuse policy with the U.S. FOIA (b) who confirmed she was familiar with policy. When asked what she would have done if there was an allegation of Ex Order 26.4B1, the U.S. FOIA (b) stated "I am an advocate"

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and that the police would be called, the resident would be interviewed, and interview the residents and staff. When inquired to the [U.S. FOIA (b)] if the staff were interviewed, she stated "no". The [U.S. FOIA (b)] stated the [U.S. FOIA (b)(6)] closed this investigation after viewing the video surveillance footage, and speaking with the residents, and she confirmed there was no documentation to ensure the residents were okay.

On 09/27/22 at 3:03 PM, the surveyor interviewed LPN #3, who stated she was unaware why Resident #10's room was changed on [NJ Ex Order 26.4b1], when she arrived for shift, the resident was in a new room. LPN #3 stated that she changed the resident's room number in the eMR only.

On 9/27/22 at 3:16 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated she was not at the facility on the morning the incident occurred when Resident #63 was observed exiting Resident #10's room by a U.S. FOIA (b)(6). When the [U.S. FOIA (b)] went upstairs, two behavioral aides that she cannot recall their names said Resident #63 came out of Resident #10's room and they reported they did not see what occurred in the room, just Resident #63 exited "quickly". The [U.S. FOIA (b)] stated that Resident #63 had a history of Ex Order 26.4B1 and discussed this with the [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)] stated she asked staff for statements, but none were provided, and she had no documentation to corroborate that. The [U.S. FOIA (b)] stated she checked Resident #10, and their Ex Order 26.4B1 and clothing was in place and believed the incident occurred on [Ex Order 26.4B1]. The [U.S. FOIA (b)] stated she did not feel this situation was an allegation of abuse because "no one saw anything." Resident #63 stated he/she went to use the bathroom and there was no evidence on the resident. The [U.S. FOIA (b)] acknowledged there was

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no documented assessment of either resident as well as there were no documented statements from the residents, staff, or herself. The [U.S. FOIA (b)] stated she changed Resident #10's room maybe, a day or two later since Resident #10 was not appropriately placed on the locked nursing unit. The [U.S. FOIA (b)] stated that since Resident #63 was a Ex Order 26.4B1, she "should have" interviewed other residents and looked into another facility placement for Resident #63. The [U.S. FOIA (b)] stated if the facility policy was followed, the police should have been called, and Resident #10 should have been sent to the hospital for an assessment, as well as a thorough investigation conducted, and Resident #63 should have been monitored. The [U.S. FOIA (b)] then confirmed none of that was completed.

On 09/27/22 at 5:27 PM, the surveyor conducted a telephone interview with LPN #1. LPN #1's first asked if she would lose her job due to speaking with the surveyor. When asked if there had been any incident/s that occurred with Resident #10, LPN #1 stated [Ex Order 26.4] but the incident was resolved. LPN #1 stated that another resident (Resident #63) was in their bathroom, and she could not recall the date, maybe occurred sometime in [NJ Ex Order 26.4]. LPN #1 stated that she had administered Resident #10's medication and then was down the hall with her medication cart when she heard CNA #1 hollering in the hallway saying get out of the room, this was not your room. The resident who CNA #1 hollered at, was Resident #63. The LPN #1 then called downstairs to the U.S. FOIA (b)(6) to let them know what occurred. LPN #1 stated she was "down a ways in the hallway" and when CNA #1 was heard hollering, she then observed Resident #63 exit Resident #10's room. LPN #1 stated she went into Resident #10's room with the U.S. FOIA (b)(6),

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and at that time observed Resident #10 in bed [redacted]. The LPN #1 could not recall if they were [redacted]. LPN #1 stated the resident had on a [redacted], and she could not recall if the resident had a [redacted] since she did not check, but the [redacted] was fastened at one side but could not recall the other side. LPN #1 could not recall if this was how the resident looked when she administered his/her medications. When asked what the resident's demeanor was, LPN #1 first responded the resident's [redacted]. When asked what that was, LPN #1 stated [redacted] When asked if Resident #10 was [redacted] LPN #1 stated no, the resident was saying [redacted]. When asked why the resident would say [redacted], LPN #1 responded she was unsure, maybe the resident thought she was a doctor. LPN #1 stated that she asked Resident #63 why they were in Resident #10's room, and the resident stated he/she was in the bathroom. LPN#1 stated she did not see Resident #63 in Resident #10's room when she was in there, he/she could have been in the bathroom since the bathroom door was closed. When asked if the door opened into the room or into the bathroom, LPN #1 stated the door opened into the room and she confirmed the door could be closed to move towards the exit. LPN #1 stated she assessed Resident #10, but did not complete documented assessment, or provide any information to the surveyor regarding the type of assessment completed. The LPN #1 stated the [redacted] also entered Resident #10's room, but then stated she was not present for that. LPN #1 stated she was unsure how long Resident #63 was in the room, but believed there was camera footage, but the footage would not have shown inside the room.

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On 09/28/22 at 10:38 AM, the surveyor re-interviewed TNA #3, who stated she only saw Resident #63 Ex Order 26.4B1 a resident once into his/her room. TNA #3 stated she just did not think it was safe for two residents of the opposite sex to be in the same resident room so had a Ex Order 26.4B1 take that resident to the dayroom. TNA #3 stated she was aware she had to report incidents to the nurse, but she did not feel Resident #63 Ex Order 26.4B another resident into their room was a concern.

On 09/28/22 at 11:42 AM, the surveyor re-interviewed CNA #1 via telephone who stated she was informed by multiple staff on the day of the incident that Resident #63 was a Ex Order 26.4B1 Ex Order 26.4B1.

On 09/28/22 at 11:50 AM, the surveyor re-interviewed the U.S. FOIA (b) who stated the U.S. FOIA (b)(6 was the Ex Order 26.4B1, but she was trained on abuse during orientation including investigating and reporting.

On 09/28/22 at 12:02 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated Resident #63 was transferred to this facility from their sister facility who was contracted with the [redacted] NJ Ex Order 26.4b1. The U.S. FOIA (b)(6) stated Resident #63's admitting Face Sheet indicated they were admitted from the [redacted] NJ Ex Order 26.4b1 and at this time she looked at Resident #63's thinned chart and stated someone removed that Face Sheet from the chart. The U.S. FOIA U.S. FOIA (b)(6) continued on Ex Order 26.4B1, there was commotion that Resident #63 was witnessed coming out of another resident's room

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by multiple staff including BA #1 and CNA #1 who were all upset. The U.S. FOIA (b)(6) records stated that the U.S. FOIA (b) was not present at the time of the commotion, but she knew staff made her aware of their concerns.

On 09/28/22 at 1:12 PM, two surveyors requested the U.S. FOIA (b)(6) to show the video surveillance footage associated with the pictures provided. The U.S. FOIA (b)(6) stated he did not have access to the video footage, but the U.S. FOIA (b)(6) who was regional, emailed him the video footage. The U.S. FOIA (b)(6) produced an email from the a U.S. FOIA (b)(6), dated 08/23/22 at 3:33 PM, that did not include details of the video footage. The U.S. FOIA (b)(6) was unable to play the video footage. for the surveyors, and stated that he, "recorded" the video footage using his cell phone, and while watching the video surveillance footage on the computer monitor. At that time the surveyors requested the original video surveillance, not the cell phone footage. The footage was never provided.

On 09/28/22 at 1:41 PM, the U.S. FOIA (b)(6) U.S. FOIA (b)(6) confirmed Resident #63's admitting Face Sheet with the [redacted] NJ Ex Order 26.4b1 could not be located.

On 09/29/22 at 11:14 AM, the surveyor asked BA #1 if she had ever witnessed Resident #63 Ex Order 26.4 Ex Order 26.4B1, and she responded that once Resident #63 Ex Order 26.4B1 Ex Order 26.4B1. The resident was ambulating in the hallway with a walker, when Resident #63 wheeled themselves towards the resident and they tried to Ex Order 26.4B1, but I stopped them. BA #1 stated she reported it to the nurse, but

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cannot recall which nurse because there was inconsistent nurses in the facility. BA #1 stated the day of the incident, she observed Resident #63 exit Resident #10's room. BA #1 stated that she, along with CNA #1 and LPN #1, entered Resident #10's room, and observed the resident in bed NJ Ex Order 26.4b1 ; their Ex Order 26.4B1 was twisted with a evidence of a Ex Order 26.4B1 out of the side, and their hospital type gown NJ Ex Order 26.4b1 BA #1 stated that she had not written a statement until yesterday.

On 10/03/22 at 12:31 PM, the surveyor interviewed the U.S. FOIA (b)(6) who was currently overseeing the U.S. FOIA (b)(6) and facility, in the presence of the U.S. FOIA (b)(6) informed the surveyor Resident #63 was transferred to this facility from their "sister facility" after an incident occurred at their facility in Ex Order 26.4B1 after a Ex Order 26.4B1 Ex Order 26.4B1 between Resident #63 and a Ex Order 26.4B1

On 10/07/22 at 11:29 AM, the surveyor conducted a telephone interview with the U.S. FOIA (b)(6) who stated she had no contact with the U.S. FOIA (b)(6) The U.S. FOIA (b)(6) stated she was unaware there were Ex Order 26.4B1 in the building; she was not aware of the alleged Ex Order 26.4B1 abuse between Resident #10 and #63, and the IJ associated with it. Ex Order 26.4B1

Part B

The facility's failure to have a system in place to ensure: a.) that staff immediately reported an

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allegation of NJ Ex Order 26.4b1 that occurred on NJ Ex Order 26.4b1 between staff , a Temporary Nurse Aide (TNA #4), and a resident (Resident #56), b.) prevent further abuse from occurring (TNA #4 continued to work, and on NJ Ex Order 26.4b1 had an allegation of abuse), and c.) conducted an investigation, and implemented interventions to prevent further abuse posed a serious and immediate treat to the health and welfare of all residents who resided in the facility and was evidenced by the following:

An adverse outcome had occurred, and was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that began on Ex Order 26.4B1, when TNA #4 was Ex Order 26.4B1 Resident #56's Ex Order 26.4B1. Resident #56 Ex Order 26.4B1 and expressed concerns over his/her needs not being met. Staff did not report the incident, and TNA #4 was allowed to work the next day and was involved in another incident when a family member, and a staff observed TNA #4 dragging another resident while sitting in a chair, from one table to another table during the lunch meal. This caused Resident #56 to be Ex Order 26.4B1

The IJ was identified on 09/30/22 at 1:36 PM.

The facility submitted an acceptable removal plan on 09/30/22 at 4:36 PM, which was verified as implemented during an onsite survey conducted on 10/03/22 at 1:49 PM.

The evidence was as follows:

On 09/23/22 at 6:30 AM, the surveyor went to the locked unit and observed the medication pass administration with the Registered Nurse (RN #1).

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F 600	Continued From page 54 On 09/23/22 at 7:20 AM, while in the hallway, the Surveyor (#2) overheard a loud verbal exchange that was occurring near the nursing station. While approaching the nursing station, the surveyor observed a resident [Resident #56] standing in the hallway facing the nursing station and was talking loudly. Then a female staff exited the nursing station and was yelling, screaming and pointing the finger as she walked toward Resident #56 and in resident's face. The surveyor stood by the nursing station and observed the US FOIA (b)(6) was directly facing the hallway, with an unobstructed view and where the verbal argument was taking place. A Certified Nursing Assistant (CNA#3) was sitting at the desk, a U.S. FOIA (b)(6) was in the hallway, the NJ Ex Order 26.4b1, US FO a Registered Nurse (RN #1), all witnessed the incident, and none of the staff intervened. The resident was later identified by staff as Resident #56. Resident #56 approached Surveyor #2 and stated, "Can you help me, all I want is Ex Order 26.4B1. Ex Order 26.4B1 ". The surveyor informed TNA #4 of the resident's requested needs. TNA #4 then continued to argue with Resident #56 and remained in the hallway near the linen cart. TNA#4 did not provide the Ex Order 26.4B1 Ex Order 26.4B1 to the resident. On 09/23/22 at 7:30 AM, Surveyor #2 interviewed TNA #4, who was involved in the above incident. TNA #4 informed the surveyor that she had been working at the facility for the NJ Ex Order 26.4b1. The surveyor inquired about any in-service education received on Ex Order 26.4B1 care, she acknowledged receipt of in-service education. The surveyor asked her to comment on the observed behavior	F 600		

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witnessed in the hallway. TNA #4 stated that Resident #56 pointed fingers at her first because she did not allow Resident #56 to obtain a Ex Order 26.4B1 from the linen cart that was parked in the hallway. In return TNA #4 stated she pointed the fingers back at him/her. TNA #4 stated there were no Ex Order 26.4B1 on the floor.

On the morning prior to the above incident, Surveyor #2 entered the nursing station of the Ex Order 26.4B Unit and observed a pack of Ex Order 26.4B1 Ex Order 26.4B1 the counter of the low side of the unit. Although TNA #4 stated there was no Ex Order 26.4B1 Ex Order 26.4B1 on the floor, the pack of Ex Order 26.4B1 were still on the counter following the witnessed Ex Order 26.4B altercation with TNA #4 and Resident #56. CNA #3 who was sitting at the nursing desk on the locked unit, stood up and provided a Ex Order 26.4B1 Ex Order 2 to Resident #56. Resident #56 thanked CNA #3 and returned to his/her room.

On 09/26/22 at 12:06 PM, Surveyor #2 met with the U.S. FOIA (b)(6) and the U.S. FOIA (b) and requested the investigation for the incident of Ex Order 26.4B1. Both indicated that they were not aware of the incident. They both stated that they would investigate the incident of Ex Order 26.4B1. The U.S. FOIA (b)(6) stated that he could ask one of the regional liaison staff to review the video camera surveillance footage located in the hallway near the nursing station. The U.S. FOIA (b) then informed the surveyor that TNA #4 was involved in another incident on Ex Order 26.4B1 Ex Order 26.4B1 and TNA #4 was suspended pending the investigation.

On 09/27/22 at 9:30 AM, during an interview with Surveyor #2, the U.S. FOIA (b)(6) revealed that the U.S. FOIA (b)

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forwarded an email regarding the incident. When asked to provide a copy of the e-mail, the [U.S. FOIA (b)(6)] indicated that he could not locate the e-mail on his phone. The email was never provided.

On 09/27/22 at 12:30 PM, Surveyor #2 requested the employee file for review. The file provided reflected in service attendance for hand hygiene, dementia, Residents Rights, Dining Experience, Trauma Informed Care, Abuse Prevention, Accidents and Incident reporting... No disciplinary action or written warning was included in the file. There were none of these incidents included in the file. The facility did not have any monitoring in place to monitor the TNA #4's interaction with other residents after the incidents.

The surveyor reviewed the medical record for Resident #56 which revealed the following:

According to the Admission Face Sheet, (an admission summary), Resident #56 was admitted to the facility with diagnoses which include; [Ex Order 26.4B1].

A review of Resident #56's Plan of Care dated [NJ Exec Order 26.4b], revealed a [NJ Ex Order 26.4b1]. The goal was for Resident #56 to have no evidence of [Ex Order 26.4B1]. Interventions included; "We will provide you with emotional support and reassurance. We will [Ex Order 26.4B1] and as needed." Resident #56 was [NJ Ex Order 26.4b1] with care and required the staff to provide what was needed only.

Another Focus identified on the Plan of Care was for [Ex Order 26.4B1]. The goal was for Resident #56 to feel comfortable enough to ventilate his/her feelings to others. Interventions in place included:

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1. We will allow you time to respond
2. We will establish a comfortable environment for you.
3. We will recognize your feelings.
4. We will maintain a calm environment.

On 09/26/22 at 1:14 PM, Surveyor #2 interviewed Resident #56 regarding the incident. Resident #56 stated it was upsetting not being able to get what you need. Resident #56 stated that overnight he/she would be Ex Orde and had to have the Ex Order 26.4B1 . Several times when you ask the nursing staff for an Ex Order 26.4B1 they will say they don't have any available. "It is like insurance, you have to have them". Resident #56 stated, "if you want it right you have to do it yourself. "

On 09/27/22 at 12:37 PM, Surveyor #2 interviewed the U.S. FOIA (b)(6) regarding her involvement with the investigation. She stated this was her first job after graduation and the facility did not give her clear directive regarding her role.

On 09/30/22 at 11:20 AM, during an interview with Surveyor #2, the U.S. FOIA (b)(6) stated that a corporate liaison reviewed the video camera surveillance footage and he would report the incident to the DOH. The U.S. FOIA (b)(6) stated that the investigation was not completed.

On 09/30/22 at 1:30 PM, the U.S. FOIA (b)(6) provided an incident report dated Ex Order 26.4B1 for review. The U.S. FOIA (b)(6) stated that the incident was called to U.S. FOIA (b), and TNA #4 was sent home immediately.

On 09/30/22 at 3:00 PM, the U.S. FOIA (b)(6) informed Surveyor #2 that the incident of Ex Order 26.4B1 was reported to DOH. The U.S. FOIA (b)(6) stated, he met with

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Resident #56 with the [NJ Ex Order] regarding the incident. The [U.S. FOIA (b)(6)] provided an undated statement where he concluded that the incident could not be substantiated. When asked to elaborate on his conclusion, the [U.S. FOIA (b)(6)] stated that Resident #56, although able to recall the incident, was not upset. In his summary, the [U.S. FOIA (b)(6)] indicated that the resident indicated that he/she did not like what had happened. The [U.S. FOIA (b)(6)] did not ask Resident #56 if he/she would like to file a grievance.

On 10/06/22 at 9:14 AM, Surveyor #2 interviewed the U.S. FOIA (b)(6) regarding the incident. She also provided an undated statement where she indicated that Resident #56 was not upset regarding the incident.

On 10/06/22 at 10:30 AM, the [U.S. FOIA (b)(6)] stated that prior to submitting the undated statement, he was not aware that TNA #4 was yelling at Resident #56. The [U.S. FOIA (b)(6)] indicated he would provide another statement.

On 10/06/22 at 1:15 PM, the [U.S. FOIA (b)(6)] provided an Investigation Report for review. The [U.S. FOIA (b)(6)] stated that TNA #4 was called in and provided a statement on 10/03/22. TNA #4 confirmed the incident and two staff who witnessed the incident confirmed the incident.

The [U.S. FOIA (b)(6)] stated that prior to the [NJ Ex Order 26.4b1] incident she had a lengthy conversation with the TNA #4 regarding her behavior. TNA #4 acknowledged that she needed to work on her behavior but could not process the information. The [U.S. FOIA (b)(6)] added based on information from other coworkers and some observed interaction, TNA #4 should not be allowed to work in healthcare.

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The U.S. FOIA (b provided the summary of the investigation and stated that TNA#4 was terminated.

A statement from CNA #3 who witnessed the incident documented: Resident #56 attempted to get a Ex Order 2 of the linen cart. Resident #56 was stopped by TNA #4 by yelling at him/her and pointing her fingers at the Resident - Resident responded by yelling back.

The RN (RN #1) who was in the hallway and witnessed the incident wrote: TNA#4 was trying to stop Resident #56 from going into a clean linen cart.- "Yelling and finger pointing was inappropriate".

TNA #4 who was involved with above incident documented: "On NJ Ex Order 26.4b1 at around 7:40 AM, Resident #56 was going to my co-worker's cart to take something off her cart. I stopped him/her told him/her they cannot take anything off the cart. He/she got mad and pointed at me. I pointed back at him/her, then I asked him/her what he/she need, he/she said a "Ex Order 26.4B". I gave him/her one. A state worker saw me point at him/her and thought he/she was mad at me". TNA #4 did not provide Resident #56 with the Ex Order 26.4B1 . TNA #4 continued to argue and prevent Resident #56 from obtaining the Ex Order 26.4B1 from the linen cart.

On 09/26/22 at 12:06 PM, Surveyor #2 met with theU.S. FOIA (b)(6) regarding an incident of Ex Order 26.4B1 The U.S. FOIA (b) at that time informed the surveyor that the TNA #4 had been involved in another incident on Ex Order 26.4B1 Ex Order 26.4B1. The TNA was suspended pending investigation at that time.

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F 600	Continued From page 60 On 09/27/22 at 12:30 PM, Surveyor #2 requested the employee file of a TNA #4 who was involved in an investigation of verbal abuse. The file provided reflected in service attendance for hand hygiene, dementia, Residents Rights, Dining Experience, Trauma Informed Care, Abuse Prevention, Accidents and Incident reporting. The facility did not have any monitoring in place to monitor the TNA's interaction with other residents after the NJ Ex Order 26.4b1 incident on NJ Ex Order 26.4b1. On 09/30/22 at 1:30 PM, the U.S. FOIA (b)(6) provided an incident report dated U.S. FOIA (b)(6), for review. On 10/07/22 at 12:04 PM, Surveyor #2 was able to reach the family member who witnessed the incident on Ex Order 26.4B1. The family member stated she was on the Ex Order 2's unit on Ex Order 26.4B1 AM, there were no staff in the day room. Resident #24 was seated in the dayroom with another resident and Ex Order 26.4B1. She observed a nurse at the medication cart at the end of the hallway. She observed a CNA in the hallway who informed the family member that the facility was short handed and the CNA's were pulled from another unit to assist with resident's care. The family went and Ex Order 26.4B1 for the resident. The family member next stated that during lunch at 12:30 PM, Resident #24 was seated at a table with another resident. The TNA #4 walked in and placed a tray in front of Resident #24. Another male resident was now seated at the table. Suddenly the TNA #4 grabbed the tray, placed it on another table and started dragging Resident #24 from the chair to another table without informing the resident. She stated that Resident #24 was Ex Order 26.4B1, and she asked the TNA #4 what she was doing. The TNA	F 600		

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informed the family member that she moved Resident #24 to prevent the other resident from touching the food tray. She stated that the other resident was[Ex Order 26.4B1]. Another staff member witnessed the incident and gestured and informed her that the TNA #4 had some issues and she was glad the family member witnessed it. The other staff member informed her she would report it. The family member added that the TNA did not provide any directive or rationale for displacing Resident #24 from the table. The family member stated that she was upset and concerned and that she texted a message to the [U.S. FOIA (b)(6)] that same day at 2:00 PM.

The following statements were provided:

1. CNA #1 who witnessed the incident wrote: "I was feeding a resident in the dayroom on the [Ex Orde] floor. I witnessed TNA remove a resident sitting in a chair at the table, spin the chair and pull the resident across the floor to another table."

2. CNA #3 who was also in the dining room wrote:" Pt (Patient) Resident #24 was sitting in an armchair in the dayroom eating lunch. The TNA pulled the resident away from the table and dragged the chair to the next table".

3. CNA #3 "On Saturday 09/24/22, I witnessed my coworker pull a resident dragging him/her in a chair from one side of the dining room to the other side. Family of a resident were present and very upset."

4. A statement from the LPN on the unit revealed: "employee stated she was moving (Resident #24) because another resident was trying to eat his/her

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food". Immediate action taken, TNA sent home.

A review of the medical record for Resident #24 revealed the resident was admitted with diagnoses which included but were not limited to; Ex Order 26.4B1 [redacted].
The Quarterly MDS dated Ex Order 26.4B1 reflected that Resident #24 was Ex Order 26.4B1 and NJ Ex Order 26.4b1 on all staff for ADLs.
The care plan dated Ex Order 26.4B1 included a focus for ADLs with a goal to have all needs met. The interventions included to maintain current level of functioning, assist with eating, dressing, and bathing.

A review of a package titled, "Sensitivity, Individuality and Resident Rights", undated, provided by the facility as part of the sensitivity training for TNA #4, the following were documented;
Key Facts to Remember:
A resident is not dependent on us. we are dependent upon him.
A resident is not an interruption of our work, he is the purpose of it.. We are not doing [resident] a favor by serving [resident]. [Resident] is doing us a favor by giving us an opportunity to do so.

A resident is not someone to argue with. Nobody ever won an argument.
A resident is someone who brings us [resident's] wants. It is our job to fill them.

Under Resident Rights the following was revealed:

Rights are both human privileges and legal

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protections.
Frailty, dependency factors and advanced age cause nursing home residents to be highly vulnerable to violations of their individuality and autonomy. Residents have the same rights as you;
To be treated with respect and dignity.
To pursue a meaningful life.
To be free from fear.
The facility and staff are legally responsible for protecting and promoting each resident's rights. Violating a resident's right is breaking the law, and punishment could include being fired or sent to jail by a court of law.

The deficient practice remained for actual harm that is not immediate jeopardy and is evidenced by the following:

Complaint #NJ156357.

Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to investigate a Ex Order 26.4B1 of unknown origin that occurred in a Ex Order 26.4B1 resident, who required NJ Ex Order 26.4b1 for completion of activities of daily living. This deficient practice occurred for 1 of 6 residents reviewed for abuse (Resident #65), who sustained a Ex Order 26.4B1

This deficient practice was evidenced by the following:

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F 600	Continued From page 64 On 09/21/22 at 10:37 AM, during the initial tour of the Ex Order 26.4B1 floor, surveyor #3 observed Resident #65 in bed. Surveyor # 3 attempted to interview Resident #65, who responded to the surveyor's questions with a smile and a thumbs up. The surveyor reviewed the medical record for Resident #65 which revealed the following: The Admission Record revealed Resident #65 was admitted to the facility with diagnoses, which included but were not limited to; Ex Order 26.4B1 Ex Order 26.4B1 Ex Order 26.4B1 The Quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26.4B1, Resident #65 had a Brief Interview for Mental Status (BIMS) score of Ex Orde, which indicated that Resident #65 had a Ex Order 26.4B1. The MDS documentation indicated that Resident #65 required NJ Ex Order 26.4b1 for Activities of Daily Living (ADLS). Review of the Care Plan Activity Report revealed Focus: Communication ....Goals: We will ensure Ex Order 26.4B1 is in place before attempting to communicate, active effective date Ex Order 26.4B1 Focus: Ex Order 26.4B1 Goals: will be Ex Order 26.4B1 Review of Licensed Practical Nurse (LPN) #5 Nursing Progress, dated EX Order 26.4B1 revealed: U.S. FOIA (b)(6)) brought to my attention that patient was Ex Order 26.4B1 during am	F 600		

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[morning] Ex Order 26.4B1 [putting on] socks. Examination reveals Ex Order 26.4B1 as compared to the Ex Order 26.4B1 warm to touch Ex Order 26.4B1 normal for patient Ex Order 26.4B1 or NJ Ex Order 26.4b1 noted no open areas noted MD made aware orders for Ex Order 26.4B1 and Ex Order 26 obtained and Ex Order 26.4B1 . patient appears to only be uncomfortable during movement. patient is NJ Ex Order 26.4b1 type of Ex Order 26.4B1

Nursing Progress note (unidentified nurse), dated Ex Order 26.4B1 , revealed: "Resident c/o Ex Order 26.4B1 PRN Ex Order 26.4B1 Ex Order 26.4B1 was given with + (positive) effect. Awaiting NJ Ex Order 26 to be performed. A follow up call was placed to [redacted]. Confirmation was received of the orders and a staff member from [redacted] stated they will be out to perform the NJ Ex Order 2 with the next available mobile unit. Ex Order 26.4 Ex Order 26.4B1 was noted to the Ex Order 26.4B1 with Ex Order 26.4B1 or Ex Order 26.4B1 . Normal NJ Ex Order 26.4b1 Ex Order 26.4B1 Ex Order 26.4B1".

Review of subsequent Nursing Progress note documented by LPN #5, dated Ex Order 26.4B1 am, revealed: "Called to follow up on NJ Ex Order 26 ordered Saturday and was told that the US FOIA (b)(6) will be here sometime this afternoon 7/4/22".

Review of an additional Nursing Progress note documented by LPN #5, dated Ex Order 26.4B1 PM, revealed: 'Ex Order 26.4B1 complete awaiting results".

A Nursing Progress note (unidentified nurse), dated Ex Order 26.4B1 revealed Ex Order 26.4B1 Ex Order 26.4B1 was done, result was relayed to the

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nurse on call, that the pt. (patient) has an Ex Order 26.4B Ex Order 26.4B1 recommend; Ex Order 26.4 Series, dr (doctor) made aware of the Ex Order 26.4B1 and the recommendation with new order to apply NJ Ex Order 26.4b1, and an Ex Order 26.4B1 consult ASAP (as soon as possible), NJ Ex Order 26.4b1 applied pt in bed, no actual NJ Ex Order 26.4b1 noted, no facial grimaces noted at this time, awaiting for the hard copy of the NJ Ex Order 26.4

A Radiology Report of the Ex Order 26.4B1 dated Ex Order 26.4B1, revealed Impression: Ex Order 26.4 .

The Physician's Orders revealed an order dated Ex Order 26.4B1, "Treatment: Ex Order 26.4B1 daily only remove for care" and an order dated Ex Order 26.4B1, for "Consultation: pt to have an Ex Order 26.4B1 appt for the Ex Order 26.4B1 Ex Order 26.4B1 ASAP".

Nursing Progress note (unidentified nurse), dated Ex Order 26.4B1 revealed: "Appointment made for Ex Order 26.4B1 ...Family has been made aware of appointment ...Transportation needs to be made. Family may be able to accompany patient".

Review of Nursing Progress (unidentified nurse) note dated Ex Order 26.4B1, revealed: "Resident Transportation has been scheduled for apt on Ex Order 26.4B1

On 09/27/22 at 10:04 AM, Surveyor #3 interviewed CNA #4, who stated that Resident # 65 required NJ Ex Order 26.4b1 from staff, and that you have to make sure the resident's Ex Order 26.4B1 were in to communicate. She stated Resident #65 required NJ Ex Order 26.4b1 with the use of a

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Ex Order 26.4B1 (Ex Order 26.4B1 [redacted]
When surveyor asked CNA #4 about the resident's Ex Order 26.4B1, she stated the resident 'Ex Order 26.4B1 [redacted] CNA #4 stated that if there was a bruise or an injury of unknown origin, she would tell the nurse right away and would have to give a statement as to what was found and where it was.

On 09/27/22 at 10:15 AM, Surveyor #3 interviewed LPN #6, who stated that an injury of unknown origin Ex Order 26.4B1 would have to be assessed by the nurse, the physician would be called, and the family notified. There would be an incident report completed, a three day look back for nurses aids and she would obtain statements from the nurse aides that had taken care of the resident. She stated that the findings would be listed on the 24-hour report. LPN #6 stated that Resident #65 required use of a Ex Order 26.4B1 with NJ Ex Order 26.4b1. She stated she did not know how the Ex Order 26.4B1 had occurred but she knew NJ Ex Order 26.4b1 was taken off a few weeks ago. She stated there "should have been an investigation started by the nurse caring for the resident when the NJ Ex Order 26 was found."

On 09/27/22 at 12:09 PM, in the presence of the survey team, Surveyor #4 requested the grievance policy, incident policy, any investigation policy from the U.S. FOIA (b)(6). He then confirmed that the surveyors had all the investigations, incidents, and grievances from the past three months. This did not include an investigation regarding the alleged incident with Resident #65, On Ex Order 26.4B1 at 11:20 AM, any soft files, incident reports, investigations, or reportable events from the U.S. FOIA (b

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for Resident #65 were requested) at that time the U.S. FOIA (b)(6) confirmed that there was nothing further for Resident # 65.

On 9/29/22 at 10:19 AM, Surveyor #3 interviewed LPN# 7, who stated that if there was an Ex Order 26.4B1 , there "should be an investigation" which included going back 72 hours and getting statements from all staff that had come into contact with the resident. If possible, try to get information from the resident. Notify the supervisor, the family and the physician. There should be an incident report, a progress note and an investigation. The nurse should complete a full body check to make sure there were no other NJ Ex Order 26.4b1 the clothing. LPN #7, who was assigned to Resident # 65 at the time of the interview, stated she did not know about the resident's recent Ex Order 26.4B1 She further stated that Resident #65 was NJ Ex Ord with ADLs and that there "absolutely should be an incident report and investigation from all staff that had contact with that resident for past 72 hours". Surveyor #3 asked LPN #7 the process for when a resident went to a physician visit. She stated the "report of consultation" form was sent with the patient, the nurse filled out the reason why the facility was sending the resident and the consulting physician should fill out findings and recommendations and send the form back with the resident. She further stated that the form should be in paper chart. At this time, Surveyor #3 requested LPN #7 to show the surveyor the consult from the Ex Order 26.4B1 physician for Ex Order 26.4B1. She was unable to locate the consult form or the physician's consult in the chart. She stated she would have to check to see if the chart was thinned.

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On 09/29/22 at 10:30 AM, Surveyor #3 interviewed CNA #4 in regards to Resident #65, she stated she was assigned to the resident at the time of the interview. She stated she knew the resident well. She stated the resident had a recent Ex Order 26.4B1, but she didn't know how it happened. CNA#4 took the surveyor to Resident #65's room and showed the surveyor Resident #65's Ex Order 26.4B1 which was propped up on a pillow.

A review of the Ex Order 26.4B1 consults provided by the facility on Ex Order 26.4B1 revealed a consult dated Ex Order 26.4B1 Treatment: Ex Order 26.4B1 initial closed fracture; Procedure: Ex Order 26.4B1, Ex Order 26.4B1

On 09/30/22 at 10:15 AM, Surveyor #3 interviewed Registered Nurse/Unit Manager (RN/UM) #1, who stated that if there was an injury of an unknown origin it would be initially investigated, an incident report would be done, interview who identified the injury, inspect the surroundings, written statements would be taken from all staff shifts going back 72 hours, the family and the physician would be notified. The incident would be discussed in morning meeting and depending on what the interdisciplinary team found, it would be reported to the New Jersey Department of Health (NJDOH). The family and the physician would be notified of the investigation results.

Review of the "Daily CNA Assignments" sheet for the 7A-3P shift on 07/01/22 revealed CNA #5 was assigned to Resident #65 and CNA #6 was working on the unit; On 07/02/22, CNA#4 was assigned to Resident #65 and CNA#5 and

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CNA#6 were working on the unit.

On 09/30/22 at 10:46 AM, Surveyor #3 interviewed CNA #5, who stated that if there was an injury of unknown origin, tell the nurse immediately. The nurse would start an investigation and the CNA would write a statement about what they found and what they saw. CNA#5 stated she was aware of Resident #65's Ex Order 26.4B1 but does not know how it occurred. She stated she remembers the residents Ex Order 26.4B1 Ex Order 26.4B1 " but was not asked to write a statement. She further stated that Resident #65 Ex Order 26.4B1 and when transferring, the resident was unable to Ex Order 26.4B1

On 09/30/22 at 11:06 AM, Surveyor #3 interviewed CNA#6, who stated if she found a new bruise or any changes to a resident, she would get the nurse. Then the US FOIA (b)(6), the U.S. FOIA (b)(6) would get written statements. They would ask the resident and ask for a statement from everyone on that shift. She stated she knew about Resident #65's Ex Order 26.4B1 but was not asked to give a statement.

On 09/30/22 at 11:18 AM, Surveyor #3 observed 2 CNAs in Resident #65's room with a Ex Order 26.4B1. At 11:30 AM, Resident #65 was observed dressed sitting in NJ Ex Order 26.4b1 wheelchair in the room.

On 10/04/22 at 10:41 AM, Surveyor #3 conducted a phone interviewed with LPN #5, who was taking care of resident #65 at that time of the incident. She stated with an injury of unknown origin, it would be reported to nurse, who would immediately assess the injury. An incident report would be initiated. There would be a look back 24

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to 72 hours of staff that cared for the resident. It would be reported to administration. The family and the physician would be called. LPN#5 recalled the incident the CNA reported to her that Resident #65's Ex Order 26.4B1. LPN#5 stated she assessed the Ex Order 26.4B1 she interviewed the resident but the resident was unable to tell her what happen. She called the physician who ordered NJ Ex Order 26.4b1 and that the Ex Order 26.4 be wrapped. She further stated, she started an incident report and gave it to the current U.S. FOIA (b)(6) LPN #5 stated that she did not do a statement because "I thought since I did the incident report and a progress note that was my statement". She stated she definitely called the family, Ex Order 26.4B1, not sure which one". She stated I took care of the resident "I think 2 days later and the NJ Ex Order 26.4b1 not done yet, so I called the mobile NJ Ex Order 2 and they came that day". She further stated that she was unaware of the results of the investigation.

On 10/04/22 at 10:49 AM, Surveyor #3 requested any investigation for resident # 65 since Ex Order 26.4B1 from the U.S. FOIA (b)(6)).

On 10/05/22 at 8:45 AM, Surveyor #4 requested from the U.S. FOIA (b)(6) for any incidents/investigations for Resident #65. The U.S. FOIA (b)(6) stated she will look again.

On at 10/05/22 at 9:24 AM, during a meeting with the survey team and the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)), Surveyor #4 asked for documents that have been repeatedly requested by the survey team(On 09/27/22 at 10:46 AM from U.S. FOIA (b), On 09/27/22 at 11:09 AM from U.S. FOIA (b)(6).

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F 600	Continued From page 72 On 10/05/22 at 9:44 AM, Surveyor #3 interviewed the [redacted], who stated if there was an injury of unknown origin, "i.e.. skin tear or bruises", they would go back 72 hours and question all staff that took care of the resident. She stated she would talk to the resident and look at their habits. She stated that if a CNA discovered it, they should report it to the nurse, the nurse would start the incident report and report it to the [redacted]. She stated she would start investigation by looking back at the last 72 hours and contacting everyone the resident had been in contact with. The [redacted] stated she would obtain written statements, but if the employee was unable to come to the facility "I write it". She stated a completed investigation report should have been done within 3 to 5 days. She stated a summary should be done once all information was obtained. The [redacted] stated that the family would be notified of the results of the investigation. Surveyor #3 asked the [redacted] about the incident involving Resident#65. She stated she was "Ex Order 26.4B1 [redacted], it was prior to coming here". She further stated she was "later told it happened during transfer when the resident's Ex Order 26.4B1 [redacted]". She stated that it wasn't reported because it wasn't something from an unknown origin. At that time, the [redacted] confirmed that she was unable to locate an incident report. On 10/05/22 at 11:13 AM, Surveyor #3 interviewed the [redacted], who stated that if there was an injury of unknown origin, staff tells the nurse, who tells the [redacted] or the supervisor. They look to see what caused the injury, "i.e. bruise". He stated written statements would be taken from all staff that took care of resident for the last 72 hours and from all the unit aides to find out what happened because they help each other out. The	F 600		

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U.S. FOIA (b)(6) stated an incident report was for the base line facts and it should be completed by the nurse assigned the resident. He stated an investigation would be done to see if it was from a mechanical lift, during care, if new equipment used to see if education is needed. He stated they would ask the resident what happened. He stated they would try to recreate the environment, "i.e.: therapy new way to transfer". They would, try to make an educated decision of how something happened, if unable to find a cause, it would be reported to the NJDOH within 2 hours "especially with a new bruise". He stated an investigation must be completed as soon as possible while it was fresh in everyone's mind, usually within 3 days. He further stated that the family and physician would be notified at the time of discovery by the nurse, but the U.S. FOIA (b)(6) would usually notify the family with the investigation results. The U.S. FOIA (b)(6) stated that the purpose of doing an investigation was to find root cause. He stated that there cannot be an assumption, there must still be a complete investigation and administration must be made aware. Surveyor #3 reviewed the incident for Resident #65 with the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated "I remember being told it happened while NJ Ex Order 26.4b1 on the resident, the EX Order 26.4B1 and hit floor". He further stated that an incident report was done but "does not recall if family was notified of conclusion and that it was not reported because the cause was identified". Surveyor #3 made the U.S. FOIA (b)(6) aware that LPN#5 stated she did incident report and it was given to him. The U.S. FOIA (b)(6) acknowledged that the facility was unable to provide an incident report/investigation for the incident. Surveyor #3 asked the U.S. FOIA (b)(6) "If there is not a report, or an investigation how can you show it was investigated?" The U.S. FOIA (b)(6) stated "I can't".

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F 600	Continued From page 74 On 10/06/22 at 9:19 AM, Surveyor #3 interviewed the U.S. FOIA (b)(6)) in regard to the incident involving Resident # 65, who stated she did not know about the incident, and did not have "soft file" regarding the incident. On 10/06/22 at 10:25 AM, in the presence of the survey team, Surveyor #3 interviewed the U.S. FOIA (b)(6), who stated that if there was an injury of unknown origin, an incident report would be generated to determine how the incident happened. She stated that statements would be taken from every staff including activities and therapy for the past 48 to 72 hours to determine if they knew how it happened. The U.S. FOI stated she would ensure the incident/accident was completed in its entirety. She stated a complete head to toe assessment would be done and the injuries would be documented to include the size and location. The family and physician should be notified at the time the incident was discovered and then "circle back" when the investigation was completed and review any interventions being implemented with them. She stated staff would be in services if the incident occurred during care; equipment would be assessed like the wheelchair or the bedside tables to determine the cause and to prevent further injuries. The U.S. FO stated an investigation summary would be completed and kept for future purpose. She stated that if unable to determine the cause, it would be reported to the NJDOH. At that time, Surveyor #3 made the U.S. FO aware of the incident Resident #65. She stated that the incident should "absolutely have been an investigated and yes 100% it should have been reported to the NJDOH". She further stated, "If it is not documented it was not done, that is a	F 600		

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nursing standard of practice".

On 10/06/22 at 2:45 PM, in the presence of the survey team and the U.S. FOIA (b)(6), and U.S. FOIA (b)(6), Surveyor #3 presented the concern of not being provided with an incident report/investigation for Resident #65.

On 10/07/22 at 9:08 AM, in the presence of the survey team, the U.S. FOIA (b)(6) stated that an Incident/Accident report for Resident #65 was "found" in the U.S. FOIA (b)(6) s office.

Review of the undated Incident/Accident report revealed Incident Occurred: NJ Ex Order 26.4b1 AM, Incident description: Injury of unknown origin was checked; Incident Type: unwitnessed was checked; Mobility Status: dependent was checked; investigation initiated by: was blank and undated, Contributing Factors and Possible causes of incident was blank; Signatures lines for the Administrator, Director of Nursing, Medical Director, and Nurse were blank. Review of the Investigative Statements revealed three statements; one from CNA #4 dated EX Order 26.4B1 revealed: "...am care on Resident #65, I noticed a Ex Order 26.4B1 and I told the nurse" and one from an unidentified staff (who was later identified as the assigned 3:00 PM to 11:00 PM CNA on EX Order 26.4B1 ".. was in the bed. I call the nurse come see it"; and a undated statement from a CNA (who was later identified as the assigned EX Order 26.4B1 "I took care of the resident in room ...did not complained of EX Order 26 The resident was fine when I left him/her". There was no assignment sheet attached and no indication that an investigation was completed.

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F 600	Continued From page 76 On 10/07/22 at 10:04 AM, in the presence of the survey team, the U.S. FOIA (b) stated she could not find the incident report for Resident #65. The U.S. FOIA (b) stated the U.S. FOIA (b)(6) handed it to her after he found it in a pile in her office. She stated she does not know who completed it, she didn't sign it and "it should have been signed, LPN #5 no longer works here". She stated "I am saying investigation sheet was here, not that it was complete". When asked by the survey team if the document was complete with causative factors, the U.S. FOIA (b) stated "no". When asked, what would you have expect to see, she stated "since it was found in am care, I would have went back a few days, if it was found by the CNA which was documented as such, you don't know if it happened then or prior, there is nothing from a nurse regarding a statement. The U.S. FOIA (b) stated the incident/accident report was "absolutely incomplete", there are no times. The U.S. FOIA (b) read the summary and conclusion and stated "it doesn't tell you what happened or an attempt to find out what happened". The U.S. FOIA (b) again confirmed that she did not find it, the U.S. FOIA (b)(6) handed it to her. On 10/07/22 at 11:34 AM, Surveyor #4 conducted a telephone interview with the U.S. FOIA (b)(6) U.S. FOIA (b), who confirmed she takes care of Resident #65. She stated they did not tell her that the NJ Ex Order 2 wasn't completed the same day, and not until EX Order 26.4B1. She stated she "may have sent her to the Emergency room". She stated she was not aware that there was no appointment available until the EX Order 2 for the EX Order 26.4B1 physician, and that it did not appear that the facility called until EX Order 26.4B1. The MD stated "I 100 % expect them to call her if they cannot get an appointment, I can send them out".	F 600		

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F 600	Continued From page 77 On 10/12/22 at 12:40 PM, in the presence of the survey team, the US FOIA (b)(6) confirmed that there was no additional information, or evidence to provide regarding any of the requested information including investigations, besides what had already been provided to the surveyors throughout the survey process. A review of a package titled, " Sensitivity, Individuality and Resident Rights" provided by the facility as part of the sensitivity training for the TNA, the following were documented: Key Facts to Remember: A resident is not dependent on us. we are dependent upon him. A resident is not an interruption of our work, he is the purpose of it.. We are not doing him a favor by serving him. He is doing us a favor by giving us an opportunity to do so. A resident is not someone to argue with. Nobody ever won an argument. A resident is someone who brings us his wants. It is our job to fill them. Under Resident Rights the following were noted: Rights are both human privileges and legal protections. Frailty,dependency factors and advanced age cause nursing home residents to be highly vulnerable to violations of their individuality and autonomy. Residents have the same rights as you: To be treated with respect and dignity. To pursue a meaningful life. To be free from fear. The facility and staff are legally responsible for	F 600		

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protecting and promoting each resident's rights. Violating a resident's right is breaking the law, and punishment could include being fired or sent to jail by a court of law.

A review of facility policy, "Charting and Documentation" reviewed 5/26/22, Policy Interpretation and Implementation: 2. The following information is to be documented in the resident medical record: d. changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives.

A review of facility policy, "Abuse Prevention & Reporting" revised 5/20/22, Policy: 1. Residents of Atrium Center for Rehabilitation and Nursing will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations. 2. All alleged or suspected incidents of abuse, neglect, mistreatment, or misappropriation of residents' property will be thoroughly investigated, and findings documented in report format. 3. Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. 4. Allegations of abuse will be investigated in accordance with abuse and reporting guidelines.
Identification: 2. The facility will investigate all unusual incidents and all injuries of unknown origin.
Clues to help Identify Abuse: A. Physical Abuse Clues: Resident denies physical abuse however physical exam reveals...fractures.
Responsibility:

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F 600	Continued From page 79 All non-licensed employees, Actions: 1. reports complaints and/or evidence of suspicion of abuse neglect injury of unknown origin or mistreatment to their supervisor immediately, 2. will complete written statements to aid in investigation. All licensed employees, Actions: 1. Notifies their supervisor immediately, 2. Notifies Administration of same. 3. Will complete written statement to aid in investigation. Nursing Supervisor/Social worker, Actions: 1. Obtains a statement from the resident in question, 2. Takes immediate necessary precautions/management pending complete investigation, 3. Interim case conference is held to develop interventions to ensure resident physical harm, pan, and/or anguish is minimized. Administrator/DNA/Designee, Actions: 1. Will ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source ... are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), 2. Will ensure that the results of all investigations are reported to the administrator ...within 24 hours of the incident. Allegation of Abuse, neglect, exploitation or mistreatment and injuries of unknown source, Action: 1. All alleged violations of abuse are to be reported immediately but no later that 2 hours if the alleged violation involve abuse or results in serious bodily injuries. A review of the facility provided, "Rehabilitation and Care Center Abuse Prevention & Reporting" policy dated revised 5/20/22, included all residents of [name of another facility] will be protected from abuse, neglect, mistreatment, or	F 600		

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misappropriation of property in accordance with State and Federal Regulations; all alleged suspected incidents of abuse, neglect.....will be thoroughly investigated and findings documented in a report format; any case of abuse, neglect...has been identified via the investigation, or a conclusion cannot be drawn will be reported to the State Department of Health; allegations of abuse will be investigated in accordance with abuse and reporting guideline..... sexual abuse: includes but is not limited to sexual harassment, sexual coercion, or sexual assault by family, visitor, staff or another resident...prevention:..the facility will continue to provide individualized care plans that identify risk factors of residents at risk to implement plans for protecting their rights...identification: the facility will investigate any complaint, observation, or suspicion of resident abuse, mistreatment, or neglect...a report is to be filed if any individual has "reasonable cause to believe the resident has been physically abused, mistreated, or neglected" by the staff of this facility and/or by a family member or visitor...sexual abuse cues: difficulty walking or sitting; torn, stained, or bloody under clothes; pain or itching in genital area; bruising or bleeding in external genitalia, vaginal, and/or anal area; unexplained sexually transmitted disease...actions: all non-licensed employees should report complaints and/or evidence or suspicion of abuse, neglect...to their supervisors immediately; will complete a written statement to aid in investigation; all licensed employees: should notify supervisor immediately and administration at same time; will complete written statement to aid in investigation; Administrator/DON will ensure all alleged violations of mistreatment, neglect, or abuse...are reported immediately to the administrator and/or

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representative and to other officials in accordance with State law through established procedures...law enforcement to be notified no later than twenty-four hours.

A review of the facility's "Charting and Documentation" policy dated effective 1/5/22 and reviewed 5/26/22, included...any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...the following information is to be documented in the resident medical record: objective observations...events, incidents or involving the resident; and progress toward or changes in the care plan and objective goals...

A review of the facility provided, "Rehabilitation and Care Center Abuse Prevention & Reporting" policy dated revised 5/20/22, included all residents of [name of another facility] will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations; all alleged suspected incidents of abuse, neglect.....will be thoroughly investigated and findings documented in a report format; any case of abuse, neglect...has been identified via the investigation, or a conclusion cannot be drawn will be reported to the State Department of Health; allegations of abuse will be investigated in accordance with abuse and reporting guideline..... sexual abuse: includes but is not limited to sexual harassment, sexual coercion, or sexual assault by family, visitor, staff or another resident...prevention:..the facility will continue to provide individualized care

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plans that identify risk factors of residents at risk to implement plans for protecting their rights...identification: the facility will investigate any complaint, observation, or suspicion of resident abuse, mistreatment, or neglect...a report is to be filed if any individual has "reasonable cause to believe the resident has been physically abused, mistreated, or neglected" by the staff of this facility and/or by a family member or visitor...sexual abuse cues: difficulty walking or sitting; torn, stained, or bloody under clothes; pain or itching in genital area; bruising or bleeding in external genitalia, vaginal, and/or anal area; unexplained sexually transmitted disease...actions: all non-licensed employees should report complaints and/or evidence or suspicion of abuse, neglect...to their supervisors immediately; will complete a written statement to aid in investigation; all licensed employees: should notify supervisor immediately and administration at same time; will complete written statement to aid in investigation; Administrator/DON will ensure all alleged violations of mistreatment, neglect, or abuse...are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures...law enforcement to be notified no later than twenty-four hours.

A review of the facility's "Charting and Documentation" policy dated effective 1/5/22 and reviewed 5/26/22, included...any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...the following

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F 600	Continued From page 83 information is to be documented in the resident medical record: objective observations...events, incidents or involving the resident; and progress toward or changes in the care plan and objective goals...	F 600		
F 609 SS=F	N.J.A.C. 4.1(a)(3)(5)(12)(15) Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		12/5/22

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F 609	Continued From page 84 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy to report a.) an allegation of EX Order 26.4B1 between two residents, b.) EX Order 26.4B1 between a staff member and a resident, c.) NJ Ex Order 26.4b1 by a resident against two other residents, and d.) an NJ Ex Order 26.4b1 for two residents. This deficient practice was identified for 5 of 6 residents reviewed for EX Order 26.4B (Resident #10, #56, #63, #65, and #72) and 1 of 1 resident reviewed for NJ Ex Order 26.4b1 (#193), and was evidenced by the following: Refer to F600 and F684 a.) On 08/10/22, multiple staff members observed on the locked nursing unit, Resident #63, a Ex Order 26.4B1, exit Resident #10's room. Resident #10 had EX Order 26.4B1 and was NJ Ex Order 26.4b1 on staff for Activities of Daily Living (ADLs). Resident #63 was reported to be Ex Order 26.4B1", Ex Order 26.4B1 " while smiling with Ex Order 26.4B1. Certified Nursing Aide (CNA #1) reported this observation "was alarming" and reported it to a Licensed Practical Nurse (LPN #1). CNA #1, LPN #1, and Behavioral Aide (BA #1) entered Resident #10's room and observed the bed curtain was open, the resident was lying in bed with the NJ Ex Order 26.4b1, their EX Order 26.4B1 was Ex Order 26.4B1 their Ex Order 26.4B1 was twisted and opened to one side with Ex Order 26.4B1 Ex Order 26.4B1. Resident #10 was reported to be Ex Order 26.4B1 while saying, "Ex Order 26.4B1	F 609	F 609 SS=F Reporting of Alleged Violations 1. Immediate Action a. Resident # 63 was Ex Order 26.4B1 and does not currently reside at the facility b. Resident # 193 is currently Ex Order 26.4B1 c. Resident #10 Incident reported to DOH d. Resident # 56 Incident reported to DOH e. Resident # 65 Education provided to staff about incident and accident reports f. Resident #72 Education provided to staff about incident and accident reports g. Staff was immediately educated on reporting of incident and accidents and reportable events 2. Identification of others All residents have the potential to be affected by the deficient practice 3. Systemic Changes o The facility policy on alleged violations has been reviewed and revised to include a rapid response/trigger call policy. Alleged violations will be reviewed during the trigger call to ensure the incident is being managed in accordance with federal regulations to include reporting. The director of nursing or designee will report all reportable events to the Department of Health. o An alleged violation tracking log will be maintained by the director of nursing or	

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F 609	Continued From page 85 LPN #1 reported the incident to the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)) who both failed to investigate and report the situation. Resident #10 remained on the locked nursing unit for two weeks with Resident #63 until Resident #10's room was changed on Ex Order 26.4B1 by the U.S. FOIA (b) since the resident reportedly did not need to be on a locked unit. Resident #63 remained on the locked unit with no additional monitoring and was free to roam around the unit and into other resident rooms. An interview with the U.S. FOIA (b)(6) revealed that the facility observed Resident #63 exit Resident #10's room on video surveillance footage, footage that was unable to be provided to the survey team. The U.S. FOIA (b)(6) stated that Resident #63 was only in Resident #10's room for six to seven minutes, and upon interview, Resident #63 stated he/she was in Resident #10's bathroom by mistake, the U.S. FOIA (b)(6) stated that was determined as plausible since LPN #1 was at some point inside Resident #10's room while administering medication and did not observe Resident #63. The U.S. FOIA (b)(6) concluded that no abuse had occurred, therefore, no investigation was required. The facility did not report the allegation to the police or Department of Health (DOH) for review. Resident #10 was not sent to the hospital for examination of possible Ex Order 26.4 On 09/27/22 at 10:46 AM, Surveyor #1 interviewed the U.S. FOIA (b) who stated she had been at the facility since Ex Order 26.4B1 and was in charge of investigations. The U.S. FOIA (b) stated the facility investigated Ex Order 26 anything EX Order 26.4B1 Ex Order 26 tears, any kind of abuse including physical, verbal, and misappropriation of property. The U.S. FOIA (b) stated the process for an investigation was to collect statements from all staff who saw the	F 609	designee. The tracking log will be reviewed weekly by the facility administrator and director of nursing to ensure proper reporting of reportable events to department of health. 4. Quality Monitoring The Administrator/designee will audit the alleged violations tracker log weekly x 6 months. Audit results will be reported to the quality assurance and performance improvement committee monthly. The first of which will take place in December 2022.	

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resident or took care of the resident; interview the resident if able to, even if the resident was confused. Then the facility notified the family or representative and the physician. The U.S. FOIA (b) stated that abuse and/or neglect was investigated with the U.S. FOIA (b)(6), and abuse was reported to the New Jersey Department of Health (NJDOH). At this time, the U.S. FOIA (b) provided the surveyor with all investigations and incidents Ex Order 26 the facility conducted from Ex Order 26.4B1 through present time.

On 09/27/22 at 11:09 AM, the U.S. FOIA (b)(6) stated and confirmed that the surveyor had all of the facility investigations. The U.S. FOIA (b)(6), upon inquiry, stated that he did not keep any "soft files", but then stated, "there may be one or two reportable events (mandatory facility reporting)" and he would check.

On 09/27/22 at 3:16 PM, the surveyor interviewed the U.S. FOIA (b) who stated she was not at the facility on the morning the incident occurred when Resident #63 was observed exiting Resident #10's room by a behavioral aide. The U.S. FOIA (b) stated that Resident #63 had a history of Ex Order 26.4B1 and discussed this with the U.S. FOIA (b)(6). The U.S. FOIA (b) stated she asked staff for statements, but none were provided, and she had no documentation to corroborate that. The U.S. FOIA (b) stated she did not feel this situation was an NJ Ex Order 26.4b1 because "no one saw anything". The U.S. FOIA (b) acknowledged there was no documented assessment of either resident as well as there were no documented statements from the residents, staff, or herself. The U.S. FOIA (b) stated if facility policy had been followed, the police should have been called and Resident #10 should have been sent to the hospital for an assessment as well as a thorough investigation conducted, and Resident #63 should have been

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monitored. The U.S. FOIA (b) also stated the NJDOH would have been informed. The U.S. FOIA (b) acknowledged none of this was done.

Refer F600

b.) On 09/23/22 around 7:20 AM, while in the hallway, Surveyor #2 heard a Ex Order 26.4B1 Ex Order 26.4B1 near the nursing station. While approaching the nursing station, the surveyor observed a resident standing in the hallway facing the nursing station and talking loudly. Then a female staff member exited the nursing station and was yelling, screaming, and pointing a finger in the resident's face. The surveyor stood by the nursing station and observed the night nurse facing the hallway where the verbal argument was taking place, a Certified Nursing Assistant (CNA #3) sitting at the desk, a US FOIA (b)(6) member in the hallway, the US FOIA (b)(6) , and a US FOIA (b)(6) who all witnessed the incident, yet none intervened.

The resident was identified by staff as Resident #56. Resident #56 approached Surveyor #2 and stated, " Can you help me, all I want is Ex Order 26.4B1. The one that I had on would be Ex Order 26.4B1". The surveyor informed TNA #4 of the Resident #56's request for the Ex Order 26.4B1 Ex Order 2. TNA #4 continued to argue and remained in the hallway near the linen cart. TNA #4 did not provide the Ex Order 26.4B1 to the resident.

On 09/23/22 at 7:30 AM, Surveyor #2 interviewed TNA #4 who was involved in the above incident. TNA #4 informed the surveyor that she had been working at the facility for the NJ Ex Order 26.4b1. The surveyor inquired about any in-service education

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received on Ex Order 26.4B1 care, she acknowledged receipt of in-service education. The surveyor asked her to comment on the observed behavior witnessed in the hallway. TNA #4 stated, Resident #56 pointed their NJ Exec Order 2 at her first because she stopped Resident #56 from obtaining a Ex Order 26.4B1 from the linen cart parked in the hallway. In return TNA #4 pointed the NJ Exec Order 26 back at him/her (Resident #56). TNA #4 stated there were no Ex Order 26.4B1 Ex Order 26.4 on the floor. She stated she would have to get a key and go to the first floor to get some Ex Order 26.4B1 .

On 09/26/22 at 12:06 PM, Surveyor #2 met with the U.S. FOIA (b)(6 and the U.S. FOIA (b) and requested the investigation. The U.S. FOIA (b)(6 stated that there was no investigation. The U.S. FOIA (b) walked in and stated that they were not aware of the incident. Therefore, the incident had not been reported to the DOH.

The facility did not report the NJ Ex Order 26.4b1 until Ex Order 26.4B1, after surveyor inquiry.

c.1.) Surveyor #2 reviewed Resident #63 clinical notes dated Ex Order 26.4B1, and noted the following: Ex Order 26.4B1, Resident #63 was involved in a Ex Order 26.4B1 Ex Order 26.4B1 with his/her roommate. Resident #63 Ex Order 26.4B1 when he/she observed the Ex Order 26.4B1 . During the Ex Order 26.4B1 , Resident #63 sustained a Ex Order 26.4B1 . The surveyor reviewed the clinical Notes with the U.S. FOIA (b. The U.S. FOIA (b stated that she was not employed by the facility during the incident. She admitted that documentation was lacking, and that the incident should have been entered in the clinical record. She was unable to locate any investigation or provided any incident report that

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was generated. The physical altercation by Resident #63 was not reported to the state agency.

c.2) Surveyor #2 reviewed the nurse's notes dated 01/06/22 timed 2:00 PM, which documented, "Resident #63 Ex Order 26.4B1 Ex Order 26.4B1 When asked why he/she Ex Order 26.4B1 Ex Order 26.4B1, Resident #63 replied, Ex Order 26.4B1 [him/her] Ex Order 26.4B1 [he/she] Ex Order 26.4B1 The facility did not generate an incident report nor report the incident to the State Agency.

d.1.) On 09/21/222 at 10:37 AM, during the initial tour of the Ex Order 26.4B1-floor, Surveyor #3 observed Resident #65 in bed.

Review of Nursing Progress Note, dated 07/2/22 at 1:29 PM, revealed: US FOIA (b)(6) U.S. FOIA (b)(6)) brought to my attention that patient was Ex Order 26.4B1 during am care and Ex Order 26.4B1 Examination reveals Ex Order 26.4B1 as compared to the Ex Order 26.4B1 color normal for patient Ex Order 26.4B1 noted no open areas noted MD made aware.

On 09/27/22 at 10:46 AM, Surveyor #1 interviewed the U.S. FOIA (b), who stated she had been at the facility since Ex Order 26.4B1 and was now in charge of investigations. She stated that there should be an investigation on Ex Order 26, anything EX Order 26.4B1, NJ Exec Order 26, NJ Exec Order 26.4b1, any kind of abuse verbal or physical, and misappropriation of property. She stated they get statements from all staff who took care of the resident, "if they saw anything". If it was a bruise of unknown origin, they would get a statement from the resident, if they were able to

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give one. Then the facility would call the family and physician to notify them of the incident. She stated anything that warranted such as abuse or neglect, would be called in to the New Jersey Department of Health (NJDOH).

On 10/05/22 at 09:44 AM, Surveyor #3 interviewed the [redacted] about the incident involving Resident #65. The [redacted] confirmed that she was unable to locate incident report and stated that it would have been reported to the NJDOH if they did not know the cause.

On 10/05/22 at 11:13 AM, Surveyor #3 interviewed the [redacted] who stated that if there was an injury of unknown origin, staff tells the nurse, who tells the [redacted] or the [redacted]. They look to see what caused the injury, "ie bruise". He stated written statements would be taken from all staff that took care of resident for the last 72 hours and from all the unit aides to find out what happened because they help each other out. The [redacted] acknowledged that the facility was unable to provide an incident report/investigation for the incident. Surveyor #3 asked the [redacted] "If there is not a report or an investigation how can you show it was investigated?" The [redacted] stated "I can't".

On 10/06/22 at 2:45 PM, in the presence of the survey team and the [redacted], Surveyor #3 presented the concern of not being provided with an incident report/investigation for Resident # 65 and that it was not reported to the NJDOH.

d.2.) On 9/21/22 at 9:45 AM, during the initial tour of the [redacted] floor unit, Surveyor #3 observed resident #72 [redacted] in his/her

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room. The resident was pleasant and agreed to be interviewed. The resident did not speak to any concerns to the Ex Order 26.4B1 .

A review of the nursing progress note dated 09/5/22 at 09:06 PM, revealed "Resident was noted with Ex Order 26.4B1 to Ex Order 26.4B1 Ex Order 26.4B1, cool to touch. Denies Ex Order 26. Doppler from last week is Ex Order 26.4B1 for Ex Order 26.4B1). Resident is on Ex Order 26.4B1. Ex Order 26.4B1 monitoring is ordered Q shift".

On 09/27/22 at 10:46 AM, Surveyor #1 interviewed the U.S. FOIA (b), who provided the surveyor with all investigations and incidents (five) the facility conducted from Ex Order 26.4B1 through present time. The U.S. FOIA (b) stated the facility was searching for additional investigations and if they could find any, they would give to the surveyor. Review of these investigations by Surveyor #3 did not reveal an investigation regarding the incident from Ex Order 26.4B1 with Resident #72.

On 10/05/22 at 11:13 AM, Surveyor # 3 interviewed the U.S. FOIA (b)(6), who stated that if there was an injury of unknown origin, staff told the nurse, who told the U.S. FOIA (b) or the supervisor. They looked to see what caused the injury, "NJ Exec Order 26.4B ". They would, try to make an educated decision of how something happened, if unable to find a cause, it would be reported to the NJDOH within 2 hours "especially with a Ex Order 26.4B1 He stated an investigation must be completed as soon as possible while it was fresh in everyone's mind, usually within 3 days. He further stated that the family and physician would be notified at the time of discovery by the nurse, but the U.S. FOIA (b) would usually notify the family with the investigation

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results. The U.S. FOIA (b)(6) stated that the purpose of doing an investigation was to find root cause. He stated that there cannot be an assumption, there must still be a complete investigation and administration must be made aware. At that time, Surveyor #3 reviewed the incident involving Resident #72 on Ex Order 26.4B1 with the U.S. FOIA (b)(6) who stated, the "U.S. FOIA (b)(6)) should have been made aware", an investigation should have been done. He stated a root cause analysis should have been done and if not able to determine the cause, it should have been reported to the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) confirmed he was unaware of the incident with #72.

On 10/06/22 at 2:45 PM, in the presence of the survey team and theU.S. FOIA (b)(6) , and U.S. FO , Surveyor #3 presented the concern of not being provided with an incident report/investigation for Resident #72 and that it was not reported to the NJDOH.

On 10/12/22 at 12:40 PM, in the presence of the survey team, the US FOIA (b)(6) confirmed that there was no additional information or evidence to provide besides what was already given to the surveyors throughout the survey process.

Refer to F684

d.3) A review of the closed medical record revealed an Admission Record that Resident #193 had admitting diagnoses that included, but were not limited to, Ex Order 26.4B1

The closed medical record also included a

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F 609	Continued From page 93 hospital record dated NJ Ex Order 26.4b1 for Resident #193. The hospital record revealed a Computer Aided Ex Order 26.4B1 was completed on Ex Order 26.4B1 and revealed, "There are NJ Ex Order 26.4b1 findings". On 10/04/22 at 11:16 AM, the surveyor reviewed the entirety of the closed medical record for Resident #193 which was provided by the facility on Ex Order 26.4B1 and revealed the following conclusion. Resident #193 had sustained Ex Order 26.4B1 including Ex Order 26.4B1 that occurred on Ex Order 26.4B1, and Ex Order 26.4B1 that resulted in transfer to the emergency room on Ex Order 26.4B1, which resulted in an Ex Order 26.4B1, which required an Ex Order 26.4B1 and Ex Order 26.4B1 Ex Order 26.4B1. On 10/04/22 at 4:18 PM, the surveyor, in the presence of another surveyor, inquired to the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) U.S. FOIA (b)(6)) if there were any investigations for Resident #193. The U.S. FOIA (b)(6) stated "no" there were no investigations that the facility was aware of. On 10/05/22 at 9:56 AM, the surveyor interviewed the U.S. FOIA (b) regarding what the process was if a resident sustained an NJ Exec Order 26.4b1 The U.S. FOIA (b) stated it should be investigated and reported to the State. There was no reference to being NJ Exec Order 26.4b1. On 10/05/22 at 10:49 AM, the surveyor interviewed the U.S. FOIA (b)(6), regarding what the process was for injuries of unknown origin. The	F 609		

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U.S. FOIA (b)(6) stated there should be an investigation for injuries of unknown origin.

On 10/05/22 at 4:05 PM, the surveyor inquired to the U.S. FOIA (b)(6) regarding any incidents, investigations or reportable events (events that require the facility to report to the U.S. FOIA (b)(6)) for Resident #193. The U.S. FOIA (b)(6) stated, "I have nothing" on Resident #193 and the U.S. FOIA (b)(6) stated that she and the U.S. FOIA (b)(6) could not locate any incidents or reportable events.

10/06/22 at 10:31 AM, the U.S. FOIA (b)(6) stated to the surveyor that with any injury of unknown origin, an incident report with statements and a full head to toe investigation should have been completed. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) possibly the [redacted] but definitely the last [redacted] if there were injuries it should have been reported to the Department of Health.

The following facility provided policies were reviewed:

Accidents-Occurrence Investigation, dated 01/2022 revealed All accidents will be investigated, documented and reported to the New Jersey Department of Health as appropriate. Definitions: Accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident... Fall: refers to unintentionally coming to rest on the ground, floor or other lower levels, but not as a result of an overwhelming external force (i.e. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without an injury is still a fall unless there is evidence suggesting otherwise when a resident is

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F 609	Continued From page 95 found on the floor, a fall is considered to have occurred... Procedure: Responsibility Person responsible for area in which the accident occurred (Initiator). Action: Initiated the accident report and enters required information. Notifies RN/Clinical Care Manager; RN/Clinical Care Manager: Action: Investigates the situation and assesses the resident/patient, completes the "nurse" section of the Accident Report, Determines/implements immediate corrective action. Licensed Nurse RN/LPN: Notifies M.D. & Clinical Care Manager, Identifies relevant environmental risk factors, Notifies Plant Operations and/or housekeeping as appropriate, Documents the accident event and notification of family in the progress notes, Place resident/patient on 24 hour report x 72 hours, Documents resident/patient status in the progress notes X 72 hours, RN/CCM: Initiates/updates CCP with a new intervention, Clinical Care Manager: Reviews the accident report and other pertinent information with the interdisciplinary Team at morning report the following business day, RN/Clinical Care Manager: Initiates Incident report, Obtains statements from all staff, residents, visitors, volunteers present at the time of the accident, by the end of the shift, Obtains statements until a determination can be made as to the time of the accident, Clinical Care Manager: Reviews accident report, statements occurrence report, clinical record and surveillance data as indicated. Completes "Summary of Findings" and "Determination" regarding Abuse, Neglect, and Mistreatment, Initiates Corrective Action Plan, Notifies family/significant others of the findings of the Occurrence Investigation, Submits all documents to the A.D.N./D.N.S., D.N.S./A.D.N.: Reviews each case, relevant	F 609		

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documents and the clinical record to validate findings and determine results, Forwards "original" accident reports to the Education Dept., DNS/ADN: Reviews significant injuries and injuries of unknown origin with the Administrative Team (Administrator/Associate Administrator/ Medical Director/Associate Medical Director), Administrative Team: Conducts root cause analysis, as needed, DON/Designee: Notifies DOH and other regulatory agencies as per regulations if: reasonable cause to suspect abuse, neglect and mistreatment has been determined, failure to follow the CCP, which resulted in resident injury, injuries of unknown origin.

A review of facility policy, "Abuse Prevention & Reporting" revised 5/20/22, Policy: 1. Residents of [redacted] for Rehabilitation and Nursing will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations. 2. All alleged or suspected incidents of abuse, neglect, mistreatment, or misappropriation of residents' property will be thoroughly investigated, and findings documented in report format. 3. Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. 4. Allegations of abuse will be investigated in accordance with abuse and reporting guidelines.
Identification: 2. The facility will investigate all unusual incidents and all injuries of unknown origin.

Clues to help Identify Abuse: A. Physical Abuse Clues: Resident denies physical abuse however

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F 609	Continued From page 97 physical exam reveals...fractures. Responsibility: All non-licensed employees, Actions: 1. reports complaints and/or evidence of suspicion of abuse neglect injury of unknown origin or mistreatment to their supervisor immediately, 2. will complete written statements to aid in investigation. All licensed employees, Actions: 1. Notifies their supervisor immediately, 2. Notifies Administration of same. 3. Will complete written statement to aid in investigation. Nursing Supervisor/Social worker, Actions: 1. Obtains a statement from the resident in question, 2. Takes immediate necessary precautions/management pending complete investigation, 3. Interim case conference is held to develop interventions to ensure resident physical harm, pan, and/or anguish is minimized. Administrator/DNA/Designee, Actions: 1. Will ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source ... are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), 2. Will ensure that the results of all investigations are reported to the administrator ...within 24 hours of the incident. Allegation of Abuse, neglect, exploitation or mistreatment and injuries of unknown source, Action: 1. All alleged violations of abuse are to be reported immediately but no later than 2-hours if the alleged violation involve abuse or results in serious bodily injuries. A review of the facility provided, "Rehabilitation	F 609		

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F 609	Continued From page 98 and Care Center Abuse Prevention & Reporting" policy dated revised 5/20/22, included all residents of [name of another facility] will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations; all alleged suspected incidents of abuse, neglect.....will be thoroughly investigated and findings documented in a report format; any case of abuse, neglect...has been identified via the investigation, or a conclusion cannot be drawn will be reported to the State Department of Health; allegations of abuse will be investigated in accordance with abuse and reporting guideline...Administrator/DON will ensure all alleged violations of mistreatment, neglect, or abuse...are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures...law enforcement to be notified no later than twenty-four hours. A review of the facility's policy indicated the following: "Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. The facility did not follow their own policy.	F 609		
F 610 SS=F	N.J.A.C. 8:39-13.4(c)(2)(v), 27.1(a)(b) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		12/5/22

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F 610	Continued From page 99 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy to investigate a.) an Ex Order 26.4B1 between two residents, b.) thoroughly and timely investigate allegation of verbal abuse, c.) thoroughly and timely investigate injuries of unknown origin identified for 4 of 6 residents reviewed for NJ Ex Order 26 (Resident #10, #56, #63, #65), and 1of 1 resident's (Resident #193) reviewed for NJ Ex Order 26.4b1 and was evidenced by the following: Refer to F600 and F684 On 08/10/22, multiple staff members observed on the locked nursing unit, Resident #63, a Ex Order 26.4B1, exit Resident #10's room. Resident #10 had Ex Order 26.4B1 and was NJ Ex Order 26.4b1 on staff for Activities of Daily Living (ADLs). Resident #63 was reported to be Ex Order 26.4B1 .	F 610	1. Immediate Action a. Resident # 63 has been NJ Ex Order 26.4b1 and does not currently reside at the facility b. Resident # 10 has been has been transferred from Ex Order 2 unit to room within the facility. Post incident, the resident was seen by Ex Order 26.4B1 c. Resident # 56 was seen by NJ Exec Order 26.4b1 assessment completed d. Resident # 65 received specialized Ex Order 26.4B1 and Ex Order 26.4B1 is now healed e. Facility policy was reviewed to ensure compliance with federal regulations f. Staff was immediately educated on investigation/prevention/correction of alleged violation g. The US FOIA (b)(6) were immediately educated by the regional Administrator on investigation/prevention and correction of alleged violations.	

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F 610	Continued From page 100 Certified Nursing Aide (CNA #1) reported this observation "was alarming" and reported it to a Licensed Practical Nurse (LPN #1). CNA #1, LPN #1, and Behavioral Aide (BA #1) entered Resident #10's room and observed the bed curtain was open, the resident was lying in bed with the NJ Ex Order 26.4b1, their hospital Ex Order 26.4B1 [redacted]. Resident #10 was reported to be Ex Order 26.4B1 [redacted] while saying, Ex Order 26.4B1 [redacted]". LPN #1 reported the incident to the U.S. FOIA (b)(6) [redacted] and the U.S. FOIA (b)(6) [redacted]) who both failed to investigate and report the situation. Resident #10 remained on the locked nursing unit for two weeks with Resident #63 until Resident #10's room was changed on Ex Order 26.4B1 by the U.S. FOIA (b) since the resident reportedly did not need to be on a locked unit. Resident #63 remained on the locked unit with no additional monitoring and was free to roam around the unit and into other resident rooms. An interview with the U.S. FOIA (b)(revealed that the facility observed Resident #63 exit Resident #10's room on video surveillance footage, footage that was unable to be provided to the survey team. The U.S. FOIA (b)(stated that Resident #63 was only in Resident #10's room for six to seven minutes, and upon interview, Resident #63 stated he/she was in Resident #10's bathroom by mistake, the U.S. FOIA (b)(stated that was determined as plausible since LPN #1 was at some point inside Resident #10's room while administering medication and did not observe Resident #63. The U.S. FOIA (b)(concluded that no abuse had occurred, therefore, no investigation was required.	F 610	2. Identification of Others All residents residing in the facility have the potential to be affected by the deficient practice 3. Systemic Changes a. A policy was written for rapid response/trigger calls b. The staff was educated on the rapid response/trigger call policy c. All accidents incidents, unusual occurrences, injuries of unknown origin will be documented on the 24-hour report. The 24-hour report will be reviewed by the IDT at the daily clinical meeting to ensure compliance with facility policy. 4. Quality assurance monitoring The director of nursing/designee will audit all alleged and actual violations to ensure proper handling in accordance with facility policy and federal regulations. Negative audit results will be corrected immediately. Audit results will be reported to the QAPI committee on a monthly basis x 6 months for review and further recommendations. The first of which will take place in December 2022.	

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On 09/27/22 at 11:02 AM, the surveyor reviewed the [EX Order] investigations provided by the [U.S. FOIA (b)]. None of which included the incident alleged by staff that occurred between Resident #10 and Resident #63.

On 09/27/22 at 11:09 AM, the [U.S. FOIA (b)(] stated and confirmed that the surveyor had all of the facility investigations. The [U.S. FOIA (b)(], upon inquiry, stated that he did not keep any "soft files", but then stated "there may be one or two reportables (mandatory facility reporting)" and he would check.

b. On 09/23/22 at 7:20 AM, while in the hallway, the surveyor (#2) overheard a loud verbal exchange that was occurring near the nursing station. While approaching the nursing station, the surveyor observed a resident [Resident #56] standing in the hallway facing the nursing station and was talking loudly. Then a female staff exited the nursing station and was yelling, screaming and pointing the finger as she walked toward Resident #56 and in the resident's face. The surveyor stood by the nursing station and observed the night nurse was directly facing the hallway, with an unobstructed view and where the verbal argument was taking place. A Certified Nursing Assistant (CNA#3) was sitting at the desk, a US FOIA (b)(6) was in the hallway, the US FOIA (b)(6) , a Registered Nurse (RN #1), all witnessed the incident, and none of the staff intervened.

The resident was later identified by staff as Resident #56. Resident #56 approached surveyor #2 and stated, "Can you help me, all I want is a [EX Order 26.4B1] The one that I had on would be [EX Order 26.4B1] [EX Order 26.4B]. The surveyor informed TNA #4 of the resident's requested needs. TNA #4 then

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continued to argue with Resident #56 and remained in the hallway near the linen cart. TNA#4 did not provide the Ex Order 26.4B1 Ex Order 26.4B1 to the resident.

On 09/23/22 at 7:30 AM, surveyor #2 interviewed TNA #4 who was involved in the above incident. TNA #4 informed the surveyor that she had been working at the facility for the NJ Ex Order 26.4b1. The surveyor inquired about any in-service education received on Ex Order 26.4B1 care, she acknowledged receipt of in-service education. The surveyor asked her to comment on the observed behavior witnessed in the hallway. TNA #4 stated that Resident #56 NJ Exec Order 26.4b1 at her first because she did not allow Resident #56 to obtain a Ex Order 26.4B1 from the linen cart that was parked in the hallway. In return TNA #4 stated she NJ Exec Order 26.4b1 back at him/her. TNA #4 stated there were no Ex Order 26.4B1 on the floor.

On the morning prior to the above incident, Surveyor #2 entered the nursing station of the Ex Order 26 Unit and observed a pack of Ex Order 26.4B1 Ex Order 2 on the counter of the low side of the unit. Although TNA #4 stated there was no Ex Order 26.4B1 on the floor, the pack of Ex Order 26.4B1 were still on the counter following the witnessed Ex Order 26.4B1 altercation with TNA #4 and Resident #56. CNA #3 who was sitting at the nursing desk on the locked unit, stood up and provided a Ex Order 26.4B1 Ex Order 26.4B1 Resident #56. Resident #56 thanked CNA #3 and returned to his/her room.

On 09/26/22 at 12:06 PM, Surveyor #2 met with the U.S. FOIA (b)(and the U.S. FOIA (b and requested the investigation for the incident of NJ Exec Order 26.4b1. Both

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indicated that they were not aware of the incident.

c. Review of an additional Nursing Progress note documented by LPN #5, dated Ex Order 26.4B1 PM, revealed; NJ Ex Order 26 of Ex Order 26.4B1 complete awaiting results".

A Nursing Progress note (unidentified nurse), dated Ex Order 26.4B1, revealed " NJ Ex Order of the Ex Order 26.4B1 was done, result was relayed to the nurse on call, that the pt. (patient) has an Ex Order 26.4 appearing Ex Order 26.4B1 recommend; Ex Order 26.4 Ex Order 26.4B1, dr (doctor) made aware of the Ex Order 26.4B1 and the recommendation with new order to apply Ex Order 26.4B1, and an Ex Order 26.4B1 consult ASAP (as soon as possible), NJ Ex Order 26.4b1 applied pt in bed, no NJ Ex Order 26.4b1 noted, NJ Exec Order 26.4b1 noted at this time, awaiting for the hard copy of the NJ Ex Order 2.

A Radiology Report of the Ex Order 26.4B1) dated Ex Order 26.4B1, revealed, Impression: Ex Order 26.4 appearing Ex Order 26.4B1.

The Physician's Orders revealed an order dated NJ Ex Order 26.4b1 at 8:19 PM, "Treatment: apply NJ Ex Order 26.4b1 to Ex Order 26.4B1 only remove for care" and an order dated Ex Order 26.4B1, for "Consultation: pt to have an Ex Order 26.4B1 appt for the Ex Order 26.4B1 Ex Order 26.4B1 ASAP".

Nursing Progress note (unidentified nurse), dated at 4:05 PM, revealed; "Appointment made for Wednesday NJ Ex Order 26.4b1 at 930 am ...Family has been made aware of appointment ...Transportation needs to be made. Family may be able to accompany patient".

Review of Nursing Progress (unidentified nurse)

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note, dated [redacted] at 10:41 am, revealed; "Resident Transportation has been scheduled for apt (appointment) on[redacted]

On 09/27/22 at 10:04 AM, Surveyor #3 interviewed CNA #4, who stated that Resident # 65 required [redacted] from staff, and that you have to make sure the resident's[redacted] were in to communicate. She stated Resident #65 required[redacted] with the use of a [redacted] When surveyor asked CNA #4 about the resident's [redacted] she stated the resident [redacted] but the resident had a [redacted] recently from [redacted]". CNA #4 stated that if there was a [redacted], she would tell the nurse right away and would have to give a statement as to what was found and where it was.

On 09/27/22 at 10:15 AM, Surveyor #3 interviewed LPN #6, who stated that an injury of unknown origin wound would have to be assessed by the nurse, the physician would be called, and the family notified. There would be an incident report completed, a three day look back for nurses aids and she would obtain statements from the nurse aides that had taken care of the resident. She stated that the findings would be listed on the 24-hour report. LPN #6 stated that Resident #65 required use of a[redacted] with [redacted] to get out of bed. She stated she did not know how the [redacted] had occurred but she knew [redacted] off a few weeks ago. She stated there "should have been an investigation started by the nurse caring for the resident when [redacted] was found."

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F 610	Continued From page 105 On 9/29/22 at 10:19 AM, Surveyor #3 interviewed LPN# 7, who stated that if there was an injury of unknown origin, there, "should be an investigation" which included going back 72 hours and getting statements from all staff that had come into contact with the resident. If possible, try to get information from the resident. Notify the supervisor, the family and the physician. There should be an incident report, a progress note and an investigation. The nurse should complete a full body check to make sure there were no other injuries underneath the clothing. LPN #7, who was assigned to Resident # 65 at the time of the interview, stated she did not know about the resident's recent Ex Order 26.4B1 . She further stated that Resident #65 was NJ Ex Ord with ADLs and that there, "absolutely should be an incident report and investigation from all staff that had contact with that resident for past 72 hours". Surveyor #3 asked LPN #7 the process for when a resident went to a physician visit. She stated the "report of consultation" form was sent with the patient, the nurse filled out the reason why the facility was sending the resident and the consulting physician should fill out findings and recommendations and send the form back with the resident. She further stated that the form should be in paper chart. At this time, Surveyor #3 requested LPN #7 to show the surveyor the consult from the NJ Exec Order 26.4b1 physician for NJ Exec Order 26.4b1 . She was unable to locate the consult form or the physician's consult in the chart. She stated she would have to check to see if the chart was thinned. On 09/29/22 at 10:30 AM, Surveyor #3 interviewed CNA #4 in regards to Resident #65, she stated she was assigned to the resident at the time of the interview. She stated she knew the	F 610		

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resident well. She stated the resident had a recentEx Order 26.4B1, but she didn't know how it happened. CNA#4 took the surveyor to Resident #65's room and showed the surveyor Resident #65's Ex Order 26.4B1 which was NJ Ex Order 26.4b1

A review of the Ex Order 26.4B1 consults provided by the facility on 09/29/22, revealed a consult dated NJ Ex Order 26.4b1, Treatment: Ex Order 26.4B1, initial closed Ex Order 26.4B1 Procedure: Ex Order 26.4B1.

On 09/30/22 at 10:15 AM, Surveyor #3 interviewed Registered Nurse/Unit Manager (RN/UM) #1, who stated that if there was an injury of an unknown origin it would be initially investigated, an incident report would be done, interview who identified the injury, inspect the surroundings, written statements would be taken from all staff shifts going back 72 hours, the family and the physician would be notified. The incident would be discussed in morning meeting and depending on what the interdisciplinary team found, it would be reported to the New Jersey Department of Health (NJDOH). The family and the physician would be notified of the investigation results.

d. Resident #193 sustained Ex Order 26.4B1 including Ex Order 26.4B1 that occurred on Ex Order 26.4B1, and Ex Order 26.4B1 that resulted in transfer to the emergency room on Ex Order 26.4B1, which resulted in an Ex Order 26.4B1 There were no facility investigations.

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F 610	Continued From page 107 On 10/04/22 at 11:16 AM, the surveyor reviewed the entirety of the closed medical record for Resident #193 which was provided by the facility on Ex Order 26.4B1 and revealed the following: Dated Ex Order 26.4B1" and timed at 'Ex Order 26.4B1], Ex Order 2 ", "Resident found by aide Ex Order 26.4B1, on [his/he] Ex Order 26.4B1, no NJ Ex Order 26 Ex Order 26.4B1 NJ Ex Order 26.4b1 transferred resident back to bed and push bed towards wall, monitored through the night and signed by a Licensed Practical Nurse (LPN #1). There was no documented evidence that a documented physical assessment was completed. Dated Ex Order 26.4 " and timed at Ex Order 26.4B1 Ex Order 26.4B1 " Ex Order 26.4B1 , "after talking to Ex Order 26.4B1 heard resident yelling out 'Ex Order 26.4B1 [him/her] before has [sic.] bed Ex Order 26.4B1. Transfer back to bed and in w/c [wheelchair] out to nurses station ....No NJ Ex Order 26.4b1. Ex Order 26.4B1 and signed by LPN #1. There was no documented physical assessment for resident #193. A subsequent un-timed and un-dated NN revealed, " MD [physician] to be informed later of Ex Order 26 and also Ex Order 26.4B1 for Ex Order 26.4B1 signed by LPN #1. A subsequent NN un-timed and dated Ex Order 26.4B1 revealed "resident received in the hallway sitting in [his/her] wheelchair, Ex Order 26.4B1 (an Ex Order 26.4B1) initiated, no NJ Ex Order 26.4b1, resident was compliant with adl [activities of daily living] care and meds [medications], NJ Ex Order 26.4b1 [within normal limits], will continue to monitor"	F 610		

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signed by LPN #2. There was no documented evidence that the physician, or Ex Order 26.4B1 were notified of the Ex Order 26.4B1 that occurred on Ex Order 26.4B1.

Dated Ex Order 26.4B1 "Resident received awake and lying in bed. Around 8:30 A.M. was found by CNA [certified nurse aide] on the Ex Order 26.4B1. The CNA noted writer and resident was observed Ex Order 26.4B1 Ex Order 26. No NJ Ex Order 26.4b1. Resident remained in NJ Exec Order 26.4b1. Signed by LPN #2. A NN dated Ex Order 26.4B1 "Resident didn't return on the 7-3 shift and signed by LPN #2.

Dated Ex Order 26.4B1 and then continued on another page titled Interdisciplinary Progress Notes (IPN) revealed, Date and Time: TC 7-3 (No specific time documented) which revealed "this morning when one of the aide went into the residents room and found [him/her] Ex Order 26.4B1 , with Ex Order 26.4B1, on the Ex Order 26.4B1 and on Ex Order 26.4B1. I called his/her [Doctor] and was told to send NJ Exec Order 26.4b1 [he/she] was transported to the NJ Exec. at about Ex Order 26.4 [He/she] was sent with [his/her] face sheet and personal belongings and was signed by LPN.

On 10/04/22 at 3:22 PM, the surveyor conducted and interview with the U.S. FOIA (b)(6)) and inquired if there were any incidents or investigations for Resident #123 and she stated she will inquire.

On 10/04/22 at 4:18 PM, the surveyor, in the presence of another surveyor, inquired to the U.S. FOIA (b)(6)

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and U.S. FOIA (b)(6) if there were any investigations for Resident #193. The U.S. FOIA (b)(6) stated "no" there were no investigations that the facility was aware of.

On 10/05/22 at 9:56 AM, the surveyor interviewed the U.S. FOIA (b) regarding what the process was if a resident sustained an injury of unknown origin. The U.S. FOIA (b) stated it should be investigated and reported to the State. The surveyor inquired as to the documentation on Ex Order 26.4B1 regarding Resident # 193. The U.S. FOIA (b) stated, "we should have done a Ex Order 26.4B1 before they went out" to the hospital. The U.S. FOIA (b) stated she would want to know why the resident Ex Order 26.4B1. The U.S. FOIA (b) stated, "there should absolutely be specifics on the transfer sheet regarding the Ex Order 26.4B1 and how the resident was found", and the U.S. FOIA (b) stated, "it is imperative". The U.S. FOIA (b) also stated she would get a statement from the CNA. The U.S. FOIA (b) stated the hospital needed to know that information and she stated, "I would expect to see any additional information related to the resident, it doesn't end [the resident] going out". The U.S. FOIA (b) stated, "I would want to know what happened and they have to notify the responsible party and the doctor."

On 10/05/22 at 10:49 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding what the process was for injuries of unknown origin. The U.S. FOIA (b)(6) stated there should be an investigation for injuries of unknown origin.

On 10/05/22 at 3:57 PM, the U.S. FOIA (b)(6)), in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b), informed the surveyor that there were no investigations for

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Resident #193. The U.S. FOIA (b)(6) stated she had checked with the U.S. FOIA (b)(6) to look through her office and there was also nothing from the U.S. FOIA (b)(6) The U.S. FOIA (b)(6) stated 100% there should be an investigation completed for all Ex Order 26.4B1 or unusual occurrences.

On 10/05/22 at 4:05 PM, the surveyor inquired to the U.S. FOIA (b)(6) regarding any incidents, investigations or reportable events for Resident #193. The U.S. FOIA (b)(6) stated, "I have nothing" on Resident #193 and the U.S. FOIA (b)(6) stated that she and the U.S. FOIA (b)(6) could not locate any incidents or reportable event. The U.S. FOIA (b)(6) stated that Resident #193 Ex Order 26.4B1, and none of the information was found out, "nothing" was on the transfer note. The U.S. FOIA (b)(6) stated she was not aware that Resident #193 had any Ex Order 26.4B1 and was unsure why the resident's belongings were sent to the hospital. At that time, the surveyor requested a timeline of events for Resident #193 from the U.S. FOIA (b)(6)

On 10/06/22 at 10:00 AM, the U.S. FOIA (b)(6) provided the timeline for Resident #193. The U.S. FOIA (b)(6) stated that Resident #193 .... was transferred to the hospital on Ex Order 26.4B1 due to a change in Ex Order 26.4B1 and readmitted to the facility on Ex Order 26.4B1. The U.S. FOIA (b)(6) confirmed the Ex Order 26.4B1 occurred on Ex Order 26.4B1 and there were no investigations completed, and no incident reports were completed regarding the Ex Order 26.4B1 either. The U.S. FOIA (b)(6) confirmed there was no documented nursing physical assessment for the NJ Exec Order 26.4 that occurred on Ex Order 26.4B1 and the [redacted] on Ex Order 26.4B1.

10/06/22 at 10:31 AM, the U.S. FOIA (b)(6) stated to the surveyor that with any NJ Ex Order 26.4b1, an incident report with statements and a full head to toe investigation should have been completed.

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F 610	Continued From page 111 The following facility provided policies were reviewed: Accidents-Occurrence Investigation revealed All accidents will be investigated, documented and reported to the New Jersey Department of Health as appropriate. Definitions: Accident: refers to any unexpected or unintentional incident, which may result in injury or illness to a resident... Fall: refers to unintentionally coming to rest on the ground, floor or other lower levels, but not as a result of an overwhelming external force (i.e. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without an injury is still a fall unless there is evidence suggesting otherwise when a resident is found on the floor, a fall is considered to have occurred... Procedure: Responsibility Person responsible for area in which the accident occurred (Initiator). Action: Initiated the accident report and enters required information. Notifies RN/Clinical Care Manager; RN/Clinical Care Manager: Action: Investigates the situation and assesses the resident/patient, completes the "nurse" section of the Accident Report, Determines/implements immediate corrective action. Licensed Nurse RN/LPN: Notifies M.D. & Clinical Care Manager, Identifies relevant environmental risk factors, Notifies Plant Operations and/or housekeeping as appropriate, Documents the accident event and notification of family in the progress notes, Place resident/patient on 24 hour report x 72 hours, Documents resident/patient status in the progress notes X 72 hours, RN/CCM: Initiates/updates CCP with a new intervention, Clinical Care	F 610		

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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Manager: Reviews the accident report and other pertinent information with the interdisciplinary Team at morning report the following business day, RN/Clinical Care Manager: Initiates Incident report, Obtains statements from all staff, residents, visitors, volunteers present at the time of the accident, by the end of the shift, Obtains statements until a determination can be made as to the time of the accident, Clinical Care Manager: Reviews accident report, statements occurrence report, clinical record and surveillance data as indicated. Completes "Summary of Findings" and "Determination" regarding Abuse, Neglect, and Mistreatment, Initiates Corrective Action Plan, Notifies family/significant others of the findings of the Occurrence Investigation, Submits all documents to the A.D.N./D.N.S., D.N.S./A.D.N.: Reviews each case, relevant documents and the clinical record to validate findings and determine results, Forwards "original" accident reports to the Education Dept., DNS/ADN: Reviews significant injuries and injuries of unknown origin with the Administrative Team (Administrator/Associate Administrator/ Medical Director/Associate Medical Director), Administrative Team: Conducts root cause analysis, as needed, DON/Designee: Notifies DOH and other regulatory agencies as per regulations if: reasonable cause to suspect abuse, neglect and mistreatment has been determined, failure to follow the CCP, which resulted in resident injury, injuries of unknown origin.

A review of facility policy, "Abuse Prevention & Reporting" revised 5/20/22, Policy: 1. Residents of Atrium Center for Rehabilitation and Nursing will be protected from abuse, neglect, mistreatment, or misappropriation of property in

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accordance with State and Federal Regulations.
2. All alleged or suspected incidents of abuse, neglect, mistreatment, or misappropriation of residents' property will be thoroughly investigated, and findings documented in report format. 3. Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. 4. Allegations of abuse will be investigated in accordance with abuse and reporting guidelines.
Identification: 2. The facility will investigate all unusual incidents and all injuries of unknown origin.
Clues to help Identify Abuse: A. Physical Abuse Clues: Resident denies physical abuse however physical exam reveals...fractures.
Responsibility:
All non-licensed employees, Actions: 1. reports complaints and/or evidence of suspicion of abuse neglect injury of unknow origin or mistreatment to their supervisor immediately, 2. will complete written statements to aid in investigation.
All licensed employees, Actions: 1. Notifies their supervisor immediately, 2. Notifies Administration of same. 3. Will complete written statement to aid in investigation.
Nursing Supervisor/Social worker, Actions: 1. Obtains a statement from the resident in question, 2. Takes immediate necessary precautions/management pending complete investigation, 3. Interim case conference is held to develop interventions to ensure resident physical harm, pan, and/or anguish is minimized.
Administrator/DNA/Designee, Actions: 1. Will ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknow source ... are reported immediately to

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F 610	Continued From page 114 the administrator and/or representative and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), 2. Will ensure that the results of all investigations are reported to the administrator ...within 24 hours of the incident. Allegation of Abuse, neglect, exploitation or mistreatment and injuries of unknow source, Action: 1. All alleged violations of abuse are to be reported immediately but no later that 2 hours if the alleged violation involve abuse or results in serious bodily injuries. NJAC 8:39 4.1 (a)(5), 27.1(a)(b)	F 610		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		12/5/22

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discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 116 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and or the resident's representative	F 623	1. Immediate Action a. Resident # 86 was provided written notice of transfer. Resident returned from the hospital and currently resides in the	

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F 623	Continued From page 117 written notification of the reason for transfer to the hospital and also send a copy to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 resident's (Residents #86 and #193) reviewed for hospitalization. This deficient practice was evidenced by the following: On 09/22/22 at 09:49 AM, the surveyor reviewed Resident #86's medical record which revealed a Progress Note (PN), dated [NJ Exec Order 26] that indicated that the resident was transferred to the hospital. A PN, dated [NJ Exec Order 26], indicated that Resident #86 returned to the facility from the hospital on that date. There was no documented evidence of written notification to the resident or resident's representative and the Ombudsman of the reason for transfer to the hospital. On 09/28/22 at 01:16 PM, during surveyor interview, the [US FOIA (b)(6)] stated that the nurse would notify the family when a resident was transferred to the hospital. She added that she did not know who would provide the written notification to the family. She then stated that she was not sure who would notify the Ombudsman. On 09/30/22 at 11:00 AM, during surveyor interview, the [US FOIA (b)(6)]) stated that the facility had not been sending a written notification to the resident or resident's representative and the Ombudsman of the reason for transfer to the hospital. She added that the DSS was not aware that she was the person that was supposed to send out the notification. The surveyor had previously asked the [US FOI] if there was a policy regarding the	F 623	facility b. Resident # 193 was discharged to hospital on [NJ Exec Order 26.4], resident did not return from the hospital and does not currently reside at the facility c. Staff received immediate education on notice requirements before transfer or discharge 2. Identification of Others a. Any resident being transferred or discharged has the potential to be affected by the deficient practice b. All transfers and discharges were from 10/12/2022 to date have been identified and provided a written notice of discharge/transfer. c. Written notice of discharge/transfers have been uploaded to each resident's electronic health record d. The Ombudsman has been provided a list of all residents who have been discharged or transferred from 10/12/22 to date 3. Systemic change a. A policy for notice requirements before discharge/transfer has been written in accordance with federal regulations. Staff received education on notice requirements before discharge/transfer and the policy has been implemented. b. Director of nursing/designee will provide written notification to resident or their representative when appropriate when resident I transferred or discharged. c. Resident discharges/transferred will be reviewed by IDT in daily clinical meeting to ensure compliance with facility	

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F 623	Continued From page 118 notification. The [NJ Exec] stated that the facility did not have a policy. On 09/30/22 at 11:23 AM, during surveyor interview in presence of the [NJ Exec], the DSS confirmed that she had not sent written notification to the resident or family or the Ombudsman of the reason for transfer to the hospital. On 10/04/22 at 11:16 AM, the surveyor reviewed Resident #193's closed medical record which revealed a PN, dated [NJ Exec Order 26.4] that the resident was transferred to the hospital. Resident #193 did not return to the facility. There was no documented evidence of written notification to the resident or resident's representative and the Ombudsman of the reason for transfer to the hospital. The facility was unable to provide the survey team any documented evidence that written notification to the resident or resident's representative and the Ombudsman for Resident #86 and Resident #193. On 10/07/22 at 10:49 AM, during surveyor interview, the [U.S. FOIA (b)(6)] stated that there was no written notification to the resident or family and ombudsman and that there should have been. On 10/07/22 at 11:29 AM, during surveyor interview, the [U.S. FOIA (b)(6)] stated that there should have been written notification to the resident or family and ombudsman. On 10/07/22 at 01:36 PM, in the presence of the	F 623	policy 4. Quality assurance The director of social services /designee will audit all resident transfers and discharges weekly for compliance with facility policy and to ensure the provision of written notice. Negative audit findings will be corrected immediately. Audit results will be communicated to the QAPI committee monthly for review and further recommendations. The first of which will take place in December 2022.	

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F 623	Continued From page 119 survey team and the [redacted], the [redacted] confirmed that the facility did not have a policy regarding written notification of the reason for transfer to the hospital or notification of the Office of the State Long-Term Care Ombudsman. N.J.A.C. 8:39-4.1(a)31,32	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		12/5/22

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F 625	Continued From page 120 This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for 2 of 2 resident's (Resident #86 and #193) reviewed for hospitalizations. This deficient practice was evidenced by the following: On 9/22/22 at 09:49 AM, the surveyor reviewed Resident #86's medical record which revealed a Progress Note (PN), dated [NJ Exec Order], that indicated that the resident was transferred to the hospital. A PN, dated [NJ Exec Order 26.4] indicated that Resident #86 returned to the facility from the hospital on that date. There was no documented evidence of written notification to the resident or resident's representative of the facility's bed hold policy prior to transfer to the hospital. On 09/28/22 at 01:16 PM, during surveyor interview, the [U.S. FOIA (b)(6)] stated that the admissions department would provide the notification of the bed hold policy. On 09/28/22 at 01:19 PM, during surveyor interview, the [U.S. FOIA (b)(6)]) stated that she was not aware that the admissions department provided the bed hold notification. She added that she would try to find out who provided it. On 09/29/22 at 10:42 AM, during surveyor interview, the [US FOIA] stated that upon admission the	F 625	1. Immediate Action a. Resident #86 was transferred to the hospital on [NJ Exec Order 26.4b] and returned to the facility on [NJ Exec Order 26.]. The resident currently resides in the facility b. Resident #193 was transferred to the hospital on [NJ Exec Order 26.4b] and did not return to the facility. The resident does not currently reside at the facility c. Notice of Bed hold policy before/upon discharge was reviewed and revised to ensure compliance with federal regulations d. Social Service, licensed and unlicensed nursing staff and department heads was provided education on the bed hold policy before/upon discharge 2. Identify Other a. All residents transferred have the potential to be affected by the deficient practices 3. Systemic Change a. A facility bed hold policy before/ upon transfer was written and implemented b. Social Service, licensed and unlicensed nursing staff and department heads was provided education on the bed hold before/ upon transfer policy c. All residents transferred were reviewed and resident/representatives who had not returned to the facility have been provided with the bed hold policy 4. Quality Monitoring An audit tool was created to monitor transfers to ensure compliance with facility policy and federal/state requirement for bed hold notification	

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F 625	Continued From page 121 bed hold policy is reviewed. She added that when a resident is transferred to the hospital, the written notification should be sent out by the Social Services department. On 09/30/22 at 11:00 AM, during surveyor interview, the U.S. FOI stated the facility had not been sending written notification of the bed hold policy prior to transfer to the hospital. She added that the U.S. FOIA (b) was not aware that she was the person that was supposed to send out the notification. On 09/30/22 at 11:23 AM, during surveyor interview in the presence of the U.S. FOIA (b)(6) confirmed that she had not sent written notification of the bed hold policy prior to hospitalization. On 10/04/22 at 11:16 AM, the surveyor reviewed Resident #193's closed medical record which revealed a PN, dated NJ Exec Order 26, that the resident was transferred to the hospital. Resident #193 did not return to the facility. There was no documented evidence of written notification to the resident or resident's representative of the facility's bed hold policy prior to transfer to the hospital. The facility was unable to provide the survey team any documented evidence that written notification to the resident or resident's representative of the facility's bed hold policy prior to transfer to the hospital for Resident #86 and Resident #193. On 10/07/22 at 10:49 AM, during surveyor interview, the U.S. FOIA (b)(6) stated that there was no written notification to the resident or family about the bed	F 625	before/upon discharge. The Director of Social Service/designee will conduct weekly audits on all residents discharged or transferred from the facility. Audit results will be reported to QAPI on a monthly basis times 6 months. The first of which will take place in December 2022. Based on the results of these audits, The QAPI committee will review audit results and make further recommendations.	

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hold policy prior to transfer to the hospital and that there should have been.

On 10/07/22 at 11:29 AM, during surveyor interview, the U.S. FOIA (b)(6) [redacted] stated that there should have been written notification to the resident or family of the bed hold policy prior to transfer to the hospital.

A review of the facility provided policy titled, "Bed Hold Policy," with a reviewed date of 5/26/22, included the following:
Medicaid Residents
Medicaid recipients who reside in the facility and who require hospitalization on a physician's order the Should said resident return within 30 days the facility will continue the use of the previous chart.
Private Residents
Private paying residents or their responsible parties may authorize the facility to retain their beds pending their return from the hospitalization. By authorizing the bed hold the responsible party assumes the financial responsibility until the resident returns to the facility or the responsible party gives 14 days discharge notice.
Upon admission to the hospital, the responsible parties of private paying residents shall be informed by telephone and will be asked to authorize a bed hold. If authorized, the bed hold will remain in effect until the resident returns or until appropriate notice is given.
A facility representative will follow up with the resident or resident representative via a telephone conversation in regards to the bed hold policy.
The policy did not contain information regarding written notification of the facility's bed hold policy prior to transfer to the hospital.

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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 625	Continued From page 123 N.J.A.C. 8:39-5.1 (a)	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 636		12/5/22

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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F 636	Continued From page 124 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a comprehensive Minimum Data Set Assessment (MDS), an assessment tool, as required for 2 of 20 residents (Resident #10 and #248), system selected for MDS over 120 days and was evidenced by the following: On 9/27/22 at 11:52 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the U.S. FOIA (b)(6) resigned "about three weeks ago" and that the U.S. FOIA (b)(6) was now responsible for completing the MDS assessments. The U.S. FOIA (b) further stated that the	F 636	1. Corrective Action: Upon identification, MDS assessments were completed for resident #10 and resident #248. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: An audit was completed by regional MDS to determine any additional MDS assessments that have not been completed per the MDS schedule.	

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F 636	Continued From page 125 Regional MDS coordinator was only in the facility, "once in a while" but usually communicated via email. The surveyor asked the U.S. FOIA (b) how often the MDS assessments should be completed. The U.S. FOIA (b) replied, "quarterly, annually and for changes in the resident's condition." On 9/28/22 at 1:02 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she had been the facility's U.S. FOIA (b)(6) since NJ Exec Order 26.4b1, and the in-house facility U.S. FOIA (b)(6) for "about five weeks." The U.S. FOIA (b)(6) stated that she was in the facility once weekly and that she completed the MDS for all the residents upon admission, quarterly, annually, and if there was a significant change. The U.S. FOIA (b)(6) stated that each assessment had an assessment reference date (ARD) and the facility completed a seven-day look-back period from that date. The facility had fourteen days to complete the assessment from the ARD and then they had an additional seven days to submit the assessment. At this time, the U.S. FOIA (b)(6) stated that not all of the MDS assessments were completed because the in-house facility MDS coordinator resigned so she was trying to play catch up. The U.S. FOIA (b)(6) acknowledged that as the U.S. FOIA (b)(6), it was her responsibility to ensure that the facility's MDS coordinator completed the MDS assessments within the requirements of the Centers for Medicare and Medicaid Services. The MDS coordinator stated that there were late and incomplete MDS assessments, and she was trying to put everything in order. At this time, the surveyor and US FOIA (b)(6)	F 636	An MDS interim team has been secured to complete outstanding MDS assessments and will be completed by: 12/6/22 while the facility actively recruits for the open position Monthly audits of scheduled MDS will be completed by the facility RNAC (Registered Nurse Assessment Coordinator) and/or designee to assure timely completion 4. How Will These Actions Be Measured: The facility RNAC will submit monthly audit results to the QAPI committee on a monthly basis for 6 months. The first of which will take place in December 2022. Based on the results of these audits, The QAPI committee will review audit findings and make further recommendations	

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F 636	Continued From page 126	F 636		

reviewed the Electronic Medical Record (EMR) for the twenty-system selected MDS assessments over 120 days not completed for each of the system-selected MDS which revealed that two residents did not have a completed comprehensive MDS as follows:

1.) Resident # 10's last completed MDS was a quarterly dated [NJ Exec Order 26]. The next comprehensive annual ARD was [NJ Exec Order 26], which was not completed.

2.) Resident # 248's Admission ARD was [NJ Exec Order 26], which was not completed.

At this time, the U.S. FOIA (b)(6) acknowledged the above MDS assessments were not completed, and that the facility was behind on MDS assessments.

A review of the Facility Policy, Resident Assessment Instrument (RAI) Process, reflected that the facility complies with the existing federal and state regulations governing the implementation of the RAI process as a basis for the provision of quality care to its residents. The purpose is to outline the procedure of identifying and addressing residents' strengths and needs through the RAI process. The MDS department will schedule MDS assessments, Care Area Assessment, and Care Planning in accordance with the current requirements of the Centers for Medicare and Medicaid Services. Members of the Interdisciplinary Care Team shall endeavor to complete their respective MDS sections on or before the End Date.

On 10/12/22 at 12:40 PM, the U.S. FOIA (b)(6)

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F 636	Continued From page 127 acknowledged the facility was behind on MDS assessments. No further information was provided by the facility.	F 636		
F 638 SS=E	N.J.A.C. 8:39-11.1 Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set Assessment (MDS), an assessment tool, as required for 6 of 20 residents (Resident #8, #12, #13, #14, #26 and #34) system selected for MDS over 120 days and was evidenced by the following: On 9/27/22 at 11:52 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the U.S. FOIA (b)(6) resigned "about three weeks ago" and that the U.S. FOIA (b)(6) was now responsible for completing the MDS. The U.S. FOIA (b)(6) further stated that the U.S. FOIA (b)(6) was only in the facility, "once in a while" but usually communicated via email. The surveyor asked the U.S. FOIA (b) how often the MDS should be completed. The U.S. FOIA (b) replied, "quarterly, annually, and for changes in the resident's condition."	F 638	1. Corrective Action: Upon identification, MDS assessments were completed for residents #8, #12, #13, #14, #26 and34. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: An audit was completed by facility RNAC (Registered Nurse Assessment Coordinator) to determine any additional MDS assessments that have not been completed per the MDS schedule. An MDS interim team has been secured to complete outstanding MDS assessments and will be completed by: 12/6/22 while the facility actively recruits for the open position	12/6/22

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F 638	Continued From page 128 On 9/28/22 at 1:02 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she had been the facility's NJ Exec Order 26.4b1 since NJ Exec Order 26.4b1, and the in-house facility US FOIA (b)(6) for "about five weeks." The U.S. FOIA (b)(6) stated that she was in the facility once weekly and that she completed the MDS for all the residents upon admission, quarterly, annually, and if there was a significant change. The U.S. FOIA (b)(6) stated that each assessment had an assessment reference date (ARD) and the facility completed a seven-day look-back period from that date. The facility had fourteen days to complete the assessment from the ARD and then they had an additional seven days to submit the assessment. The U.S. FOIA (b)(6) further stated that not all of the MDS assessments were completed because the in-house facility U.S. FOIA (b)(6) resigned, and the facility had not hired another MDS coordinator, so she was trying to play catch up. At this time, the US FOIA (b)(6) acknowledged that it was her responsibility to ensure that the facility US FOIA (b)(6) completed the MDS assessments in accordance with current Centers for Medicare and Medicaid Services requirements. The MDS coordinator stated that there were late and incomplete MDS assessments, and she was trying to put everything in order. At this time, the surveyor and US FOIA (b)(6) reviewed the Electronic Medical Record (EMR) for the twenty-system selected MDS assessments over 120 days not completed for each of the system-selected MDS which revealed that six residents did not have a completed	F 638	The Facility RNAC (Registered Nurse Assessment Coordinator) and/or designee audits of MDS will be completed monthly to assure compliance with assessment calendar by 4. How Will These Actions Be Measured: Audit findings will be submitted to the Quality Assurance and Process improvement committee monthly x 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 638	Continued From page 129	F 638		

quarterly MDS as follows:

1. Resident #12's last completed MDS was a quarterly dated [NJ Exec Order 26]. The next ARD was [NJ Exec Order 26.4] which was not completed.

2. Resident #8's last completed MDS was a quarterly dated [NJ Exec Order 26]. The next ARD was [NJ Exec Order 26.4] which was not completed.

3. Resident #26's last completed MDS was a quarterly dated [NJ Exec Order 26]. The next ARD was [NJ Exec Order 26], which was not completed.

4. Resident #13's last completed MDS was a quarterly dated [NJ Exec Order 2]. The next ARD was [NJ Exec Order 26.4] which was not completed.

5. Resident #14's last completed MDS was a quarterly dated [NJ Exec Order 26.4]. The next ARD was [NJ Exec Order 26], which was not completed.

6. Resident #34's last completed MDS was a quarterly dated [NJ Exec Order 26.4]. The next ARD was [NJ Exec Order], which was not completed.

At this time, the [US FOIA (b)(6)] acknowledged the above MDS assessments were not completed, and that the facility was behind on MDS assessments.

A review of the Facility Policy, Resident Assessment Instrument (RAI) Process, reflected that the facility complies with the existing federal and state regulations governing the implementation of the RAI process as a basis for the provision of quality care to its residents. The purpose is to outline the procedure of identifying and addressing residents' strengths and needs

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F 638	Continued From page 130 through the RAI process. The MDS department will schedule MDS assessment, Care Area Assessment, and Care Planning in accordance with the current requirements of the Centers for Medicare and Medicaid Services. Members of the Interdisciplinary Care Team shall endeavor to complete their respective MDS sections on or before the End Date. On 10/12/22 at 12:40 PM, the U.S. FOIA (b)(6) [redacted] acknowledged the facility was behind on MDS assessments. No further information was provided by the facility.	F 638		
F 656 SS=E	N.J.A.C. 8:39-11.1 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		12/6/22

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F 656	Continued From page 131 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 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 develop and revise a person-centered comprehensive care plan to: a.) address a resident's EX Order 26.4B1 and EX Order 26.4B1 (Resident #63); b.) specify supervision required for residents at risk for EX Order (Resident #24 and #13); and c.) update the care plan, identify steps to be implemented to manage the behavior of residents with history of EX Order 26.4B1 NJ Ex Order 26.4 and prevent them from attempting to engage in EX Order 26.4B1 (Resident #63 and #8), for 4 of 35 residents reviewed for person-centered care plans. Findings included:	F 656	1. Immediate action a. Resident # 63 has been transferred and does not currently reside at the facility b. Resident # 24's care plan and tasks have been reviewed and revised to address current care needs c. Resident # 13's care plan and tasks have been reviewed and revised to address current care needs d. Resident # 8 has been transferred and no longer resides at the facility e. Interdisciplinary staff member was re-educated on development and implementation of comprehensive care plans	

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F 656	Continued From page 132 Refer F600 a. On 09/21/22 at 10:40 AM, Surveyor #1 toured the [redacted] locked unit and observed Resident #63 lying in bed; he/she was awake and alert. He/she reported to the surveyor that he/she had a [redacted], the surveyor left the room and informed the nurse. Surveyor #1 reviewed Resident #63's medical record on [redacted] which revealed the following: According to the Admission Face Sheet, Resident #63 was admitted to the facility with diagnoses which included [redacted] The Admission Minimum Data Set (MDS) a resident assessment document dated [redacted] included that Resident #63 had displayed some [redacted]. The Quarterly MDS dated [redacted], revealed that Resident #63 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had [redacted]. Section E which addressed behavior indicated that Resident #63 had [redacted]. On 09/21/22 at 11:45 AM, an interview with the Temporary Nursing Assistant (TNA #1) who cared for Resident #63 revealed, that Resident #63 required [redacted] with care, was able to [redacted] but at times would use the wheelchair to self-propel in the hallway. On 09/22/22 at 12:45 PM, Surveyor #1 observed Resident #63 in bed, awake and alert and did not have any [redacted].	F 656	f. All residents care plans were reviewed any identified deficiencies were corrected 2. Identification of Others All residents residing in the facility have the potential to be affected by the deficient practice 3. Systemic changes a. The facility policy for comprehensive care plans was reviewed. Interdisciplinary team members will be re-educated on comprehensive care plan policy. b. Care plan will be reviewed, by the interdisciplinary care team, in accordance with facility policy and federal regulation. c. Care plans will be reviewed and revised, by the interdisciplinary care team, in accordance with changes in resident's condition and in accordance with federally mandated assessment schedule. 4. Quality assurance monitoring The director of nursing/designee and unit manager will audit care plans weekly to ensure compliance with facility policy. weekly audit results will be submitted to QAPI x 6 months. Audit results will be reported to the QAPI committee on a monthly basis for review and further recommendations. The first of which will take place in December 2022.	

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On 09/23/22 at 1:30 PM, Surveyor #1 reviewed Resident #63's Baseline Care Plan dated [redacted] which identified Resident #63 as a [redacted] risk and having [redacted] of engaging in [redacted] with others. The intervention was to separate and place on EX Order 26.4B1 observation.

Resident #63's Comprehensive Care Plan initiated on [redacted] was reviewed. The Comprehensive Care Plan did not include a focus nor interventions in place for the management of [redacted] or [redacted]. There was no identified focus, goals or interventions related to the [redacted] of being [redacted] with male/female residents and being [redacted] with other residents. The [redacted] was not addressed in the care plan. There was no directive in place for the staff to manage the [redacted] The inappropriate [redacted] was not addressed as a concern. There were no specific interventions in place to supervise Resident #63. Four direct care staff confirmed that Resident #63 displayed [redacted] toward [redacted] male/female residents on the locked unit. None of the observed [redacted] reported were documented or addressed in the plan of care.

On 09/26/22 at 1:43 PM, TNA #1 reported that on [redacted] Resident #63 was involved in [redacted] with Resident #10. Resident #63 was observed to have exited Resident #10's room. Resident #10 was an [redacted] resident.

On 09/27/22 at 8:38 AM, another surveyor interviewed (CNA #2) who recounted the same

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story and informed the survey team that the administrative staff was aware of the incident and did not ask staff to provide statements.

On 09/27/22 at 11:04 AM, an interview with CNA #1 who worked the [redacted] unit the day of the incident, confirmed the alleged [redacted].

On 09/27/22 at 12:30 PM, Surveyor #1 reviewed Resident #63's electronic Progress Notes (PN) and could not identify any entry pertaining to the above incident. There was no entry regarding the incident in Resident #63's medical record. The Care Plan was not revised to include the incident.

On 09/27/22 at 12:45 PM, Surveyor #1 reviewed the PN (not clinical notes) On top of the pages it said (clinical Notes) dated [redacted], which documented, "Resident # 63 was involved in a NJ Exec Order 26.4b1 with the roommate. Resident #63 found the roommate laying in his/her bed, NJ Exec Order 26.4b1. The staff heard noise emerging from the room, the CNA attempted to separate the two residents, Resident #63 NJ Exec Order 26.4b1 and sustained NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Resident #63 continued to be EX Order 26.4B1 with staff. The physician and the nursing supervisor were notified."

No documentation of any follow up done after the incident was entered in the Progress Notes. The documentation did not indicate that Resident #63 was being monitored after the incident, or that NJ Exec NJ Exec Order 26.4b1 was initiated as reflected in the Baseline Care Plan.

Surveyor #1 continued to review the PNs and noted another entry dated NJ Exec Order 26.4b1 which

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documented that Resident #63 [redacted] resident [redacted]. When asked what had happened, Resident #63 stated, [redacted]

The [redacted] was not addressed in the plan of care. There was no indication that the Interdisciplinary Team convened and discussed with the direct care staff measures to prevent Resident #63 from being [redacted] toward other residents.

On 09/29/22 at 10:15 AM, Surveyor #1 reviewed the above PNs with the [redacted]) and requested the investigative reports for review. The [redacted] stated that she was not aware of the above incidents and would look for the investigative reports. The surveyor then requested the Care Plan policy for review.

On 9/29/22 at 10:46 AM. the [redacted] stated she could not locate any investigation and no additional information was provided. The [redacted] provided the care plan policy for review.

The facility did not revise and implement any interventions in the Care Plan after the above incidents.

b. Surveyor #1 reviewed Resident #24's medical record on [redacted] which reflected that Resident #24 had diagnoses which included but were not limited to: [redacted].

The Quarterly MDS assessment dated [redacted], reflected that Resident #24 was [redacted] [redacted]. Resident #24 was [redacted]

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NJ Ex Order 26.4b1 on staff for all Activities of Daily Living (ADL's).

A review of the plan of care dated NJ Ex Order 26.4b1 included a focus for [redacted] and documented the following: "I am at risk for [redacted] based on score risk of [redacted]". The goal was for Resident #24 to be free from NJ Ex Order 26.4b1 related to [redacted] Resident #24 [redacted] interventions included:

We will maintain a clutter free environment.
We will bring you to the dayroom during the day for closer supervision.
We will not leave you in the room and on toilet.
We will place you in high visibility area while you are awake.

On 09/23/22 at 10:30 AM, an interview with TNA #4 who cared for Resident #24, stated that Resident #24 was [redacted] and NJ Ex Order 26.4b1 on staff for care. The CNA stated that Resident #24 was a [redacted].

On 09/24/22 at 9:47 AM, surveyor #1 further reviewed the PNs which revealed that Resident #24 [redacted] at the facility on the following dates: [redacted]. The following were documented:

NJ Ex Order 26.4b1 at 4:36 PM, patient [redacted] during the last part of day shift. NJ Ex Order 26.4b1 noted. The physician was notified. [redacted] implemented. Patient is NJ Exec Order 26.4b1.

NJ Ex Order 26.4b1 at 3:07 PM, Resident #24 attempted to walk between the [redacted] and NJ Exec Order 26.4b1 sign, then NJ Exec Order 26.4b1 and [redacted] NJ Ex Order 26.4b1 noted. Family and Nurse Practitioner notified.

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F 656	Continued From page 137 On 09/22/22 at 9:49 AM, surveyor #1 observed Resident #24 [redacted] on the locked unit very [redacted] No staff attempted to redirect him/her into the dayroom for activities. On 09/26/22 at 11:35 AM, surveyor #1 observed Resident #24 [redacted] in the hallway, entering other resident's room. On 09/28/22 at 10:30 AM, surveyor #1 requested the incident reports for the [redacted] from the [redacted]. The [redacted] stated that she was not aware of the [redacted]. The surveyor reviewed the PNs with the [redacted] who stated she would locate the incident reports. On 10/04/22 at 1:45 PM, the [redacted] stated that she could not locate the incident reports. A review of the Care Plan with the [redacted] lacked evidence that the care plan was revised, and meaningful interventions were implemented to keep Resident #24 safe. c. On 09/27/22 at 11:00 AM, surveyor #1 reviewed the clinical record of Resident #13 which reflected that Resident # 13 was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 [redacted] The Quarterly MDS with an assessment Reference date of [redacted], revealed that Resident #13 was Ex Order 26.4B1 [redacted]. Resident #13 received a score of [redacted] on the [redacted] Resident #13 was NJ Ex Order 26.4b1 on staff to meet his/her needs in bed mobility, transfer, toilet use, eating and dressing.	F 656		

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The clinical record further revealed that Resident #13 sustained [redacted] at the facility on [redacted]. Resident #13 was identified as being at [redacted] for [redacted]. Resident #10 received a score of [redacted] on the [redacted] Assessment. The causal factor identified: "Resident[redacted] The Care Plan was not revised to implement specific interventions and provide [redacted] to the direct care staff on how to keep Resident #13 safe. Resident #13 sustained another [redacted] on [redacted]. Resident #13 was [redacted] in the room, sustained a [redacted] and had to be transferred to the hospital for evaluation.

d. On 09/27/22 at 10:45 AM, Surveyor #2 observed Resident #08's room closed. The surveyor knocked on the Resident's door and was invited to enter by Resident #08. The surveyor observed Resident #08 lying in bed and conversational.

At that time, during an interview with Surveyor #2, Resident #08 stated he/she was [redacted] Resident #08 also stated that the reason for the transfer to this facility was because the previous facility was for [redacted].

On 9/29/22 at 2:23 PM, the surveyor verified the [redacted] website which revealed Resident #08 was a [redacted].

On 09/30/22 at 10:20 AM, during an interview with the survey team, the [redacted] stated the family representative for Resident #08 had informed them (the facility) that

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Resident #08 was Ex Order 26.4B1 and was in search of the verifiable documents. The U.S. FOIA (b)(6) informed the surveyors that she would reach out to the Resident's US FOIA (b)(6) The Regional U.S. FOIA (b)(6) stated that Resident #08 was not being transferred to a different facility but was monitored. The U.S. FOIA (b)(6) could not further define the parameters of monitored for Resident #08.

A review of the Admission Record revealed the resident was admitted from [redacted] Nursing Home on Ex Order 26.4B1. The nearest relative reflected no visitors listed/county should be contacted and the address listed was [redacted] correctional facility.

A review of the Nursing Admission Assessment dated NJ Ex Order 26.4b1, revealed the resident was independent with mobility using a wheelchair and had no risk for [redacted] on previous admission/home. Further review of the form under section NJ Ex Order 26.4b1 reflected 0 errors which indicated the resident had NJ Exec Order 26.4b1.

A review of the Physician Order Activity Detail Report (PO) for Ex Order 26.4B1 reflected that the resident had diagnoses which included Ex Order 26.4B1 [redacted]

On 10/04/22 at 10:10 AM, Surveyor #2 requested all of the admission documents from the U.S. FOIA (b)(6) [redacted]).

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On 10/04/22 at 12:41 PM, during an interview Surveyor #2, the [redacted] stated that [redacted] were completed the next day and weekend admissions were completed the following Monday. The [redacted] informed the surveyor that for existing residents, their [redacted] Annual/Reassessments were completed quarterly along with the Resident's Care Plan.

At that time, the [redacted] stated she had known that Resident #08 was a [redacted] since [redacted] which she learned from the previous [redacted]. [redacted] admitted to doing nothing with the information she received. The [redacted] stated she was concerned for Resident #08's privacy and acknowledged she should have been equally concerned with the other Resident's safety. The [redacted] stated she should have informed her Superiors, informed the clinical team and care planned Resident #08.

On 10/04/22 at 12:47 PM, Surveyor #2 requested for all the documents pertaining to all social worker assessments [redacted] from the [redacted].

On 10/5/22 at 9:38 AM, Surveyor #2 requested for all of Resident #08's [redacted] and care plans from the [redacted].

On 10/05/22 at 1:50 PM, during an interview with Surveyor #2, the [redacted] stated she was unable to locate the [redacted] /Initial [redacted] and Admission care plan.

A review of the [redacted] revealed
-Admission/Initial assessment, was not provided,

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F 656	Continued From page 141 lost. -First quarter/Reassessment after admission, was not provided, lost. NJ Ex Order 26.4b1 no Ex Order 26.4B1 that addressed Resident was a Ex Order 26.4B1 Ex Order 26.4B1 r. NJ Ex Order 26.4b1 - Ex Order 26.4B1 no Ex Order 26.4B1 that addressed Resident was a Ex Order 26.4B1 Ex Order 26.4B1 A review of the Care Plan (CP) Activity Report marked with a status of active, printed on Ex Order 26.4B1 did not include a focus, goals and interventions for Resident #08's Ex Order 26.4B1 History as a Ex Order 26.4B1 . On 10/06/22 at 10:25 AM, during an interview with Surveyor #2, the U.S. FOIA (b)(6) informed the surveyor that Resident #08 should have been care planned from admission under social history or social services assessment. On 10/06/22 at 11:37 AM, during an interview with Surveyor #2, the U.S. FOIA (b) stated that the social worker was responsible for obtaining Resident #08's Ex Order 26.4B1 history assessment during admission on Ex Order 26.4, which should have triggered the inclusion of a focus on history of NJ Exec Order 26.4b1 within the care plan. The U.S. FOIA (b) confirmed that the resident should have been care planned and was not. The U.S. FOIA (b) acknowledged that there were at least four opportunities to have developed, revised and/or updated Resident #08's care plan. On 10/12/22 at 12:40 PM, in the presence of the survey team the U.S. FOIA (b)(6)) confirmed no additional information could be provided.	F 656		

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The facility policy dated 01/05/22 and titled, "Policy and procedure for Care Planning " reflected that the policy of the facility is to provide an individualized comprehensive care plan for each resident based on assessments done at the time of admission, quarterly, annually and when there is a change in condition.
Purpose: To ensure that the residents plan of care is reflective of the current condition and needs of the resident.

The facility failed to develop and implement meaningful interventions to care for the residents based on their assessed needs. The policy was not being followed.

The facility was made aware of the above findings on 10/04/22 and 10/11/12 and no additional information was provided on the exit day.

A review of the facility provided, "Care Planning" last reviewed 5/26/22 include but was not limited to the following:
Policy: It is the policy of ___ [redacted] Rehabilitation and Care Center __to provide an individualized comprehensive care plan (CCP) for each resident based on assessments done at the time of admission, quarterly, annually, and when there is a significant change in condition.
Purpose: To ensure that the residents plan of care is reflective of the current condition and needs of the resident.
General Information:
-A comprehensive care plan will be written for all new admission.
-A new care plan will be initiated for significant change if the current care plan is more than 12

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F 656	Continued From page 143 months old OR if the CCP does not reflect the current needs of the resident. -Care plan will be listed on the front cover of the CCP sheet with the initiation and discontinuation date of each care plan. Procedure: Individual, Registered Nurse Responsibility 2. Based on the above assessment, will initiate or update the care plan to reflect raps that were triggered by the initial assessments. Individual, All disciplines Responsibility 9. Formulates care plan for specific discipline on Admission, quarterly, significant change, return from the hospital and as needed with change in condition. N.J.A.C. 8:39-11.2 (e) 1 (h)	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide residents with the care needed to meet the resident's assessed needs. This deficient practice was identified for 2 of 19 residents reviewed for care, (Resident #48 and #54) was evidenced by the following: On 09/21/22 at 10:20 AM, during the initial tour of	F 677	1. Corrective Action: Upon identification, the rooms for resident #48 and resident #54 were terminally [redacted] were discarded and replaced with new ones. [redacted] services were administered to these rooms on [redacted]. Extra towels, linens and wash clothes were provided to	12/5/22

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F 677	Continued From page 144 the locked Ex Order 26.4 unit, the surveyor observed Resident #48 in their room, the room had a Ex Order 26.4B1 . NJ Exec Ord were noted in the room, the mattress was Ex Order 26.4B1 On 09/21/22 at 11:00 AM, an interview with LPN # 6 assigned to the EX Order 26.4 unit low side, revealed that all residents on the low side were NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . The U.S. FOIA could not comment if Resident #48 was on a NJ Exec Order 26.4 program or what had been done to address the NJ Exec Order 26.4b1 . On 09/21/22 at 11:01 AM, the surveyor interviewed the U.S. FOIA (b)(6) assigned to the Ex Order 26.4 Unit, she stated that she reported to work at 7:00 AM daily, her role was to remove the trash, clean the dining room, the nursing station, and the shower rooms. She stated that she would clean the rooms (resident) after breakfast. She stated she was not informed of any particular room that needed to be cleaned and disinfected daily. On 09/21/22 at 11:55 AM, an interview with a Temporary Assistant (TNA #2) revealed that they did not have enough linen, towels, wash cloths to care for the residents. TNA #2 stated that she discussed the concern with the U.S. FOIA (b)(6) . TNA #2 stated that she had been employed at the facility since NJ Exec Order 26.4b1 On 09/23/22 at 7:01 AM, during an interview with the 11:00 PM-7:00 AM Licensed Practical Nurse (LPN #4) who cared for the residents on the 11:00 PM-7:00 AM shift, she stated that her role was to ensure that all residents that were	F 677	the floor to provide care to the residents. Updated resident #54 and #48 plan of care to include NJ Exec Order 26.4b1 management interventions 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: The facility reviewed and re-educated staff on the policy for providing care to dependent residents Facility created and implemented a policy for clinical walking rounds on each shift to ensure timely assessment and intervention of dependent resident needs by unit manager/designee interdisciplinary rounds (Guardian Angel rounds) were implemented to monitor and facilitate timely resident care and environmental cleanliness. Daily environmental rounding on all resident rooms by the director of Environmental Services/designee to assess for cleanliness, odors, and the need for pest control Rooms identified as needing more frequent housekeeping attention were addressed with a modified cleaning schedule Rooms identified with contaminated flooring secondary to incontinence, had flooring replaced The facility policy for terminal cleaning of resident rooms was reviewed and revised and Environmental Services team was in-serviced Inventory level audit completed with	

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F 677	Continued From page 145 EX Order 26.4B1 were up and changed during the shift. LPN #4 confirmed that the EX Order 26.4B1 were EX Order 26.4B1. When asked if EX Order 26.4B1 care was provided, she did not have any comment. On 09/23/22 at 7:19 AM, the surveyor interviewed CNA #3 assigned to the EX Order 26.4 Unit, she stated that some days when she reported to work in the morning, EX Order 26.4B1 care was not provided for EX Order 26.4B1 residents if they were short handed. On 09/26/22 at 8:38 AM, the surveyor observed Resident #48 in the elevator going out to smoke. The surveyor went to the room and noted NJ Exec Or all over the room. The sheet and the blanket were EX Order 26.4B1. The surveyor observed the gown and the linen on the floor, all were NJ Ex Order 26.4b1. On 09/26/22 at 10:07 AM, the surveyor escorted the Licensed Practical Nurse (LPN#5 in the room where we both observed the linen on the floor, NJ Exec Or on the bed and the sheets and Ex Order 26.4B1 were Ex Order 26.4B1. The surveyor reviewed Resident #48's clinical record on 09/26/22 at 12:30 PM. The Admission Face Sheet (an admission summary) reflected that Resident #48 had diagnoses which included but were not limited to: Ex Order 26.4B1 The Annual Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated Ex Order 26.4B1, reflected that Resident #48 was Ex Order 26.4B1 and received a score of EX O on the Brief Interview For Mental Status (BIMS). Normal score 15. Section E 008 which addressed	F 677	ongoing weekly audits to assure proper inventory levels by environmental service director/designee 4. How Will These Actions Be Measured: The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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rejection of care was coded as Zero indicative of being in compliance with care.

The resident plan of care dated EX Order 26.4B1 last revised EX Order 26.4B1, revealed a focus for ADL and Elimination. The goal was for Resident #48 to maintain current level of functioning. The interventions implemented included: I want you to assist me with toileting and dressing. For toilet use Resident #48 was assessed as being EX Order 26.4B1 The goal was Resident #48 to be changed every EX Order 26.4B1 and PRN (as needed). Another intervention was to provide Resident #48 with a EX Order 26.4 at the bedside. On 09/21/22 at 10:20 AM and 09/26/22 at 8:38 AM, the surveyor looked and could not locate a EX Order 26.4B in the room.

On 09/26/22 at 10:30 AM, the surveyor and the LPN #5 assigned to the desk, went to the room, looked and could not locate a EX Order 26.4 in the room or the bathroom.

On 09/28/22 at 11:30 AM, the surveyor reviewed the electronic medical record and noted a Progress Notes dated NJ Ex Order 26.4b1 which addressed non compliance with care. The Progress Notes indicated the following: "Resident was found in the room in bed by this nurse with the bed EX Order 26.4B1 Ex Order 26.4B1 and so were his/her clothes. This nurse asked CNA for assistance in cleaning up resident, and changing his/her bed and clothes. Resident refused." There was no documentation in the clinical record regarding approaches attempted regarding resident behavior of Ex Order 26.4B1 on the bed and on the floor.

The facility was aware of Resident #48's behavior of being non-compliant with care and failed to implement measures to address the behavior.

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The care plan had not been revised to provide directives to the direct care staff regarding the behavior. There was no measures in place to disinfect the room.

2.) Resident #54 was admitted to the facility with diagnoses which included but were not limited to: Ex Order Ex Order 26.4B1 Ex Order 26.4B1

The Annual MDS, a resident assessment tool used by the facility to prioritize care dated Ex Order 26.4B1, revealed that Resident #54 was Ex Order 26.4B1. Resident #54 scored Ex on the Brief Interview for Mental Status (BIMS). Normal score 15. Section E of the MDS which addressed behavior indicated that Resident #54 had NJ Ex Order 26.4b1 of Ex Order 26.4B1. Section E 0600 impact on behavior subpart c was coded as Ex Order 26 for disruption of care in the living environment.

On 09/21/22 at 9:52 AM, the surveyor toured the Ex Order 26 locked unit assigned to residents with behavior. The surveyor observed Resident #54 seated in a wheelchair in the hallway. A strong Ex Order 26.4B1 was permeated in the hallway while approaching Resident #54's room. The surveyor entered the room and observed the linen included the Ex Order 26.4B1, and the sheets were Ex Order 26.4B1. Some clothing was observed on the radiator in the room.

On 09/21/22 at 10:12 AM, the surveyor observed the U.S. FOIA (b)(6)) in the hallway and escorted him to the room. The U.S. FOIA (b)(6 entered the room with the

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surveyor and we both observed the bedding included the EX Order 26.4B1 were NJ Exec Order 26.4 and Ex Order 26.4B1 . The U.S. FOIA (b)(stated he made rounds every day and had not identified concerns with Ex Order 26.4B1 care. After seeing the Ex Order 26.4B1 the administrator stated that his expectations would be thatEx Order 26.4B1 care would be provided every 2 hours for residents that were

On 09/23/22 at 6:53 AM, the surveyor observed Resident #54 seated in a wheelchair in the doorway. The surveyor entered Resident #54's room, the Ex Order 26.4B1 were Ex Order 26.4B1 Ex Order 26.4B1 noted in the room, bedding, included fitted sheet and blanket were Ex Order 26.4B1 , NJ Exec Order noted crawling on the floor.

On 09/23/22 at 6:57 AM, the surveyor interviewed Resident #54. Resident #54 stated that he/she NJ Ex Order 26.4b1 during the night. The surveyor escorted the US FOIA (b)(6) to the room where we both observed the same. Resident #54 had NJ Ex Order 26.4 on the bed, Ex Order 26.4B1 Ex Order 26.4B1 . The bedding linen was Ex Order 26.4B1 Ex Order 26.4B1 , the mattress was also Ex Orde and Ex Order 26.4B1 .

On 09/23/22 at 6:58 AM, the surveyor interview CNA #4 who cared for Resident #54 on the 11:00 PM-7:00 AM shift. CNA #4 stated that Resident #54 would not get up to be changed during the night, she had to wait until the morning to change Resident #54. The U.S. FOIA (did not indicate that she asked either the nurse or another U.S. FOIA (b) to assist with care. CNA #4 confirmed that Resident #54 had not been changed during the 11:00 PM-7:00 AM shift. She did not indicate that she attempted

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F 677	Continued From page 149 to change the resident and the resident refused. On 09/23/22 at 7:01 AM, the surveyor interviewed LPN #4 who cared for Resident #54. The [U.S. FOIA] stated all residents that are [Ex Order 26.4B1] were to be changed every 2 hours. When asked if [Ex Order 26.4B1] care was provided during the shift for Resident #54, she did not have any comment. On 09/23/22 at 7:19 AM, CNA #3 confirmed stated that[Ex Order 26.4B1] care would not be provided during the 11:00 PM-7:00 AM shift when the facility was short handed. She stated that Resident #54 had to be changed but could be [NJ Exec Order 26.4b1] with care. On 09/27/22 at 10:14 AM, a TNA#1 assigned to the [Ex Order 26.] Unit stated that Resident #54 had a [Ex Order 26.4B1] and required [NJ Ex O] with [Ex Order 26.4B1] care. This information was not entered in the Plan of Care. A review of Resident #54's Plan of Care dated [NJ Ex Order 26.4b1] indicated the following: I want you to encourage me to participate to the best of my ability in all aspects of ADL,s. I want to[NJ Ex Order 26.4b1],s in the following areas: eating-set up dressing bathing toileting transfers Resident #56 plan of care had a focus for "Elimination". The goal was for Resident #54 to maintain adequate [NJ Exec Order 26] functioning as demonstrated by quantity sufficient [NJ Ex Order 26.4b1] each shift.	F 677		

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F 677	Continued From page 150 Interventions included: We will toilet you every 2-4 hours and PRN (as needed) We will provide EX Order 26.4B1 care every 2-4 hours and PRN. We will keep your EX Order 26.4 at the bedside for ease of use. Resident #54 did not have a EX Order 26.4 at the bedside when observed from EX Order 26.4B1. A EX Order 26.4 was noted at the bedside on EX Order 26.4B1 A review of the facility's policy for ADL,s dated 07/09/20 last revised 04/02/2022, documented the following: Policy: It is the policy of the facility to provide ADL care to all residents based on assessment of needs. Procedure : Review plan of care for each resident before care. In accordance with the plan of care, provides the necessary assistance resident requires with each ADL,s. If Resident refused care, notify the charge nurse and social service for intervention. There was no documentation in the medical record that the U.S. FOIA (b)(6) were aware of the above concerns with Resident #48 and #54. The facility was made aware of the above concerns on NJ Exec Order 26.4b1 during the exit conference, no additional information was provided.	F 677		

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F 677	Continued From page 151 N.J.A.C. 8:39-27.2(d) (h) (j)	F 677		
F 684 SS=H	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: Complaint # NJ152936 Based on interview, closed record review and review of pertinent documents, it was determined that the facility failed to ensure the facility policies for Accidents, Occurrence Investigation and Prevention of [redacted] were followed to ensure: a.) a resident identified at risk for [redacted] on [redacted] and at high risk for [redacted] on [redacted] had a care plan initiated for the prevention of [redacted], b.) an assessment of any [redacted] was completed and documented post [redacted], c.) an accident report was completed and verified incident post [redacted] d.) post [redacted] the Interdisciplinary Team re-evaluated the resident and revised interventions to prevent a recurrence, e.) a root cause analysis would be conducted post occurrence and immediate measures to protect the resident was implemented, and f.) any interventions are consistently documented per professional standards of practice. This deficient practice occurred for 1 of 1 closed records reviewed for hospitalization (Resident #193), who	F 684	1. Immediate Action a. Resident # 193 was discharged and does not currently reside in the facility. b. Staff received in service education on quality of care, accidents and incidents comprehensive care planning and change in condition c. Care plans for all residents identified as a fall risk have been reviewed and revised to include appropriate care plan interventions 2. Identification of Others a. All residents at risk for falls have the potential to be affected by the deficient practice 3. Systemic Changes a. The facility policies for accidents, occurrence, and investigation and prevention of falls in addition to injuries of unknown origin were reviewed and revised	12/5/22

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F 684	Continued From page 152 sustained [redacted], including [redacted] that occurred on [redacted], and [redacted] that resulted in an emergent transfer to the hospital on [redacted] The [redacted] resulted in Resident #193 sustaining an [redacted], which required an [redacted] and and required [redacted] intensive care. 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 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 well-being, 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 restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 684	b. Inservice education was provided to all nursing staff and department heads on revised policies c. Facility policy for comprehensive care planning and risk mitigation has been reviewed and revised. Nursing staff has been educated on revised policy d. Policy for neuro checks was reviewed and revised. Nursing staff has been educated on revised policy e. Facility policy for Universal Transfer Form was written and implemented and nursing staff received education on the policy f. Facility policy on change in condition was reviewed and revised. Stop and Watch policy was implemented, and Interdisciplinary staff was educated on both policies 4. Quality Monitoring a. The director of nursing/designee will audit all accidents/incidents to ensure compliance with facility policy. Director of Nursing/Designee will conduct a weekly Quality Assurance audit, to include updating care plans, weekly X 6 months, the first of which will take place in December 2022. b. The medical records director will audit transfer forms for all transferred/discharged patients to assure compliance with facility policy. Results will be submitted to the Quality Assurance and Process Improvement Committee on a monthly basis. The QAPI committee will provide recommendations for further action.	

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On 10/04/22 at 11:16 AM, the surveyor reviewed the entirety of the closed medical record for Resident #193 which was provided by the facility on 09/26/22 at 3:00 PM, and revealed the following:

A hospital record dated NJ Ex Order 26.4b1 completed for Resident #193, prior to admission to the facility, revealed a [redacted]. The scan revealed "There are no acute findings". The hospital Plan of Care dated [redacted] revealed Resident #193 had a Problem: At [redacted], "Patient is [redacted], has experienced [redacted] or [redacted]

After admission to the facility a [redacted] Risk Evaluation dated [redacted], revealed the resident scored an [redacted] on the [redacted] Evaluation. On a subsequent [redacted] Evaluation dated [redacted], revealed "If the total score is [redacted] or greater, the resident should be considered at [redacted] for potential [redacted] A prevention protocol should be initiated immediately and documented on the care plan." Resident #193 scored [redacted] on the evaluation which is considered [redacted]

A review of a U.S. FOIA (b)(6) Evaluation and Plan of Treatment, dated [redacted], revealed Resident #193 was a [redacted].

A review of the Interdisciplinary Care Plan for Resident #193 revealed four Care Plans which included: Ex Order 26.4B1 [redacted] Ex Order 26.4B1 [redacted] as r/t [result to] [redacted]

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mobility. Goal: will have minimal [redacted] through review date. The interventions dated [redacted] with a target date [redacted], included the following: "Keep call bell and frequently used items within reach", "Keep room clutter free and well lit", "keep bed in lowest position", "encourage resident to wear appropriate no skid footwear", "Assist with transfers [redacted] screen as needed, Check all that apply was D/C (discontinued) with a line through it on [redacted], and bed alarm, chair alarm, and floor mat was unchecked. The Care Plan for Resident #193 did not reflect any documented interventions to prevent [redacted] despite being identified at risk for [redacted] on [redacted], a Care Plan for [redacted] was not initiated until twenty-one days later.

The [redacted] Treatment Administration Record (TAR) and Medication Administration Record (MAR) were reviewed and did not reveal documented evidence of [redacted] interventions that were identified in the Care Plan that were initiated on [redacted].

[redacted] A Nurses Note (NN) dated [redacted] and timed at '[redacted] "Resident found by aide [redacted], 2 assist transferred resident back to bed and push bed towards wall, monitored through the night, VS [vital signs] [redacted] called and notify of incident and signed by a Licensed Practical Nurse (LPN #1). There was no documented evidence that the physician was notified of the [redacted] and no evidence that a documented physical assessment was completed. This [redacted] was not documented on the Care Plan and Interventions were not revised to prevent further [redacted]

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[redacted] A NN dated [redacted] and timed at [redacted] [redacted] , "after talking to [redacted] heard resident yelling out "[redacted] [redacted] Found [him/her] before has [sic.] bed [redacted]. Transfer back to bed and in w/c [wheelchair] out to nurses station and, [redacted] and signed by LPN #1. There was no documented physical assessment for resident #193. A subsequent un-timed and un-dated NN revealed, " MD [physician] to be informed later on [redacted] and also [redacted] [redacted]" signed by LPN #1. This [redacted] was not documented on the Care Plan and Interventions were not revised to prevent further [redacted]

A subsequent NN un-timed and dated [redacted], revealed "resident received in the hallway sitting in [his/her] wheelchair [redacted] (an [redacted]) initiated, no [redacted], resident was compliant with adl [activities of daily living] care and meds [medications], [redacted] [within normal limits], will continue to monitor" signed by LPN #2. There was no documented evidence that the physician, or [redacted] was notified of the [redacted] that occurred on [redacted].

A NN dated [redacted], and timed at 1PM [redacted] checks in progress, s/p [status post] [redacted]. All [redacted] checks WNL [within normal limits], no [redacted] [redacted] at this time. will cont. [continue] to [redacted], signed by Registered Nurse (RN #1). There were no additional NN documented regarding any completed [redacted] [redacted]s or monitoring. There was no documented evidence of [redacted] checks having been completed in the medical record, or in the MAR or TAR for

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August 2021.

[redacted] A NN dated [redacted], and timed at [redacted] "Resident received awake and lying in bed. Around 8:30 A.M. was found by CNA [certified nurse aide] on the [redacted]. The CNA noted writer and resident was observed [redacted]. No [redacted]. Resident remained in stable condition. [redacted], [redacted] in place. Resident c/o [redacted]) [redacted] rated [redacted]. PRN [as needed] [redacted] s) administered. MD (physician) made aware and [redacted]. The [redacted] r requested for her [family member's] name to be removed due to being [redacted], signed by LPN #2.

A NN dated 09/01/21, and timed at 3:30 PM, "Resident didn't return on the 7-3 shift and signed by LPN #2.

Incident #4: A NN [redacted] and then continued on another page titled Interdisciplinary Progress Notes (IPN) revealed, Date and Time: TC 7-3 (No specific time documented) which revealed "this morning when one of the aide went into the residents room and found [him/her] [redacted] elevated, [redacted], [redacted]. I assessment [sic.] [Resident #193] [redacted] [redacted] when I called to to [Resident #193] [he/she] [redacted]. I called his/her [Doctor] and was told to send [him/her] to

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the E.R. [emergency room] [he/she] was transported to the E.R. Ex Order 26.4B1. [He/she] was sent with [his/her] face sheet and personal belongings and was signed by LPN #1. There was no documented nursing notes, or notes from other disciplines documented in the medical record on either an IPN or NN.

A New Jersey Universal Transfer Form NJ Exec Ord) had a Date of Transfer: "Ex Order 26.4B1", Time of Transfer: [blank] revealed Resident #193 was transferred to the hospital on Ex Order 26.4B1 at an unknown time. The Reasons for Transfer:(Must include brief medical history and recent changed in physical function or cognition) [redacted] The following areas were left blank; Code Status, Ex Order 26.4B1 Attached, Secondary Diagnosis, Ex Order 26.4B1 [redacted]

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the Form Completed by and Title section was blank. There was no information on the [redacted] that correlated with the [redacted] LPN #1 NN that indicated the recent changes in physical function.

The Admission Record revealed Resident #193 had Admitting Diagnosis that included, but was not limited to, [redacted].

On 10/04/22 at 2:41 PM, the surveyor conducted a telephone interview with LPN #1 regarding the documentation on [redacted], regarding Resident #193. LPN #1 asked the surveyor if "she was in trouble" and stated she did not recall the resident, or remember her documentation, or any incident on [redacted] and she was unable to speak to it.

On 10/04/22 at 3:22 PM, the surveyor conducted and interview with the [redacted]) and showed the [redacted] the [redacted] for Resident #123 dated [redacted]. The surveyor inquired if there were any incidents or investigations for Resident #123 and she stated she will inquire. At that time the surveyor reviewed the [redacted] with the [redacted] The [redacted] stated the [redacted] was incomplete.

On 10/04/22 at 4:18 PM, the surveyor, in the presence of another surveyor, inquired to the [redacted] if there were any investigations for Resident #193. The [redacted] stated "no" there were no investigations that the facility was aware of.

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On 10/04/22 at 4:30 PM the surveyor, in the presence of another surveyor, requested any information from the U.S. FOIA (b)(6) [redacted]) related to the reason #193 was sent to the hospital on Ex Order 26.4B1

On 10/05/22 at 8:27 AM, the U.S. FOIA (b)(6) provided the surveyor a Daily Report dated Ex Order 26.4B1, and showed the surveyor that Resident #193 was transferred to the emergency room on Ex Order 26.4B1, for a change in mental status and had no other information related to Ex Order 26.4B1

On 10/05/22 at 9:56 AM, the surveyor interviewed the U.S. FOIA (b) regarding what the process was if a resident sustained an injury of unknown origin. The U.S. FOIA (b) stated it should be investigated and reported to the State. The surveyor inquired as to the documentation on NJ Exec Order 26.4b1 regarding Resident # 193. The U.S. FOIA (b) stated "we should have done a Ex Order 26 check before they went out" to the hospital. The U.S. FOIA (b) stated she wanted to know why the personal belongings were documented as sent with Resident #193 to the hospital, and what was the reason the resident Ex Order 26.4B1 The U.S. FOIA (b) stated "there should absolutely be specifics on the transfer sheet regarding the Ex Order 26.4B1 and how the resident was found", and the U.S. FOIA (b) stated "it is imperative". The U.S. FOIA (b) also stated she would get a statement from the CNA and confirmed the NJ Exec O had to be accurate, filled out and include the contact information on the NJ Exec O. The U.S. FOIA (b) stated the hospital needed to know that information and she stated, "I would expect to see any additional information related to the resident, it doesn't end [the resident] going out". The U.S. FOIA (b) stated "I would want to know what happened and they have to notify the responsible party and the doctor." The

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surveyor requested the policy for the UTR, emergent transfer policy. The surveyor inquired to the U.S. FOIA (b) if the resident had Ex Order 26.4B1 at the hospital, would the facility know. The U.S. FOIA (b) stated she was unaware if Resident #193 Ex Order 26.4B1, but the facility should know that information. The surveyor requested the assignment sheet for Resident #193 on Ex Order 26.4B1. On 10/05/22 at 2:30, the U.S. FOIA (b)(6) provided the assignment sheet for EX Order 26.4B1. Upon review and discussion with the Human Resource Staff, the surveyor was unable to contact any additional staff that worked on Ex Order 26.4B1.

On 10/05/22 at 12:54 PM, the U.S. FOIA (b)(6) stated there was no faciliy policy for completion of the NJ Exec O and no facility discharge policy.

On 10/05/22 at 10:49 AM, the surveyor interviewed the U.S. FOIA (b)(6), regarding what the process was for injuries of unknown origin. The U.S. FOIA (b)(6) stated there should be an investigation for injuries of unknown origin.

On 10/05/22 at 3:57 PM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b), informed the surveyor that there were no investigations for Resident #193. The U.S. FOIA (b)(6) stated she had checked with the U.S. FOIA (b) and she confirmed that the U.S. FOIA (b)(6) also had no investigations. The U.S. FOIA (b)(6) stated "100% there should be an investigation completed for all Ex Order 2 or unusual occurrences."

On 10/05/22 at 4:05 PM, the surveyor inquired to the U.S. FOIA (b) regarding any incidents, investigations or reportable events for Resident #193. The U.S. FOIA (b) stated "I have nothing" on Resident #193 and the U.S. FOIA (b) stated that she and the U.S. FOIA (b)(6) could not

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locate any incidents or reportable event records for Resident #193. The [U.S. FOIA (b)(6)] stated that Resident #193 [Ex Order 26.4B1], and none of the information was found out about what happened, "nothing" was on the transfer note. The [U.S. FOIA (b)(6)] stated she was not aware that Resident #193 had any [Ex Order 26.] and was unsure why the resident's belongings were sent to the hospital. At that time, the surveyor requested a time line of events for Resident #193 from the [U.S. FOIA (b)(6)]

On 10/06/22 at 10:00 AM, the [U.S. FOIA (b)(6)] provided the time-line for Resident #193. The [U.S. FOIA (b)(6)] stated the that Resident #193 was identified as a [redacted] risk on [redacted], with a [Ex Order 26.4B1] assessment score of [redacted] then transferred to the hospital on [redacted] due to a change in mental status, readmitted to the facility on [Ex Order 26.4B1] and scored an [Ex Or] on the [Ex Order 26.4B1] assessment. The [U.S. FOIA (b)(6)] stated on [redacted], is when the Care Plan for [Ex Order 26.] was first initiated and reviewed the interventions. The surveyor inquired if the interventions were documented as being implemented and the [U.S. FOIA (b)(6)] stated that "from time to time" and they were "just" in the nursing notes which the [U.S. FOIA (b)(6)] confirmed were [NJ Exec Order 26.4b1] The [U.S. FOIA (b)(6)] confirmed the [redacted] occurred on [redacted], and there were no investigations completed, and no incident reports were completed regarding the [redacted] either. The U.S. FOIA (b)(6) she spoke to LPN #1 regarding the incident that she documented with Resident #193 on [redacted]. The [U.S. FOIA (b)(6)] stated that LPN #1 informed her that "she does remember the incident" and LPN #1 confirmed that Resident #193 sustained a [redacted], and stated to the [U.S. FOIA (b)(6)] that she had remembered the [redacted]. The [U.S. FOIA (b)(6)] confirmed that there was no documented nursing physical assessment completed for Resident

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#193 and confirmed there was no documented nursing physical assessment for the [redacted] that occurred on [redacted]. The [redacted] stated that LPN #1 confirmed that she did not document that Resident #193 had a [redacted] on the [redacted], and the [redacted] stated "it doesn't even appear that the person[redacted] per what was documented on the [redacted] and the [redacted] confirmed there were no [redacted] documented.

10/06/22 at 10:31 AM, the [redacted] stated to the surveyor that with any injury of unknown origin, an incident report with statements and a full head to toe investigation should have been completed. The [redacted] stated that the [redacted], possibly the first three, but definitely the last [redacted] if there were injuries it should have been reported to the Department of Health.

On 10/27/22, the surveyor reviewed the hospital records provided by the receiving hospital for Resident #193's [redacted] transfer on [redacted], which revealed the following:

The Hospital Patient Information sheet revealed Resident #193 was admitted to the Emergency Department from the nursing facility on [redacted]

A Physician Progress Note, dated [redacted], and Electronically Signed by the Physician (MD) at 11:03 AM. (Resident #193) was admitted after being found with Ex Order 26.4B1 in nursing home and Ex Order 26.4B1. Ex Order 26.4B1 was performed in the emergency department and revealed a Ex Order 26.4B1 [redacted]

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Ex Order 26.4B1 Ex Order 26.4B1 status post a Ex Order 26.4B1 Ex Order 26.4B1.

A Internal Medicine Progress Note, dated Ex Order 26.4B1 and Electronically Signed by the MD at 1:34 PM. The Patient (Resident #193) came to the hospital "Ex Order 26.4B1." Patient was diagnosed with an Ex Order 26.4B", Ex Order 26.4B1 Ex Order 26.4B1 " and was admitted to Ex Order 26.4B Ex Order 26.4B1 after having "an Ex Order 26.4B1 " (Ex Order 26.4B1).

The following facility provided policies were reviewed:

Accidents-Occurrence Investigation Policy Originated:1/2022, revealed All accidents will be investigated, documented and reported to the New Jersey Department of Health as appropriate. Definitions: Accident: refers to any unexpected or unintentional incident, which may result in injury or illness to a resident... Fall: refers to unintentionally coming to rest on the ground, floor or other lower levels, but not as a result of an overwhelming external force (i.e. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without an injury is still a fall unless there is evidence suggesting otherwise when a resident is found on the floor, a fall is considered to have occurred...

Procedure: Responsibility Person responsible for area in which the accident occurred (Initiator). Action: Initiated the accident report and enters

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required information. Notifies RN/Clinical Care Manager; RN/Clinical Care Manager: Action: Investigates the situation and assesses the resident/patient, completes the "nurse" section of the Accident Report, Determines/implements immediate corrective action. Licensed Nurse RN/LPN: Notifies M.D. & Clinical Care Manager, Identifies relevant environmental risk factors, Notifies Plant Operations and/or housekeeping as appropriate, Documents the accident event and notification of family in the progress notes, Place resident/patient on 24 hour report X 72 hours, Documents resident/patient status in the progress notes X 72 hours, RN/CCM: Initiates/updates CCP with a new intervention, Clinical Care Manager: Reviews the accident report and other pertinent information with the interdisciplinary Team at morning report the following business day, RN/Clinical Care Manager: Initiates Incident report, Obtains statements from all staff, residents, visitors, volunteers present at the time of the accident, by the end of the shift, Obtains statements until a determination can be made as to the time of the accident, Clinical Care Manager: Reviews accident report, statements occurrence report, clinical record and surveillance data as indicated. Completes "Summary of Findings" and "Determination" regarding Abuse, Neglect, and Mistreatment, Initiates Corrective Action Plan, Notifies family/significant others of the findings of the Occurrence Investigation, Submits all documents to the A.D.N./D.N.S., D.N.S./A.D.N.: Reviews each case, relevant documents and the clinical record to validate findings and determine results, Forwards "original" accident reports to the Education Dept., DNS/ADN: Reviews significant injuries and injuries of unknown origin with the Administrative Team (Administrator/Associate Administrator/

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Medical Director/Associate Medical Director), Administrative Team: Conducts root cause analysis, as needed, DON/Designee: Notifies DOH and other regulatory agencies as per regulations if: reasonable cause to suspect abuse, neglect and mistreatment has been determined, failure to follow the CCP, which resulted in resident injury, injuries of unknown origin.

Policy and Procedure for the Prevention of Fall, undated;..Communication of Risk, Residents at risk for falls will be communicated to the interdisciplinary team via the care plan, Evaluation of Fall Incidents, Assess residents for any obvious injuries, notify the medical provider and document a progress note reflecting the resident's appearance, evidence of injury and location, Monitor resident post incident to observe for latent injury, After a fall has occurred, the interdisciplinary team will re-evaluate the resident and revise intervention to prevent recurrence, PT/OT to screen residents and recommend interventions, if indicated, Quality Assurance, Complete an occurrence and conduct post occurrence and conduct post occurrence review to attempt to ascertain root cause analysis of the incident and implement immediate measures to protect the resident, Occurrence will be discussed in the morning report; current and alternative interventions/preventative measures will be explored and implemented upon agreement by the IDC team, Nursing department will track the number of falls per month by collecting data from accident/incident reports to identify trends and patterns.

Charting and Documentation Policy, Effective 01/02/22; 2. The following information is to be

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F 684	Continued From page 166 documented in the resident medical record: a. objective observations, d. changes in the resident's condition, e. events, incidents or accidents involving the resident, f. progress toward or changes in the care plan goals and objectives. Change in Condition Policy, Effective 01/05/22; It is the policy of this facility to identify and communicate changes in condition to the physician and other team members to implement interventions to prevent further deterioration and possibly prevent hospitalization. All staff are encouraged to promptly report any changes in condition to the charge nurse, supervisor or DNS/ADNS or designee immediately, A complete assessment will be conducted of all systems including but not limited to: functional status, respiratory evaluation, abdominal pain or GI evaluation, GU/Urine evaluation, Skin evaluation, pain evaluation, vital signs, A care plan will be initiated and/or updated based on the reason for the change in condition as soon as feasible (in case of emergency/acute transfer, patient's safety comes first and family will be notified once patient is stabilized). N.J.A.C. 8:39-27.1(a)(b)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		12/5/22

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F 688	Continued From page 167 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide appropriate services for a resident with NJ Ex Order 26.4b1 by failing to ensure: a.) appropriate interventions were in place for a resident with NJ Ex Order 26.4b1 and b.) a resident with limited range of motion received appropriate services in accordance with person centered care plan to prevent further NJ Ex Order 26.4b1, and c.) interventions were appropriately documented as administered for resident with NJ Ex Order 26.4b1 for 1 of 4 residents (Resident #20) reviewed for NJ Ex Order 26.4b1 This deficient practice was evidenced by the following: On 09/22/22 at 12:43 PM, the surveyor observed Resident #20 seated in a chair. Resident #20 had Ex Order 26.4B1) of both hands. The surveyor did not observe any devices including a in either of Resident #20's . The surveyor attempted to interview	F 688	1. Immediate Action Resident #20 was evaluated by Ex Order 26.4B1 . Conclusion-NJ Ex O . a. Resident #20's care plan was reviewed and revised to address Ex Order 26 integrity 2. Identification of Others a. All residents with contractures and the potential to develop contractures have the potential to be affected by the deficient practice b. All residents were evaluated to identify residents with contractures or potential to develop contractures. Care plans for all identified residents were reviewed, revised and updated to address resident specific needs.	

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F 688	Continued From page 168 Resident #20 and the resident was Ex Order 26.4B1 Ex Order 26.4B1 On 09/27/22 at 10:29 AM, the surveyor observed Resident #20 lying in bed. The surveyor did not observe any NJ Ex Order 26.4b in either of Resident #20's NJ Ex Order 26.4b1. On 09/27/22 at 11:38 AM, the surveyor reviewed Resident #20's electronic medical record. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to; Ex Order 26.4B1 [redacted] A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated Ex Order 26.4B1 reflected that the resident had no speech and that the resident's cognitive skills for decision making were Ex Order 26.4B1. A further review of the resident's MDS, Section G - Functional Status indicated that the resident had functional limits in range of motion on both upper extremities and Section O- Special Treatments, Procedures and Programs indicated that the resident did not receive any range of motion techniques or a splint or brace assistance. The surveyor reviewed Resident #20's individualized, comprehensive care plan (CP) which did not include a care concern related to Resident #20's NJ Ex Order 26.4b1 of Ex Order 26.4B1 Ex Order 26.4B1.	F 688	3. Systemic Changes a. A facility policy was written and implemented on prevention and management of contractures b. Nursing Staff received education on the prevention and management on the policy and prevention of contractures c. Stop and Watch policy was written and implemented for early identification of changes in resident condition. Interdisciplinary staff was educated on the Stop and Watch Policy d. Nursing Staff received education on documentation and communication of change in resident condition e. Interdisciplinary rounding implemented weekly with nursing and rehabilitation to monitor residents with current contractures and identify new contractures or residents with the potential for contractures f. Director of Rehabilitation/designees will conduct weekly rounds to assure proper utilization/appropriateness of and documentation of splint utilization 4. Quality Monitoring The Director of rehab/designee will conduct audits to ensure that all residents are managed in accordance with the	

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F 688	Continued From page 169 The surveyor reviewed Resident #20's September 2022 electronic Treatment Administration Record (TAR) which included the following: An order, with a start date of [redacted] for [redacted] application, NJ Ex Order 26.4b1 and [redacted] Checks. There was not a diagnosis listed for the order. An order, with a start date of [redacted] for [redacted] application. NJ Ex Order 26.4b1 at bedtime. Off during ADL's and [redacted] Check. Protocol: Ex Order 26.4B1 [redacted]. Both orders were signed by a nurse on [redacted] and [redacted] to indicate that the [redacted] were administered. There were two orders for [redacted] application. The facility had not contacted the physician to clarify the orders. On 09/28/22 at 01:37 PM, the surveyor interviewed Resident #20's assigned Temporary Nurses Aide (TNA) regarding the resident's contracted hands. The TNA stated that she only cleaned Resident #20's [redacted]. She added that Resident #20's [redacted] had been [redacted] since she had started at the facility in [redacted]. The surveyor then asked the TNA if she had seen [redacted] placed in Resident #20's [redacted]. The TNA stated that she had not seen any [redacted]. She added that she had seen other residents that had [redacted]. On 09/28/22 at 01:40 PM, the surveyor interviewed the Licensed Practical Nurse (LPN	F 688	facility policy. The results of the monthly reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 688	Continued From page 170 #1) assigned to Resident #20, in the presence of LPN #2, regarding the resident's order for [redacted] LPN #1 stated that today was her first day that she had Resident #20 and that she made the [redacted] department aware that she could not place the [redacted] in Resident #20's [redacted] Then LPN #2 stated that when she had Resident #20 that the [redacted] department was aware that Resident #20's [redacted]" was [redacted] that she could not place a [redacted]. She added that since she had been at the facility for [redacted] that she had not seen Resident #20 with [redacted] and that the [redacted] department was aware. The surveyor then asked LPN #2 why the nurses were signing that the [redacted] were being administered if they were not being administered. LPN #2 stated that they were "getting used to" the computer system. She added that the nurses have to sign their initials but that there was a drop down that you could write the reason why an order was not administered. On 09/29/22 at 10:32 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]), who was an U.S. FOIA (b)(6) [redacted], regarding the process for a resident who had [redacted] The [redacted] stated that nursing would refer the resident to them either verbally or written on a form. The [redacted] would then screen (evaluate) the resident and determine the appropriate recommendation and then get an order from the physician. The surveyor then asked the [redacted] how long Resident #20 had [redacted] and if Resident #20 had been evaluated for [redacted] or other [redacted]. The [redacted] stated that the present [redacted] group had been at the facility since [redacted] and that he had been at the facility since [redacted] He added that he would try to	F 688		

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get the information but that he may have to reach out to the previous [redacted] company.

On 09/29/22 at 10:52 AM, the [redacted] provided the surveyor with a Progress Note, dated [redacted] written by U.S. FOIA (b)(6) [redacted] for Resident #20, which included the following:

Screen requested re: contracture management of Ex Order 26.4B1 [redacted]. Pt (patient) NJ Ex Order 26.4b1 feel of Ex Order 26.4B1, no active movement in Ex Order 26.4B1 and resting in protective position. Ex Order 26.4B1 [redacted]. Pt visibly refuses Ex Order 26.4B1. No [redacted] breakdown is noted at this time, management of [redacted] integrity should continue w/ nursing interventions.

The [redacted] also provided the surveyor with a Screen/Referral Form, dated Ex Order 26.4B1 for Resident #20 which included the following:

Decreased ROM/contracture-indicated yes with the comment Ex Order 26.4B1 as per nursing) Need for Ex Order 26.4B1 -indicated no with the comment NJ Ex Order 26.4b1 secondary to NJ Ex Order 26.4b1

On 09/29/22 at 11:32 AM, the surveyor interviewed the [redacted] regarding the Ex Order 26.4B1 screen done for Resident #20. The [redacted] stated that the recommendation was not to put any Ex Order 26.4B1 in the resident's [redacted] and to maintain resident's [redacted] integrity. He added that we would communicate to the nurse and that the nurse would contact doctor.

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F 688	Continued From page 172 On 09/29/22 at 1:05 PM, the surveyor reviewed Resident #20's Medication Administration Records and TARs for Ex Order 26.4B1 which were provided by the U.S. FOIA (b)(6). There were no orders for to be applied. On 09/30/22 at 9:53 AM, the surveyor interviewed the US FOIA regarding handrolls versus and Resident #20. The US FOIA stated that if a resident cannot tolerate in their NJ Ex Order 26, then there is not much of anything else that can be used. The US FOIA stated that he had spoken to the Ex Order 26.4B1 that evaluated the resident on NJ Ex Order 26.4b and that the U.S. FOIA (b)(6) stated that Resident #20 was NJ Ex Order 26.4b1 back when the Ex Order 26.4B1 was trying to move the resident's Ex Order 26.4B1 to insert the trial . He then added that he would not say that were appropriate for Resident #20 and that in his opinion the resident should not have an order for . On 10/04/22 at 12:35 PM, during surveyor interview, LPN #3 stated that when she was hired almost NJ NJ Ex Order ago that Resident #20 had the of both but that she did not know when the first started. On 10/6/22 at 8:40 AM, the surveyor reviewed the facility provided TAR for Resident #20 which included the following: The order with the start date of was signed by a nurse indicating that the were administered during the 7:00a-3:00p shift all the days of September except for two days, NJ Ex Order 26.4b1, which had a comment as	F 688		

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to the reason why they were not applied and three days, [redacted] which had a dash which indicated that a nurse did not sign or document the order for those days. The order also was signed by a nurse indicating that the [redacted] were removed during the 3:00p-11:00p shift all the days of September except for [redacted].

The order with the start date of [redacted] was signed by a nurse indicating that the [redacted] were administered during the 7:00a-3:00p shift all the days of September except two days, [redacted] and [redacted], which had a comment as to the reason why they were not applied and three days, [redacted] which had a dash which indicated that a nurse did not sign or document the order for those days. The order also was signed by a nurse indicating that the [redacted] were removed during the 3:00p-11:00p shift all the days of September except for two days, [redacted].

On 10/06/22 at 11:25 AM, the surveyor interviewed LPN#2 regarding the orders for [redacted] for Resident #20. LPN #2 stated that she did not know why a new order for [redacted] was ordered by the physician. She added that she thought that when [redacted] does an evaluation, that they will try to get a [redacted] " but that they were not successful. LPN #2 then stated that she met with the [redacted] yesterday and that she told the [redacted] to discontinue the [redacted] order for Resident #20. The surveyor then asked LPN #2 if she would expect documentation by the physician or a nurse to indicate the reason a new order was written. LPN #2 stated that there should be documentation. The surveyor then asked LPN #2

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if there should be two of the same order. LPN #2 stated that there should not be two orders but that they just recently transferred to a new computer system. She added that she thought someone should have called the physician to clarify the orders. The surveyor asked LPN #2 if a nurse should have signed that NJ Ex Order 26.4b1 were administered when they were not. LPN #2 stated that a nurse should put in a comment the reason it was not placed, that they should not document that it was administered if it was not. The surveyor then asked LPN #2 if Resident #20 should have had a care plan related to the resident's NJ Ex Order 26.4b1 and management of the contractures. LPN #2 stated that the resident should have had a care plan related to NJ Ex Order 26.4b1. Lastly, the surveyor asked LPN #2 how long it should take before a physician is notified of an order that has not been able to be administered. LPN #2 stated that yesterday the Ex Order 26.4B1 told her that she "would take care of" discontinuing the Ex Order 26.4B1 order. She added that she thought the [redacted] department would take care of the discontinue but that she could be wrong.

On 10/06/22 at 01:16 PM, the surveyor interviewed the U.S. FOIA (b) regarding Resident #20 and the reason that the new order for Ex Order 26.4B1 was ordered in Ex Order 26.4B1. The U.S. FOIA (b) stated that she did not know. The surveyor asked the U.S. FOIA (b) to review the NJ Ex Order 26.4b1 screen done by U.S. FOIA (b)(6) [redacted] and if Resident #20 should have an order for Ex Order 26.4B1. The U.S. FOIA (b) then reviewed the screen and stated that there should not be an order for Ex Order 26.4B1 for Resident #20. The surveyor then asked the U.S. FOIA (b) if the nurses should have been signing that the order was administered. The U.S. FOIA (b) stated that the nurses

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should not be signing since "obviously" they were not [applying it]. The surveyor asked the [redacted] if there should have been two of the same order and how long before the physician should be notified if an order is not able to be carried out. The [redacted] stated that there should not be two orders and that it should not be long before the nurse should contact the physician. She added 2-3 days "at max". The surveyor then asked the [redacted] what the difference between the [redacted] and the [redacted] were. The [redacted] stated that if the [redacted] could not be placed in the [redacted] then the [redacted] would never be able to be placed.

On 10/07/22 at 11:04 AM, the surveyor interviewed th [redacted]) regarding Resident #20's concerns about the [redacted] orders. The [redacted] stated that he would expect that they would search for something effective. He added that if they could not find something effective then the nurses should not have signed for anything that was not administered. He then stated that he did not know the facility policy but that the nurse should have notified the physician after 3 days which he thought was a reasonable amount of time.

On 10/07/22 at 11:34 AM, during surveyor interview, the [redacted] stated that for a resident that had limited range of motion a screen from NJ Exec Order 26.4b1 should be done and that their recommendation should be followed. She then stated that if a nurse was unable to place the physician ordered [redacted] in the resident's [redacted] that the nurse should not be signing that the order was administered. The surveyor then

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F 688	Continued From page 176 asked how long it should be before the nurse would contact the physician. The U.S. FOIA (b)(6) stated that it should be three days and then the nurse should contact the physician that the order is unable to be carried out. The surveyor then asked the U.S. FOIA (b)(6) if a resident with NJ Ex Order 26.4b1 [redacted] should have had a care plan for that concern. The U.S. FOIA (b)(6) stated that they should have had a care plan for that. A review of the facility provided policy titled, "Range of Motion Exercises" with a reviewed date of 5/2/22, did not include information regarding physician orders for handrolls or care plan for contractures. N.J.A.C. 8:39-27.1(a);27.2(m)	F 688		
F 689 SS=E	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 observation, interview, and record review, the facility failed follow the facility policy for fall prevention, and to ensure: a.) interventions in place to prevent accidents were consistently implemented, and b.) residents NJ Ex Order 26.4b1 received adequate supervision to NJ Ex Order 26.4b1. This deficient practice was identified for 2 of 5 of five residents (Resident #13 and #24) reviewed	F 689	Immediate Action a. Resident #13's care plan has been reviewed and revised b. Resident #24 was reviewed by the interdisciplinary team and individualized care plan was reviewed and revised to updated NJ Ex Order 26.4b1 [redacted]. NJ Exec Order 26.4b1 screened resident	12/6/22

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F 689	Continued From page 177 for accidents and was evidenced by the following: On 09/21/22 at 10:15 AM, the surveyor observed Resident #13 in a low bed and his/her EX Order 26.4B1 EX Order 26.4B1. Resident #13 hac EX Order 26.4B1 on the EX Order 26.4 area. Resident #13 was alert and was calling out EX Order 26.4B1 continuously. On 09/21/22 at 11:30 AM, the surveyor returned to the room and observed that Resident #13 remained in bed. Resident #13 was able to hold a conversation for a brief period of time and denied being in EX Order 26 On 09/22/22 at 1:02 PM, the surveyor observed Resident #13 in bed. A Certified Nursing Assistant (CNA #1) was in the room assisting Resident #13 with the lunch meal. Resident #13 was EX Order 26.4B1 and EX Order 26.4B1 out EX Order 26.4B1" during the meal. On 09/22/23 at 1:30 PM, the surveyor interviewed CNA #1 who stated that Resident #13 required NJ Ex Order 26.4b1 from staff with all activities of daily living (ADL's). All needs must be anticipated, does not use the call light. Resident #13 continuously calling out "EX Order 26.4B1". CNA #1 stated that Resident #13 sustained a EX Ord last week and the facility placed a EX Order 26.4B1 on the bed after the EX Orde. She declined to comment further on the EX Orde and she stated that the EX Orde occurred early in the morning on the 11:00 PM-7:00 AM shift. On 09/23/22 at 7:08 AM, the surveyor entered the room and observed Resident #13 in bed calling out "EX Order 26.4B1 The bed was in a high position, the bed rail on the right side was elevated with a bumper pad in place. The bed rail on the left side was lowered and the bumper pad was not	F 689	c. All residents reviewed for fall risks. Residents identified as a fall risk had their care plans reviewed and revised for fall risk interventions by Administrator and Interdisciplinary team. d. Facility policy on accidents/incidents was reviewed by Administrator and Interdisciplinary team. Interdisciplinary staff was re-educated. e. Facility fall prevention policy was reviewed by Administrator and Interdisciplinary team. Staff was re-educated. f. Facility policy on universal transfer form was reviewed by Administrator and Interdisciplinary team. Staff was re-educated. Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice Systemic changes a. Residents identified as a fall risk will be reviewed with interdisciplinary team at clinical meeting for care plan review and revision to include fall prevention interventions b. All residents sustaining a fall will be referred to the rehabilitation department and screened for fall risk prevention recommendations	

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F 689	Continued From page 178 adjusted. The Registered Nurse Registered Nurse (RN #1) entered the room, administered medication to Resident #13, and then left the room. On 09/23/22 at 7:14 AM, the surveyor returned to the room and observed the bed was in the same position. The surveyor escorted the Licensed Practical Nurse Licensed Practical Nurse (LPN #4) to the room where we both observed the resident's bed in high position, the bumper pad not adjusted. The nurse stated that all staff who provided care were aware that the bed had to be in the lower position. On 09/27/22 at 11:00 AM, the surveyor reviewed the clinical record of Resident #13 which reflected that Resident #13 was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 The Quarterly Minimum Data Set (MDS) with an assessment Reference date of Ex Order 26.4B1 revealed that Resident #13 was Ex Order 26.4B1 Ex Order 26.4B1 . Resident #13 received a score of " on the Ex Order 26.4B1 for daily decision making (section c1000). Resident #13 wasNJ Ex Order 26.4b1 staff to meet his/her needs in bed mobility, transfer, toilet use, eating and dressing. The surveyor reviewed Resident #13's care plan and noted a Ex Ord care plan initiated on Ex Order 26.4B1 . The Care plan received from the Charge Nurse on Ex Order 26.4B1 , did not indicate that Resident #13 was at risk for Ex Order 26 . The Care plan received from theUS FOIA (b)(6) dated NJ Ex Order 26.4b1 , identified that Resident #13 was NJ Ex Order 26.4b1 based on	F 689	c. Facility policy for change in resident condition has been reviewed. Interdisciplinary staff received education to facilitate early identification on change in condition and fall prevention d. Stop and Watch policy was initiated for early identification of resident change in condition. Interdisciplinary staff was educated. e. The Universal Transfer Form Policy was reviewed. Interdisciplinary staff was educated on the Universal Transfer form policy Quality monitoring Monthly audit of completed Universal transfer forms will be completed by the Social Worker and submitted to the QAPI Committee Monthly audit of completed incident/accident reports will be completed by the Regional Nurse and submitted to the QAPI Committee Audits will be submitted monthly month X 6 months. The first of which will take place in December 2022.	

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score of EX Order The EX Order Risk Assessment was not provided. The goal was for Resident #13's safety to be maintained in the least restrictive environment. Further review of the care plan revealed that Resident #13 was at risk for EX Order related to EX Order 26.4B1, EX Order 26.4B1 and EX Order 26.4B1. Interventions included but were not limited to:

Staff will answer your call bell promptly.
We will maintain a clutter free environment.
Will place all personal belongings within reach
We will place you in high visibility areas while you are awake
We will not leave you alone in the room or on toilet.

On 09/27/22 at 10:30 AM, the surveyor further reviewed the clinical record of Resident #13 and noted that Resident #13 sustained EX Order at the facility on the following dates: EX Order 26.4B1 and EX Order 26.4B1

The following information were entered in the electronic medical records:

09/10/22, "Resident noted in bed at EX Order 26.4B1 Awake, alert and NJ Ex Order 26.4b1 only. yelling out "EX Order 26.4B1" NJ Ex Order 26.4b1 noted. PRN (as needed) EX Order 26.4B1 given with little effect. At EX Order EX Order, resident was still EX Order 26.4B1 out, then he/she started EX Order 26.4B1. Noted resident NJ Ex Order 26.4b1 by the bed. Appeared to have EX Order 26.4B1 of his/her bed. Noted EX Order 26.4B1 the EX Order 26.4B1." Causal factor: Resident EX Order 26.4B1 the bed and was noted EX Order 26.4B1. Steps taken to prevent recurrence: EX Order 26.4B1 EX Order 26.4B1.

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NJ Ex Order 26.4b1 at 7:15 AM, an entry in the Progress notes indicated, "Resident found at Ex Order 26.4B1 Ex Order 26 . Ex Order 26.4B1 Ex Order 26.4B1 Resident NJ Ex Order 26.4 happened, continued to NJ Ex Order 26.4b Ex Order 26.4B1" Assist NJ Ex Order 26.4b1, physician notified, sent to the hospital for evaluation."The causal factor was not identified. The hospital record indicated the following under diagnosis: 'Ex Order 26.4B1

09/23/22 at 3:45 PM, Resident was found by CNA Ex Order 26.4B1 . When asked what happened, he/she replied "I don't know." Steps taken to prevent recurrence: "Educated to call for help or use the call bell. The facility identify Resident #13 as being Ex Order 26.4B1 NJ Ex Order 26.4b1 on staff.

On 09/23/22 at 7:15 AM, the surveyor interviewed the 11:00 PM -7:00 AM Licensed Practical Nurse (LPN #4) regarding the NJ Exec Order 26.4b1 that happened on her shift. She stated, "it did not happened like that", and declined to comment. The surveyor attempted to call the nurse several times, she did not return the call.

On 09/26/22 at 11:30 AM, the surveyor reviewed the electronic Progress Notes and noted an entry dated timed NJ Exec Order 26.4b1 which documented, "It is recommended that Resident #13 is out of the bed everyday to hallway, dayroom/ downstairs activity room to increase environmental stimulation and tolerance to positioning in chair, NJ Ex Order 26.4b1 improves but

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1 pillow may be used to keep patient in midline..." The facility did not follow the above recommendations. Staff could not identify what measures could be implemented to keep Resident #13 from NJ Exec Order 26.4b1 out when left alone in the room.

On 09/27/22 at 9:30 AM, the surveyor observed Resident #13 in bed, calling out Ex Order 26.4B1 " Ex Order 26.4B1 .

On 09/28/22 at 10:00 AM, the surveyor requested the New Jersey Universal Transfer Form (NJUTF) for review. The U.S. FOIA ((indicated she could not locate the NJUTF.

On 09/28/22 at 10:30 AM, the surveyor interviewed CNA #3 who was familiar with Resident #13's routine. CNA#3 stated that Resident #13 was always Ex Order 26.4B1 continuously Ex Order 26.4B1 . Resident #13 NJ Ex Order 26.4b1 himself/herself but now NJ Ex Order 26.4b1 with meals. She added that Resident #13 could be Ex Order 26.4B1 .

On 10/05/22 at 10:30 AM, the surveyor showed to the the Emergency Department Documentation which stated the following under diagnosis:
Ex Order 26.4B1 .
Ex Order 26.4B1 .
The U.S. FOIA ((declined to comment on the discrepancy. The incident report provided documented that Resident #13 was found Ex Order 2 .

On 10/06/22 at 3:36 PM, during an interview with the U.S. FOIA ((regarding the Ex Order 2 , she stated that if she had known about the incident more closely, she

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would have called an Interdisciplinary meeting and would implement more meaningful interventions. The surveyor then asked if any in-service education had been done, the [redacted] stated that the night nurse did not report that Resident #13's bed was in a [redacted] the morning of [redacted]. No in service was done.

There was no documentation in the clinical record that an Interdisciplinary meeting was called, discussed the falls and implemented meaningful interventions to keep Resident #13 safe.

Resident #13 was [redacted] in the room on [redacted], the facility indicated that he/she [redacted] the bed. The facility did not take any action to prevent recurrence. The Resident was not provided with a [redacted] as indicated in the policy. The care plan was not updated. Resident #13 sustained another [redacted] in the room on [redacted] and and was sent to the hospital for evaluation. Resident #13 sustained a [redacted].

b.) The surveyor reviewed Resident #24's medical record on [redacted] which reflected that Resident #24 had diagnoses which included but not limited to: [redacted].

The Quarterly MDS assessment dated [redacted], reflected that Resident #24 was [redacted] Resident #24 was [redacted] on staff for all ADLs.

A review of the plan of care dated [redacted] included a focus for [redacted] and documented the following: "I am [redacted] for [redacted] based on score

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risk of [redacted]. The goal was for Resident #24 to be [redacted] related to [redacted] Resident #24's [redacted] interventions included:

We will maintain a clutter free environment.
We will bring you to the dayroom during the day for closer supervision.
We will not leave you in the room and on toilet.
We will place you in high visibility area while you are awake.

On 09/23/22 at 10:30 AM, an interview with the Certified Nursing Assistant (CNA #2) who cared for Resident #24, revealed that Resident #24 was [redacted] on staff for care. CNA #2 stated that Resident #24 was a [redacted].

On 09/24/22 at 9:47 AM, the surveyor further reviewed the Progress Notes which revealed that Resident #24 [redacted] on the following dates: [redacted]. The following entries were entered in the electronic medical record:

[redacted] 4:36 PM, [redacted] during the last part of day shift. [redacted] noted. The physician was notified, [redacted] implemented. Patient is resting comfortably.

[redacted] 3:07 PM, Resident attempted [redacted] between the [redacted] and wet floor sign, then [redacted]. No injuries noted. Family and Nurse Practitioner notified.

On 09/22/22 at 9:49 AM, the surveyor observed Resident #24 [redacted] on the locked unit. [redacted]. No staff attempted to redirect him/her in the dayroom for activities.

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F 689	Continued From page 184 On 09/26/22 at 11:35 AM, the surveyor observed Resident #24 Ex Order 26.4B1 and Ex Order 26.4B1. No staff were observed to redirect Resident #24. On 09/28/22, the surveyor requested the investigative reports for the Ex Order 26.4B1. The U.S. FOIA (b) stated that she was not aware of the Ex Order 26.4B1. The surveyor reviewed the Progress notes with the U.S. FOIA (b), the U.S. FOIA (b) stated she would locate the investigative reports. On 10/04/22 at 1:45 PM, the U.S. FOIA (b) provided the fall facility's policy and stated that she could not locate the investigative reports. No additional information was provided on the exit day. A review of the facility's fall prevention Policy and Procedure dated 01/05/22 last revised 05/26/22 revealed the following: Policy: It is the policy of the facility to identify specific risk factors that may indicate the resident is at risk for falls upon admission, readmission, quarterly annually, and with any significant change. Based upon the assessment the resident will have a preventative plan of care initiated as well as be revised, and evaluated throughout their stay at the facility. The interdisciplinary team will collaborate in developing, evaluating, and revising fall prevention plan of care to prevent falls/ injury, or to minimize injury and/ or complications if a fall should occur. The policy also indicated that beds should remain in a low position and brakes on at all times. Call bell and personal belongings should be within the resident's reach. Utilize a floor mattress or scoop mattress as	F 689		

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F 689	Continued From page 185 indicated and needed. Include in falling star program as indicated. N.J.A.C. 8:39-27.1 (a)	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to document the NJ Ex Order 26.4b1 administered by nursing for 1 of 2 residents (Resident #69) reviewed for EX Order 26.4B1 while on EX Order 26.4B1 (EX Order 26.4B1 [redacted]). This deficient practice was evidenced by the following: On 09/21/22 at 10:41 AM, the surveyor observed Resident #69 sitting in a chair by the window in his/her room. Resident #69 stated he/she was on NJ Ex O and there was an EX Order 26.4B1 [redacted] . On 09/26/22 at 11:03 AM, the surveyor observed Resident #69 in their room eating ice chips out of a pink water pitcher. Resident #69 stated that he/she had EX Order that day and would be picked up at 1 PM. The resident further stated he/she was not on any EX Order 26.4B1. He/she stated they	F 698	1. Immediate action a. Resident # 69's EX Order 26.4B1 [redacted], and resident's medical record was updated. b. All residents on a fluid restriction were identified, medical records were reviewed for accuracy and updated as needed. c. Staff received immediate education on fluid restriction policy and documentation 2. Identification of Others a. All residents on fluid restriction have the potential to be affected by this deficient practice 3. Systemic Action a. Facility policy for fluid restrictions was revised. Nursing staff was educated b. Facility policy on change in condition	12/6/22

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F 698	Continued From page 186 would eat before he/she would leave. The surveyor asked again if anyone ever told him/her to [redacted]. The resident stated, [redacted] A review of the Resident Face Sheet revealed Resident #69 was admitted to the facility [redacted] with diagnoses which included but were not limited to [redacted] The Admission Minimum Data Set (MDS-an assessment tool) dated [redacted], revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating [redacted] cognition. Section I1500 revealed an active diagnosis [redacted], [redacted] revealed Resident #69 was on a [redacted] was on [redacted]. A review of the "Physician Order Activity Detail Report" revealed an order dated [redacted] for Diet: special instructions: nursing [redacted]. A review of Resident #69's on-going Care Plan revealed a focus area effective [redacted] "will comply with [redacted] and [redacted] restrictions.." and a focus area effective [redacted], [redacted] ([redacted])." A review of the [redacted] Medication Administration Record (MAR) revealed the [redacted] with a start date of	F 698	was reviewed and staff was educated to included reporting of new orders on 24 hour report sheet. c. New/changes in orders for fluid restrictions will be communicated from nursing to dietary on a communication tool and in daily clinical meeting. d. Care plans will be updated accordingly. e. Facility created and implemented a policy to identify residents on fluid restrictions. f. Orders for fluid restrictions will be communicated to the dietary department via a written communication tool. 4. Quality Assurance monitoring a. The dietitian/designee will audit residents on a fluid restriction weekly x 6 months. The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations. The first of which will take place in December 2022. Audit results will be reported to the QAPI committee monthly for review and further recommendations	

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NJ Ex Order 26.4b1 and a protocol to document intake every shift. A review of the Ex Order 26.4B1 and Ex Order 26.4B1 MARs failed to display the NJ Ex Order 26.4b1 order for the nursing staff to document the amount of NJ Ex Order 26.4b1 shift the resident was administered.

A review of the Progress Notes revealed a note entered by the U.S. FOIA (b)(6)) dated Ex Order 26.4B1 The NJ Ex O noted that she had a conversation with the NJ Ex O at Resident #69's NJ Ex O center. The note revealed the Ex Order 26.4B1 Ex Order 26.4B1)".

On 09/30/22 at 11:08 AM, during an interview with the surveyor, the U.S. FOIA (b)(6)) caring for Resident #69 stated if a resident was on Ex Order 26.4B1, it would show up in the orders. The U.S. FOIA (b) accessed Resident #69's electronic medical record (eMR) but was unable to provide any documentation of NJ Ex Order 26.4b1. The U.S. FOIA stated the amounts documented should be in the MAR so that nursing could check it NJ Ex Order off.

On 10/04/22 at 09:21 AM, during an interview with the surveyor, the U.S. FO stated if a resident was on a NJ Ex Order 26.4b1, the amount would be split between dietary and nursing. The U.S. FOIA stated the order would be put it in the eMR and be sent into "[computerized menu software]" to determine how much NJ Ex Orde would be provided for dietary and nursing. The U.S. FO accessed Resident #69's eMR and was unable to provide any documentation of the NJ Ex Order 26.4b1 in the MAR starting in Ex Order 26 Ex Order 26 when the order was given. The U.S. FOIA acknowledged the NJ Ex Order 26.4b1 order was given Ex Order 26.4B1. The U.S. FO further stated she had no way to know if nursing was administering the correct NJ Ex Order 26.4b1 because it was not

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F 698	Continued From page 188 documented anywhere that she was aware of. The[U.S. FOIA] stated if a resident on[NJ Ex Order 26.4b1] was provided extra[NJ Ex Orde], it could be detrimental to the resident's health. On 10/04/22 at 9:32 AM, during an interview with the surveyor, the[U.S. FOIA (b)(6)]) stated that dietary would notify the nursing staff of any[NJ Ex Order 26.4b1] amount they were responsible to administer. The[U.S. FOIA (b)] stated the[NJ Ex Orde] amount would be split between nursing and dietary and that she would be ultimately responsible to ensure the[NJ Ex Order 26.4b1] were in place and being followed. The[U.S. FOIA (b)] stated it was important for the nurses to monitor the[NJ Ex Order 26.4b1] so the resident would not become[EX Order 26.4B1]. A review of the facility provided, "Fluid Restrictions" policy last reviewed 08/07/22, included but was not limited to Policy: ..to maintain fluid restrictions as per.. orders and /or in accordance with the recommendations from nephrology or dialysis. Purpose: to maintain fluid restrictions and allow resident to "exchange" fluids as desired for quality of life. Procedure: 2. the dietitian communicates with nursing and dietary ....their respective daily allotted fluid amount. 6. Nursing to review fluids consumed during medication pass. 8. Document fluid restriction and updates care plans. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-27.1(a)	F 698		
F 725 SS=F	Sufficient Nursing Staff	F 725		12/5/22

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F 725	Continued From page 189 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) provide EX Order 26.4B1 care on 1 of 3 units (unsampled resident), b.) provide EX Order 26.4B1 consultation per physician order for a resident who expressed EX Order 26.4B1 and feelings of	F 725	1. Immediate action a. Facility staffing was reviewed to evaluate compliance with New Jersey state certified nursing assistant staffing requirements. b. Resident #54 s NJ Ex Order 26.4b1 [redacted]	

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F 725	Continued From page 190 NJ Ex Order 26.4b1 for 1 of 3 residents reviewed for NJ Ex Order 2 [redacted] (Resident #63), c.) schedule a resident's appointment with their preferred EX Order 26.4B1 after a hospital visit for 1 of 5 residents who attended a Resident Council Meeting (unsampled resident), and d.) maintain the required minimum direct care staff-to-shift ratios as mandated by New Jersey State requirement, CHAPTER 112 (An Act related to staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes). The deficient practice was evidenced as follows: Refer to: F584, F740, F636, F638, and F882 a.) On 09/23/22 at 6:53 AM, Surveyor #1 went to the locked unit and observed the following: Resident #54, pads on the bed were Ex Order 26.4B1 Ex Order 26.4B1 in the room, and a NJ Exec Order was noted crawling on the floor. During an interview at that time with the surveyor, the resident indicated that he/she had NJ Ex Order 26.4b1 during the night. Surveyor #1 escorted the 11:00 PM - 7:00 AM Licensed Practical Nurse (LPN) #1 to the room where they both observed the same. The resident had NJ Ex Order 26.4b1 [redacted] were Ex Order 26.4B1 [redacted], and the fitted sheet was also Ex Order 26.4B1 [redacted]. On 09/23/22 at 6:58 AM, during an interview with Surveyor #1, the 11:00 PM - 7:00 AM US FOIA (b)(6) [redacted] revealed that the resident would not get up to be changed during the night and that she had to wait until the resident got up. Surveyor #1 went to Resident #54's room and observed that the mattress was also Ex Order 26.4B1.	F 725	care was provided. c. Resident # 48□s NJ Ex Order 26.4b1 [redacted] leaned, and EX Order 26.4B1 care was provided d. Resident # 63 was discharged and does not currently reside in the facility. e. US FOIA (b)(6) was educated on New Jersey state certified nursing assistant staffing requirements. f. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will use staffing agencies and offer additional shifts to current staff. 2. Identification of Others a. All residents have the potential to be affected by the deficient practice. 3. Systemic changes Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. The facility administrator/designee will continue to document all recruitment and retention efforts weekly. 4. Quality monitoring The administrator/designee will review staffing schedules weekly to ensure Adequate staffing for all shifts. The results of these reviews will be submitted to the Quality Assurance Performance	

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F 725	Continued From page 191 On 09/23/22 at 7:01 AM, Surveyor #1 interviewed LPN #1 who worked the 11:00 PM -7:00 AM shift, LPN#1 stated that her role was to ensure that all EX Order 26.4B1 residents were up and changed every 2 hours and as needed. Surveyor#1 escorted LPN #1 into Resident #48's where we both observed the same, the NJ Ex Order 26.4b1. LPN#1 confirmed the unsampled resident did not receive EX Order 26.4B1 care during the shift. When asked if EX Order 26.4B1 care was provided, she did not have any comment. On 09/23/22 at 7:19 AM, the surveyor interviewed CNA #3 assigned to the EX Order 26.4 Unit, she stated that some days when she reported to work in the morning, EX Order 26.4B1 care was not provided for EX Order 26.4B1 residents if they were short handed. b.) On 09/27/22 at 12:34 PM, Surveyor #2 observed Resident #63 lying in bed. The resident NJ Ex Order 26.4b1 but informed the surveyor they were in EX Order 2 and had received medicine for the EX Order 26 The resident stated that he/she mainly stayed in bed because of the EX Order 26.4 The surveyor reviewed the medical record for Resident #63. A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in Ex Order 26.4B1 with diagnoses which included Ex Order 26.4B1, Ex Order 26.4B1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 reflected a brief interview for mental	F 725	Improvement Committee monthly for 6 months. The first of which will take place in December 2022. Based on the audit results, a decision will be made regarding the need for continued submission and reporting	

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F 725	Continued From page 192	F 725		

status (BIMS) score of [redacted] out of 15, which indicated Ex Order 26.4B1 .

A review of the Physician Order Activity Detail Report reflected the resident had a physician's order (PO) dated Ex Order 26.4B1 for Ex Order 26.4B1 as needed.

A review of the Clinical Notes included a Nurses Note dated Ex Order 26.4B1 , reflected the resident stated, Ex Order 26.4B1 ." Resident will have a room change to be with his/her friend. Staff instructed to monitor closely, and Ex Order 26.4B1 ordered.

A review of an additional Nurses Note dated Ex Order 26.4B1 , reflected the resident was seen by [name redacted Ex Order 26.4B1 Ex Order 26.4B1 and screening staff today at 5:10 PM, recommended follow-up with Ex Order 26.4B1

On 10/5/22 at 9:39 AM, the U.S. FOIA (b) in the presence of the Ex Order 26.4B1 stated Resident #63 was never seen by a psychiatrist while at this facility. The U.S. FOIA (b)(6) called the previous US FOIA (b)(6) who confirmed the resident was not seen because they were unaware the resident needed to be seen. The U.S. FOIA (b)(6) confirmed the nurse should have informed the Ex Order 26.4B1 .

On 10/05/22 at 12:01 PM, during surveyor interview, the facility US FOIA (b)(6) stated she had been at the facility NJ Ex Order 26.4b1 . She stated she did not know the CNA staffing ratios off the top of her head, but she believed the ratio was met most days. She further stated that

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AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

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F 725	Continued From page 193 sometimes staffing was difficult on the weekend. c.) During a Resident Council meeting conducted on Ex Order 26.4B1, 1 of 5 residents (unsampled) stated that 5 or 6 months ago he/she Ex Order 26.4B1 and was Ex Order 26.4B1 and upon return he/she had to wear a Ex Order 26.4B1 "for a while." The resident stated that his/her Ex Order 26.4B1 sent a letter because he was unable to reach anyone in the facility. The resident showed the surveyor another Ex Order 26.4 " from his/her Ex Order 26.4B1 that revealed they had made 3 attempts to contact him/her at the numbers provided. "Unable to reach and no call back. Trying to schedule testing [redacted] On 09/28/22 at 1:25 PM, the resident stated that he/she told the NJ Ex Order 26.4b1, who was out with Ex Order 26.4B1 took her Ex Order 26.4B1 letter and lost it. The resident stated he/she was still waiting for an appointment. On 10/07/22 at 10:52 AM, during surveyor interview, the U.S. FOIA (b)(6) stated he was aware of the CNA ratios as 1-8 (7 AM - 3 PM), 1-10 (3 PM - 11 PM) and 1-14 (11 PM - 7 AM) and that to his understanding the facility had been meeting the ratios. d.) Per the New Jersey State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. On 09/30/22, 2 weeks of staffing had been calculated (09/04/2022 to 09/10/2022 and 09/11/2022 to 09/17/2022) for the 10/12/2022 Standard survey at the facility and the results were as follows:	F 725		

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F 725	Continued From page 194 The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -09/04/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -09/05/22 had 10 CNAs for 103 residents on the day shift, required 13 CNAs. -09/06/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -09/07/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/08/22 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. -09/10/22 had 10 CNAs for 100 residents on the day shift, required 13 CNAs. -09/11/22 had 11 CNAs for 100 residents on the day shift, required 12 CNAs. -09/12/22 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -09/13/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/14/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/15/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -09/16/22 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. N.J.A.C. 8:39-5.1(a)(c); 25.2 (a); 27.1(a)	F 725		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		12/5/22

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F 726	Continued From page 195 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility provided documentation, the facility failed to ensure that staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety, and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice was evidenced by the following: On 10/07/22 at 11:48 AM, the surveyor	F 726	1. Immediate Action a. The interim infection preventionist was replaced with a CDC trained infection preventionist b. The US FOIA (b)(6) [redacted] were educated by the Regional Nursing Home Administrator on competent nursing staffing. c. The facility “Competency of Nursing Staff” policy was reviewed for compliance with Federal regulations. The policy was compliant with federal regulations and no	

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F 726	Continued From page 196 interviewed the US FOIA (b)(6) who had been the facility US FOIA (b)(6) prior to becoming the US FO regarding staff competencies. The US FOIA stated that she was only the US FOIA (b)(6) and that she had been implementing the new computer system during that time. She added that the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)) were the facility's educators and that the competency book would possibly be located in the U.S. FOIA (b)(6) office. On 10/07/22 at 11:57 AM, the surveyor interviewed the Ex Order 26.4B1 floor U.S. FOIA (b)(6) regarding staff competencies. The U.S. FOIA stated that she had occasionally given in-services to staff but that she had not done any staff competencies. She added that she had thought the US FOIA (b)(6) r or the U.S. FOIA (b)(6) were responsible for staff competencies. On 10/07/22 at 11:59 AM, the surveyor interviewed the U.S. FOIA (b) regarding staff competencies and requested to view the facility's documentation of staff competencies. The U.S. FOIA (b) stated that if there were staff competencies done that she did not know where they were. She stated that the educator would be responsible for staff competencies. The U.S. FOIA (b) then stated that she had not done any competencies with staff but that she was not saying that they were not done. She added that she believed that the former Infection Preventionist had done an in-service on donning (to put on) and doffing (remove) of personal protective equipment but that she was not aware if the former Infection Preventionist had done any competencies. On 10/12/22 at 09:53, the surveyor interviewed the U.S. FOIA (b)(6)	F 726	changes were made. d. An audit of the facility nursing staff was done to identify missing mandatory competencies. e. Missing nursing competencies were completed. 2. Identification of Others a. All nursing staff has the potential to be affected by the deficient practice 3. Systemic changes a. Nursing competencies will be done during new hire orientation, annually and as dictated by facility need. b. Staffing coordinator/designee will ensure that nursing competency packets are available for scheduled agency staff. c. The staff educator/designee will ensure that agency nursing staff competencies will be completed. 4. Quality monitoring a. The facility educator will audit nursing competencies monthly x 6 months. Audit results will be reported to the Quality Assurance and Performance Improvement committee monthly x 6 months for review and further recommendations. The first of which will take place in December 2022.	

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F 726	Continued From page 197	F 726		

U.S. FOIA (b)(6) regarding staff competencies. The U.S. FOIA (b)(6) stated that the expectation would be to follow what the current policy was but that he did not know what the policy was in detail. He then stated that after orientation, the expectation was a competency which was the ability for them to perform the task. The surveyor then asked the U.S. FOIA (b)(6) who was responsible for staff competencies. The U.S. FOIA (b)(6) stated that the department heads should have done their staff competency. He then added that the Unit Managers should have done their staff competencies. The surveyor then asked who would do the third floor staff competencies since there was not a Unit Manager on the third floor. He stated that the U.S. FOIA (b)(6) or U.S. FOIA (b)(6) should then do them. He added that there was a good chance the policy was not updated. He then stated that he was trying to get things on track before this survey and that was why "we have survey to get back on track."

The facility was unable to provide the survey team any documented evidence that staff competencies were completed.

A review of the facility provided policy titled, "Competency of Nursing Staff," with a reviewed date of 2/2/22, included the following:
Under Policy Statement
1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law.
2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will:
a. participate in a facility-specific, competency-based staff development and

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F 726	Continued From page 198 training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of resident, as identified through resident assessments and described in the plans of care. Under Policy Interpretation and Implementation 1. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents ... 3. The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population ... 5. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. 6. Facility and resident-specific competency evaluations will include: a. Lecture with return demonstration for physical activities; b. A pre- and post-test for documentation issues; c. Demonstrated ability to use tools, devices, or equipment used to care for residents; d. Reviewing adverse events that occurred as an indication of gaps in competency; or e. Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform. 7. competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge. 8. Inquires concerning staff competency evaluations should be referred to the Director of Nursing Services or to the Personnel Director.	F 726		

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F 726	Continued From page 199 N.J.A.C. 8:39-9.3(a)2,3	F 726		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		12/5/22

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F 732	Continued From page 200 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the posted 24-hour staffing report was completed in its entirety and provided accurate information. This deficient practice was evidenced by the following: On 09/30/22 at 11:24 AM, the surveyor observed the facility's version of the "Nursing Home Resident Care Staffing Report," dated 09/30/22, posted near the receptionist desk, which included the following: On 09/30/22 Day Shift, the Staffing Report omitted the Current Resident Census, the number of Staff for each staff category and the Staff to Resident Ratios for each staff category. The Total Hours Worked for Registered Nurse (RN) was 3; for Licensed Practical Nurse (LPN) was 4; and Certified Nurses Aide (CNA) was 10. On 09/30/22 Evening Shift, the Staffing Report omitted the Current Resident Census, the number of Staff for each staff category and the Staff to Resident Ratios for each staff category. The Total Hours Worked for RN was 2; for LPN was 4; and CNA was 9. On 09/30/22 Night, the Staffing Report omitted the Current Resident Census, the number of Staff for each staff category and the Staff to Resident Ratios for each staff category. The Total Hours	F 732	1. Corrective Action: US FOIA (b)(6) was in serviced on the proper way to complete the daily staffing report 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected due to the nature of the deficiency 3. Measures Put into Place: DON and/or designees will audit 3 times/week to assure proper completion of the daily staffing report to assure accuracy and completion. 4. How Will These Actions Be Measured: The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 732	Continued From page 201 Worked for RN was 0; for LPN was 4; and CNA was 4. On 10/05/22 at 12:01 PM, the surveyor interviewed the US FOIA (b)(6) regarding posting the 24-hour staffing report. The US FOI stated that she posts the number of employees that work that shift that day. The surveyor then asked the SC if the posted information had to include the number of hours worked and the SC stated "no." On 10/06/22 at 12:05 PM, during surveyor interview, the US FOI stated that she was never told to write the census on the form when she was trained at this facility. She added that when she worked at another facility, she had put the census on the form. On 10/6/22 at 01:15 PM, during surveyor interview, the U.S. FOIA (b)(6)) stated that she looked at the 24-hour staffing report. The U.S. FOIA (b) stated that the information that was to be posted was the number of nursing staff, census, actual hours worked and the ratio of staff to number of residents. On 10/07/22 at 10:52 AM, during surveyor interview, the U.S. FOIA (b)(6) stated that the 24-hour staffing report should have the census, how many nursing staff each shift, the actual hours worked and the ratio of staff to number of residents. On 10/07/22 at 11:34 AM, during surveyor interview, the U.S. FOIA (b)(6) stated the 24-hour staffing report should have the census, how many nursing staff each shift, the actual hours worked and the ratio	F 732		

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F 732	Continued From page 202	F 732		

of staff to number of residents. She added that usually the facility would print the form from the state.

Review of the facility provided policy titled, "Posting Direct Care Daily Staffing Numbers" with a reviewed date of 2/5/22 included the following:
Under Policy Statement
Our facility will post, on a daily basis for each, the number of nursing personnel responsible for providing direct care to residents.
Under Policy Interpretation and Implementation
1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ...
3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include:
a. The name of the facility.
b. The date for which the information is posted.
c. The resident census at the beginning of the shift for which the information is posted.
d. Twenty-four (24)-hour shift schedule operated by the facility.
e. The shift for which the information is posted.
f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift.
g. The actual time worked during that shift for each category and type of nursing staff.
h. Total number of licensed and non-licensed nursing staff working for the posted shift ...
5. Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the

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F 732	Continued From page 203 number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator. 6. The form may be typed or handwritten ... N.J.A.C. 8:39-41.2 (a)(b)(c)	F 732		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other pertinent facility documentation, it was determined that the facility failed to provide NJ Ex Order 26.4b1 for a resident who expressed NJ Ex Order 26.4b1 as ordered by the physician in NJ Ex Order 26.4 This deficient practice was identified for 1 of 3 residents reviewed for NJ Ex Order 26.4b1 (Resident #63) and was evidenced by the following: On 09/27/22 at 09:57 AM, the surveyor interviewed Temporary Nursing Aide (TNA) #1,	F 740	1. Immediate Action a. Resident # 63 was transferred and no longer resides in the facility b. All residents were reviewed to identify residents with outstanding orders for behavioral health treatment. c. Nursing team received immediate education on timely execution of physicians' orders for behavioral health treatment. 2. Identification of Others a. All residents with orders for behavioral health services have the	12/5/22

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F 740	Continued From page 204 who stated the facility's locked unit was for residents who had a tendency to [redacted] off of a unit, had [redacted], and more '[redacted] [redacted]. TNA #1 continued Resident #63 was a resident on the unit who usually stayed in their room or in the hallway and went outside to [redacted] [redacted] TNA #1 stated the resident had [redacted] but there was an incident last month where Resident #63 was observed exiting a resident of the [redacted] room. Resident #63 had not had a tendency to [redacted], and the incident was reported to the nurse. On 09/27/22 at 10:30 AM, the surveyor interviewed TNA #2, who stated Resident #63 was [redacted] and liked to be [redacted] and liked to [redacted] when they tried to [redacted] them. TNA #2 reported the resident could also be [redacted] with residents and could try [redacted] residents of the [redacted] into their room. TNA #2 stated she witnessed the incident occur once and removed the other resident from Resident #63's room. On 09/27/22 at 12:34 PM, the surveyor observed Resident #63 lying in bed. The resident spoke [redacted], but informed the surveyor they were in [redacted] and had received medicine for the [redacted]. The resident stated that he/she mainly stayed in bed because of the [redacted] The surveyor reviewed the medical record for Resident #63. A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in [redacted] with diagnoses which included [redacted], [redacted]	F 740	potential to be affected by the deficient practice. 3. Systemic Changes a. Behavioral health referral binders were placed on each unit. Residents referred for non-emergency behavioral health services will be recorded in the behavioral health referral binder. b. Behavioral Health practitioners were educated on the new policy and will be scheduled to see residents in the facility on a weekly basis and/or as needed. The behavioral health practitioner will check the referral binder on each unit weekly and as needed for new referrals. In the event of a delay in the availability of behavioral health services the ordering physician is to be notified c. Behavioral health referral binders will be reviewed by the Unit Managers or Nursing designee to ensure that residents are seen in an appropriate time frame. 4. Quality monitoring a. Unit managers/designee will audit referral binders on a weekly basis. Audits will be done on a monthly basis X 6 months and audit results will be forwarded to the QAPI committee monthly x6 months. The first of which will take place in December 2022. The QAPI committee will provide recommendations for further action	

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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([redacted]),
[redacted]

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated [redacted].

A review of the Physician Order Activity Detail Report, reflected the resident had a physician's order (PO) for [redacted] to administer [redacted] (mg) delayed release tablets every morning for [redacted] and current episode of [redacted]. The resident had an additional PO for [redacted] dated [redacted]; to administer [redacted] disorder and current [redacted]. The resident also had a PO dated [redacted] for [redacted] evaluation and treatment as needed.

A review of a Social Service Progress Note dated [redacted], reflected a [redacted]) reported resident was [redacted] and said to her, [redacted]." [redacted] stated other staff members reported hearing similar statements. A certified nursing aide suggested the resident be moved to another room with his/her friend so they would not [redacted]. Called [name redacted] [redacted] requesting an evaluation on Resident #63 for their [redacted]. [redacted] told nurses to make sure resident stayed in hallway and they [redacted] from resident's room that could be used to [redacted]

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A review of the Clinical Notes included a Nurses Note dated NJ Ex Order 26.4b1 at 03:00 PM, reflected the resident stated, "I am NJ Ex Order 26.4b1 ." Resident will have a room change to be with his/her friend. Staff instructed to monitor closely, and NJ Ex Order 26.4b1 ordered.

A review of an additional Nurses Note dated NJ Ex Order 26.4b1 at 08:40 PM, reflected the resident was seen by [name redacted NJ Ex Order 26.4b1 staff today at 05:10 PM, recommended follow-up with NJ Ex Order 26.4b1

A review of the Physician's Orders reflected a telephone physician's order dated NJ Ex Order 26.4b1 for a NJ Ex Order 26.4b1 from Physician #1, and a telephone physician's order dated NJ Ex Order 26.4b1 for a NJ Ex Order 26.4b1 from Physician #2.

A review of NJ Ex Order 26.4b1 dated NJ Ex Order 26.4b1, recommended a follow-up with NJ Ex Order 26.4b1.

The surveyor was unable to locate any NJ Ex Order 26.4b1 follow-up in the medical record.

A review of the resident's comprehensive care plan included a focus area dated effective Ex Order 26.4B1 for at risk for NJ Ex Order 26.4b1 . Interventions included to bring activities that you enjoy; to arrange phone calls or video chats with your family; to ensure you have activities of your choosing available; and to provide you with tools you need to do your favorite activity if applicable. The care plan did not include the resident's NJ Ex Order 26.4b1 , or the resident's diagnoses of Ex Order 26.4B1

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On 09/28/22 at 10:44 AM, the surveyor interviewed the US FOIA (b)(6)), who stated she was a US FOIA (b)(6) who worked mostly on the locked nursing unit for the 7:00 AM to 3:00 PM shift. The US FOI stated the resident was okay and did NJ Ex Order 26.4b1 on her shift. The US FOIA continued the resident was able to make his/her needs known and had not been unpleasant towards her. The US FOI also stated since she was NJ Ex Order 26.4b1, she really would not know if the resident had been in any fights or altercations with other residents. When the surveyor asked who created or updated the care plan, the US FOIA responded any nurse could. The US FOI stated they care planned for NJ Ex Order 26.4b1, certain medications, safety, Activities of Daily Living (ADLs). The US FOI stated care plans were updated every ninety days or as soon as an issue arises that would be care planned for.

On 09/28/22 at 12:48 PM, the surveyor interviewed the U.S. FOIA (b)(6) (U.S. FOIA (b)(6) who stated he came to the facility weekly and touched base with the nursing staff to determine the residents who needed to be seen. The U.S. FOIA (b)(6) stated this company had only started at the facility this NJ Ex Order, and he had only been coming to this facility for about NJ Ex Order 26.4b1. The U.S. FOIA (b)(6) stated he did not recall seeing Resident #63 ever, but the resident was scheduled to be seen today and could not speak to why the resident needed to be seen.

On 09/29/22 at 11:54 AM, the US FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) who was currently overseeing the facility U.S. FOIA (b)(6), informed the surveyor that Resident #63 was transferred from

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the facility last night for appropriate placement.

On 10/4/22 at 12:56 PM, the surveyor interviewed the US FOIA (b)(6)), who stated if the resident had a physician's order for a Ex Order 26.4B1 consultation, it was the nurse's responsibility to let the U.S. FOIA (b)(6), or the U.S. FOIA (b)(6) know a resident needed to be seen. If after the resident was seen and there were new orders, it was the nurse's job to communicate the recommendation to the resident's physician and transcribe any new physician's orders. The LPN stated she was unfamiliar with Resident #63.

On 10/4/22 at 01:04 PM, the surveyor interviewed the U.S. FOIA (b) who stated if a resident had a Ex Order 26.4B1 consultation, the physician documented either on a consultation sheet that was uploaded to the electronic Medical Record (eMR), or they documented directly into the eMR. The U.S. FOIA (b) stated it was the nurses' responsibility to read all consultations and communicate any recommendations to the physician and carry out any new physician's orders. The nurse should document in the eMR that they spoke to the physician and any new orders, which is a nursing standard of practice.

At this time, the surveyor reviewed with the U.S. FOIA (b) the [name redacted Ex Order 26.4B1 screening] dated U.S. FOIA (b)(6) with the recommendation for a Ex Order 26.4B1 follow-up. The surveyor then reviewed the Nurse's Note dated Ex Order 26.4B1 the resident was seen today by [name redacted Ex Order 26.4B1 screening] with a recommendation to follow-up with Ex Order 26.4B1 The surveyor then reviewed with the U.S. FOIA (b) the telephone physician's orders from Ex Order 26.4B1 for a Ex Order 26.4B1 consultation which the

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U.S. FOIA (b) confirmed the resident should have seen the U.S. FOIA (b)(6). The surveyor requested all U.S. FOIA (b)(6) consultations the resident had at this facility. The U.S. FOIA (b) stated the facility had a new U.S. FOIA (b)(6) company that started this summer, but she would look for the information.

On 10/5/22 at 09:39 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b)(6), and U.S. FOIA (b)(6) stated Resident #63 was never seen by a U.S. FOIA (b)(6) while at this facility. The U.S. FOIA (b) stated the U.S. FOIA (b)(6) called the previous Ex Order 26.4B1 who confirmed the resident was not seen because they were unaware the resident needed to be seen. The U.S. FOIA (b)(6) confirmed the nurse should have informed the Ex Order 26.4B1.

On 10/7/22 at 10:16 AM, the U.S. FOIA (b) informed the surveyor that Resident #63 was not seen by the U.S. FOIA (b)(6), because the resident was transferred out of the facility before the U.S. FOIA (b)(6) saw them.

A review of the facility's "Change of Condition" policy dated effective 1/5/22 and reviewed 7/1/22, included it is the policy of the facility to identify and communicate changes in condition to the physician and other team members to implement interventions to prevent further deterioration and possibly to prevent hospitalization...the resident will be monitored until condition significantly improves...a care plan will be initiated and/or updated based on the reason for the change, goals and interventions...

A review of the facility's "Care Planning" policy dated effective 1/5/22 and reviewed 5/26/22, included care planning will be based on the MDS

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F 740	Continued From page 210 triggers as well as the medical diagnoses and complex medical conditions noted upon assessment...the comprehensive care plan will be reviewed and revised as needed upon re-admission, return bed hold, quarterly and upon significant change...care plans will be updated to reflect interval problems as they arise...	F 740		
F 755 SS=E	N.J.A.C. 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		12/5/22

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F 755	Continued From page 211 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure: a.) a medication was removed from active inventory after being discontinued in [redacted] for one (1) of three (3) medication carts inspected; and b.) expired medications were removed from emergency (back-up) supply box for 1 of 1 back up supply box. This deficient practice was evidenced by the following: 1.) On 09/26/22 at 11:58 AM, the surveyor inspected the Low side medication cart on the third floor in the presence of the Licensed Practical Nurse (LPN #1). The surveyor found one bingo card (a multidose card containing individually packaged medication) of [redacted]) 250 milligrams (mg) with Unsampled Resident #393's name crossed off with a marker and Resident #48's name had been handwritten in. The bingo card was dated [redacted], labeled 1 of 1. The bingo card found was opened with 13 tablets remaining. At that time, LPN #1 stated she did not know why Unsampled Resident #393's name was crossed	F 755	1. Immediate Action a. All medication carts were inventoried, and all manually altered medication bingo cards were removed. Discontinued medications and medications for discharged residents were returned to pharmacy and needed replacement medications were obtained from pharmacy. b. Nursing Staff was immediately educated on discontinuation of medication, returning discontinued medications to pharmacy, medication ordering, handling of discontinued medications, checking medication expiration dates ordering medications for back up medication box and declining inventory documentation. 2. Identification of Others a. All residents receiving medication in the facility have the potential to be affected by the deficient practice 3. Systemic changes a. Back up medication box has been relocated from the Director of Nursing office to 2nd floor nursing medication room to facilitate pharmacy account representative's access for inventory and expiration date auditing. b. Pharmacy account representative will	

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F 755	Continued From page 212 off and Resident 48's name was handwritten in. She also stated that a Resident's bingo card should not be relabeled with another resident's name because it can result in a medication administration error. A review of the Resident Face Sheet (an admission summary) revealed that Unsampled Resident #393 was admitted to the facility with diagnoses which included but were not limited to; other [redacted]. A review of the [redacted] electronic Medication Record (eMR) for Unsampled Resident #393 revealed that [redacted] A review of the Physician's Orders (PO) generated on [redacted] for Unsampled Resident #393 did not reveal an active order for [redacted] A review of Unsampled Resident #393's electronic Medication Administration Record (eMAR) from [redacted], revealed [redacted] was last administered on [redacted]. A review of the Resident Face Sheet revealed that Resident #48 was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of the PO generated on [redacted] at 1:21 PM for Resident #48 revealed an active order for [redacted] with an original order date of [redacted]	F 755	continue to audit all medication storage areas for medication expiration dates monthly. Upon identification of expired medications, the pharmacy account representative will remove expired medications and reorder as needed. c. Facility policy for discontinuation of medication was reviewed and revised as facility transitioned to an electronic health record platform. 4. Quality assurance monitoring The pharmacy account representative will continue to audit medication storage and declining inventory sheets, negative findings will be immediately corrected and reported to the Director of Nursing. The consultant pharmacist will continue monthly auditing and will provide written monthly reports. The pharmacy account representative and consultant pharmacy reports will be ongoing with no stop date and audit results will be reported to Director of Nursing. The Director of Nursing will report audit findings and actions taken to the Quality Assurance and Performance Improvement Committee monthly X 6 months for review and further recommendations. The first of which will take place in December 2022.	

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F 755	Continued From page 213 A review of Resident #48's eMAR for Ex Order 26.4B1 revealed Ex Order 26.4B1 was last administered on Ex Order 26.4B1 The US FOIA (b)(6) unit inspection report in the past three months for the Ex Order 26.4 floor, low side medication cart revealed the following: EX Order 26.4B1 -All expired and discontinued medication out of cart, N - not in compliance EX Order 26.4B1 - All expired and discontinued medication out of cart, Y- in compliance EX Order 26.4B1 - All expired and discontinued medication out of cart, Y-in compliance A review of the back-up box reorder form revealed no listing for medication NJ Ex Order 26.4b1 2. On 09/26/22 at 12:17 PM, the surveyor, in the presence of the second floor U.S. FOIA (b)(6), observed the following items in the locked back-up box located in the U.S. FOIA (b)(6) office on the Ex Order 26.4B1 floor: Ex Order 26.4B1 quantity of two (2) expired on EX Order 26.4B1 Ex Order 26.4B1 quantity of two (2) expired on EX Order 26.4B1 -Ex Order 26.4B1 quantity of two (2) expired on EX Order 26.4B1	F 755		

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F 755	Continued From page 214 quantity of two (1) expired on Ex Order 26.4B1 quantity of two (1) expired on Ex Order 26.4B1 -Back-Up medication utilization declining inventory sheet for Ex Order 26.4B1 reflected a recorded"ending balance" quantity of 10. quantity of zero (0) was found in the back-up box -Missing Back-Up medication utilization declining inventory sheet for Ex Order 26.4B1 quantity of ten (10) was found On 9/26/22 at 12:26 PM, during an interview with surveyor, the U.S. FOIA (b) stated the facility's par levels (minimum quantity limits) were low. She explained that the nurses signed out the medication by deducting the medication from the par level, wrote the Resident's name, signed their [the nurse's] name and was replenished by the pharmacy. The pharmacy was alerted by the nurse that signed out the back-up medication. The U.S. FOIA (b) also stated that she started EX NJ Ex Order 26. ago and the task of ensuring medications were not expired and reconciled had not been assigned to anyone. At that time, the U.S. FOIA (b) stated she had no process for replenishing, reconciliation or ensuring back-up medications were not expired. The U.S. FOIA (b) acknowledged that the reconciliation task was important to avoid diversion and the replenishment task was equally important since it ensured medications listed on the back-up list were available for administration to residents in an emergency. The U.S. FOIA (b) also stated that medications in the back-supply should be checked for expiration to avoid administration of expired medication to residents. The U.S. FOIA (b) stated	F 755		

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emergency delivery from the pharmacy was available within four to five hours of the same day.

On 10/05/22 at 09:36 AM, the surveyor requested for any policy relating to discontinued medications and/or expired medications from the US FOIA (b)(6) .

On 10/06/22 at 11:06 AM, during an interview with the surveyor, the U.S. FOIA (b) stated that discontinued and expired medications should be pulled from the cart or storage and returned to the pharmacy if returnable and destroyed in the facility if not returnable. The U.S. FOIA (b) also stated that all nurses on all shifts were responsible to pull the discontinued and expired medications.

At that time, the concern regarding Unsampled Resident #393's name crossed off on the bingo card and Resident 48's name handwritten on the bingo card was brought to the attention of the U.S. FOIA (b). The U.S. FOIA (b) stated that writing another person's name on a bingo cart is not an acceptable practice.

On 10/06/22 at 2:38 PM, in the presence of the survey team, the U.S. FOIA (b)(6) , and the U.S. FOIA (b)(6) the surveyor presented the above concerns and requested any additional information.

On 10/12/22 at 12:40 PM, in the presence of the survey team, the U.S. FOIA (b)(6) confirmed no additional information could be provided.

A review of facility policy provided, "5.0 Reordering, Changing & Discontinued Medication

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

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F 755	Continued From page 216	F 755		

Orders" revised on 10/01/18, included but was not limited to the following:
Policy: The facility will communicate any medication reorders, changes or discontinuation to the pharmacy in accordance with pharmacy guidelines and state/federal regulations; thus ensuring standardized process of communication. Communications may be transmitted through verbal or electronic orders.
Procedure
D. Discontinuation of Orders
1. All orders that are discontinued must be indicated on the POS/EMAR and either faxed, sent electronically or provided verbally to the pharmacy for profile update. The POS & MAR/TAR should be marked indicating the discontinuation of order with date and nurse's signature.

A review of facility policy provided, "7.0 Back-Up Box/Stat/Emergency Kit Supply of Medications" revised on 10/01/18, included but was not limited to the following:
Procedure
E) 1. Back-Up Boxes
(d) Facility staffs are responsible for replacing the medication in the box/kit.
(e) Consultant Pharmacist or designee review the Back-Up Box/stat/emergency supply for correct quantity and expiration. Any discrepancies determined in quantity or expiration are communicated to the pharmacy immediately.

A review of facility policy provided, "Medication Storage" last reviewed on 05/26/22, included but was not limited to the following:
Purpose: To make sure all medications and medical supplies are checked before using meds or supplies on a patient.

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F 755	Continued From page 217 Procedure: Individual, Licensed Nurse/NM [Nurse Manager] Responsibility 1. Checks medication storage at least monthly to ensure all meds [medication] and supplies are checked for labels, expiration dates and to ensure the labels are legible. 2. Any meds expiring should be removed before the expiration date. If pending expiration, will determine if supply will be completed before expiration date. A review of facility policy provided, "4.0 Medication Disposal/Destruction" revised on 10/01/18, included but was not limited to the following: Policy: The facility will adhere to all federal, state, and local regulations related to medication destruction/disposal when discarding any medication and medical waste.	F 755		
F 761 SS=E	N.J.A.C. 8:39- 29.2 (d); 29.4 (a) (f) (g) 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 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	F 761		12/5/22

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F 761	Continued From page 218 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 other facility documentation, it was determined that the facility failed to properly label, date and discard expired biologicals in 2 of 3 medication carts, and 1 of 2 medication rooms inspected on the [redacted] floor unit. This deficient practice was evidenced by the following: On 09/26/22 at 10:10 AM, the surveyor, in the presence of the [redacted] floor[redacted], observed the following items in the High side unit medication cart [redacted] floor): -one unlabeled inhaler [no Resident's name and unmarked with open date] of Ventolin HFA (albuterol oral inhaler; a medication used to help in breathing) 90 micrograms (mcg) per actuation. -one unlabeled bottle [no Resident's name] of Linzess (linaclotide; a medication used to treat chronic constipation or chronic irritable bowel	F 761	Immediate action a. All medication carts were inventoried to identify any medications improperly stored or labeled b. All improperly labeled medications were discarded and replaced with properly labeled medication from the pharmacy. c. All improperly stored medications were removed, and storage issues were immediately corrected d. Staff was immediately educated on proper storage of drugs and biologicals 2. Identification of Other a. All residents receiving medications have the potential to be affected by the deficient practice 3. Systemic Changes a. Instructional /reference information was added to the medication cart binder to provide information on storage of drugs and biologicals, labeling and use by dates for common medications b. Nurses have been	

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F 761	Continued From page 219 syndrome) 145 milligrams (mg). During an interview with the surveyor at that time, the U.S. FOIA (b)(6) stated that each medication should have been in a bag or a box and labeled with the Resident's name on the medication to avoid medication administration to the wrong resident. On 09/26/22 at 11:01 AM, the surveyor, in the presence of the U.S. FOIA (b)(6), observed the following item in the Ex Order 26 side unit medication cart (second floor): -one opened and unlabeled [no Resident's name, unmarked with an open date] nebulizer solution foiled package of Ipratropium bromide and Albuterol inhalation solution (a medication used to help in breathing) 0.5mg/3mg. During an interview with the surveyor at that time, the U.S. FOIA (b)(6) stated that the medication should have been labeled with the Resident's name on the medication package to avoid medication administration to the wrong resident. On 09/26/22 at 11:07 AM, the surveyor, in the presence of the U.S. FOIA (b)(6), observed the following within the medication room on the Ex Order 26.4B1 floor Unit: -one open box of Mantoux Test (a tuberculin skin test performed to check if a person has been infected with tuberculosis), containing one vial of medication in the refrigerator. The opened box was dated 08/25/22. At that time, the surveyor and U.S. FOIA (b)(6) reviewed the manufacturer's package that indicated "Discard opened product after 30 days." The	F 761	instructed/educated to monitor and correct deficiencies with labeling and storage of medication and biologicals on an ongoing basis as part of their shift responsibilities C . The consultant pharmacist will continue to inspect all medication carts monthly for proper storage and labeling of medications and biologicals. The consultant pharmacist will continue to provide a written report of monthly audit findings and submit to the DON and Administrator. Upon receipt of the monthly consultant pharmacist report the unit manager/designee will correct deficiencies D. The unit manager will conduct weekly medication cart audits to monitor labeling and storage of drugs and biologicals, audits will be ongoing with no stop date. 4. Quality Monitoring Audit results will be reported to the Quality Assurance and Performance Improvement committee monthly x 6 months for review and further recommendations. The first of which will take place in December 2022.	

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F 761		F 761		

Continued From page 220

U.S. FOIA (b)(6) stated she would discard the expired biological.

On 10/06/22 at 11:06 AM, during an interview with the surveyor, the U.S. FOIA (b)(6)) stated that discontinued and expired medications should be pulled from the cart or storage room and returned to the pharmacy if returnable and destroyed in the facility if not returnable. The U.S. FOIA (b) also stated that all nurses on all shifts were responsible to pull the discontinued and expired medications.

On 10/6/22 at 11:25 AM, during the continuation of an interview with the surveyor, the U.S. FOIA (b) stated that all medications should have been labeled and kept in the proper container or bag received from the pharmacy. The U.S. FOIA (b) also stated that medications without labels should have been thrown away to avoid medication administration errors [given to the wrong resident] which could lead to adverse events (unwanted side effects). The U.S. FOIA (b) stated that all nurses on all shifts were responsible to ensure all medications were labeled properly.

On 10/12/22 at 12:40 PM, in the presence of the survey team, the U.S. FOIA (b)(6) confirmed no additional information could be provided.

Review of the facility provided, "Medication Storage" policy last reviewed 5/26/22, included but was not limited to the following:
Procedure:
Individual, Licensed Nurse/NM Responsibility
1. Checks medication storage at least monthly to

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F 761	Continued From page 221 ensure all meds [medications] and supplies are checked for labels, expiration dates and to ensure the labels are legible. 2. Any meds that will be expiring should be removed before the expiration date. If pending expiration, will determine if supply will be completed before expiration date.	F 761		
F 812 SS=F	N.J.A.C. 8:39-29.4 (a) (f) (h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation, it was determined that the facility failed to store, label, and date potentially hazardous food, and maintain kitchen sanitation	F 812	1. Correction Action: A) Black debris on baffle area located in the bucket with ice: ice machine was cleaned	12/5/22

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F 812	Continued From page 222 in a manner intended to limit the spread of food-borne illnesses. The deficient practice was evidenced by the following: On 09/21/22 at 9:38 AM to 10:09 AM, the surveyor entered the facility kitchen and toured with the US FOIA (b)(6)). On 09/21/22 at 9:41 AM, the surveyor observed the facility ice machine. The baffle area (the interior back of the basin in direct contact with the ice) located in the bucket with ice, contained black streaked debris, and accumulated debris above it. The US FOIA (b) confirmed the ice machine was not clean. The US FOIA (b) stated maintenance would come monthly to clean filters and the cover of the ice machine. On 09/21/22 at 9:54 AM, the surveyor observed 1/2 package of meatballs in the freezer, wrapped, but with no label and no use by date. The US FOIA (b) stated the meatballs were good for 30 days. On 09/21/22 at 9:55 AM, the surveyor observed two frozen pie shells in plastic wrap and not in the box, both were open to air and on top of the box. The pie shells were not labeled with a use by date. The US FOIA (b) took the two pie shells, placed them back in the box, and stated that the rest of the pie shells were open in the box. On 09/21/22 at 9:59 AM, the surveyor observed three bags of sealed frozen collards and one bag of corn inside of an egg crate (a plastic container with holes on all sides) stored directly on the floor. The US FOIA (b) stated the crate should be elevated.	F 812	B) ½ pack of meatballs unlabeled: discarded C) Two frozen pie shells unlabeled: discarded D) Three bags of collards and one bag of corn stored in egg crate on floor: discarded E) Bag of frozen hamburgers unlabeled: discarded F) Soiled can opener and base with caked on sticky debris: Can opener and base was cleaned 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: A) The Policy and Procedure titled Ice Machine Sanitation Policy was reviewed by the Administrator and CDM and found to be in compliance. B) The Policy and Procedure titled Manual Can Opener Policy was reviewed by the Administrator and CDM and found to be in compliance. C) The Policy and Procedure titled Dating and Labeling was reviewed by the Administrator and CDM and found to be in compliance. D) All kitchen staff was reeducated by the Certified Dietary Manager on the following topics. a. Ice Machine Sanitation procedures b. Manual Can Opener cleaning procedures c. Dating and Labeling of Food Items procedure 4. How will these actions be measured	

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F 812	Continued From page 223 On 09/21/22 at 10:00 AM, the surveyor observed a bag of 6 frozen hamburgers. The surveyor asked about being dated and when they expired. The [redacted] stated, "no they didn't" date (the bag of frozen burgers), and that they are supposed to date everything. The surveyor observed a very soiled can opener with dark caked on debris on the outside, and dark, caked on, sticky sticky in appearance debris on the inside. The base of the can opener base was attached to the stainless steel table and was observed to have brownish colored spots around it. The holder for the can opener was located on the side of the workstation next to the base. The holder had visible black caked on, greasy debris. The cook was present and stated that the can opener had been cleaned two days ago. The surveyor asked the cook to pull out the can opener insert in presence of the [redacted] The insert was observed to be very soiled with dark caked on debris. A review of the facility provided policy, "Ice Machine Maintenance", dated 5/2022, included but was not limited to; policy: ....to maintain proper functioning and sanitation of the ice machine .....schedule sanitizing for the unit ice machines. Procedure: machines will be sanitized/clean with an EPA (Environmental Protection Agency) and manufacturer approved product daily by the food service department and as needed. A review of the facility provided policy, "Ice Machine Sanitation Policy", revised 6/3/13, included but was not limited to; kitchen staff will wash, rinse, and sanitize the ice making machine weekly. Procedure: 11. Record date of sanitation	F 812	A) Weekly Audits will be conducted by the CDM of all areas of the kitchen including but not limited to ice machine cleaning, manual can opener cleaning, dating, and labeling of food. B) Any negative findings will be brought to the Administrator immediately. C) Audits will be done by the CDM/supervisor weekly and submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. 5. Person Responsible: Certified Dietary Manager (CDM)/supervisor	

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F 812	Continued From page 224 on the ice machine cleaning log. A review of the facility provided policy, "Manual Can Opener Policy", undated, included but was not limited to; kitchen will assure safe usage of manual can opener for food preparation. Procedure: 1. Can opener blade will be inspected before opening cans for ... ...cleanliness, 4. Staff will inspect opener blade, clean and sanitize after each usage, and 5. FSD or designee will replace blade each month or as needed. A review of the facility provided policy, "Dating and Labeling Policy"; revised 4/2019, included but was not limited to; assure food safety by maintaining proper dates and labels to all ready to eat food products. Procedure: 1. Inspect all deliveries for proper labeling and damage, 2. Label products in storage with date the package was opened or expiration date with no more than 48 hours after opening, whichever is appropriate, 4. Use the [redacted] address label dating and labeling system to date all items, 6. Foods marked with manufactures use by date may be used and stored until expiration date, 7. Foods that are marked with manufactures use by date may not be used if opened or prepared including portioning. A review of the facility provided Department of Health inspection dated 12/21/21, included but was not limited to; the facility was found out of compliance for food protected from potential contamination during preparation, storage, display.	F 812		
F 835 SS=L	NJAC 8:39-17.2(g) Administration	F 835		12/5/22

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F 835	Continued From page 225 CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review it was determined that the U.S. FOIA (b)(6) [redacted] failed to ensure policies, procedures and systems were developed and implemented to ensure immediate action was taken to make certain that the facility operated in a manner to ensure residents' attained or maintained the highest practicable physical, mental and psychosocial well-being of each resident by ensuring that a resident was free of Ex Order 26.4B1, and the facility maintained an effective infection control program that limited the spread of Ex Order 26.4B1 an infectious deadly virus as was identified during an on-site survey that began on Ex Order 26.4B1 and was evidenced by the following: Refer to 600L, 880L, 886L This IJ situation began on 9/28/22 and the facility administration was notified of the IJ on 9/28/22 at 2:55 PM. The facility submitted an acceptable removal plan on 09/27/22 at 3:46 PM. The IJ removal plan was verified as implemented during an onsite visit on 10/04/22 at 12:02 PM. Two Immediate Jeopardy (IJ) situations were	F 835	1. Corrective Action: - Upon identification, 9/29/2022, of this deficient practice, the US FOIA (b)(6) [redacted] was in serviced by the Regional Administrator in the presence of the regional nurse on: COVID contact tracing upon identification of a new case of covid, COVID testing upon identification of a new patient or staff case of COVID, Abuse and Neglect including sexual abuse, abuse reporting and investigation, Peggy's law, timely reporting of any abuse allegation and following corporate guidelines. - The Licensed Nursing Home Administrator, DON, immediately reviewed the Abuse and Neglect Policy and Procedure and an addendum was done on 9/29/22 to reflect the National sex offender background check prior to acceptance into center to ensure appropriate admissions and that patients with a sexual offence history would not be admitted to the facility. - The Licensed Nursing Home Administrator and Director of Nursing reviewed and revised the policy on COVID 19 testing. - Root cause analysis was initiated by	

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F 835	Continued From page 226 identified on 09/23/22 at 1:04 PM for 880L and 886L, which began on 09/21/22 at 1:09 PM, when the U.S. FOIA (b)(6) was unable to provide the survey team with requested policies, procedures and documentation required to conduct the survey, and on 10/11/22 at 2:03 PM, the 880L and 886L were revised to incorporate additional IJ findings of deficient practice. A subsequent IJ situation was identified on 09/28/22 at 2:55 PM for 600K, and on 09/30/22 at 1:31 PM was revised to incorporate additional findings which elevated the deficient practice to widespread finding of abuse at 600L. An additional finding of IJ was identified on 10/11/22 at 2:03 PM for 888L. Refer to 880L Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance was implemented to limit the spread of NJ Ex Order 26.4b1 by failing to ensure: 1.) a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of NJ Ex Order 26.4b1 for 3 of 3 resident care units, and 2.) a process was in place to ensure all required staff were appropriately fit tested for an N-95 respirator for 3 of 3 resident care units which placed all residents and staff at risk for contracting a contagious infectious and potentially deadly virus. Refer to 886L Based on interview, record review and document review it was determined that the facility failed to: 1.) conduct immediate resident and staff testing	F 835	Regional Administrator, Corporate nurse and Infection Control nurse on 9/28/2022 regarding the identified issues. As a result, the Licensed nursing Home Administrator was NJ Ex Order 26.4b1 . - Licensed Nursing Home Administrator is no longer employed by facility. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: - Management and clinical staff were in-serviced as it relates to F Tags: F880, F886, F600. - Incoming Administrator will receive a full orientation and in-service to corrective plan related to F835 - Regional Administrator and Regional nurse and/or designee will provide oversight to US FOIA (b)(6) weekly and as needed at the facility and remotely to assure that the facilities policies, procedures, and systems are developed and implemented in accordance with regulations and corporate policy. 4. How Will These Actions Be Measured: Finding from the US FOIA (b)(6) weekly oversight will be completed and submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be	

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F 835	Continued From page 227 upon the identification of a single NJ Ex Order 26.4b1 staff or resident result, and 2.) ensure a system was in place, and the facility US FOIA (b)(6) followed the facility policy to ensure that all staff who required weekly or bi-weekly NJ Ex Order 26.4b1 testing was completed and documented during a NJ Ex Order 26.4b1. The facility's failure to take immediate action, follow Centers for Medicare and Medicaid Services (CMS) guidance, Centers for Disease Control and Prevention (CDC) and facility policies to limit exposure risks placed all residents and staff at risk for contracting NJ Ex Order 26.4b1 . Refer to 600L Based on observation, interview, record review, and other pertinent facility documentation, it was determined the facility failed to ensure a.) residents were free from Ex Order 26.4B1 after an allegation of Ex Order 26.4B1 involving (Resident #10), and b.) protect vulnerable residents from being Ex Order 26.4B1 by staff (Resident #56). Refer to 888L Based on interview, record review and document review it was determined that the facility failed to: 1.) ensure the facility policy, Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS) for NJ Ex Order 26.4b1 was implemented to ensure that all staff were up to date with NJ Ex Order 26.4b1, or have been granted a qualifying exemption during a COVID-19 outbreak that began on NJ Ex Order 26.4b1 and 2.) ensure all staff that were not up to date with vaccinations, or had been granted a qualifying exemption were not permitted to work in the facility. The facility's failure to take immediate action, follow Centers	F 835	made regarding the need for continued submission and reporting.	

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F 835	Continued From page 228	F 835		

for Medicare and Medicaid Services (CMS) guidance, Centers for Disease Control and Prevention (CDC) and facility policies to limit exposure risks placed all residents and staff at risk for contracting NJ Ex Order 26.4b1 [redacted].

The non-compliance remained on 10/12/22 for no actual harm with the potential for more than minimal harm that is not IJ based on the following:

1. Based on interview and document review during the on-site survey conducted on 10/12/22, multiple Immediate Jeopardy situations were identified, in addition to a subsequent IJ identified on 10/11/22 at 2:03 PM for 888L, multiple deficient practices that were identified that had the potential to affect the health, safety and welfare of all residents who resided at the facility on 3 of 3 resident units.

Refer to 609F, 610F, 689H, 865F, 725F, 812F, 843F, 865F, 867F, 882F

On 09/21/22 at 9:05 AM, the [redacted] informed the survey team that the facility was presently experiencing a NJ Ex Order 26.4b1 utbreak and he would provide the facility line listing. The surveyor requested all of the infection control information, including staff vaccination policies and matrix, information on residents who smoked and times, and Quality Assurance and Performance Improvement (QAPI) information.

On 09/21/22 at 1:09 PM, the surveyor conducted a follow-up interview with the [redacted] who stated the U.S. FOIA (b)(6) [redacted], who had not completed an infection control certification, was

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responsible for "all of the vaccination effort" and would be able to provide all the information.

On 09/22/22 at 10:06 AM, the Ex Order 26.4B1 U.S. FOIA (b)(6) provided the survey team with a list of smokers, without the corresponding policy.

On 09/22/22 at 2:14 PM, the U.S. FOIA (b)(6) were unable to provide the survey team with all of the requested entrance conference documents including all infection control policies and procedures, vaccination matrix (document with the vaccination status of all staff) and a current facility line listing.

On 09/22/22 at 2:26 PM, the U.S. FOIA (b)(6) confirmed that the facility infection control policies and procedures were not available.

On 09/23/22 at 10:00 AM, the facility uncertified U.S. FOIA (b)(6) provided the survey team with a copy of the facility line listing two days after the initial request.

On 09/23/22 at 11:32 AM, the U.S. FOIA (b)(6) informed the survey team that he was unable to provide the QAPI policies and procedures.

On 09/23/22 at 11:34 AM, the survey team conducted an interview with the U.S. FOIA (b)(6) regarding the National Health and Safety Network information that is required to be submitted regarding the staff vaccination status. The U.S. FOIA (b)(6) confirmed he inputted the information and confirmed there was no current employee vaccination list since not all employees were on it. The U.S. FOIA (b)(6) stated "I am not making up what I don't have."

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On 10/06/22 at 2:43 PM, the survey team presented findings to the Ex Order 26.4B1 U.S. FOIA (b)(6) [redacted].

On 10/12/22 at 12:41 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] who confirmed there was no rebuttal for the findings presented by the survey team and the facility had not additional information to provide.

A review of the Administrator Job Description, signed by the U.S. FOIA (b)(6) [redacted], revealed the Purpose of Your Job Position; "The primary purpose of your position is to direct the day-to day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times.", Delegation of Authority; "As Administrator you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties.", Administrative Functions; " Plan, develop, organize, implement, evaluate, and direct the Facility's programs and activities in accordance with guidelines issues by management, Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility, Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice, Review the Facility's policies and procedures at least annually and make changes as necessary to assure continued compliance with current regulations,

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F 835	Continued From page 231 Interpret the Facility's policies and procedures to employees, residents, family members, visitors, government agencies, etc., as necessary, Ensure that all employees, residents, visitors, and the general public follow the Facility's established policies and procedures, Assist the Medical Director in the development and implementation of medical and nursing services policies and procedures and professional standards of practice, Inform the Medical Director of all suspected or known incidents of resident abuse...", Resident Rights; "...Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident and family as appropriate, Ensure that all policies governing the timely notice for resident discharges and/or room or roommate changes are strictly followed by all personnel..."; Administrator;..."Report all allegations of resident abuse and/or misappropriation of resident property", The Acknowledgement section of the jog description, dated U.S. FOIA (b)(6) and signed by the U.S. FOIA (b)(6) revealed "I have read this job description and fully understand that the requirements set forth therein have be determined to be essential to this position. I hereby accept the position of Administrator and agree to perform the tasks outlined in this job description in a safe manner and in accordance with the Facility's established procedures." N.J.A.C. 8:39-9.2(a)	F 835		
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	F 838		12/5/22

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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 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;

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F 838	Continued From page 233 (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 all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility provided documents, it was determined that the facility failed to ensure the facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies was reviewed and updated, as necessary, and at least annually. This deficient practice was evidenced by the following: On 09/21/22 at 01:09 PM, during the entrance conference held with the facility administration, another surveyor requested a copy of the Facility Assessment (FA). On 9/22/22 at 2:28 PM, the U.S. FOIA (b)(6) [redacted] provided the other surveyor with the FA. The FA was not signed or	F 838	1. Corrective Action: Upon identification, the Facility Assessment was signed and dated to indicate when the Facility Assessment was conducted or reviewed. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: The Facility Assessment will be audited monthly by the Administrator and/or designee to assure it is signed and dated commensurate with this document being updated and/or reviewed. 4. How Will These Actions Be Measured: Results of the monthly audit will be completed by the Administrator and/or	

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F 838	Continued From page 234 dated to indicate when the FA was conducted or reviewed. On 10/07/22 at 10:49 AM, the surveyor interviewed the [redacted] regarding the FA. The [redacted] stated that the FA should have been dated and signed. He then stated that it looked like the wrong one was given. He added that the corporate person had given it to him. He then added that it was in the binder for survey (binder which contains documents for recertification survey). The surveyor then asked the [redacted] who was responsible for the FA. The [redacted] stated that typically the [redacted] was responsible but that the binder for survey was already ready to go before he had come to the facility. He added that the FA was done prior to his arrival but he could not say when. On 10/07/22 at 11:29 AM, the surveyor interviewed the [redacted] regarding the FA process. The [redacted] stated that the FA should be signed and dated. She added that it should done at a minimum once a year but that she would review it every quarter. A review of the facility provided policy titled, "Facility Assessment" with a reviewed date of 5/2/22, included the following: Under Policy Statement A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. Under Policy Interpretation and Implementation	F 838	designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting	

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F 838	Continued From page 235 1. Once a year, and as needed, a designated team conducts a facility-wide assessment to ensure that the resources are available to meet the specific needs of our residents ... 6. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment and supplies needed. It is separate from the Quality Assurance and Performance Improvement evaluation ... 9. The facility assessment is reviewed and updated annually, and as needed ... 10. The QAPI Committee is responsible for reviewing facility and resident information quarterly to determine if a facility reassessment is warranted. N.J.A.C. 8:39-5.1(a)	F 838		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to ensure the Medical Director (MD) duties per the MD Job Description were implemented to ensure resident care policies and services were provided to all residents that were consistent with current	F 841	Corrective Action: - Upon identification, 10/7/2022, of this deficient practice, the US FOIA (b)(6) [redacted] was in serviced by the Regional Administrator in the presence of the regional nurse on: COVID contact	12/5/22

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F 841	Continued From page 236 professional standards of practice on 3 of 3 resident units. The deficient practice was evidenced by the following: Refer to: F600K, F609F, F610F, F684H, F835L, 838F, 850F, F865F, F867F, F880L, F886L, F888L During a recertification survey conducted on 10/12/22, the survey team identified multiple findings of Immediate Jeopardy which included, but were not limited to: The facility failed to ensure residents were free from Ex Order 26.4B1 after an allegation of Ex Order 26.4B1 Ex Order 26.4B involving (Resident #10), and b.) protect vulnerable residents from being Ex Order 26.4B1 by staff (Resident #56). The U.S. FOIA (b)(6)) failed to ensure policies, procedures and systems were developed and implemented to ensure immediate action was taken to ensure the facility operated in a manner to ensure the facility residents' attained or maintained the highest practicable physical, mental and psychosocial well-being of each resident by ensuring that a resident was free of Ex Order 26.4B1, and the facility maintained an effective infection control program that limited the spread of an infectious deadly disease. The facility failure to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance was implemented to limit the spread of infectious disease by failing to ensure: 1.) a process was in place to conduct comprehensive contact tracing upon the	F 841	tracing upon identification of a new case of covid, COVID testing upon identification of a new patient or staff case of COVID, Abuse and Neglect including sexual abuse, abuse reporting and investigation, Peggy's law, timely reporting of any abuse allegation and following corporate guidelines. The new Administrator will be in-serviced. - The Licensed Nursing Home Administrator, DON, immediately reviewed the Abuse and Neglect Policy and Procedure and an addendum was done on 9/29/22 to reflect the National sex offender background check prior to acceptance into center to ensure appropriate admissions and that patients with a sexual offence history would not be admitted to the facility. - The Licensed Nursing Home Administrator and Director of Nursing reviewed and revised the policy on COVID 19 testing. - The Medical Director Job Description was reviewed with the Medical Director - Root cause analysis was initiated by the Regional Administrator on 9/28/2022 regarding the identified issues. As a result, theUS FOIA (b)(6) was placed under indefinite corporate oversight for operations oversight and clinical oversight. - Licensed Nursing Home Administrator is no longer employed by facility. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents.	

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F 841	Continued From page 237 identification of a single new case of NJ Ex Order 26.4b1 for 3 of 3 resident care units, and 2.) a process was in place to ensure all required staff were appropriately fit tested for an N-95 respirator and documentation was completed for 3 of 3 resident care units which placed all residents and staff at risk for contracting a contagious infectious and potentially deadly virus. On 10/07/22 at 11:29 AM, the surveyor conducted a telephone interview with the facility U.S. FOIA (b)(6) The U.S. FOI informed the surveyor that she has been the U.S. FOI for NJ Ex Order 26.4b1. The surveyor inquired as to how the U.S. FOI was involved with the facility. The U.S. FOIA stated that the facility had a lot of contracts to provide care for people without insurance, and persons without a home, "they have nothing". The U.S. FOI stated she would admit those residents under her care as the U.S. FOIA The U.S. FOIA stated that she had reviewed policies in the past and the facility had a great deal of turnover with the U.S. FOIA (b)(6) position. The MD stated she had just found out yesterday (10/06/22) that there were serious concerns at the facility. The U.S. FOIA stated she had met the U.S. FOIA (b)(6) and stated at present "I have no contact with the U.S. FOIA (b)(6) The surveyor inquired to the MD if she provided medical care for Resident #65. The U.S. FOIA confirmed that she was responsible for the medical care of Resident #65. The surveyor inquired if she was informed about a delay in Resident #54 receiving an NJ Ex Order 2 The US FOIA stated the facility did not tell her that the NJ Ex Order 26.4b1 occur on NJ Ex Order 26.4b1 (the day it was ordered) and not until NJ Ex Order 26.4b1 She stated if she had been told, she "may have sent [Resident #65] to the Emergency room." The US FOIA confirmed she was	F 841	3. Measures Put into Place: - Management and clinical staff were in-serviced as it relates to F Tags: F880, F886, F600. - Survey findings were reviewed with the Medical Director - Incoming Administrator will receive a full orientation to corrective plan related to F835 and F841 - Weekly meetings either in person or by phone will occur by Administrator to update the Medical Director on facility and patient status. - Regional Administrator and Regional nurse and/or designee will provide oversight to the Administrator weekly and as needed at the facility and/or remotely to assure that the facilities policies, procedures, and systems are developed and implemented in accordance with regulations and corporate policy. 4.How Will These Actions Be Measured: Finding from the Regional Administrator, Regional nurse and/or designee's weekly oversight will be completed and submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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also not made aware that there was not an appointment available until NJ Ex Order 26.4b1 for an NJ Ex Order 26.4b1, and that it did not appear that the NJ Ex Order 26.4b1 was contacted until NJ Ex Order 26.4b1. She stated "I 100 % expect them to call her if they cannot get an appointment, I can send them out." The surveyor asked the U.S. FOI if she had been involved regarding the facility policies or the facility assessment. The U.S. FOI stated nothing was in writing. The surveyor reviewed the signed and un-dated Job Description for the Medical Director. The U.S. FOI stated she was provided a blank job description by the facility and she had crossed out what she was not going to do. The U.S. FOIA stated she was not the person who was going to guide all of the care for all of the patients, or supervise any other doctors and also crossed out the section with the other duties, and that is why she crossed it out on the job description. At that time, the surveyor observed under Duties and Responsibilities, three areas were crossed out and included "Involvement at all levels of individualized patient care and supervision", "Supervises medical practitioners who provide the direct patient care for the facility", and a crossed out area with error written beside it revealed "I further understand that the duties listed above my change at any time either verbally or in writing according to the needs of the facility. I understand that I may be required to work weekends, holidays, and may be temporarily assigned to other positions as needed." The surveyor inquired if the U.S. FOIA was involved with the QAPI or any QAPI projects that she was involved in and the U.S. FOIA stated "not really". The U.S. FOIA stated there has been so much change they have "not gone over much". When the U.S. FOI was asked about knowledge of Ex Order 26.4B1Ex Order 26.4B1 that resided in the facility or an incident involving Ex Order 26.4B1 allegation,

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the [US FOIA] stated no, "they should have told me" and stated "I should have been involved in that", and confirmed she had not been made aware of the Immediate Jeopardy situations or the [Ex Order 26.4B1] Ex Order 26.4B1.

The MD Job Description revealed: The Purpose: "The Medical Director helps coordinate and evaluate the medical care within the facility by reviewing and evaluating aspects of physician care and practitioner services and helping the facility identify, evaluate and address health care issues related to the quality of care and quality of life of residents." "The Medical Director is an important member of the healthcare team in a nursing home, and is responsible for overall coordination of care and for implementation of policies related to care of the residents in a nursing home. The residents in nursing homes are frail, medical-ly complex, and have multiple disabilities., Delegation of Authority: As Medical Director you are delegated as the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties." Duties and Responsibilities: (in addition to what was crossed out as referenced above) Serves as the clinician who oversees and guides the care that is provided to residents, Serves as the physician responsible for the overall care and clinical practice carried out at the facility., Applies clinical and administrative skills to guide the facility in providing care., Helps the facility develop and manage both quality and safety initiatives, including risk management., Provided information that helps others (including facility staff, practitioners, and those in the community) understand and provide care. Acknowledgement: I have read this job description and fully understand that the requirements set forth therein

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F 841	Continued From page 240 have been determined to be essential to this position. I hereby accept the position of Medical Director and agree to perform the tasks outlined in this job description in a safe manner and in accordance with the Facility's established procedures... N.J.A.C. 8:39-23.1(a)1-7	F 841		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		12/5/22

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F 842	Continued From page 241 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #EX Order 26.4B1	F 842	1.Corrective Action:	

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F 842	Continued From page 242 Based on observation, interview, and other facility documentation, it was determined that the facility failed to maintain complete, accurate, and readily accessible medical records. This deficient practice was identified for (a) 1 of 4 residents closed medical records reviewed (Resident #194), and (b) 1 of 35 Sampled residents reviewed (Resident #8). The deficient practice was evidenced by the following: a) On 09/27/22 at 11:47 AM, the surveyor requested Resident #194's closed records from the Medical Records department. On 09/28/22 at 12:02 PM, the surveyor interviewed the U.S. FOIA (b)(6) who explained her process. She stated she thinned the paper charts, closed charts, and sent data to other physicians when needed. She informed the surveyor that the electronic Medical Record (eMR) started in NJ Ex Order 26.4b1. A review of the eMR under Admission Discharge Transfer (ADT) reflected Resident #194 was admitted to the facility on Ex Order 26.4B1 On 10/04/2022 at 11:51 AM, the US FOIA (b)(6) provided the surveyor with Resident #194's face sheet, the minimum data set and the hospital medical record, which were the only documents the facility had. On 10/03/22 at 12:35 PM, the surveyor followed up on the request made for the paper medical closed record with the NJ Ex Order 26.4b, who stated she	F 842	Upon identification that medical records for Residents # 194 and #8 were unable to be located, medical records department designee was in serviced as to the importance of maintaining a complete, accurate, and readily accessible medical record as well as the process to assuring that this occurs. A New Medical Records Clerk was hired on 11/7/22. Director of Medical Records performed audit of current patients that reside in the facility was completed to assure that all patient medical records could be located. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Director of Medical Records/Designee will perform Monthly random audits of a total of ten (10) current and discharged patient medical records to assure that Patient Medical records are complete, accurate, and readily accessible. 4. How Will These Actions Be Measured: The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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could not locate the documents. She confirmed that the documents within the paper medical charts that were thinned or closed were collected and placed in a filing cabinet in the medical records room by her. She stated she could not locate Resident #194's paper medical records.

On 10/06/22 at 02:32 PM, during an interview with the surveyors, the U.S. FOIA (b)(6) stated she was unable to locate Resident #194's paper medical record.

On 10/07/22 at 08:35 AM, during an interview with the surveyors, the U.S. FOIA (b)(6) confirmed Resident #194's paper medical record was missing.

Reference F 656

b) On 10/04/22, the surveyor requested Resident #8's Admission documents, Interdisciplinary notes, progress notes, and MDS from the US FOIA (b)(6) (formerly the US FOIA (b)(6)

On 10/04/22 at 12:47 PM, the surveyor requested all of Resident #8's NJ Ex Order 26.4b1 assessments (NJ Ex Order 26.4b1) from the US FOIA (b)(6) .

On 10/05/22 at 09:38 AM, the surveyor requested all of Resident # 8's NJ Ex Order 26 and admission care plan from the U.S. FOIA (b)(6)

On 10/05/22 at 01:50 PM, during an interview with the surveyor, the U.S. FOIA (b)(6) stated she was unable to locate the Admission/Initial NJ Ex Order 26 and the Admission/Initial care plan for Resident

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F 842	Continued From page 244 #8. On 10/06/22 at 02:38 PM, in the presence of the survey team, U.S. FOIA (b)(6) [redacted], the surveyor presented the above concerns and requested any additional information. On 10/12/22 at 12:40 PM, in the presence of the survey team, the U.S. FOIA (b)(6) [redacted] confirmed no additional information could be provided. A review of the facility provided, "Medical Records" policy reviewed 1/5/2022, included but was not limited to the following: Policy Statement: Our facility shall protect and safeguard all medical records. Policy Interpretation and Implementation: 1. All current medical records are filed in the Medical Records Department and are maintained by the Medical Records Clerk. 2. Medical records are stored in a locked room and protected from fire, water damage, insects, and theft. 3. Archived medical records (those being retained for a specified period beyond the resident's discharge or death) will be clearly identified as archived records and stored appropriately. N.J.A.C. 8:39-35.2 (d)(6)(16)	F 842		
F 843 SS=F	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian	F 843		12/5/22

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F 843	Continued From page 245 reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documentation, it was determined that the facility failed to have a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. The deficient practice was evidenced by the following: On 10/11/22 at 01:00 PM, the surveyor asked the	F 843	1. Corrective Action: Upon identification of the facility not having a written transfer agreement with a hospital, efforts were initiated to secure a meeting with local hospitals to facilitate this agreement. Transfer agreement was initiated on 11/11/22 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:	

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F 843	Continued From page 246 U.S. FOIA (b)(6) to view the written transfer agreement that the facility had with one or more hospitals. The U.S. FOIA (b)(6) was unable to provide the surveyor a written transfer agreement. On 10/12/22 at 10:53 AM, the surveyor asked the U.S. FOIA (b)(6)) to view the written transfer agreement that the facility had with one or more hospitals. The U.S. FOIA (b)(6) stated that the agreement would be in the Emergency Preparedness (EP) manual. The U.S. FOIA (b)(6) then, in the presence of the surveyor, began looking through different binders that were not labeled as the EP manual. He then stated that the previous owner would have had the agreement. He stated that he was unable to locate it at this time. The U.S. FOIA (b)(6) then continued to look in a binder labeled EP, and he then provided the surveyor with one unsigned agreement, and three signed agreements that were titled with the names other Nursing Home facilities. The U.S. FOIA (b)(6) was unable to provide a written transfer agreement with a hospital for the current facility. On 10/12/22 at 11:13 AM, in the presence of the survey team, the surveyor asked the U.S. FOIA (b)(6) about the transfer agreement with the hospital. The U.S. FOIA (b)(6) stated that the hospital agreement was with their transport company. The surveyor then asked the U.S. FOIA (b)(6) what the purpose of a transfer agreement with a hospital was. The U.S. FOIA (b)(6) stated that it was in case the facility needed to relocate residents in the event of any medical emergency. The surveyor then asked the U.S. FOIA (b)(6) if he had ever seen the written transfer agreement with a hospital, and he stated "no." The facility was unable to provide the survey	F 843	The deficient practice has the potential to affect all residents. 3. Measures Put into Place: The Administrator and/or designee will update the transfer agreement annually as required 4. How Will These Actions Be Measured: The results of the annual updates will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 843	Continued From page 247 team with a written transfer agreement. A review of the facility provided policy titled, "Transfer Agreement," with a reviewed date of 11/11/2021, included the following: Under Policy Statement Our facility has a transfer agreement in place with a designated hospital should our residents need care that is beyond the scope of our available care and services. Under Policy Interpretation and Implementation 1. The hospital with which we have an agreement is approved for participation under Medicare/Medicaid Certified programs. 2. Our transfer agreement: a. Is in writing and authorized by individuals who are permitted to execute such an agreement on behalf of the institutions; b. Ensure that residents are transferred from the facility to the hospital and admitted in a timely manner when medically appropriate (as determined by the attending physician); c. Ensure that residents are transferred from the facility to the hospital and admitted in a timely manner in an emergency situation by another practitioner, consistent with the state law; ... 3. Completed copies of our transfer agreements are on file in the business office. 4. Inquiries concerning transfer agreements should be referred to the Administrator. N.J.A.C. 8:39-11.2(j)	F 843		
F 850 SS=F	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A	F 850		12/5/22

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F 850	Continued From page 248 qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to employ a U.S. FOIA (b)(6) with the required experience per facility policy and Centers for Medicare and Medicaid Services (CMS). This was identified for 1 of 1 SW employed and was evidenced by the following: On 09/27/22 at 12:31 PM, during an interview with a surveyor, the U.S. FOI stated she had been in the position of U.S. FOIA (b)(6)) since NJ Ex Order 26.4b1 The U.S. FOI stated some of her responsibilities included initial social services assessments, communication with residents and families, handling concerns such as any investigations, and interviewing anyone involved. The U.S. FOIA reiterated that she had started in March 2022 and added that this was NJ Ex Order 26.4b1 she had not been educated on "this" (her job), and had not been provided with clear direction to handle grievances. She stated that the U.S. FOIA (b)(6) had started in NJ Exec Order 26.4b1 and had trained her. The U.S. FOI further stated she could not recall if she was provided a job description but, "I'm going	F 850	1. Corrective Action: The social worker documented in the 2567 no longer works at the facility. Upon identification of the facility not having a social worker that met the experience requirement for a social worker, a social worker from the sister facility was transferred to EX Order 26.4b until the new social worker begins on EX Order 26.4B1 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Newly employed social worker will receive orientation and education upon the start of her employment to assure they have a thorough understanding of their roles and responsibilities with a sign off on the facilities social work competency assessment. Administrator and/or designee will meet weekly with Social Worker to assure they continues to receive education, guidance	

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F 850	Continued From page 249 to be honest, no." On 09/27/22 at 2:37 PM, during an interview with the surveyors, the U.S. FOI stated she was not working on 08/23/22 but when she worked on 08/24/22, she was informed of an incident that took place on 08/23/22. The U.S. FOI stated the incident was regarding one resident that had gone into another resident's room. She stated she was told by the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) that they reviewed the incident and there was no need to take it any further. The U.S. FOI reviewed the facility Abuse Policy in the presence of the surveyors and commented that if there were an allegation of abuse, she would be responsible to be an advocate, call police if need be, and interview the residents. The U.S. FOIA stated she did not follow up with any staff interviews, or investigations. On 10/04/22 at 2:54 PM, during an interview with the surveyors, the NJ Exec O stated she had graduated in NJ Ex Order 26.4b1, and obtained her NJ Exec license in NJ Ex Order 26.4b1. She stated she had never "officially" worked with another US FOIA (b)(6) and had not met the facility's corporate U.S. FOI yet. The U.S. FOI stated she had completed "a lot of learning on my own" and that the facility had provided some education since the survey started. On 10/05/22 at 12:53 PM, during an interview with the surveyors, the U.S. FOIA (b)(6) stated the U.S. FOI had been hired through the previous administration. The U.S. FOIA (b)(6) further stated "end of story" there was no education, guidance, or training for the U.S. FOIA and that with the "switch" (change in ownership), the U.S. FOI was "lost in the shuffle". The U.S. FOIA (b)(6) stated he was not a U.S. FOI, but had been trying to work with the U.S. FOI, and reached out to other facilities	F 850	and/or training to assure compliance with facility policies and protocols. 4. How Will These Actions Be Measured: Findings from the Social work oversight designee's weekly oversight will be completed and submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

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F 850	Continued From page 250	F 850		

for help. He stated there was no regional (corporate) U.S. FOIA (b) but there were two "nice buildings" that the facility could team the U.S. FOI up with. The U.S. FOIA (b)(6) stated the plan now was to have the U.S. FOI work with another U.S. FOI when possible to be afforded the training she needed.

A review of the facility provided resume for the U.S. FOI revealed she had not been employed as a U.S. FOI in any health care facility since obtaining her U.S. FOIA (b)(6) . The U.S. FOI was noted to have shadowed a U.S. FOIA (b)(6) at a behavioral health facility from Ex Order 26.4B1 NJ Ex Order 26.4b1. The U.S. FOI was also noted as a U.S. FOIA (b)(6) in a NJ Ex Order 26.4b1 .

A review of the facility provided, "Social Worker Job Description" provided on 09/28/22 and signed on 09/28/22 by the U.S. FOI, included but was not limited to Experience: must have, as a minimum three (3) years supervised social work experience in a health care setting working directly with individuals.

The facility was on record as being licensed for 149 beds. The CMS guidelines implemented 11/28/17, included but were not limited to a qualified U.S. FOI full-time for a facility with over 120 beds. The qualifications included one year of supervised social work experience in a health care setting working directly with individuals.

The U.S. FOIA had not met the experience requirement for a U.S. FOI and the facility did not have another U.S. FOI employed to provide supervision.

On 10/07/22, the above concern was presented

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F 850	Continued From page 251 to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-9.3(a)(1)(3); 39.2; 39.4(i)	F 850		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on concerns identified during this survey that ended 10/12/2022, interviews and review of pertinent facility provided documentation, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to put forth a good faith attempt to identify and correct their own concerns related to infection prevention and control during an ongoing [redacted] ([redacted] that began on [redacted].	F 865	1. Corrective Action: A QAPI meeting was immediately scheduled to review the thoroughness of the QAPI program. Identified concerns related to Infection control, COVID-Testing and Vaccination of facility staff reviewed with the QAPI team and interventions, and next steps implemented.	12/5/22

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F 865	Continued From page 252 This deficient practice was identified during the standard survey and was evidenced by the following: Refer to F880L, F886L, F888L On 09/21/22 at 01:09 PM, during the entrance conference held with the facility administration, another surveyor requested information regarding the QAA (Quality assessment and assurance) committee and QAPI plan. The administration informed the survey team that the facility was presently in an outbreak of COVID-19 which began on 06/24/22. On 10/07/22 at 10:00 AM, the surveyor reviewed the facility provided Quality Assurance Meeting August 2022 minutes which included the following: Outbreak Plan: We reviewed the outbreak plan as it effects each and every dept. Since I am new to the team I wanted to bring it to an almost beginning step. We had a question answer session which gave me an idea as to where we are. There was no other documentation in the minutes in relation to infection control or COVID-19. On 10/07/22 at 11:29 AM, another surveyor interviewed the U.S. FOIA (b)(6) regarding the QAPI process. The U.S. FOIA (b)(6) stated that she had been at the facility for more than two years and that she attended the QAPI committee meetings. The other surveyor then asked if there were any QAPI plans that she was involved in. The U.S. FOIA (b)(6) stated, "not really". She	F 865	2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: The IP Coordinator will conduct weekly audits related to F880, F886 and F888 The Administrator and/or DON will review weekly the tracking and trending of patient outcomes, incident reports and quality metric reports and refer to the QAPI committee to identify and correct concerns related to infection prevention and control during an ongoing COVID-19 virus outbreak. 4. How Will These Actions Be Measured: The results of the weekly reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 865	Continued From page 253	F 865		

added that at every QAPI Committee meeting they would "go over things", but that there had been so much change in staff that they had "not gone over much," and that the U.S. FOIA (b)(6) were very new to the facility.

On 10/12/22 at 09:53 AM, in the presence of another member of the survey team, the surveyor interviewed the U.S. FOIA (b)(6) regarding the facility's QAPI program. The U.S. FOIA (b)(6) stated that the QAPI committee met on a quarterly basis and that the U.S. FOIA (b)(6)) was the lead person with the U.S. FOIA (b)(6) . He stated that he had only attended the last meeting which occurred in July 2022 and that it was a "reintroduction" and went over what he would "expect from them." The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) would oversee the process and that if she could not attend the meeting, she would get the information and would "sign off on it." He added that he had only attended one meeting since he started at the facility and that the US FOIA (b)(6) was not at that meeting and there was not another physician in her place. The surveyor asked the U.S. FOIA (b)(6) for an example of what the QAPI committee was working on. The U.S. FOIA (b)(6) stated that there were certain topics like infection control that we discuss, the prior deficiencies and "what that looks like for the facility." The U.S. FOIA (b)(6) then stated that the current focus was residents that were eating with their hands. The surveyor asked if the staff vaccination for COVID-19 status had been presented to the QAPI committee. The U.S. FOIA (b)(6) stated that he knew that it had but that he was not sure how "deep we went in." He added that he could not recall the conversation but that it should be a daily conversation and that obviously they should have "been better with that." The

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surveyor asked the U.S. FOIA (b)(6) if he kept up to date with the current infection control guidelines. The U.S. FOIA (b)(6) stated "yes." The surveyor then asked the U.S. FOIA (b)(6) if he was able to identify any breaches in infection control prior to the survey. The U.S. FOIA (b)(6) stated that if he "saw" staff doing something wrong then he would train them but that once trained there was some forgetfulness. The surveyor then asked the U.S. FOIA (b)(6) if the facility had an U.S. FOIA (b)(6)) and their process. The U.S. FOIA (b)(6) stated that the U.S. FOIA met at the same time that the QAPI committee met. He added that information was discussed monthly and that it was recapped at the QAPI meeting but that he did not think there were formal meeting minutes for the U.S. FOIA. He then stated that there were "a lot of things we need to work on." He added that before the survey the facility was "trying to get things on track," but that was the reason we have survey, "to get back on track."

On 10/12/22 at 10:53 AM, the U.S. FOIA (b)(6) showed the surveyor a U.S. FOIA (b)(6) Meeting sign in sheet dated 08/2/22 which included the Medical Director's signature. The surveyor then asked about the NJ Exec Order 26.4b1 signature since the U.S. FOIA (b)(6) previously stated that the NJ Exec Order 26.4b1 had not attended. He then stated that the NJ Exec Order 26.4 was there and must have entered the meeting maybe at the end or after the meeting began.

On 10/12/22 at 11:52 AM, during surveyor interview, the US FOIA stated that she had been on the QAPI committee since 2008. The surveyor asked the US FOIA if she was the QAPI committee chair or coordinator. The EX ORD stated that she was not in charge of the committee and that the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) would be in charge. She

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added that she did not know who the QAPI committee chair or coordinator was. The surveyor then asked the [redacted] if there were any plans of action to correct identified quality deficiencies. The [redacted] stated that she did not have any plans in place. The surveyor then asked the IIP if the committee had identified any of the concerns that the survey team had found or had any plans of action to correct them already in place prior to the survey. The [redacted] stated that she could not recall that they had any QAPI plans going on prior to survey.

On 10/12/22 at 12:41 PM, the surveyor interviewed the [redacted]), in the presence of the Regional Nurse, regarding the QAPI program. The [redacted] stated that the expectation would be that each department team would review monthly that their systems were "running to move forward and to meet best practices" and would present the information to the QAPI committee. The surveyor then asked the [redacted] if the concerns that were identified by the survey team should have been identified by the facility. The [redacted] stated that the expectation would be that some of the concerns should have been identified and that they should have been working on plans to improve. The surveyor then asked the [redacted] who the QAPI committee chair or coordinator was. The [redacted] stated that it should be the [redacted]. The surveyor then asked the [redacted] if the facility had any plans of action to correct identified quality deficiencies already in place prior to the survey. The [redacted] stated that she was not aware of any performance improvement plans that they were working on and that there was none that she could find.

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F 865	Continued From page 256 The facility was unable to provide any documented evidence that the QAPI Committee attempted to put forth a good faith attempt to identify and correct their own concerns. A review of the facility provided policy titled, "Quality Assurance and Performance Improvement (QAPI) Program", dated August 2017, included the following: Under Policy Statement The facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Under Policy Interpretation and Implementation The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Under Five Strategic Elements The QAPI program has been developed with five strategic elements in mind: Under Five Strategic Elements 1. Design and Scope: a. The program is ongoing and comprehensive. b. It involves the full range of services and department in the facility. c. It covers all systems of care and management practices, with priority given to quality care, quality of life and resident choice. d. Goals, targets and benchmarks are established and measured based on the best available evidence. 2. Governance and leadership: ... c. Member of the facility leadership are accountable for QAPI efforts.	F 865		

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F 865	Continued From page 257 Under QAPI Action Steps The following steps are employed or will be employed to support and enhance the facility QAPI program: ... 9. Establishing a QAPI Plan that guides quality efforts and serves as the main document that supports the QAPI program .... 16. Recognizing patterns in systems of care that can be associated with quality problems. 17. Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs ... 19. Conducting Root Cause Analysis to identify the underlying issues that contribute to recognized problems. A review of the facility provided policy titled, "QAPI Committee" dated August 2017, included the following: Under Policy Interpretation and Implementation The Administrator shall delegate the necessary authority for the QAPI committee to establish, maintain and oversee the QAPI program. Under Goals of the Committee The primary goals of the QAPI Committee are to : 1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; ... 3. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; 4. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problem' 5. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality care' 6. Coordinate the development, implementation,	F 865		

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monitoring, and evaluation of performance improvement projects to achieve specific goals;
Under Committee Authority
5. The QAPI Coordinator shall coordinate the activities of the QAPI Committee.
Under Committee Reports and Records
The committee shall maintain minutes of all regular and special meetings that include at least the following information:
-The date and time the committee met;
-The names of committee members present and absent;
-A summary of the reports and finding;
-A summary of any approaches and action plans to be implemented;
-Conclusions and recommendations from the committee; and
-The time the meeting adjourned.

A review of the facility provided policy titled, "QAPI Plan," dated August 2017, included the following information:
Under Policy Statement
This facility shall develop, implement, and maintain an ongoing, facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.
Under Policy Interpretation and Implementation
The Objectives of the QAPI Plan are to:
1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services; ...
3. Provide structure and processes to correct identified quality and/or safety deficiencies;
4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome..,

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F 865	Continued From page 259 7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program ... Under Authority 2. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements. N.J.A.C. 8:39-33.1(a)(b)(c)(e); 8:39-33.2 (a)(b)(c)(d)	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on concerns identified during the survey through interviews, and review of pertinent facility provided documents, it was determined that the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. This deficient practice was identified during the standard survey and was evidenced by the following: On 09/21/22 at 01:09 PM, during the entrance conference held with the facility administration, another surveyor requested information regarding	F 867	1. Corrective Action: A QAPI meeting was immediately scheduled to review the thoroughness of the QAPI program. A QAPI meeting was immediately scheduled with Identified concerns related to Infection control, COVID- Testing and Vaccination of facility staff and was reviewed with the QAPI team and interventions, and next steps implemented. QAPI meeting minutes from the last three months were reviewed with the QAPI team. Plans of action to correct identified quality deficiencies were implemented. 2. Identification of other residents or	12/5/22

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F 867	Continued From page 260 the QAA (Quality assessment and assurance) committee and QAPI plan. On 10/07/22 at 10:00 AM, the surveyor reviewed facility provided Quality Assurance Meeting minutes for the last three meetings. There was no documented evidence in the minutes to confirm plans of action to correct identified quality deficiencies were implemented. On 10/07/22 at 11:29 AM, the other surveyor interviewed the U.S. FOIA (b)(6) regarding the QAPI process. The U.S. FOIA (b)(6) stated that she had been at the facility for more than two years and that she attended the QAPI committee meetings. The other surveyor then asked if there were any QAPI plans that she was involved in. The Medical Director stated, "not really". She added that at every QAPI Committee meeting they would "go over things", but that there had been so much change in staff that they had "not gone over much," and that the U.S. FOIA (b)(6) were very new to the facility. On 10/12/22 at 09:53 AM, in the presence of another member of the survey team, the surveyor interviewed the U.S. FOIA (b)(6) regarding the facility's QAPI program. The U.S. FOIA (b)(6) stated that the QAPI committee met on a quarterly basis and that the U.S. FOIA (b)(6)) was the lead person with the NJ Exec Order 26.4b1 . He stated that he had only attended the last meeting which occurred in Ex Order 26.4B1 and that it was a "reintroduction" and what he would "expect from them." The U.S. FOIA (b)(6) stated that the NJ Exec Order 26.4b1 would oversee the process and that if she could not attend the meeting, she would get the information and would "sign off on it." The	F 867	areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Education was provided to the QAPI team on the QAPI policy, process, and procedure by the Regional Licensed Nursing Home Administrator. The Administrator and/or DON will review weekly the tracking and trending of patient outcomes, incident reports and quality metric reports and refer to the QAPI committee to identify and correct concerns related to infection prevention and control during an ongoing COVID-19 virus outbreak. Outcomes of identified quality deficiencies will be monitored weekly by The Administrator and/or DON to assure quality deficiencies are resolved or continued to be addressed by the QAPI committee. 4. How Will These Actions Be Measured: The results of the weekly reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 867	Continued From page 261	F 867		

surveyor asked the U.S. FOIA (b)(6) for an example of what the QAPI committee was working on. The U.S. FOIA (b)(6) stated that there were certain topics like infection control that we discuss, the prior deficiencies and "what that looks like for the facility." The U.S. FOIA (b)(6) then stated that the current focus was residents that were eating with their hands. The surveyor asked if the staff vaccination for COVID-19 status had been presented to the QAPI committee. The U.S. FOIA (b)(6) stated that he knew that it had but that he was not sure how "deep we went in." He added that he could not recall the conversation but that it should be a daily conversation and that obviously they should have "been better with that." The surveyor asked the U.S. FOIA (b)(6) if he kept up to date with the current infection control guidelines. The U.S. FOIA (b)(6) stated "yes." He then stated that there were "a lot of things we need to work on." He added that before survey the facility was "trying to get things on track," but "that was the reason we have survey", "to get back on track."

On 10/12/22 at 11:52 AM, during surveyor interview, the US FO stated that she had been on the QAPI committee since 2008. The surveyor asked the US FO if she was the QAPI committee chair or coordinator. The US FO stated that she was not in charge of the committee and that the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) would be in charge. She added that she did not know who the QAPI committee chair or coordinator was. The surveyor then asked the U.S. FO if there were any plans of action to correct identified quality deficiencies. The U.S. FO stated that she did not have any plans in place. The surveyor then asked the U.S. FO if the committee had identified any of the concerns that the survey team had found or had any plans of action to correct them already in place prior to the survey. The U.S. FO stated that she could not recall

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F 867	Continued From page 262 that they had any plans going on prior to the current survey. On 10/12/22 at 12:41 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted], in the presence of the Regional Nurse, regarding the QAPI program. The U.S. FOIA (b)(6) stated that the expectation would be that each department team would review monthly that their systems were "running to move forward and to meet best practices" and would present the information to the QAPI committee. The surveyor then asked the U.S. FOIA (b)(6) if the concerns that were identified by the survey team should have been identified by the facility. The U.S. FOIA (b)(6) stated that the expectation would be that some of the concerns should have been identified and that they should have been working on plans to improve. The surveyor then asked the U.S. FOIA (b)(6) who the QAPI committee chair or coordinator was. The U.S. FOIA (b)(6) stated that it should be the U.S. FOIA (b)(6). The surveyor then asked the U.S. FOIA (b)(6) if the facility had any plans of action to correct identified quality deficiencies already in place prior to the survey. The U.S. FOIA (b)(6) stated that she was not aware of any performance improvement plans that they were working on and that there was none that she could find. The facility was unable to provide any documented evidence that the QAPI Committee developed and implemented appropriate plans of action to correct identified quality deficiencies. A review of the facility provided policy titled, "Quality Assurance and Performance Improvement (QAPI) Program", dated August 2017, included the following: Under Policy Statement	F 867		

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F 867	Continued From page 263 The facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Under Policy Interpretation and Implementation The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Under Five Strategic Elements The QAPI program has been developed with five strategic elements in mind: ... 2. [G]overnance and leadership: ... e. Staff are encouraged to identify and report quality concerns as well as opportunities for improvement ... 4. Performance Improvement projects: a. Performance improvement projects (PIPs) are initiated when problems are identified. b. PIPs involve systematically gathering information to clarify issues and to intervene for improvements ... 13. Gathering and using QAPI data in an organized and meaningful way. Areas that may be appropriate to monitor and evaluate include: a. Clinical outcomes: pressure ulcers, infections, medication use, pain, falls, etc.; b. Complaints from residents and families; c. Re-hospitalizations; d. Staff turnover and assignments; e. Staff satisfaction; f. Care plans; g. State surveys and deficiencies; and h. MOS assessment data ... 16. Recognizing patterns in systems of care that can be associated with quality problems.	F 867		

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F 867	Continued From page 264 17. Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs. 18. Planning, conducting and documenting PIPs. 19. Conducting Root Cause Analysis to identify the underlying issues that contribute to recognized problems. 20. Taking systematic action targeted at the root causes of identified problems. This encompasses the utilization of corrective actions that provide significant and meaningful steps to improve processes and do not depend on staff to simply "do the right thing." A review of the facility provided policy titled, QAPI Committee" dated August 2017, included the following: Under Policy Interpretation and Implementation The Administrator shall delegate the necessary authority for the QAPI committee to establish, maintain and oversee the QAPI program. Under Goals of the Committee The primary goals of the QAPI Committee are to : 1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; ... 3. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; 4. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problem' 5. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality care' 6. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; Under Committee Authority	F 867		

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5. The QAPI Coordinator shall coordinate the activities of the QAPI Committee.
Under Committee Reports and Records
The committee shall maintain minutes of all regular and special meetings that include at least the following information:
-The date and time the committee met;
-The names of committee members present and absent;
-A summary of the reports and finding;
-A summary of any approaches and action plans to be implemented;
-Conclusions and recommendations from the committee; and
-The time the meeting adjourned.

A review of the facility provided policy titled, "QAPI Plan," dated August 2017, included the following information:
Under Policy Statement
This facility shall develop, implement, and maintain an ongoing, facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.
Under Policy Interpretation and Implementation
The Objectives of the QAPI Plan are to:
1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services; ...
3. Provide structure and processes to correct identified quality and/or safety deficiencies;
4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome..,
7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective

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F 867	Continued From page 266 ongoing program ... N.J.A.C. 8:39-33.1(a)(b)(c)(e); 8:39-33.2 (a)(b)(c)(d)	F 867		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		12/5/22

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F 880	Continued From page 267 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. §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, record review and review of pertinent documentation, it was determined that the facility failed to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid	F 880	Immediate Action: Residents # 44 and # 52 were placed in NJ Ex Order 26.4b1 on the NJ Exec Or floor on NJ Exec Order 26. once tested and discovered NJ Exec Order 26.4b result. Both rooms	

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F 880	Continued From page 268 Services (CMS) guidance was implemented to limit the spread of infectious disease by failing to ensure: 1.) a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of NJ Ex Order 26.4b1 for 3 of 3 resident care units, and 2.) a process was in place to ensure all required staff were appropriately fit tested for an N-95 respirator and documentation was completed for 3 of 3 resident care units. This deficient practice placed all residents and staff at risk for contracting a contagious infectious and potentially deadly virus and was evidenced by the following: Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. Reference: Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022 Part 1 The facility's failure to ensure a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of NJ Ex Order 26.4b1 for 3 of 3 resident care units resulted in an Immediate Jeopardy (IJ) situation that began on 09/20/22, when two EX Order 26.4B1 residents (Resident #44 and Resident #52) were not immediately EX Order 26.4B1 and tested one day later, on EX Order 26.4B1, and both residents	F 880	kept with the door closed due to NJ Ex Order 26.4b1 [redacted]. NJ Ex Order 26.4b1 [redacted] placed by the facility educator on the doors and isolation bins with PPE supply placed outside the doors. On NJ Ex Order 26.4b1 was done on patients #44 and #52 and it was established that both residents did not have any visitors for the previous 14 days, did not go out for any consults. NJ Ex Order 26.4b1 [redacted] lso revealed that only one of the two residents had a roommate. The roommate was placed under NJ Ex Order 26.4b1 [redacted], result was NJ Exec Order 26.4b1, and remains NJ Exec Order 26.4b1 The roommate did not have any visitors. On 9/23/22 the nurse on duty who was in charge of the two residents who tested NJ Exec Order 26.4b1 was in serviced on COVID 19 signs and symptoms including the need for testing and contact and droplet isolation as applicable. On 9/23/22 the policy on Contact tracing was reviewed and revised and a policy on Contact tracing and Exposure Risk protocols was re-introduced. On 9/23/22 the Administrator and Director of Nursing reviewed the policy for Contact Tracing and Risk assessments for residents. On 9/23/22 all staff present on the 1st floor were in serviced by the Director of Nursing and facility educator on Transmission based precautions and what type of PPE to wear in the COVID positive rooms. On 9/23/22 all patients on 3rd floor were	

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F 880	Continued From page 269 were EX Order 26.4B1 The facility U.S. FOIA (b)(6) confirmed contact tracing was not completed to identify any close contacts for Resident #44 and Resident #52, and the U.S. FOIA (b)(6) was unable to provide documented evidence of contact tracing that was completed to identify close contacts for both residents. The facility administration was notified of the IJ on 9/23/22 at 1:04 PM. The facility submitted an acceptable removal plan via electronic mail (email) on 09/27/22 at 3:46 PM. The IJ removal plan was verified as implemented during an on-site visit on 10/03/22 at 1:49 PM. The evidence was as follows: On 09/21/22 at 9:18 AM, upon entrance to the building, Surveyor #1 requested information from the U.S. FOIA (b)(6)) regarding any NJ Exec Order 26.4b1 residents currently residing in the building. The U.S. FO stated there were no NJ Exec Order 26.4b1 residents in the building, and there were two persons under investigation (PUI- a person who had been in contact with a person who had an infection, or was awaiting testing for a suspected infection) who resided on the first floor. The U.S. FOIA (b)(6) informed the survey team that the facility was currently in an NJ Ex Order 26.4b1 and would provide the survey team with a copy of the current line listing. On 09/21/22 at 1:09 PM, surveyor #1 conducted	F 880	tested, no other positive cases. On EX Order 26.4B1 testing continued and EX Or more patients were identified as EX Order 26.4B1 All positive residents were moved to EX Order 26.4B1 and placed on NJ Ex Order 26.4b1 immediately. All family members and staff notified. On 9/23/22 all staff that came in contact with the NJ Exec Order 26.4b1 residents were provide with NJ Exec Order 26.4b1 and all had NJ Exec Order 26.4b1 results. On NJ Exec Order 26.4b1 testing continued and 1 CNA on NJ Exec floor tested NJ Exec Order 26.4 . The U.S. FOIA (was sent home for 10 day quarantine. On 9/23/22 family members of the positive residents were notified and advised to refrain from visiting while residents are under precautions. On 9/23/22 US FOIA (b)(6) was in serviced on COVID testing policy and Contact tracing policy. On 9/23/22 Infection preventionist was removed from schedule pending further investigation. On 9/23/22 Infection preventionist was replaced with an interim Infection Preventionist. On 9/23/22 line list was completed by the interim Infection Preventionist. II. Identification of Others: All residents have the potential of being affected when the proper protocols and policies are not followed for residents with symptoms of COVID 19 and test positive for COVID 19. III. Systemic changes: On 9/23/22 the Management staff were in serviced by the Director of nursing and	

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F 880	Continued From page 270 an entrance conference with the U.S. FOIA (b)(6) and U.S. FOIA (b)(6)). The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) was the facility Infection Preventionist and confirmed that she did not have an infection control certification since she had not completed infection control training. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) was responsible for "all" of the facility COVID-19 vaccination effort. Surveyor #1 inquired to the number of U.S. FOIA (b)(6) residents and symptomatic residents who currently residend in the facility, and the U.S. FOIA (b)(6) confirmed there were currently no NJ Exec Order 26.4b1 residents who resided in the facility, and there were NJ Ex Order 26.4b1 residents. Surveyor #1 requested all the information related to the COVID-19 vaccination status of all residents and staff and all related testing for COVID-19. The U.S. FOIA (b)(6) stated that residents and staff were tested twice per week, however, they were unable to provide the documentation, and stated that the U.S. FOIA (b)(6) would provide it. On 09/22/22 at 9:55 AM, the U.S. FOIA (b)(6) informed the survey team that two residents (Resident #44 and Resident #52) had NJ Ex Order 26 and had been moved to the first floor for NJ Ex Order 26.4b1 . The U.S. FOIA (b)(6) stated the NJ Ex Order 26.4b1 results were identified during "routine" NJ Ex Order 26.4b1 testing. On 09/22/22 at 1:46 PM and 2:14 PM, during interviews, the U.S. FOIA (b)(6) failed to provide the survey team with the requested documents related to infection control, which included the staff vaccination documentation and staff and resident testing documentation. The U.S. FOIA (b)(6) stated the documents were now with the "corporate people" and he was unable to produce the documents.	F 880	Facility educator on the policy for Contact tracing and Risk assessments. On 9/23/22 all present nursing staff were in serviced by the Director of Nursing and Facility educator on policies and procedures on Contact tracing and Risk assessments for residents with potential for exposure to COVID 19 virus. On 9/23/22 the management team met and did a root cause analysis to identify the source of the COVID 19 infection in the initial 2 residents. It was determined that the cause of the event was due to lack of immediate identification of residents presenting with signs and symptoms for COVID 19 and immediately testing them. On 9/23/22 the Director of nursing and Facility educator conducted an in service for all staff on COVID signs and symptoms, contact tracing and testing guidelines. On 9/27/22 the Director of Nursing and Interim Infection Preventionist in serviced all staff on the correct PPE to be worn along with the donning and doffing PPE. IV. QA Monitoring The Director of Nursing and Infection Preventionist will observe 5 staff members daily x 30 days in regards to donning and doffing PPE as well as the correct PPE when entering a resident room. This will include return competency for performance of tasks of 3 staff members daily x 30 days. The Director of Nursing and interim infection preventionist will monitor daily for any reports of COVID 19 signs and	

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F 880	Continued From page 271 On 09/22/22 at 3:42 PM, the U.S. FOIA (b)(6) was interviewed by Surveyor #1, #2 and #3 regarding the facility COVID-19 testing process. The U.S. FOIA (b)(6) stated that not all staff and residents were tested twice weekly. She stated if the resident had not yet received a COVID-19 booster vaccine, they would be tested twice weekly. The survey team inquired as to what was the criteria that was used to determine which staff were tested for COVID-19. The U.S. FOIA (b)(6) then proceeded to review her COVID-19 testing log with the surveyors. The U.S. FOIA (b)(6) stated if some staff felt like they had a cold, they could be tested, and stated "there are no staff members that need to be tested" at present. The U.S. FOIA (b)(6) presented a log with handwritten "COVID retesting employees", Binax Now Test Sign Off and had a handwritten date of 09/20/22, which contained three staff names, each dated 09/20/22, with a NJ Ex Order 26.4b1. The three staff included a Licenced Practical Nurse (LPN #1), Unidentified Staff, (Staff #1), and the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated "only" residents were on her list to receive COVID-19 testing twice per week. A second document provided by the U.S. FOIA (b)(6), revealed a handwritten "COVID [sic.] res..ting, 09/20/22, pt's" The handwritten document contained EX Order 26.4B1 names and had a handwritten date of EX Order 26.4B1 with a EX Order 26.4B1 result, and EX Order 26.4B names were listed and dated EX Order 26.4B1. The U.S. FOIA (b)(6) stated the EX Order 26.4B1 names listed were not tested related to the EX Order 26.4B1 residents, (Resident #44 and Resident #52, that were tested on EX Order 26.4B1). Resident #52 and Resident #44, were listed with a EX Order 26.4B1, and the remaining EX Orde names EX Order 26.4B1. The survey team inquired to the U.S. FOIA (b)(6) regarding why the other names listed received a test, and the U.S. FOIA (b)(6) stated three staff	F 880	symptoms in residents or staff to ensure prompt testing is being performed and prompt contact tracing is done on the employee and risk assessments are done on the residents for possible exposure ongoing. The interim Infection Preventionist will keep a tracker for all Contact tracing done during an outbreak. The tracker will be reviewed by the DON weekly. All findings will be reviewed at the Quality Assurance meeting x 3 quarters. The first of which will take place in December 2022. V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee On 10/11/22 the COVID 19 management policies and procedures reviewed by facility team and medical director. The policies and procedures meet the best practices by CDC guidelines and will be implemented moving forward, along with the respiratory program. Staff in service was started on 10/11/22 Interim Infection Preventionist and Regional Nurse (who will provide oversight for the Infection Preventionist) and will be completed by 10/21/22. On 10/11/22 the facility interim Infection Preventionist, Regional Nurse and HR staff conducted an employee audit for fit testing. There were 75 employees identified as needing to be fit tested. Anyone identified will be completed with fit testing by 10/21/22. On 10/11/22 the nurse (M.T.) who could	

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F 880	Continued From page 272 requested a test, one resident requested a test, one resident was the Unsampled Resident roommate of Resident #44 who also requested to be tested after the resident had found out that the room mate EX Order 26.4B1. At 3:45 PM, the U.S. FOIA (b)(6) confirmed she was responsible for NJ Ex Order 26.4b1 testing, and the two pages that she had provided to the survey team, and reviewed with the survey team was the only facility NJ Ex Order 26.4b1 testing log that was used for residents and staff on EX Order 26.4B1. On 09/23/22 from 9:42 AM to 10:00 AM, Surveyor #2, #3 and #4 conducted a subsequent interview with the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated Resident #44 was tested for EX Order 26.4B1, and she confirmed the resident had been EX Order 26.4B1 on EX Order 26.4B1 The U.S. FOIA (b)(6) stated that Resident #52 was tested for EX Order 26.4B1 due to also having EX Order 26.4B1 and she confirmed the resident also had tested EX Order 26.4B1 The U.S. FOIA (b)(6) stated she had not been made aware until the EX Order 26.4B1 that Resident #44 and #52 were EX Order 26.4B1. When asked if she should have been informed of the EX Order 26.4B1 residents she stated "yes, I would think so". When asked who was responsible for completing any contact tracing related to the EX Order 26.4B1 cases, the U.S. FOIA (b)(6) stated "that is a good question" and stated it would be under her jurisdiction. The U.S. FOIA (b)(6) stated that she had just found out from the survey team that Resident #52 had attended a EX Order 26.4B1 otherwise, she stated she would have tested the resident for EX Order 26.4B1 before and after attending a EX Order 26.4B1 outside of the facility. The U.S. FOIA (b)(6) stated that she had tried to obtain information from staff and made rounds daily on the resident units. When inquired to the U.S. FOIA (b)(6) when the current outbreak began and what the	F 880	not be fit tested due to medical reasons, will no longer be able to work at the facility, removed from schedule, agency informed. On 10/11/22 the facility interim Infection Preventionist and Regional nurse reviewed the line list DATED 10/11/22 and found that there are EX Order 26.4B1 patients in the facility, all residing on the first floor nursing unit in COVID droplet isolation rooms. Units 2 and 3 do not have any patients who are COVID positive or PUIs. On 10/11/22 the facility interim Infection Preventionist started an in service on fit testing with instructions for anyone who is not fit tested to avoid going to 1st floor nursing unit where the COVID positive isolation rooms are located (or any PUI isolation rooms in the future) until they get fit tested. On 10/11/22 respiratory company NJRA was contacted regarding train the trainer for fit testing. Session scheduled for 10/13/22 and completed. II. Identification of Others: All residents have the potential of being affected when the proper protocols and policies are not followed for COVID 19 fit testing for N95 masks III. Systemic changes: On 10/12/22 the US FOIA (b)(6) were inserviced on fit testing and vaccination by the interim Infection Preventionist and Regional Nurse, with the understanding that moving forward, anyone who is not fit tested or up	

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F 880	Continued From page 273 status was, the U.S. FOIA (b)(6) stated she did not know when the outbreak started, "not the specific date", and as far as she knew the facility had always been in an outbreak. The U.S. FOIA (b)(6) provided the survey team with a copy of the facility "Outbreak Plan/Covid-19 Response, revised 03/10/22" which was reviewed in the presence of the U.S. FOIA (b)(6). The document revealed "Higher -risk exposure- referred to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff does not wear adequate personal protective equipment during care or interaction with an individual." The document also revealed "Upon identification of a single new case of COVID-19 in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing though two approaches, contact tracing or broad-based (e.g., facility-wide) testing". Surveyor #1 inquired to the U.S. FOIA (b)(6) regarding what staff were considered exposed to Resident #44 and Resident #52, and were any of the staff tested for NJ Ex Order 26.4b1 The U.S. FOIA (b)(6) stated "everyone could be going into the room, anyone can answer a light [call bell]", and stated, "I will be honest with you, I didn't test anyone", and stated "I tested the two [Resident #44 and #52] that were EX Order 26.4b1 and the immediate roommate". The U.S. FOIA (b)(6) then confirmed, in the presence of the survey team, that she did not complete any contact tracing, and stated the book of testing that she had provided to the survey team was the entirety of the facility NJ Ex Order 26.4b1 testing documentation, and confirmed there was no facility wide testing completed in	F 880	to date with vaccination, will not be able to be placed on the schedule. Any agency staff will have to provide proof of vaccination and fit testing prior to be placed on the schedule. Any new hire individuals will have to provide proof of up to date vaccination (must have vaccine step #1, vaccine step#2 and booster) and fit testing prior to starting orientation. IV. QA Monitoring Infection Preventionist will keep a binder with the record for N95 fit tests of all active employees, including agency personnel. A listing of all active employees and agency staff will be placed at the front of the binder for easy auditing. The interim Infection Preventionist will keep a tracker of all facility employees fit testing for N95, ensuring all employees were fit tested for the N 95 mask being used in the facility. The Director of Nursing will check the tracker for fit testing on a weekly basis. All findings will be reviewed at the Quality Assurance meeting x 3 quarters. V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee	

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response to the Residents #44 and #52 EX Order 26.4B1 EX Order 26.4B1 status.

She stated any other staff member could have completed a COVID-19 test if they were trained. When inquired if any other staff had been trained to complete COVID-19 testing she stated, "not off the top of my head." The survey team inquired to the U.S. FOIA (b)(6) regarding what should have been completed at the time a resident was experiencing symptoms of COVID-19. The U.S. FOIA (b)(6) stated that the facility has a U.S. FOIA (b), and testing supplies could be obtained as needed, and the residents should be tested if they were symptomatic. The U.S. FOIA (b)(6) stated that unvaccinated and symptomatic residents should be transferred to a COVID-19 isolation room with isolation signs placed outside. The U.S. FOIA (b)(6) stated if residents were EX Order 26.4B1 and then tested negative for COVID-19, they should be moved to an isolation room for PUI in the event they became EX Order 26.4B1. The U.S. FOIA (b)(6) stated if there was a room mate to the COVID-19 EX Order 26.4B1 resident, that person would be tested, and Resident #52 did not have a roommate. The U.S. FOIA (b)(6) stated that the roommate of Resident #44 was tested for EX Order 26.4B1 and tested negative but was not restricted to the PUI section "at this point." The U.S. FOIA (b)(6) stated both Resident #44 and Resident #52 had been EX Order 26.4B1 EX Order 26.4B1 and were EX Order 26.4B1 The surveyor inquired to the U.S. FOIA (b)(6) if she was aware that Resident #52 had attended a EX Order 26.4B1 outside of the facility, as documented in Resident #52's progress notes. The U.S. FOIA (b)(6) stated "no", she was not aware. The U.S. FOIA (b)(6) was asked if she completed the facility line listing (the spreadsheet of all COVID-19 infections that is transmitted to the Department of Health) and communicated

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with the local Department of Health (DOH) regarding new COVID-19 cases. The [redacted] stated the [redacted] was responsible for completing the line listing and contacting the DOH. The [redacted] provided the survey team with a copy of the facility line listing which revealed that the symptoms for Residents #44 and #52 had an onset date of [redacted]. The survey team inquired if that date was correct and the [redacted] stated that date should be changed to [redacted] when both residents became symptomatic. The surveyors inquired to the [redacted] if she had reviewed the staff assignment sheets for Resident #44 and Resident #52 to determine who provided care for the residents. The [redacted] confirmed that she had not looked at the assignment sheets to determine who had cared for Resident #44 and Resident #52. When asked how far back would it be reviewed to determine close contacts for the purpose of contact tracing, the [redacted] did not specify and stated that she would have to get clarification. The survey inquired if the [redacted] received a job description, and she stated, "not as of yet."

The survey team inquired to the [redacted] regarding a list of all staff vaccination status and the percent vaccinated staff. The [redacted] stated she could get that information from the employee files, however, she was not provided with that information for any new hires, and confirmed that she did not enter the information into the National Healthcare Safety Network (NHSN).

On 09/23/22 at 11:34 AM, the survey team interviewed the [redacted] regarding who was responsible for completing the NHSN information. The [redacted] stated the [redacted] completed it, however, she was unable to provide a staff vaccination list

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to the survey team, and she did not know what the percent COVID-19 vaccination status was for the staff. The [redacted] stated she did not have a completed vaccination list and "I am not making up what I don't have." The survey team inquired to the [redacted] regarding what was the process when a resident became symptomatic for COVID-19. The [redacted] stated "as soon as" symptoms developed the symptomatic person should be tested for COVID-19, and the U.S. FOIA (b)(6) [redacted] could complete the testing on the 11:00 PM-7:00 AM shift. The [redacted] stated there was "no" reason that testing should not be completed.

On 09/23/22 at 11:49 AM, Surveyor #1 interviewed the U.S. FOIA (b)(6) in the presence of the survey team regarding if contact tracing was completed after Residents #44 and #52 EX Order 26.4B1 [redacted]. Both confirmed that contact tracing was not completed.

A review of the facility provided document, "Contact Tracing Policy Covid 19 Pandemic" undated and provided on 09/26/22, included but was not limited to Purpose: .... committed to following all state and federal guidance and regulations to prevent the spread of Covid 19.....As per the CDC, contact tracing....and close contacts are critical to help slow transmission of COVID-19. Procedure: maintain a continuous log of every person, including staff and visitors, who may have close contact with individuals at the facility. The Administrator or his/her designee will maintain the contact tracing log. If a staff member, resident, or consultant that visited the facility reports EX Order 26.4B1 [redacted], the facility will immediately notify the local health officials and follow directives. For a new onset of

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a NJ Exec Order 26 Covid case in a resident or staff member, the Infection Preventionist will document all contacts and conduct contact tracing utilizing Contact Tracing Form.

Part 2

The facility's failure to ensure a process was in place to ensure all staff were appropriately fit tested for an N-95 respirator and documentation was complete for 3 of 3 resident care units, resulted in an Immediate Jeopardy situation that began on 09/23/22 at 8:53 AM, when a Licensed Practical Nurse (LPN #2) was observed at a medication cart on the 2nd floor wearing a surgical mask. LPN #2 informed the surveyor that she had not been fit tested for an N-95 mask, she worked on multiple resident units, and that she had not received a COVID-19 booster. The IJ was identified on 10/11/22 at 2:03 PM, when the facility U.S. FOIA (b)(6) was unable to confirm, and provide documented evidence that all staff who required fit-testing for an N-95 mask (a close facial fitting respiratory protection device for filtration of airborne particles) had been appropriately fit-tested.

The facility submitted an acceptable removal plan via email on 10/12/22 at 1:42 PM.

The IJ removal plan was verified as implemented on 10/12/22 at 2:35 PM.

On 09/23/22 at 9:06 AM, Surveyor #1 interviewed the U.S. FOIA (b)(6), in the presence of the survey team, regarding if staff were currently fit tested for N-95 masks, the U.S. FOIA (b)(6) stated that she did not have a test mask to complete the fit testing process. The U.S. FOIA (b)(6) stated "everybody is not fit tested". When

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asked if all staff that worked on the COVID-19 unit were required to be fit tested and wear an N-95 mask. The [redacted] stated "no" they can wear either [N-95 or surgical mask], and stated they should wear the N-95 mask. The [redacted] stated "I did not get to everybody", and "I still have to get around to doing the new people".

On 09/23/22 at 8:53 AM Surveyor #1 observed LPN #2 on the 2nd floor medication cart wearing a surgical mask. Surveyor #1 interviewed LPN #2 at that time who stated she was a new hire. The surveyor asked LPN #2 if she was vaccinated for COVID-19 and if she had been fit tested for an N-95 mask. LPN #2 stated "not fit tested, not boosted", and she stated she was vaccinated for COVID-19 and confirmed that the facility was aware that she was not boosted. LPN #2 stated that she signed a waiver form that was provided by the facility since she did not want a COVID-19 booster. Surveyor #1 inquired to LPN #2 if she had received COVID-19 testing and she stated that the facility would let her know if she needed to take a test, and she could also let the [redacted] know if she needed to take a COVID-19 test. Surveyor #1 asked if LPN #2 if she was assigned to a particular unit, and she stated that she floated to different units. Surveyor #1 inquired to LPN #2 if she was responsible for completing any COVID-19 symptom monitoring for her assigned residents. She stated, "vitals are taken on everyone usually", if there were new symptoms then she would check vital signs (clinical measurements, specifically pulse rate, temperature respiration rate and blood pressure that indicate essential body functions), and that she would do vital signs if she had to, and stated she had not seen any formal resident monitoring for vital signs.

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F 880	Continued From page 279 On 10/06/22 at 12:30 PM, Surveyor #1 observed LPN #2 on the 1st floor COVID-19 unit at the nursing station. LPN #2 was observed wearing a NIOSH tc N-95 mask. Surveyor #1 inquired what N-95 mask was she required to wear, the LPN #2 removed two different masks from the bins outside of a resident room, and stated that she could wear either one. LPN #2 stated the mask Surveyor #1 was wearing (N95 # 8210) was very tight, and she stated that she was fit tested for both masks by the U.S. FOIA (b)(6). Surveyor #1 inquired if LPN #2 had a medical or religious exemption for the EX Order 26.4B1 LPN #2 again stated that she had signed a paper waiver provided by the facility that indicated she does not want the booster, and stated "no", it was not a medical exemption or a religious exemption and stated it was a document that offered risks and benefits. Surveyor #1 asked LPN #2 if she was fit tested for the mask she was wearing and she stated she could wear both and chose the N-95 that did not Ex Order 26.4B1 which was the NIOSH tc N-95. LPN #2 stated if the masks were in the bins that they were okay to wear. On 10/06/22 at 4:03 PM, Surveyor #1 in the presence of the survey team, interviewed the U.S. FOIA (b)(6) regarding the N-95 fit testing process. The U.S. FOIA (b)(6) stated the N-95 fit testing should be done upon hire and annually. Surveyor #1 asked if the U.S. FOIA (b)(6) had received training or a certification for fit testing. The U.S. FOIA (b)(6) stated she watched videos and stated that a hood was used over a person's head and there was a solution that would be used to test the person to see if the mask fit. The U.S. FOIA (b)(6) provided the surveyor with a book of N-95 Respirator Training and Fit Testing	F 880		

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Verification Forms (FTVF) for employees, and she stated the papers proved that a person had been fit tested for an N-95 mask. The [redacted] stated there were certain brands and they fit differently. She stated that the fit testing was completed with the masks that were most prevalent and stated, "no" there was no shortage of N-95 masks. The [redacted] stated if the employee needed a special mask, we would order it and some employees medically cannot use the N-95 masks. The [redacted] stated the staff that were not up to date with their COVID-19 vaccinations were required to wear the N-95 masks, and staff who worked with the [redacted] residents.

On 10/06/22 at 4:10 PM, Surveyor #1 reviewed the FTVF form for LPN #2. The document revealed the Training and Fit Date was 09/23/22 for the "8210 N95" model. The [redacted] was the trainer's name and signature. The Respirator Fit Test Record had a blank in the "Respirator Selected" and "Manufacturer" section was blank. The "Fit Checks" section with "Negative Pressure, Positive Pressure, Pass, Fail and Not Done" was blank. The Fit Testing section with "Fit Factor for Quantitative and Qualitative, Isoamyl Acetate, Sweet, Bitter and Smoke" and "pass/fail" for each was completely blank. The employee acknowledgement of test results was signed on 09/23/22 by LPN #2 and the "Test Conducted by" section was blank. Surveyor #1 inquired to the [redacted] if the 8210 N-95 was available at the facility and she stated yes, it is a common mask. Surveyor #1 inquired about the FTVF document and was it completed since there were blanks and stated "I don't have an answer for that" and confirmed that she was unable to tell if LPN #2 passed or failed her fit test because the form was

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incomplete. The U.S. FOIA (b)(6) stated that it was important for all staff to know their results and stated although the document was incomplete that LPN #2 had been fit tested. Surveyor #1 inquired about a waiver that was completed by LPN #2 that stated she could waive the booster and the U.S. FOIA (b)(6) stated she was unaware of such a document.

On 10/06/22 at 4:22 PM, Surveyor #1 asked the U.S. FOIA (b)(6) if there was a certification needed to conduct fit testing and if the facility allowed staff to waive the COVID-19 vaccine. The U.S. FOIA (b)(6) stated "yes" a certification was required to provide fit testing and staff were required to be up to date "all three" were needed (two vaccines and one booster).

On 10/07/22 at 10:49 AM, Surveyor #1 asked the U.S. FOIA (b)(6) if there was any staff that were currently not fit-tested for an N-95 mask. She confirmed that she did not know because she was not doing fit testing prior and was currently putting a list together and stated, "it has been started". The U.S. FOIA (b)(6) stated, "I watched the O.S.H.A. [Occupational Safety and Health Administration] video and did the competency back in the pandemic." The U.S. FOIA (b)(6) was not sure how long the certification was good for.

The U.S. FOIA (b)(6) provided the survey team with a document on 09/28/22, in a packet with document related to an NJ Exec Order 26.4b1 Assistant's (OTA) COVID-19 information. The document revealed the OTA's name handwritten on the document. The document was titled "ACCEPTANCE/DECLINATION FORM/VACCINATION RECORD" with three

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areas that can be checked off. The first area revealed a Covid-19 Vaccine Administration Consent, "I wish to receive the Covid-19 Vaccine. I read or had explained to me the Covid-19 Vaccine Information. I was given the opportunity to ask questions that were answered to my satisfaction. I understand the health benefits and risks of Covid-19 and the Covid-19 Vaccine". The second area revealed Covid-19 Vaccine Declination, "I decline to be vaccinated at this time. I have been given the opportunity to be vaccinated with the Covid-19 Vaccine. I understand that by declining this vaccine, I continue to be at increased risk of acquiring Covid-19, a serious disease, and a risk to others. I understand I can request the COVID 19 vaccine at any time during my employment with this facility", and the third section revealed, and was checked off by the U.S. FOIA (b)(6) Assistant, "I have already received the COVID 19 vaccination." Please provide a copy of your COVID 19 vaccination card. (This document reflected what LPN #2 stated she had been offered and signed, however was not provided by the facility)

The non-compliance remained on 10/12/22 for no actual harm with the potential for more than minimal harm that is not IJ based on the following:

Based on observations, interview, record review and document review it was determined that the facility failed to ensure that CDC and CMS infection control guidance was followed to limit the spread of infections and ensure: a.) staff donned (put-on) the appropriate Personal Protective Equipment (PPE) upon entry into the room of residents who were on

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[redacted], a new admission and un-vaccinated for [redacted], and NJ Ex Order 26.4b1 [redacted] (Resident #245 and #249) and one unsampled resident on 1 of 3 units reviewed for [redacted], b.) COVID-19 surveillance was conducted and documented for any signs and symptoms of COVID-19 during a COVID-19 outbreak for all facility residents who resided on 3 of 3 units, c.) a resident with a EX Order 26.4B1 [redacted]) was placed on NJ Ex Ord[redacted] to prevent the spread of a NJ Ex Order 26.4b1 [redacted] for 1 of 1 resident (Resident #86) reviewed for EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted]), d.) staff disinfected a blood pressure cuff prior to use on multiple residents, on 1 of 3 units observed for nursing care, e.) all staff completed the required COVID-19 entrance screening prior to providing resident care on 1 of 3 units, f.) to maintain a clean and sanitary environment in double occupancy resident room (Resident #7 and an unsampled resident) on 1 of 3 units EX Order 26[redacted] floor unit), and g.) the facility annually reviewed Infection Control Policies and Procedures (ICPC) for 1 of 1 ICPC manuals provided and reviewed.

The deficient practice was evidenced by the following:

a.) On 09/21/22 at 11:07 AM, Surveyor #4 observed the COVID-19 PUI unit on the [redacted] floor. Surveyor #4 observed room [redacted] with a "Stop" sign affixed to the door and a plastic bin located next to the door. The plastic bin contained PPE gowns, surgical masks, N95 masks, gloves, hand sanitizer, and eye protection. Surveyor #4 observed another sign on the door "Stop Observation-Quarantine Precautions, in addition

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to standard precautions; only essential personnel should enter this room; everyone MUST: hand hygiene before gloving and after glove removal, wear Mask N95 if fit tested and available or surgical mask if not fit tested or failed fit test, and eye protection; gown and gloves required prior to entering if you anticipate contact with resident or potentially contaminated surfaces in close proximity to resident. Quarantine Precautions: for use during COVID-19 pandemic - newly admitted residents during observation period (14 days); unvaccinated residents with frequent visits outside the facility...personal protective equipment with illustration how to don (put on) and doff (take off)." Surveyor #4 then observed a staff member inside of the room without wearing eye protection, or a PPE gown, and the staff was wearing a cloth mask, and gloves. The staff member was handing Resident #245 a bar to exercise with. The staff member was identified as an U.S. FOIA (b)(6) and the U.S. FOIA proceeded to exit the room wearing the same cloth mask and gloves. The U.S. FOIA (b stated that PPE was not part of her training when she began at the facility NJ Ex Order 26.4b1 , and stated she had not been fit tested for the N95 mask. She stated she did see the signage on the door but did not wear any PPE because she had "seen the resident before" and she "did not think it was a problem." The U.S. FOIA (b then stated to Surveyor #4 that by not wearing her PPE, she could become contaminated, and possibly spread the COVID-19 infection. The U.S. FOIA stated she had been trained about a year ago on PPE, but that was with a different company. Surveyor #4 asked the U.S. FOIA if she was aware why the resident was on isolation. The U.S. FOIA (b stated she believed "something for COVID-19", but the resident did not have any symptoms that she was aware of.

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The [redacted] acknowledged the "Stop" sign affixed to the door and stated that she had not checked with the nurse prior to entering the room.

A review of Resident #245's medical records revealed the resident had been recently admitted with diagnoses which included, but was not limited to; [redacted]. A review of the Admission Minimum Data Set (MDS), an assessment tool dated [redacted], revealed a Brief Interview of Mental Status (BIMS) of [redacted] indicating the resident was [redacted]. A review of the Physician's Orders (PO) revealed an order dated [redacted] for [redacted] Screen, Evaluate and Treat. A review of the facility provided immunizations for the resident revealed Resident #245 [redacted]

During an interview with Surveyor #4 on 09/21/22 at 11:19 AM, and in the presence of the [redacted], the [redacted] stated the [redacted] department was not new to the facility. The [redacted] stated there would be signs on the doors of isolation rooms to alert the staff of what PPE should be worn inside the rooms, and the [redacted] confirmed there was a sufficient supply of PPE in the bins next to the doors. The [redacted] then informed the [redacted] that she should not be wearing a cloth mask, and could not wear gloves in the hallway. The [redacted] at that time placed her gloved hands into her scrub top pockets. The [redacted] stated if staff did not wear the appropriate PPE, they could spread infection (COVID-19). The [redacted] further stated she was not sure who would be responsible for training new [redacted] staff on PPE. The [redacted] then acknowledged the [redacted] had not been fit tested and stated the [redacted] should not be in the COVID-19 isolation room without first being fit

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tested. At that time, the [U.S. FOIA (b)] again instructed the [NJ Ex Order] to remove her gloves and wash her hands.

On 09/23/22 at 9:06 AM, during an interview with Surveyor #4, the acting [U.S. FOIA (b)(6)] stated she had not fit tested everyone working on the PUI/COVID-19 unit with the residents. The RN #1 stated the staff should be wearing N95 masks and that she had "not gotten around" to check, or work with staffing to see who should be working with the PUI/COVID-19 positive residents.

On 09/28/22 at 8:39 AM, Surveyor #4 observed a staff member on the first floor PUI/COVID-19 unit. The staff member was wearing an N95 mask that was not secured around her head and both straps of the N95 mask were sticking out of the sides of a surgical mask she was wearing. The staff member was stepping into the [NJ Ex Order 26.4b1] of Resident #249 with signage on the door. The signage, "Stop Observation-Quarantine Precautions, in addition to standard precautions, only essential personnel should enter this room, everyone MUST: hand hygiene before gloving and after glove removal, wear Mask N95 if fit tested and available or surgical mask if not fit tested or failed fit test, and eye protection; gown and gloves required prior to entering if you anticipate contact with resident or potentially contaminated surfaces in close proximity to resident. Quarantine Precautions: for use during COVID-19 pandemic .....personal protective equipment with illustration how to don (put on) and doff (take off)." At that time Surveyor #4 interviewed the staff member who identified herself as an LPN who worked with a [US FOIA (b)(6)] LPN stated she had been in-serviced on PPE before, but not at the facility. She further stated she was

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not sure if the resident was Ex Order 26.4B1 for Ex Order 26.4B1 The Ex Order 26.4B1 care LPN stated she had been fit tested for the N95 mask and knew that the straps should be around her head, but "my nose is sore, so I anchored the N95 with a surgical mask". Surveyor #4 asked how the N95 should fit. The wound care LPN stated the N95 should be a "tight fit" and acknowledged that hers was "not really" a tight seal. She further stated that by wearing the N95 incorrectly, she could become exposed to COVID-19.

A review of Resident #249's medical records revealed the resident had been admitted diagnoses, the included but were not limited to; Ex Order 26.4B1 Ex Order 26.4B1. A review of the PO revealed the following orders: dated Ex Order 26.4B1, Ex Order 26.4B1 consult and treat as needed, and dated Ex Order 26.4B1, for NJ Ex Order 26.4b1 related to NJ Ex Order 26.4b1 Ex Order 26.4B1 test on EX Order 26.4B1 A review of the Treatment Administration Record (TAR) dated Ex Order 26.4B1, revealed an [redacted]

[redacted] interview with Surveyor #4 on 09/28/22 at 11:35 AM, the U.S. FOIA (b)(6) stated newly hired staff would be oriented on their case load, the computer system, be given a tour of the facility, educated on how to enter notes into the

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computer, and orders, and also stated would be educated on COVID-19 signs and symptoms. He stated the protocol for what staff should wear into an isolation room would be to follow the signs on door. The U.S. FOIA (b)(6) stated the U.S. FOIA (b) was educated on PPE, however, the U.S. FOIA (b)(6) was not sure who conducted the education. He further stated newly hired staff orientation education would not have an orientation check list that he was aware of.

On 09/28/22 at 11:43 AM, during an interview with Surveyor #4, the U.S. FOIA (b)(6) stated the facility would inform any vendors of any EX Order 26.4B1 cases in the building. The U.S. FOIA (b)(6) stated there would be signs on the doors to let everyone know what (PPE) to wear, the type of isolation, and there was available PPE. She further stated the N95 mask needed to be "snug", or whoever was wearing it could be exposed (to COVID-19). The U.S. FOIA (b)(6) stated anyone going into a COVID-19 positive resident room "must" wear the N95 mask, eye protection, PPE gown, and gloves.

On 09/28/22 at 12:21 PM, the U.S. FOIA (b)(6), who had previously been the facility nurse educator until 09/23/22, provided new hire information dated EX Order 26.4B1 for the U.S. FOIA. The information provided did not contain any education on PPE or TBP.

On 09/30/22 at 9:26 AM, during an interview with Surveyor #4, the Human Resources (HR) staff member stated that during "on-boarding" a new employee, the facility would obtain their license and vaccination cards. The new hire would next attend orientation about policies and facility dress code. When asked about PPE training, HR stated that the Infection Preventionist would be responsible for that. HR further stated that staff

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should not work without PPE training. When asked about new hire information regarding PPE for the OTA, HR acknowledged she was unable to locate anything.

On 10/03/22 at 11:49 AM, Surveyor #5 observed a Behavioral Aide (BA) #1 working on the [redacted] unit. BA #1 was wearing an N95 mask with both straps not properly secured. Upon interview, she stated she did not know why the N95 mask was not secured properly. BA #1 was not aware of what PPE she was supposed to wear, or what was supposed to be done before entering into a COVID-19 positive room. BA #1 stated her job was to watch behavioral residents on the third floor locked unit. She further stated she had been in-serviced recently on PPE, donning/doffing.

Surveyor #5 next observed LPN #5 trying to stop BA #1, but BA #1 had already entered into the COVID-19 positive room #[redacted] wearing her N95 mask with both straps unsecured and a surgical mask. LPN #5 informed BA #1 she needed to don/doff and secure her N95 mask properly. The surveyor observed BA #1 exit the COVID-19 positive room wearing the PPE. LPN #5 in-serviced BA #1 on proper PPE usage while Surveyor #5 was still present on the unit. The [redacted] was made aware.

On 10/05/22 at 12:58 PM, the facility provided the wound care company's sign in sheet with the topic, "Proper use of PPE, COVID protocol, infection control" dated 07/20/22, with the signature of the US FOIA (b)(6) with her title listed as US FOIA (b)(6). There was a PPE "true or false" Quiz included in the documentation. The facility further provided the

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wound care company, "Infection Prevention" policy updated September 2021; which included, but was not limited to, Policy: all personnel shall follow the infection control policy and procedure of each affiliated facilities to prevent the spread of infection; Interpretation and Implementation: 6. Any signage outside patient's door, personnel shall inquire to the staff in the unit the type of infection, and follow the appropriate PPE. The facility provided the undated wound care company, "Sequence for Putting On PPE", which included 2. Mask or respirator, secure ties or elastic bands at middle of head and neck, fit flexible band to nose bridge, fit snug to face and below chin, and fit check respirator.

A review of the facility provided, "Outbreak Plan COVID-19 Response" revised 03/10/22, included but was not limited to: Suspected Case in the Facility: c. if the suspected infectious person requires care...follow...policies for isolation procedures, including all recommended PPE for staff at risk for exposure. g. implement the isolation protocol in the facility...as described in infection prevention and control plan and/or recommended by local, state or federal public authorities.

A review of the NJ DOH, "Recommendations for Long-Term Care Facilities during COVID-19 Pandemic", dated 03/20/20, included but was not limited to: for suspect or confirmed COVID-19 case(s), standard and TBP including use of N95 respirator, gown, gloves, and eye protection.

A review of the CMS, "COVID-19 Long-Term Care Facility Guidance" dated 04/02/20, included but was not limited to: 4. Longer-term care facilities should ensure all staff are using

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appropriate PPE when they are interacting with patients and residents.....full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19.

b.) On 09/21/22, during the facility entrance conference, the facility informed Surveyor #1 that they currently were in an outbreak of COVID-19 but were unsure of the date the outbreak began.

On 09/22/22 at 3:45 PM, during an interview with four surveyors, Registered Nurse (RN #1) stated she had administered a Ex Order 26.4B1 to Resident #44 on Ex Order 26.4B1 who had NJ Ex Order 26.4b1 RN #1 stated that Ex Order 26.4B1 should be completed for someone if they were Ex Order 26.4B1 RN #1 confirmed that Resident #44 had a Ex Order 26.4B1 could not state when the Ex Order 26.4B began.

A review of Resident #44's medical records revealed that the resident had been admitted with diagnoses which included, but were not limited to, Ex Order 26.4B1 A review of the Ex Order 26.4B1 Vaccination Record Card revealed that Resident #44 had Ex Order initial doses of Ex Order 26.4B1 vaccination and Ex Order booster doses. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated Ex Order 26.4B1, revealed an order to monitor for NJ Ex Order 26.4b1 a start date of EX Order 26.4B1

On 09/23/22 at 8:53 AM, during an interview with Surveyor #1, LPN #1 (working on the Ex Order floor) stated she knew symptoms of Ex Order 26.4B1 would consist of a Ex Order 26.4B1. She stated that a Ex Order 26.4B1 should be done.

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Surveyor #1 inquired to LPN #1 if she was responsible for completing any Ex Order 26.4B1 symptom monitoring for her assigned residents. She stated, "vitals are taken on everyone usually", if there were new symptoms then she would check vital signs (clinical measurements, specifically pulse rate, temperature respiration rate and blood pressure that indicate essential body functions), and that she would do vital signs if she had to and stated she has not seen any formal monitoring for vital signs.

On 09/23/22 at 8:53 AM, during an interview with Surveyor #4, RN #2 (working on the Ex Order floor) stated she would monitor residents for temperature, sneezing and coughing. She stated she would document any symptoms in the progress notes because there was no place to document in the electronic medical record (EMR). RN #2 stated that if a resident needed to have a Ex Order 26.4B1 test, the U.S. FOIA (b)(6) would have to administer it. RN #2 further stated if she had to do the rapid COVID-19 test, she would have to call to get the test.

On 09/23/22 at 9:42 AM, the U.S. FOIA (b)(6) stated she was not made aware that Resident #44 had symptoms of COVID-19 on EX Order 26.4B1, because the staff had not informed her.

On 09/23/22 at 11:45 AM, during an interview with surveyors, the U.S. FOIA (b) stated that anyone should be tested as soon as symptoms of COVID-19 develop. The U.S. FOIA (b) further stated that as of "right now I don't have a form that they (staff) are testing for symptoms" and that there was no symptom monitoring system for residents who had symptoms of COVID-19 in the currently used EMR.

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A review of the facility provided, "Outbreak Response Plan" revised 03/10/22, included but was not limited to Goal; "to protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our facility...The local state and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment...response related to a specific disease threat. " Local Threat: a...specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC).

A review of CMS, "QSO-20-26-NH", dated 04/19/20, included but was not limited to Guidance; "Nursing homes are currently required to 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. This includes a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility".

A review of the NJ DOH, "Recommendations for Long-Term Care Facilities during COVID-19 Pandemic", dated 03/20/20, included but was not limited to: Surveillance and Tracking: maintain and/or implement protocols for daily monitoring of residents and HCP for fever and other symptoms of COVID-19 (ie: gastrointestinal upset, fatigue, sore throat, dry cough, shortness of breath); enhance active surveillance: when a confirmed COVID-19 case is identified....monitor residents twice daily at minimum (ie: gastrointestinal upset,

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fatigue, sore throat, dry cough, shortness of breath) vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry.

The facility administration was unable to provide documentation of consistent monitoring of fever, respiratory illness, or other signs/symptoms of COVID-19 at least daily, in order to immediately isolate and test anyone who was symptomatic.

Surveyor: Coulanges, Jacquelin

c.) On 09/22/22 at 12:52 PM, the surveyor #5 observed Resident #86 seated up in bed eating lunch. Surveyor #5 observed that a resident had a NJ Ex Order 26.4B r (Ex Order 26.4B1 was in a blue privacy bag. Resident #86 stated that he/she was recently in the EX Order 26.4B1. The surveyor did not observe any signs on the door to indicate Resident #86 was on NJ Ex Order

On 09/22/22 at 1:02 PM, surveyor #5 reviewed Resident #86's electronic medical record which revealed:

A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to; Ex Order 26.4B1 The individualized, comprehensive care plan (CP), which included a care concern of NJ Ex Order 26.4b1 with an active effective date of Ex Order 26.4B1 The CP did not include an intervention of NJ Ex Order 2 The Ex Order 26.4B1,

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NJ Ex Order Medication and Treatment Administration Records. The Administration Records reviewed did not include an order for EX Order 2. The laboratory results which indicated that the resident had a Ex Order 26.4B1, and that the result was Ex Order 26.4B1 (deviation from normal). Surveyor #5 was unable to view the results and the organism identified in the Ex Order 26.4B1 result.

On 10/04/22 at 12:20 PM, after Surveyor #5 requested the facility to correct the inability of surveyor #5 view the complete Ex Order 26.4B1 result, surveyor #5 viewed Resident #86's Ex Order 26.4B1 result which included the following:
RESULT
EX Order 26.4B1
RESULT
EX Order 26.4B1
).

A review of the progress notes failed to include an entry that indicated Resident #86 was placed on EX Order 26

On 10/04/22 at 12:29 PM, surveyr #5 interviewed LPN #2 who stated that she had not observed any resident EX Order 26.4B1 results that were EX Order 26.4B. She added that the physician would inform them if a resident required to be placed on EX Order 26 and LPN #2 then confirmed that Resident #86 was not on EX Order 2.

On 10/04/22 at 12:46 PM, during surveyor interview, the U.S. FOIA (b)(6) stated that some residents would need to be placed on EX Order 2 for certain EX Order 26.4B1. She added that for EX Order 26.4B1 would

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include face shield, gown and gloves. The [redacted] stated that the physician, Infection Preventionist or U.S. FOIA (b)(6) would review [redacted] results and would decide if [redacted] were required.

On 10/05/22 at 10:32 AM, surveyor #5 interviewed a U.S. FOIA (b)(6) who stated that the process for the result of the Ex Order 26.4B1 would be that the result is transmitted through the computer system and that the nurse would call the physician with an Ex Order 26.4B1. The surveyor then asked the RN what would be required if a result was [redacted]. The [redacted] stated if a result was [redacted] then the nurse would contact the physician and the resident would be placed on [redacted] which would include [redacted], with a gown and gloves prior to entry into the room. The surveyor had the [redacted] view Resident #86's Ex Order 26.4B1 result. The [redacted] confirmed that Resident #86's Ex Order 26.4B1 result was Ex Order 26.4B1.

On 10/05/22 at 10:48 AM, surveyor #5 interviewed the [redacted] regarding the process for results of a resident Ex Order 26.4B1. The [redacted] stated that the nurse would view the result and notify the physician. She added that the physician would order accordingly, and the nurse would document in the medical record. The surveyor then asked the [redacted] what the process was if a Ex Order 26.4B1. The [redacted] stated that the resident would be isolated (placed on [redacted]) but was not sure for how long. The surveyor then asked the [redacted] if she would expect a physician order for [redacted] or a progress note that the resident was placed on [redacted] The [redacted] stated that she would expect both. The surveyor then asked the [redacted] to view Resident #86's Ex Order 26.4B1 Ex Order 26.4B1 in the electronic medical record. The

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U.S. FOIA (b confirmed that the Ex Order 26.4B1 result was Ex Order 26.4B and that she did not see a physician's order for Ex Order 26 or a progress note that Resident #86 was placed on Ex Order 2. The surveyor then asked the U.S. FOIA (b if she reviewed Ex Order 26.4B1 results. The U.S. FOIA (b stated that she did not review Ex Order 26.4B1 results unless someone would bring the result to her attention. She added that now she would need to. She then stated that she would expect the U.S. FOIA (b)(6) to have viewed the result and placed the resident on Ex Order 2. She added that the U.S. FOIA (b)(6) at the time of the result was no longer here. The surveyor then asked the U.S. FOIA (b if Resident #86 should have been placed on TBP. The U.S. FOIA (b stated that Resident #86 should have been placed on Ex Order 2 and that she would find out if the resident needed to be placed on Ex Order 26

On 10/05/22 at 12:09 PM, surveyor #5 interviewed the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated that she had previously been the U.S. FOIA (b)(6) and on Ex Order 26.4B1 her role was transitioned to U.S. FOIA (b)(6). The surveyor then asked the U.S. FOIA (b)(6) what the process was if a resident had Ex Order 26.4B1 The U.S. FOIA (b)(6) stated that for Ex Order 26.4B1, staff would need to wear goggles, gloves and gowns when staff had high contact care with the resident. The surveyor then asked the U.S. FOIA (b)(6) if Ex Order 26.4 was a U.S. FOIA (b)(6) (multi-drug resistant organsim) and the U.S. FOIA (b)(6) confirmed that it was. The surveyor then asked the U.S. FOIA (b)(6) how long the resident would need to be on TBP and if there was a recent change in guidance for U.S. FOIA (b)(6) isolation. The U.S. FOIA (b)(6) stated that TBP length depended on the NJ Exec Order 26.4b1. She then added that if there was new guidance on U.S. FOIA (b)(6) that she had not been aware.

On 10/05/22 at 1:06 PM, the U.S. FOIA (b stated that

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Resident #86 was now placed on TBP.

On 10/6/22 at 8:40 AM, surveyor #5 reviewed the facility provided Physician's Order set which included an order, Ex Order 26.4B1, "Maintain Contact Precautions Ex Order 26.4B1)."

On 10/07/22 at 11:04 AM, the surveyor asked the U.S. FOIA (b)(6) if a resident with Ex Order 26.4 needed to be placed on Ex Order 2. The U.S. FOIA (b)(6) stated that a resident that had Ex Order 26.4B1 should be placed on Ex Order 2. He added that he did not have a clinical background but that it should be a combined effort with nurses, the physician, U.S. FOIA (b) and U.S. FOIA (b)(6) and that they should have a discussion.

On 10/07/22 at 11:34 AM, during surveyor interview, U.S. FOIA (b)(6) stated that a resident with Ex Order 26.4 should be placed on Ex Order 26.

On 10/07/22 at 01:35 PM, in the presence of the survey team and the U.S. FOIA (b)(6) confirmed that the facility did not have a policy specifically for Ex Order 26.4.

A review of the facility provided policy titled, "Multidrug-Resistant Organisms," with a reviewed date of 1/5/22, included the following:

Under Policy Statement
Appropriate precautions are taken when caring for individuals known or suspected to have infection with a multidrug-resistant organism.
Under Policy Interpretation and Implementation
General guidelines
1. Multidrug-resistant organisms (MDROs) are bacteria and other microorganisms that have developed resistance to one or more classes of

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F 880	Continued From page 299 antimicrobial drugs ... Under Enhanced Infection Control Precautions Use of Contact Precautions 1. Implement Contact Precautions routinely for all resident colonized or infected with a target MDRO. 2. Because environmental surfaces and medical equipment, especially those in close proximity to the resident, may be contaminated, don gowns and gloves before or upon entry to the resident's room or cubicle. A review of the facility provided policy titled, "Urinary Tract Infections/Bacteriura-Clinical Protocol," with a reviewed date of 1/5/22 did not include any information on TBP for MDRO's. Reference: Centers for Disease Control and Prevention's (CDC), "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs)," with an updated date of July 12, 2022, included the following: Key Points [1]: Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: -Wounds or indwelling medical devices, regardless of MDRO colonization status	F 880		

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F 880	Continued From page 300 -Infection or colonization with an MDRO ... Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g., months) [10] which contributes to the silent spread of MDROs ... Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing [11-15]. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs [3,5,6]. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: any skin opening requiring a dressing In general, gown and gloves would not be	F 880		

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required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

Reference:
CDC's "Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes," with a last reviewed date of 7/27/22, included the following:
These FAQs were created to address questions about Enhanced Barrier Precautions as defined in the CDC guidance "Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs)"
Definition and scope of Enhanced Barrier Precautions
What are Enhanced Barrier Precautions?
Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of Multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).

d.) On 09/23/22 at 7:40 AM, during the

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Medication Pass administration, Surveyor #2 observed the RN #1 enter the room to monitor Resident #86's vital signs. Resident #86 was on NJ Ex Order 26.4b1 for Ex Order 26.4B1 The nurse used a EX Order 26.4B1 . After the procedure, the nurse returned the used EX Order 26.4B1 nside the medication cart. The nurse did not disinfect the EX Order 26.4B1 before or after use.

On 09/23/22 at 8:15 AM, Surveyor #2 interviewed RN #1 regarding the observed procedure. The RN revealed that she received in-service education regarding infection control last month. She could not remember the date. The RN stated that resident's care equipment was to be disinfected after each resident to prevent cross contamination. The RN failed to follow infection control prevention procedure during a EX Order 26.4B1 outbreak.

On 10/12/22 at 2:22 PM, the above concerns were discussed with the administrative staff during the exit conference. No further information was provided.

A review of the NJ DOH, "Recommendations for Long-Term Care Facilities during COVID-19 Pandemic", dated 03/20/20, included but was not limited to: Implement environmental infection control measures: conduct...cleaning and disinfection of...shared medical equipment using an EPA (Environmental Protection Agency) registered, hospital-grade disinfectant.

e.) On 10/04/22 at 8:32 AM, upon facility entry, Surveyor #1 went to the facility kiosk located at

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the entrance /reception desk. Surveyor #1 signed in and began screening for temperature, asked about signs or symptoms of EX Order 26.4B1 and asked about exposure to EX Order 26.4B1. Once the screening system validated Surveyor #1 was fit for facility entry, a time stamp on the visitor pass was generated at 8:19 AM. While Surveyor #1 was standing next to the kiosk waiting for the elevator, the surveyor observed a female staff member enter the facility, proceed past the surveyor, and was not observed completing the EX Order 26.4B1 screening at the kiosk. The staff then took a surgical mask from the box and proceeded to enter the elevator at 8:20 AM. Surveyor #1 observed that the receptionist was turned partially around, and did not fully see the employee enter. Surveyor #1 asked the receptionist if that kiosk would also be where employees screened and the receptionist replied, "yes". The receptionist identified the staff member as CNA #1, and that she was not supposed to go upstairs to the resident units without having a EX Order 26.4B1 screening completed first.

On 10/04/22 at 8:37 AM, Surveyor #2 was on the EX Order2 floor and observed CNA #1 on the floor for at least 5 minutes, and was in a resident room. Surveyor #2 requested to speak to CNA #1 and was told to "wait" because the staff member was collecting meal trays. Surveyor #2 observed the U.S. FOIA (b)(6) and another facility staff member escort CNA #1 off of the floor. Surveyor #2 overheard that the two staff members informed the CNA to retrieve her belongings and proceed downstairs.

On 10/04/22 at 9:08 AM during an interview with Surveyor #1, the U.S. FOIA (b)(6) stated the NJ Ex Order 26.4b1 t had informed her that CNA #1 had entered the facility and proceeded directly upstairs, did not

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stop to answer screening questions about [redacted] on the kiosk, have her temperature taken, and had not used hand sanitizer. The [redacted] stated she believed that CNA #1 had been trained.

On 10/04/22 at 9:14 AM, the [redacted] provided Surveyor #1 with a punch in log for CNA #1 and revealed she punched in at 8:19 AM and there was no punch out, [redacted] stated CNA #1 had worked today, left, and she did not punch out.

A review of the facility provided education revealed the CNA #1 had been educated on the following:
08/09/22: advanced entry [redacted] screen (Receptionist desk)
09/23/22: contact tracing and testing ([redacted])
undated: PPE donning and doffing
"July 2022": hand washing, universal precautions and [redacted] signs, symptoms and precautions

f.) The following environmental observations were made by Surveyor #2 during tour of the [redacted] floor locked Unit on [redacted]

At 9:52 AM, Room [redacted] had multiple [redacted] in the room, a trail of [redacted] on the floor, and a [redacted] in the room.

At 10:00 AM, Room [redacted] had a [redacted] in the room, and the bedding was [redacted] and [redacted].

At 10:20 AM, Room [redacted] had multiple [redacted] inside the room, the mattress was [redacted], and there was a [redacted] in the room.

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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 305	F 880		

Surveyor #2 left the room and observed the U.S. FOIA (b)(6) in the hallway of the Ex Order 26 floor. The U.S. FOIA (b)(6) stated that he toured the unit daily to ensure the residents' needs were being met. The surveyor asked the U.S. FOIA (b)(6) what his expectations were for Ex Order 26.4B1 residents. The U.S. FOIA (b)(6) stated that his expectations would be that Ex Order 26.4B1 care would be provided every two hours and as needed.

On 09/21/22 at 10:12 AM, Surveyor #2 escorted the U.S. FOIA (b)(6) in room Ex Order and observed a Ex Order 26.4B Ex Order 26.4 was still on the floor, and staff were in the room at that time providing care. The U.S. FOIA (b)(6) stated that housekeeping staff were to tour and identify areas that needed to be cleaned when they reported to work in the morning. The U.S. FOIA (b)(6) further stated that he would expect direct care staff to call housekeeping to clean the floor before providing care for infection control purposes.

On 09/21/22 at 10:58 AM, an interview with the porter assigned to the locked unit revealed that he was not assigned to clean the resident rooms. He was responsible to mop the hallway on both sides and housekeeping was responsible to clean the resident rooms.

On 09/21/22 at 11:01 AM, Surveyor #2 interviewed the housekeeping staff member. She stated, that she reported to work at 7:00 AM, removed the trash, cleaned the dining room, the nursing station and the shower rooms. She would clean the resident rooms after breakfast. She further stated that she was not informed that any room needed to be cleaned.

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F 880	Continued From page 306 On 09/21/22 at 11:22 AM, Surveyor # 2 interviewed LPN #3 who was assigned to the locked unit and inquired about the trail of Ex Order 26.4B observed on the floor. LPN #3 stated that all residents that were on the locked unit were confused, Ex Order 26.4B1 on the floor, and would wander from room to room. She stated that she was not aware of the Ex Order 26.4B on the floor. LPN #3 also stated that staff should have called for housekeeping to clean the room. On 09/23/22 at 6:53 AM, Surveyor #2 went to the locked unit and observed the following: Resident #54's room, pads Ex Order 26.4B1 in the room, and a NJ Exec Order noted crawling on the floor. During an interview at that time with the surveyor, outside of the room indicated that he/she had not been changed during the night. The surveyor escorted the US FOIA (b)(6), LPN #3, to the room where we both observed the same. The resident had NJ Ex Order 26.4b1 on the bed, both pads were Ex Order 26.4B1 , and the fitted sheet was also Ex Order 26.4B1 On 09/23/22 at 6:58 AM, during an interview with the surveyor, the 11:00 PM - 7:00 AM CNA #2 revealed that the resident would not get up to be changed during the night and that she had to wait until the resident got up. The surveyor went to the room and observed that the mattress was also Ex Order 26.4B1 On 09/23/22 at 7:01 AM, the surveyor interviewed LPN #3 who stated that her role was to ensure that all EX Order 26.4B1 residents were up and changed every 2 hours and as needed. The surveyor escorted LPN #3 into Resident #54's room where both observed the same. LPN #3 confirmed the resident did not receive	F 880		

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F 880	Continued From page 307 EX Order 26.4B1 care during the shift. LPN #3 stated that the facility was aware of NJ Exec Order 26.4b1 in the room and they NJ Exec Order 26.4b1 twice. On 09/26/22 at 8:38 AM, Surveyor #2 went to the EX Order 2 floor unit EX Order 26.4B1 and observed multiple NJ Exec O in Room Ex Order, Ex Order 26.4B1 a hospital gown and other linen were on the floor, and a Ex Order 26.4B1 noted in the room. On 09/26/22 at 10:07 AM, Surveyor #2 escorted LPN #4 to Room Ex Order where we both observed the bed covered with multiple NJ Exec O and linen was on the floor. A review of the facility provided, "Certified Nursing Assistant" job description undated, included but was not limited to; Purpose of Job Position: provide each of your assigned residents with routine daily nursing care and services ...., Personal Nursing Care Functions: assist residents with bath functions, Safety and Sanitation: keep floors dry ...notify housekeeping if equipment needs cleaning ...report hazardous conditions and equipment to management or nursing supervisor immediately. A review of the facility provided, "Environmental Services-Cleaning Resident Rooms", undated included but was not limited to; Purpose: to provide guidelines for cleaning and disinfecting residents' rooms and environmental surfaces to break the chain of infection., General Guidelines: 2. All environments/areas (.....shower rooms) ....will be disinfected (or cleaned) daily and when surfaces are visibly soiled. 3. when there is an outbreak, residents' rooms....will be disinfected and/or cleaned more often. Definitions: cleaning: removal of visible soil from surfaces through the	F 880		

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F 880	Continued From page 308	F 880		

physical action of scrubbing with a surfactant or detergent and water.

g.) On 09/21/22, during entrance conference, the survey team requested the facility's Infection Prevention Control Policies and Procedures (IPCP) to review.

On 09/23/22, Surveyor #4 reviewed the IPCPs provided by the facility. A review of the first page "Facility Policies and Procedures-Annual Reviews" revealed the last date reviewed was 02/24/21. The "Facility Policies and Procedures-Annual Reviews" included but was not limited to Policy; policies and procedures are reviewed as needed and at least annually. Interpretation and Implementation: 1. The Quality Assurance and Assessment Committee reviews policies and procedures and makes revisions as necessary...c. at least annually.

On 09/23/22 at 11:49 AM, during an interview with Surveyor #4, the U.S. FOIA (b)(6) [redacted] were shown the IPCP book with the "Facility Policies and Procedures-Annual Reviews" with the date reviewed 02/24/21. Both the U.S. FOIA (b)(6) acknowledged that the IPCPs should have been reviewed by 02/24/22, but were not.

On 10/06/22 at 2:43 PM, the survey team presented findings to the U.S. FOIA (b)(6) [redacted].

On 10/07/22 at 1:29 PM, the survey team presented additional findings to the U.S. FOIA (b)(6) [redacted]

10/12/22 at 12:41 PM, the survey team met with

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F 880	Continued From page 309 the U.S. FOIA (b)(6) who confirmed there was no rebuttal for the findings presented by the survey team and the facility had no additional information to provide.	F 880		
F 882 SS=F	N.J.A.C. 8:39-9.3(a); 19.1(a)(b); 19.2(a); 19.4(a)(c)(d)(e)(f)(g)(l); 27.1(a)(b)(c)(d); 31.4(a)(c)(f) Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced	F 882		12/5/22

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F 882	Continued From page 310 by: Based on interview and pertinent documentation, it was determined that the facility failed to employ an US FOIA (b)(6) who had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance. This deficient practice was identified for 1 of 1 employees reviewed for IP and was evidenced by the following: On 09/21/22 at 1:08 PM, entrance conference was conducted with the facility U.S. FOIA (b)(6) At that time, the surveyor was informed that the current position of US FO was held by a U.S. FOIA (b)(6)) who had not completed the Center for Disease Control and Prevention (CDC) specialized training for infection prevention and control. On 09/22/22 at 1:54 PM, during an interview with the surveyor, the US FOIA stated she had started as U.S. at the facility in EX Order 26.4B1 and had not completed her CDC training EX Order 2 On 09/23/22 at 9:42 AM, during an interview with surveyors, the U.S. FO who was acting as the facility's EX O stated she was new to the role of EX Or The U.S. FO was questioned about the facility line listing regarding recent EX Order 26.4B1 EX Order 26.4B1 residents. The U.S. FO stated the U.S. FOIA (b)(6 had been responsible to create and update the facility line listing because she did not know how to do it. The surveyor next questioned the U.S. FO about EX Order 26.4B1 positive residents or staff. The U.S. FO stated she believed contact tracing would fall under her jurisdiction, but that she would need to find out for sure. The U.S. FO reviewed the facility provided line listing and was not able to	F 882	1. Corrective action: An interim full time Infection Preventionist, with verified training program from CDC Train Long term Care module, was transferred to the facility to implement facility-wide infection plan and procedures related to COVID. 2.Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents and staff have the potential to be affected due to the nature of the deficiency 3.Measures Put Into Place: Continued education and competency training based on upcoming regulation changes will be provided to the full time infection Preventionist Human Resources will audit monthly the maintenance of the required credentials in accordance with the Federal and State requirements 4.How Will These Actions Be Measured: Monthly Human Resources audit of credentials will be submitted to the Quality Assurance and Process Improvement Committee Monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The first of which will take place in December 2022.	

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F 882	Continued From page 311 inform the surveyors when the current EX Order 26.4B1 outbreak had begun. When questioned about testing in regard to contact tracing, the RN stated, "everyone could be (exposed to EX Order 26.4B1 going into the room, anyone can answer a light" and "I will be honest with you I didn't test anyone." The US FOIA informed the surveyors that she had not received a job description and that she "got an idea" of her responsibilities from the former U.S. Fo On 9/23/22 at 10:17 AM, the US FOIA provided the surveyors with the on-line advertisement for the position of EX O at the facility. The advertisement included but was not limited to a requirement of having an Infection Prevention Certification. A review of CMS QSO-19-10-NH, dated 03/11/19, included but was not limited to Background: "Effective November 28, 2019, the final requirement includes specialized training in infection prevention and control for the individual(s) responsible for the facility's IPCP (infection prevention and control program)." Specialized Training for Infection Prevention and Control: In order to receive ....a certificate of completion, learners must complete all modules and pass a post-course exam ... .Completion of this course will provide specialized training in infection prevention and control. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-20.2	F 882		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		12/5/22

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F 883	Continued From page 312 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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F 883	Continued From page 313 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a EX Order 26.4B1 [redacted]. This deficient practice was identified for 1 of 5 residents reviewed for immunization status (Resident #11). The deficient practice was evidenced by the following: On 09/26/22 at 9:18 AM, the surveyor reviewed Resident #11's medical record which revealed the following information: Review of the Resident Face Sheet Record (an admission summary) revealed that Resident # 11 had been admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 [redacted] other under	F 883	Corrective action: Resident #11 NJ Ex Order 26.4b1 was updated and care plan updated An interim full time Infection Preventionist with verified training program from CDC Train Long term Care module was transferred to the facility to implement facility-wide infection plan and procedures related to Influenza and pneumococcal Immunization. Residents are assessed on admission and there is a standing medication order which is documented on the electronic medical record. The IP implemented a resident influenza /pneumococcal vaccination to track immunizations. 2.Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents and staff have the potential to be affected due to the nature of the	

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F 883	Continued From page 314 NJ Ex Order 26.4b1 Review of the most recent quarterly Minimum Data Set (MDS - an assessment tool), dated NJ Ex Order 26.4b1 revealed a Brief Interview for Mental Status (BIMS) of [redacted] out of [redacted] which indicated the resident was Ex Order 26.4B1 ; and under section O, O0300 Ex Order 26.4B1 revealed NJ Ex Order 26.4b1 Review of the admission MDS, dated 05/16/22, revealed a BIMS of [redacted] out of 15 which indicated the resident was Ex Order 26.4B1 ; and under section O, O0300 Ex Order 26.4B1 Ex Order 26.4B1 revealed [redacted]" NJ Ex Order 26.4b1 Review of Resident #11's Medication Orders from admission Ex Order 26.4B1 reflected a standing order for Ex Order 26.4B1 upon initial admission pending family/resident consent was not marked for yes or no. Review of Resident #11's active Care Plan (CP) printed on Ex Order 26.4B1 did not reveal any focus, goals or interventions for vaccinations. Review of Resident #11's electronic Medical Record (eMR) under Preventative Health did not reveal a Ex Order 26.4B1 administered recorded. Review of Resident #11's "Immunization Record" from Resident #11's paper medical record did not reveal a Ex Order 26.4B1 administered recorded.	F 883	deficiency 3.Measures Put Into Place: Upon admission and readmission, vaccination status will be assessed by nursing or nursing designee Monthly audit of immunization status to be completed by the Unit Manager and/or designee 4.How Will These Actions Be Measured: Monthly audit of immunization status will be submitted monthly by the Unit Manager and/or designee to the Quality Assurance and Process Improvement Committee Meeting for 6 months. The first of which will take place in December 2022.Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 883	Continued From page 315 On 09/28/22 at 12:58 PM, the concern regarding Resident #11's Ex Order 26.4B1 status, where there was not documentation that it was offered, administered, refused and there was not any education provided was brought to the attention of the Ex Order 26.4B1 floor U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) and any additional information was requested. On 09/29/22 at 11:08 AM, during an interview with the surveyor, Resident #11 stated he/she had not been offered any Ex Order 26.4B1 but if his/her doctor or nurse recommended it, "I will do it". On 10/04/22 at 10:46 AM, during an interview with the surveyor, U.S. FOIA (b)(6) stated she did not find additional information regarding Ex Order 26.4B1 for Resident #11. She acknowledged that the immunization should have been care planned since the Resident NJ Ex Order 26.4b1 s documented on the resident's face sheet. On 10/06/22 at 02:32 PM, the concern regarding Resident #11's Ex Order 26.4B1 status, where there was not any documentation that it was offered, administered, refused and no education provided was brought to the attention of the U.S. FOIA (b) in the presence of the survey team, the U.S. FOIA (b)(6) and any additional information was requested. On 10/12/22 at 12:40 PM, in the presence of the survey team, the U.S. FOIA (b)(6) Ex Order 26.4B confirmed that no additional information could be provided.	F 883		

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F 883	Continued From page 316 Review of the facility provided, "Pneumococcal Vaccine" policy reviewed 1/2022, included but was not limited to the following: Policy: All residents will be offered pneumococcal vaccines to aid on preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation: 1. Prior to or upon admission residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty days (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine ...Provision of such education shall be documented in the resident's medical record. 4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given or refused) ... 5. Residents/representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 6. For Residents who receive the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record.	F 883		
F 886 SS=L	N.J.A.C. 8:39-19.4(h), (i), (j) COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6)	F 886		12/5/22

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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 886	Continued From page 317 §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing	F 886		

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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F 886	Continued From page 318 was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review it was determined that the facility failed to: 1.) conduct immediate resident and staff testing upon the identification of a single EX Order 26.4B1 positive staff or resident result, and 2.) ensure a system was in place, and the facility Infection Preventionist followed the facility policy to ensure that all staff who required weekly or bi-weekly EX Order 26.4B1 testing was completed and documented during a EX Order 26.4B1 outbreak. The facility's failure to take immediate action, follow Centers for Disease Control and Prevention (CDC) , Centers for Medicare and Medicaid Services (CMS) guidance, and facility policies to limit exposure risks placed all residents and staff	F 886	Immediate Action: Residents # 44 and # 52 were placed in EX Order 26.4B1 on the EX Order 2 floor on EX Order 26.4B1 once tested and discovered EX Order 26.4B1 result. Both rooms kept with the door closed due to NJ Ex Order 26.4b [redacted]. NJ Ex Order 26.4b1 [redacted] placed by the facility educator on the doors and isolation bins with PPE supply placed outside the doors. On EX Order 26.4B1 was done on patients #44 and #52 and it was established that both residents did not have any visitors for the previous 14 days, did not go out for any consults. Contact	

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F 886	Continued From page 319 at risk for contracting COVID-19, a contagious deadly virus. Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. Reference: Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022 Refer to 880L, 888L Part 1 The failure to conduct immediate resident and staff testing upon the identification of a single COVID-19 positive staff or resident result. This resulted in an Immediate Jeopardy (IJ) situation which began on 09/20/22 and was identified on 09/23/22 at 1:04 PM. The facility's EX Order 26.4B1 outbreak began on EX Order 26.4B1. Two residents (Resident #44 & #52) were EX Order 26.4B1 on EX Order 26.4B1, and the facility's uncertified U.S. FOIA (b)(6)) confirmed testing was not immediately performed on EX Order 26.4B1 The facility administration was notified of the IJ on 9/23/22 at 1:04 PM.	F 886	EX Order 26.4B1 also revealed that only one of the two residents had a roommate. The roommate was placed under NJ Ex Order 26.4b1, EX Order 26.4B1 done on EX Order 26.4B1 result was negative on EX Order 26.4B1, and remains EX Order 26.4B1. The roommate dic EX Order . On 9/23/22 the nurse on duty who was in charge of the two residents who NJ Ex Order 26 was in serviced on COVID 19 signs and symptoms including the need for testing and contact and droplet isolation as applicable. On 9/23/22 the Administrator and Director of Nursing reviewed and revised the policy on COVID 19 testing. Rapid antigen test kits supply checked and found in adequate amounts. All present staff were inserviced on COVID 19 testing and made aware where Rapid antigen test kits were kept. On 9/23/22 all staff present on the 1st floor were in serviced by the Director of Nursing and facility educator on Transmission based precautions and what type of PPE to wear in the COVID positive rooms. On 9/23/22 all patients on 3rd floor were tested, no other positive cases. On 9/24/22 and 9/25/22 testing continued and NJ Ex Order 26.4b1 . All NJ Ex Order 26.4b1 mmediately. All family members and staff notified. On 9/23/22 all staff that came in contact with the NJ Ex Order 26.4b1 were provide with rapid antigen testing and all had	

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F 886	Continued From page 320 The facility submitted an acceptable removal plan on 09/27/22 at 3:46 PM. The IJ removal plan was verified as implemented during an onsite visit on 10/03/22 at 1:49 PM. The evidence was as follows: On 09/21/22 at 9:18 AM, upon entrance to the building, Surveyor #1 requested information from the U.S. FOIA (b)(6) regarding if there were any EX Order 26.4B1 residents in the building. The Corporate Nurse stated there was no EX Order 26.4B1 resident in the building, and there were two persons under investigation (PUI- a person who had been in contact with a person with an infection or awaiting testing for a suspected infection) who resided on the EX Order 1 floor. At 9:05 AM, the U.S. FOIA (b)(6) informed the survey team that the facility was currently in an outbreak of EX Order 26.4B1 and would provide the survey team with a copy of the current line listing. On 09/21/22 at 1:09 PM, Surveyor #1 held an entrance conference with the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) was not certified since she had not yet completed the infection control training. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) was responsible for "all" of the facility vaccination effort. Surveyor #1 inquired to the number of EX Order 26.4B1 residents and symptomatic residents who were currently residing in the facility and the U.S. FOIA (b)(6) stated there were currently no EX Order 26.4B1 residents who resided at the facility, and there were two residents who were considered persons under investigation. Surveyor #1 requested all the information related to the current EX Order 26.4B1	F 886	NJ Ex Order 26.4b1. On 9/24/22 rapid antigen testing continued and 1 CNA on 3rd floor tested positive. The CNA was sent home for 10 day quarantine. On 9/23/22 family members of the positive residents were notified and advised to refrain from visiting while residents are under precautions. On 9/23/22 US FOIA (b)(6) was in serviced on COVID testing policy and Contact tracing policy. On 9/23/22 Infection preventionist was removed from schedule pending further investigation. On 9/23/22 Infection preventionist was replaced with an interim Infection Preventionist. On 9/23/22 line list was completed by the interim Infection Preventionist. II. Identification of Others: All residents have the potential of being affected when the proper protocols and policies are not followed for testing residents with symptoms of COVID 19. III. Systemic changes: On 9/23/22 the Management staff were in serviced by the Director of nursing and Facility educator on the policy for COVID 19 testing. On 9/23/22 all present nursing staff were in serviced by the Director of Nursing and Facility educator on policies and procedures on COVID 19 testing guidelines and location of test kits. On 10/11/22 the Regional nurse and designee initiated an in service on COVID 19 testing. While in outbreak, as per local DOH requirements, facility to continue	

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F 886	Continued From page 321 vaccination status of all residents and staff and all related testing for EX Order 26.4B1. The U.S. FOIA (b)(6) stated that residents and staff were tested twice per week, however, they were unable to provide the documentation and stated that the U.S. FOIA (b)(6) would be able to provide the testing information. On 09/22/22 at 9:43 AM, the U.S. FOIA (b)(6) informed the survey team that two residents (Resident #44 & Resident #52) had tested EX Order 26.4B1 and now resided on the first floor after being transferred from the third floor due to testing EX Order 26.4B1. The U.S. FOIA (b)(6) stated the positive results were identified during routine EX Order 26.4B1. On 09/22/22 at 9:55 AM, the U.S. FOIA (b)(6) failed to provide the survey team with the requested documents related to infection control, which included staff vaccination and staff and resident testing documentation. The U.S. FOIA (b)(6) stated the documents were with the "corporate people" and he was unable to produce the documents. On 09/22/22 at 3:42 PM, the U.S. FOIA (b)(6) was interviewed by Surveyor #1, #2, and #3, regarding the facility testing process. The U.S. FOIA (b)(6) stated that not all staff and residents were tested twice weekly. She stated if the resident had not yet received a EX Order 26.4B1, they would be tested twice weekly. Surveyor #1 inquired as to what was the criteria that was used to determine what staff were tested for EX Order 26.4B1. The U.S. FOIA (b)(6) reviewed her EX Order 26.4B1 log with the surveyors and stated if some staff felt like they had a cold, they could be tested. The U.S. FOIA (b)(6) then stated "there is no staff members that need to be tested" at present. The U.S. FOIA (b)(6) presented a	F 886	testing all staff, regardless of vaccination status, 2x/week and properly document test results on the testing tracker; while out of outbreak, regular testing must be done 1-2x/week for all staff who are not vaccinated with exemption (religious or medical). In services for all staff to be completed by 10/21/22. On 10/11/22 the facility interim Infection Preventionist checked the Rapid antigen test kits supply and found in adequate amounts. All present staff were inserviced on COVID 19 rapid antigen testing and made aware where Rapid antigen test kits were kept. IV. QA Monitoring The Director of Nursing and Infection Preventionist will review 24h report on a daily basis to ensure all residents with signs and symptoms of COVID 19 were tested immediately and MD and family made aware. If result is positive, the resident will be placed in COVID 19 single room isolation immediately and contact tracing will be started immediately as well. The Director of Nursing and interim infection preventionist will monitor daily for any reports of COVID 19 signs and symptoms in residents or staff to ensure prompt testing is being performed and prompt contact tracing is done on the employee and contact tracing and risk assessments are done on the residents for possible exposure over a 48h period. Interim Infection Preventionist will test all unvaccinated staff and residents according to testing guidelines. The interim Infection Preventionist will	

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F 886	Continued From page 322 log with handwritten NJ Exec Order 26.4b retesting employees", [EX Order 26.4B1] Test Sign Off dated EX Order 26.4B1, and contained three staff names, dated EX Order 26.4B1 Practical Nurse (LPN #1), Maintenance Director (MD) and Staff #1. The U.S. FOIA (b)(6) stated "only" residents were on her list to receive NJ Exec Order 26.4b1 testing twice per week. A second document provided by the EX Order 26.4B1, revealed a handwritten "COVID testing, 09/20/22, pt's" The handwritten document contained eleven names, dated EX Order 26.4B1 with a negative result and seven names were listed and dated EX Order 26.4B1. The U.S. FOIA (b)(6) stated the eleven names that were listed did not receive a EX Order 26.4B1 due to the EX Order 26.4B1 residents identified on EX Order 26.4B1. Resident #52 and Resident #44 were also listed on the document, with a positive result, and the remaining five names were listed with a negative result. Surveyor #1 inquired to the U.S. FOIA (b)(6) regarding why the other names listed had received a EX Order 26.4B1. The U.S. FOIA (b)(6) stated three staff requested a test, one resident requested a test, one resident was the Unsampled Resident roommate of Resident #44 who also requested to be tested. At 3:45 PM, the U.S. FOIA (b)(6) confirmed the two pages that were provided to the surveyors, and reviewed with the surveyors, was the only EX Order 26.4B1 testing log for employees or staff on EX Order 26.4B1, with no other testing dates provided. A review of the Electronic Nursing Progress Notes (EPN) for Resident #44 revealed on 09/21/22 at 10:51 PM a nurse documented that "Resident has been EX Order 26.4B1 since yesterday. MD [doctor] made aware and ordered EX Order 26.4B1 test. Resident EX Order 26.4B1	F 886	keep a tracker for all COVID 19 testing (staff and residents) . The tracker will be reviewed by the DON weekly. All findings will be reviewed at the Quality Assurance meeting x 3 quarters. V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee F886L- B On 10/11/22 facility interim Infection Preventionist and Regional nurse (who will provide oversight for the Infection Preventionist) reviewed the COVID 19 management policy which includes COVID testing and will be implemented moving forward. In servicing initiated on 10/11/22 by the Regional Nurse and to be completed by 10/21/22. On 10/11/22 facility interim Infection Preventionist and Regional Nurse reviewed the CDC guidance from 9-23-22 regarding testing. On 10/11/22 facility interim Infection Preventionist and Regional Nurse reviewed the contact tracing for the last positive patient and noted 1 staff member, who came in contact with the positive patient, was not fully vaccinated, was not fit tested, but was tested 2x/week as per guidance and had negative results. On 10/12/22 the facility interim Infection Preventionist was in serviced by the Regional Administrator and Regional Nurse on COVID 19 testing, COVID 19 policy and procedure on COVID 19 testing, fit testing and vaccination. II. Identification of Others:	

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F 886	Continued From page 323 19...Resident Transferred to the EX Orde floor room..." The Care Plan Activity Report for Resident #44 revealed, "The EX Order 26.4B1 or suspected Care Plan, As Evidenced By: Confirmed NJ Exec Order 26.4 for Goals revealed, EX Order 26.4B1 , Interventions included; "We will place you in NJ Ex Order 26.4b1 " Effective EX Order 26.4B1, "We will NJ Ex Order 26.4b1 ", Effective: EX Order 26.4B1 2, "We will monitor your temp [temperature], vital signs, pulse ox [blood oxygen level] and symptoms to see if you are responding to treatment", Effective NJ Ex Order 26.4b1. A review of the EPN for Resident #52 revealed on EX Order 26.4B1 M, Licence Practical Nurse #1 (LPN #1) documented EX Order 26.4B1 .", and at EX Order 26.4B1 another nurse documented EX Order 26.4B1 made aware and ordered EX Order 26.4B1 test. Resident EX Order 26.4B1 ...Resident Transferred to the EX Ord floor..." (This represented a seven hour delay from the documented request for the EX Order 26.4B1) On 09/23/22 from 9:42 AM to 10:00 AM, Surveyor #1 again interviewed the U.S. FOIA (b)(6) in the presence of Surveyor #2, #3, and #4. The U.S. FOIA (b)(6) stated Resident #44 was tested on EX Order 26.4B1 and confirmed the resident was on EX Order 26.4B1 The U.S. FOIA (b)(6) stated that Resident #52 was EX Order 26.4B1 to also having symptoms on EX Order 26.4B1, and the resident EX Order 26.4B1 on EX Order 26.4B1 The U.S. FOIA (b)(6) stated she was not made aware until EX Order 26.4B1, that Resident #44 and #52 were EX Order 26.4B1 . When asked if she should have been informed of the	F 886	All residents have the potential of being affected when the proper protocols and policies are not followed for testing residents with symptoms of COVID 19. III. Systemic changes: On 9/23/22 the Management staff were in serviced by the Director of nursing and Facility educator on the policy for COVID 19 testing. On 9/23/22 all present nursing staff were in serviced by the Director of Nursing and Facility educator on policies and procedures on COVID 19 testing guidelines and location of test kits. On 10/11/22 the Regional nurse and designee initiated an in service on COVID 19 testing. While in outbreak, as per local DOH requirements, facility to continue testing all staff, regardless of vaccination status, 2x/week and properly document test results on the testing tracker; while out of outbreak, regular testing must be done 1-2x/week for all staff who are not vaccinated with exemption (religious or medical). In services for all staff to be completed by 10/21/22. On 10/11/22 the facility interim Infection Preventionist checked the Rapid antigen test kits supply and found in adequate amounts. All present staff were inserviced on COVID 19 rapid antigen testing and made aware where Rapid antigen test kits were kept. IV. QA Monitoring The Director of Nursing and Infection	

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F 886	Continued From page 324 symptomatic residents she stated "yes, I would think so." When asked who is responsible for completing any contact tracing related to the NJ Ex Order 26.4b1 cases, the U.S. FOIA (b)(6) stated "that is a good question" and stated it would be under her jurisdiction. The surveyor inquired to the U.S. FOIA (b)(6) if she was aware that Resident #52 had EX Order 26.4B1 as documented in Resident #52's progress notes. The U.S. FOIA (b)(6) stated "no", she was not aware. The U.S. FOIA (b)(6) stated that she had just found out from the survey team that Resident #52 had NJ Exec Order 26.4b1 otherwise, she stated she would have tested the resident for EX Order 26.4B1 before and after having left the facility out on pass. The U.S. FOIA (b)(6) stated that she tried to get information from staff and made rounds daily. When inquired to the U.S. FOIA (b)(6) when the current outbreak started and what the status was, the U.S. FOIA (b)(6) stated she did not know when the outbreak started, "not the specific date", and as far as she knew they were "always in an outbreak". The U.S. FOIA (b)(6)) provided the survey team with a copy of the facility "Outbreak Plan/Covid-19 Response, revised 03/10/22", which was reviewed in the presence of the U.S. FOIA (b)(6) . The document revealed a "Higher -risk exposure- refers to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff does not wear adequate personal protective equipment during care or interaction with an individual. The document also revealed "Upon identification of a single new case of COVID-19 in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing though two approaches, contact tracing or	F 886	Preventionist will review 24h report on a daily basis to ensure all residents with signs and symptoms of COVID 19 were tested immediately and MD and family made aware. If result is positive, the resident will be placed in COVID 19 single room isolation immediately and contact tracing will be started immediately as well. The Director of Nursing and interim infection preventionist will monitor daily for any reports of COVID 19 signs and symptoms in residents or staff to ensure prompt testing is being performed and prompt contact tracing is done on the employee and contact tracing and risk assessments are done on the residents for possible exposure over a 48h period. Interim Infection Preventionist will test all unvaccinated staff and residents according to testing guidelines. The interim Infection Preventionist will keep a tracker for all COVID 19 testing (staff and residents) . The tracker will be reviewed by the DON weekly. All findings will be reviewed at the Quality Assurance meeting x 3 quarters. The first of which will take place in December 2022. V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee	

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F 886	Continued From page 325	F 886		

broad-based (e.g., facility-wide) testing". Surveyor #1 inquired to the U.S. FOIA (b)(6) regarding what staff were considered exposed to Resident #44 and Resident #52 and were any of the staff tested for EX Order 26.4B1 in response to the exposure. The U.S. FOIA (b)(6) stated "everyone could be going into the room, anyone can answer a light", and stated, "I will be honest with you, I didn't test anyone" and stated "I tested the two [Resident #44 and #52] that were EX Order 26.4B1 and the immediate roommate". The U.S. FOIA (b)(6) then confirmed, in the presence of the survey team, that she did not complete any contact tracing and the book of testing that she had provided to the survey team was in it;s entirety, no other EX Order 26.4B1 documentation was available and confirmed there was no facility wide testing completed in response to the Residents #44 and #52 EX Order 26.4B1 status.

The U.S. FOIA (b)(6) stated any other staff member could complete a EX Order 26.4B1 if they were trained. When inquired if any other staff had been trained to do EX Order 26.4B1 testing she stated, "not off the top of my head." Surveyor #3 inquired to the U.S. FOIA (b)(6) regarding what should be done when a resident was experiencing symptoms of EX Order 26.4B1 The U.S. FOIA (b)(6) stated that the facility had a U.S. FOIA (b)(6) and testing supplies can be obtained as needed and the residents should be tested if they are symptomatic and unvaccinated, the resident should be transferred to a EX Order 26.4B1 isolation room with isolation signs placed. The U.S. FOIA (b)(6) stated if residents were symptomatic and then tested NJ Exec Order 26.4b1 for EX Order 26.4B1, they should be moved to an isolation room for PUI in the event they became EX Order 26.4B1 . The U.S. FOIA (b)(6) stated if there was a room mate to the EX Order 26.4B1 positive resident, that person would be tested,

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and Resident #52 did not have a roommate. The U.S. FOIA (b)(6) stated that the roommate of Resident #44 was tested for EX Order 26.4B1, and tested NJ Exec Order 26.4b1 but was not restricted to the PUI section "at this point". The U.S. FOIA (b)(6) stated both Resident #44 and #52 were EX Order 26.4B1, and were very alert. The U.S. FOIA (b)(6) was asked if she completed the facility line listing (the spreadsheet of all EX Order 26.4B1 infections that is transmitted to the Department of Health) and communicated with the local Department of Health (DOH) regarding new EX Order 26.4B1 cases. The U.S. FOIA (b)(6) stated the U.S. FOIA (b)(6) was responsible for the line listing and contacting the DOH. The U.S. FOIA (b)(6) provided the survey team with a copy of the facility line listing which revealed that the symptoms for Residents #44 and #52 had an onset date of EX Order 26.4B1 and the survey team inquired if that date was correct, and the EX Order 26.4B1 stated that date should be changed to EX Order 26.4B1.

On 09/24/22 at 9:30 AM, Surveyor #1 toured the EX Order 2 floor unit and observed a Certified Nursing Aide (CNA #1), who was wearing a black surgical mask and was making the bed in Resident #44's room. The surveyor inquired to CNA #1 where Resident #44 was at present and CNA #1 stated that the Resident #44 was in EX Order 26.4B1. Surveyor #1 interviewed Licensed Practical Nurse #1 regarding where Resident #44 was at present. The nurse stated that Resident #44 had tested EX Order 26.4B1 ve and had been transferred to the EX Order 26.4B1 unit and CNA #1 was not made aware. CNA #1 was not tested for EX Order 26.4B1 on EX Order 26.4B1, when she had been assigned to provide care for Resident #44 while the resident was EX Order 26.4B1 on EX Order 26.4B1, and had tested EX Order 26.4B1 on EX Order 26.4B1.

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Part 2

The facility U.S. FOIA (b)(6) failed to ensure a system was in place, and was followed to ensure the all staff who required weekly, or bi-weekly EX Order 26.4B1 testing was implemented and documented during a EX Order 26.4B1 outbreak. This resulted in an IJ situation that was identified on EX Order 26.4B1 when the facility failed to complete required EX Order 26.4B1 testing which placed all residents and staff at risk for contracting a EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4

The facility submitted an acceptable removal plan on 10/12/22 at 1:42 PM.

The survey team verified the removal plan as implemented during an onsite survey on 10/12/22 at 2:35 PM.

The deficient practice was evidenced by the following:

On 09/23/22 at 9:42 AM, Surveyor #2 conducted an interview with LPN #1 who stated she was not vaccinated, had a medical exemption, and was not fit tested.

On 09/26/22 at 12:02 PM and 2:18 PM, the U.S. FOIA (b)(6) , respectively provided the staff vaccination matrix and both did not include LPN #1. The U.S. FOIA (b) confirmed at 12:05 PM, that the facility vaccination matrix had not been completed until the past weekend.

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On 10/04/22 at 11:19 AM, Surveyor #1 conducted an interview with the U.S. FOIA (b)(6), in the presence of the survey team regarding what the frequency was for testing staff that were not up to date with EX Order 26.4B1 vaccines. She stated it depended on the county rate and the staff should be tested once or twice per week, and "we are low, so we are testing everyone every three to five days because of the outbreak." The U.S. FOIA (b)(6) stated that staff that was not up to date with COVID vaccinations should also have been wearing N-95 respirator masks when they provided care. At that time, Surveyor #1 requested that the U.S. FOIA (b)(6) review the facility Outbreak Response Plan regarding any guidance for facility testing for information regarding testing. The U.S. FOIA (b)(6) stated testing was once or twice per week, she did not write the facility policy, and she had reviewed it.

On 10/06/22 at 1:46 PM, Surveyor #1 interviewed the U.S. FOIA (b)(6) in the presence of the team regarding the staff COVID-19 vaccination requirements. The facility had been informing staff that they must receive a COVID-19 booster. The surveyor inquired regarding if the staff that are not fully vaccinated are being tested for COVID-19. The U.S. FOIA (b)(6) stated "I am going to say no", and stated the facility was in an outbreak and they were tested for that. Surveyor #3 inquired to what testing frequency should have been completed. The U.S. FOIA (b)(6) stated that everyone should have been tested twice per week due to the current COVID-19 outbreak, and confirmed the facility testing lists were not consistent and were not updated.

On 10/06/22 at 2:09 PM, Surveyor #3 conducted an interview with the U.S. FOIA (b)(6) in the presence of the survey team. The U.S. FOIA (b)(6) acknowledged that

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F 886	Continued From page 329 all staff were currently not up to date with their COVID-19 vaccinations, and the vaccination staff tracking was not current. The EX Order 26.4B1 stated this was not known until she assumed the role of U.S. FOIA (b)(6). The U.S. FOIA (b)(6) was unable to provide any documentation and confirmed staff that were currently not up to date or exempted from receiving the COVID-19 vaccination, were not being tested for COVID-19 the way they should be tested, which was twice per week during an outbreak which began on EX Order 26.4B1 On 10/07/22 at 11:52 AM, Surveyor #2 observed LPN #1 providing care on EX Order 26.4B1 During all observations, LPN #1 was observed wearing a black surgical mask. The LPN #1 stated she had cared for the Unsampled EX Order 26 floor Resident who was EX Order 26.4B1 and then tested EX Order 26.4B1 EX Order 26.4B1 on EX Order 26.4B1. LPN #1 stated she had been working at the facility for EX Order months, and confirmed to the survey team that she had not been fit tested for an N95 respirator mask. On 10/11/22 10:51 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6), provided an updated vaccination list to the survey team. Surveyor #1 inquired to the U.S. FOIA (b)(6) why the list was provided today and the U.S. FOIA (b)(6) stated "I did it yesterday" and "I don't have an answer why it was not done earlier." The U.S. FOIA (b)(stated "there are a lot of components to this program and I cannot fix it in a week or two." The U.S. FOIA (b)(6 stated "I was aware", when asked if he knew the vaccination list was incomplete, and the U.S. FOIA (b)(6 stated "she was not aware" that the vaccination list was incomplete.	F 886		

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A review of the facility's policy, "Update to COVID Vaccination and Testing" dated 04/06/22 and facility reviewed on 9/2/2022, revealed Policy: It is the policy of [redacted] Rehabilitation and Care Center to offer COVID-19 vaccination and testing as per CDC and DOH guidance as a preventative health measure to reduce the risk of infection from COVID 19. Based on the above definitions, CMS has set the requirement that if staff have not received a COVID booster they are not considered up to date and will require routine testing in accordance with CDC community transmission rates.

A review of the facility's policy, "COVID 19 Management (All Policies)", revised on 5/31/2022, revealed; Staff COVID 19 Vaccination and Testing Requirements, Procedure: Employee Vaccinations for COVID 19 (per DOH order summary action). This facility will track and securely document the COVID 19 vaccination and/or testing status of all staff including vaccination booster doses. 3. All employees of this facility must be fully vaccinated including booster vaccinations as they are mandated or have an approved medical exemption. 4. For Staff whom are partially vaccinated (one dose for multi-dose vaccine schedule or those who are eligible for the booster vaccines as it is mandated): at minimum perform weekly testing and use of NIOSH N95 or equivalent for source control, 12. All employees, contract staff and medical staff will be tested for COVID-19 as per the most current guidelines.

A review of the facility's policy, "Outbreak Plan/COVID-19 Response", revised 3/10/22, revealed Guidelines: Testing of Nursing Home Staff and Residents to enhance efforts to keep

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COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set for the the HHS Secretary.

The non-compliance remained on 10/12/22, for no actual harm with the potential for more than minimal harm that was not IJ evidenced by the following:

1. Based on interview and review of facility documentation, it was determined that the facility failed to test unvaccinated staff for Coronavirus Disease 2019 (COVID-19) at a frequency based on the facility's policy, "COVID 19 Management (All Policies)". This deficient practice was identified for 3 of 3 staff members reviewed for COVID-19 testing and was evidenced by the following:

On 09/26/22 at 12:02 PM, the U.S. FOIA (b)(6) provided the Staff Vaccination Matrix (SVM) to the survey team, she confirmed it was completed over the weekend because they did not have staff vaccination cards prior to that time.

On 09/26/22 at 2:18 PM, the U.S. FOIA (b)(6) provided an updated SVM to the survey team.

On 10/05/22 at 9:37 AM, after a review of the SVM in the presence of the survey team, the U.S. FOIA (b)(6) Surveyor #3 requested EX Order 26.4B1 weeks of testing from EX Order 26.4B1 for the two staff members identified by the facility as having COVID-19 vaccination exemptions, and one partially vaccinated staff member as listed on the SVM.

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A review of the testing from EX Order 26.4B1 provided by the U.S. FOIA (b)(6)) on U.S. FOIA (b)(6) , revealed the following:

A. The U.S. FOIA (b)(6) tested NJ Exec Order 26.4B on EX Order 26.4B1 .
B. LPN # 3 tested NJ Exec Order 26.4B EX Order 26.4B1.
C. Temporary Nurses Aide (TNA) #1 tested NJ Exec Order 26.4B on EX Order 26.4B1

On 10/05/22 at 1:18 PM, in the presence of the survey team, the U.S. FOIA (b)(6) confirmed that the above provided testing was the only COVID-19 testing that could be located for the prior nine weeks beginning EX Order 26.4B1 and confirmed that the facility's EX Order 26.4B1 started EX Order 26.4B1.

On 10/06/22 at 1:50 PM, in the presence of the survey team, Surveyor #3 interviewed the U.S. FOIA (b)(6) The U.S. FOIA (b)(6) reviewed the facility's policy "COVID 19 Management (All Policies)", and confirmed that all staff who are exempt or not up to date with the COVID-19 vaccine should be tested for COVID-19 at least once a week but they are not. Surveyor #3 reviewed the testing for the above listed staff members with the U.S. FOIA (b)(6) She then stated that staff with an exemption or partially vaccinated should be tested twice a week during an outbreak. She stated LPN #3 works per diem (as needed). Surveyor #1 confirmed LPN #3 worked on EX Order 26.4B1, the U.S. FOIA (b)(6) confirmed that there was not testing provided for EX Order 26.4B1, but she should have been tested that day. She further stated, if staff with an exemption work per diem they should test when they come to work. She stated that the U.S. FOIA (b)(6) was here every day so she should have been tested twice a week and TNA #1 is not fully vaccinated and should have been tested twice a week. The

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F 886	Continued From page 333 U.S. FOIA (b)(6) acknowledged that staff that are exempt and/or not up to date were not being tested the way that they should be during an outbreak, which was twice a week and according to the facility's policy, which was once a week. On 10/06/22 at 02:45 PM, in the presence of the survey team, Surveyor #3 made the U.S. FOIA (b)(6), the U.S. FOIA (b)(6) aware of the above concerns with testing of employees that were not up to date with their vaccination. A review of the facility's policy, "COVID 19 Management (All Policies)" revised on 5/31/2022, revealed; Staff COVID 19 Vaccination and Testing Requirements, Procedure: 3. All employees of this facility must be fully vaccinated including booster vaccinations as they are mandated or have an approved medical exemption. 4. For Staff whom are partially vaccinated (one dose for multi-dose vaccine schedule or those who are eligible for the booster vaccines as it is mandated): at minimum perform weekly testing, 12. All employees, contract staff and medical staff will be tested for COVID-19 as per the most current guidelines.	F 886		
F 887 SS=D	N.J.A.C. 8:39-5.1(a) COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the	F 887		12/5/22

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F 887	Continued From page 334 resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19	F 887		

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F 887	Continued From page 335 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident NJ Ex Order 26.4b1 . This deficient practice was identified for 1 of 5 residents reviewed for immunization (Resident #11). The deficient practice was evidenced by the following: On 09/26/22 09:18 AM, the surveyor reviewed Resident #11's medical record which revealed the following information: Review of the Resident Face Sheet Record (an admission summary) revealed that Resident # 11 had been admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 [redacted]	F 887	1. Corrective action 1.Corrective action: Resident #11 NJ Ex Order 26.4b1 was updated and care plan updated An interim full time Infection Preventionist with verified training program from CDC Train Long term Care module was transferred to the facility to implement facility-wide infection plan and procedures related to COVID-19. Residents are assessed on admission and there is a standing medication order which is documented on the electronic medical record. The IP implemented a resident COVID-19 to track immunizations. 2.Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents and staff have the potential to be affected due to the nature of the deficiency 3.Measures Put Into Place:	

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F 887	Continued From page 336 when a patient is not current on other, [redacted]). Review of Resident #11's active Care Plan (CP) printed on [redacted] did not reveal any focus, goals, or interventions for vaccinations. Review of Resident #11's electronic Medical Record (eMR) under Preventative Health did not reveal [redacted] record. Review of Resident #11's "Immunization Record" from Resident #11's paper medical record did not reveal a [redacted] administration record. On 09/28/22 at 12:58 PM, the concern regarding [redacted] status, where no documentation that it was offered, administered, refused and no education provided was brought to the attention of the [redacted] and any additional information was requested. 09/29/22 at 11:08 AM, during an interview with the surveyor, Resident #11 stated he/she had not been offered any vaccinations but if his/her doctor or nurse recommended it, "I will do it". On 10/04/22 at 10:46 AM, during an interview with the surveyor, [redacted] stated she did not find additional information regarding Covid-19 Immunization for Resident #11. She acknowledged that the immunization should have been care planned since the Resident [redacted] as documented on the resident's face sheet.	F 887	Upon admission and readmission, vaccination status will be assessed by nursing or nursing designee Monthly audit of COVID-19 status to be completed by the Unit Manager and/or designee 4.How Will These Actions Be Measured: Monthly audit of COVID-19 status will be submitted monthly by the Unit Manager and/or designee to the Quality Assurance and Process Improvement Committee Meeting for 6 months. The first of which will take place in December 2022.Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 887	Continued From page 337 On 10/06/22 at 2:32 PM, the concern regarding Resident #11's[redacted] status, where no documentation that it was offered, administered, refused and no education provided was brought to the attention of the [redacted] in the presence of the survey team, the [redacted], and the [redacted] and any additional information was requested. On 10/12/22 at 12:40 PM, in the presence of the survey team, the [redacted] confirmed that no additional information could be provided. Review of the facility provided, "Vaccination of Residents/COVID-19" policy reviewed 1/5/2022, included but was not limited to the following: Policy Statement: All residents will be offered COVID-19 vaccines to aid on preventing infectious disease unless the vaccine is medically contraindicated, or the resident has already been vaccinated. Policy Interpretation and Implementation: 1. Prior to receiving vaccination, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations ... 2. Provisions if such education shall be documented in the resident's medical record. 5. If vaccines are refused, the refusal shall be documented in the resident's medical record. 6. If the resident receives a vaccine, at least the following information shall be documented in the resident's medical record: a. Site of administration b. Date of administration c. Lot number of the vaccine (located on the vial);	F 887		

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F 887	Continued From page 338 d. Expiration date e. Name of the person administering the vaccine.	F 887		
F 888 SS=L	N.J.A.C. 8:39-19.4(a) COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with	F 888		12/5/22

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residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination

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F 888	Continued From page 340	F 888		

requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully

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F 888	Continued From page 341 vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review, it was determined that the facility failed to: a.) ensure the facility policy, Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS) for COVID-19 vaccinations was implemented to ensure that all staff were up to date with COVID-19 vaccinations, or have been granted a qualifying exemption during a EX Order 26.4B1 that began on EX Order 26.4B1; and, b.) ensure all staff that were not up to date with vaccinations, or had been granted a qualifying exemption were not permitted to work in the facility. The facility's failure to take immediate action, follow Centers for Medicare and Medicaid Services (CMS) guidance, Centers for Disease Control and Prevention (CDC), and facility policies to limit exposure risks placed all residents and staff at risk for contracting COVID-19, a deadly contagious virus. Reference: Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019	F 888	Immediate Action: On 10/11/22 facility interim Infection Preventionist and Regional nurse (overseeing the Infection Preventionist) reviewed the COVID 19 management policy which includes COVID 19 staff vaccination. The policy set forth will be implemented moving forward. In services initiated 10/11/22 and to be completed by 10/21/22. On 10/11/22 facility interim Infection Preventionist and Regional Nurse reviewed the CDC guidance from 9-23-22 regarding staff vaccination. On 10/11/22 facility interim Infection Preventionist and Regional Nurse reviewed all staff vaccination status and found that out of a total of 121 employees, there are Ex Ord fully vaccinated (step #1, step #2 and booster), 1 partially vaccinated, and Ex Ord staff not fully vaccinated. On 10/11/22 facility DON contacted all staff who were partially vaccinated to inform them of the need for vaccination.	

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F 888	Continued From page 342 (COVID-19) Pandemic, Updated September 23, 2022 Refer to F880 and F886 The failure to ensure all staff were up to date with COVID-19 vaccinations or granted a qualifying exemption during a COVID-19 outbreak were not permitted to work in the facility placed all residents and staff at risk for contracting a contagious, potentially deadly virus. This situation resulted in an Immediate Jeopardy (IJ), which began on EX Order 26.4B1 when a Licensed Practical Nurse (LPN #1), who was NJ Ex Order 26.4b1 [redacted] without having a qualifying exemption, proceeded to work forty-seven shifts from the start of the facility outbreak on EX Order 26.4B1 EX Order 26.4B1. The IJ was identified on 10/11/22 at 2:03 PM. The facility administration was notified of the IJ on 10/11/22 at 2:03 PM. The facility submitted an acceptable removal plan on 10/12/22 at 01:42 PM. The IJ removal plan was verified as implemented during an onsite visit on EX Order 26.4B1 . The evidence was as follows: On 09/21/22 at 9:09 AM, in the presence of the survey team, the U.S. FOIA (b)(6) [redacted] stated that the facility was currently in NJ Ex Order 26.4b1 , and the outbreak was three days from ending. On 09/21/22 at 1:09 PM, Surveyor #1 conducted	F 888	0n 10/11/22 the facility DON secured 36 COVID 19 Bivalent booster shots and administered COVID 19 Bivalent booster to 8 staff members. Anyone refusing vaccination, must present a medical or religious exemption as per policy. If exemption not accepted, employee cannot be placed on schedule. Full vaccination status on all employees to be completed by 10/21/22. On 10/12/22 the staffing coordinator was inserviced on fit testing and vaccination by the Infection Preventionist and Regional Nurse, with the understanding that moving forward, anyone who is not fit tested or up to date with vaccination, will not be able to be placed on the schedule. Any agency staff will have to provide proof of vaccination and fit testing prior to be placed on the schedule. II. Identification of Others: All residents have the potential of being affected when the proper protocols and policies are not followed for testing residents with symptoms of COVID 19. III. Systemic changes: On 10/11/22 the Regional nurse and designee initiated an in service on COVID 19 vaccination for staff. Infection preventionist will maintain a tracker of employees' COVID19 vaccination, ensuring employees received all required COVID 19 vaccination and booster. Infection preventionist will maintain a binder with employee vaccination record. A listing of all facility employees with be placed at the front of the binder for easy	

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F 888	Continued From page 343 an entrance conference with the U.S. FOIA (b)(6) [redacted]. During the entrance conference, Surveyor #1 requested the facility infection control policies related to COVID-19 and the COVID-19 Staff Vaccination Matrix. The U.S. FOIA (b)(6) confirmed the Uncertified U.S. FOIA (b)(6) [redacted] did not have an infection control certification and that she was responsible for all of the COVID-19 vaccination efforts. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) "has all of the documents" and noted that there was currently no symptomatic resident in the facility. On 09/22/22 at 3:42 PM, in the presence of the survey team, the U.S. FOIA (b)(6) stated that not everyone was tested twice weekly. When the survey team asked the criteria for the staff to be tested, she said, "if some people feel like they have a cold, they would be tested" and that currently, "there were no staff members that needed to be tested." The U.S. FOIA (b)(6) confirmed that her log was the only facility testing document at that time. The survey team inquired to the U.S. FOIA (b)(6) regarding the staff vaccination list, and the U.S. FOIA (b)(6) stated that she did not have a completed list for the staff's COVID-19 vaccination status. On 09/23/22 at 11:34 AM, the survey team interviewed the U.S. FOIA (b)(6) regarding the National Health and Safety Network information that is required to be submitted. The U.S. FOIA (b)(6) confirmed that he inputted the data and that there was no current employee vaccination list since not all employees were on it. The U.S. FOIA (b)(6) stated, "I am not making up what I don't have." On 09/22/22 at 9:43 AM, the U.S. FOIA (b)(6) informed the survey team that two residents	F 888	auditing. IV. QA Monitoring The Director of Nursing and Infection Preventionist will review the vaccination tracker and the facility employee list on a weekly basis. The Director of Nursing and Infection Preventionist will review the COVID 19 vaccination binder with the employee vaccination record on a weekly basis. All findings will be reviewed at the Quality Assurance meeting x 3 quarters. V. Person responsible: Director of Nursing (DON), Infection preventionist, Administrator or designee	

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(Resident #44 & Resident #52) had tested EX Order 26.4B1 and had been moved to the EX Order floor for isolation. The U.S. FOIA (b)(6) stated the EX Order 26.4B1 were identified during "routine" EX Order 26.4B1.

On 09/22/22 at 9:55 AM, the U.S. FOIA (b)(6) failed to provide the survey team with the requested infection control documents, which included the staff vaccination and staff and resident testing documentation. The U.S. FOIA (b)(6) stated the documents were now with the "corporate people," and he could not produce the documents.

On 09/23/22 at 8:53 AM, Surveyor #1 observed LPN #2 on the EX Order 26.4B1 -floor medication cart wearing a surgical mask. Surveyor #1 then interviewed LPN #2, who stated she was a new hire. The surveyor asked LPN #2 if she was vaccinated for COVID-19 and if she had been fit tested for an N-95 mask. LPN #2 replied, "not fit tested, not boosted" (a test to determine if a respirator mask appropriately fits to protect the wearer). She stated she NJ Ex Order 26.4b1 and confirmed that the facility was aware that she was not boosted. LPN #2 said that she signed a waiver form that the facility provided since NJ Ex Order 26.4b1 . Surveyor #1 inquired to LPN #2 if she had received COVID-19 testing, and she stated that the facility would let her know if she needed to take a test and that she could also let the U.S. FOIA (b)(6) know if she needed to take a COVID-19 test. Surveyor #1 asked LPN #2 if she was assigned to a particular unit. LPN #2 replied that she floated to different units.

On 10/06/22 at 12:30 PM, Surveyor #1 observed

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LPN #2 on the [redacted] floor COVID-19 unit at the nursing station wearing a National Institute of Occupational Safety and Health (NIOSH) N-95 mask. Surveyor #1 further inquired about what N-95 mask she was required to wear. LPN #2 removed two different masks from the bins outside a resident room and told the surveyor that she could wear either one. LPN #2 stated the mask Surveyor #1 was wearing (N95 #8210) was very tight, and she said that she was fit tested for both masks by the [redacted] Surveyor #1 inquired if LPN #2 had a medical or religious exemption for the COVID-19 booster. LPN #2 reiterated that she had signed a paper waiver provided by the facility, which indicated she did not want the booster and stated "no"; it was not a medical or a religious exemption, only that it was a document that offered risks and benefits.

On 10/06/22 at 1:46 PM, surveyor #3 interviewed the [redacted] in the presence of the survey team. The [redacted] stated that the facility had been telling staff they must get boosted for COVID-19. The [redacted] said the facility should have a list of all the employees, a copy of the vaccination cards, and a spreadsheet to track when everyone was due. When asked about the new hire process, the [redacted] stated the new hires should have received a booster or provided proof of COVID-19 Vaccination status. She then said, "I mean, anyone can decline," and "they shouldn't be employed in healthcare" [if the COVID-19 vaccines are declined]. The [redacted] stated it was "mandated" to be up to date with COVID-19 vaccines, per the federal government, Centers for Disease Service (CDC), and the state government. At that time, the [redacted] confirmed that all staff were not up to date with COVID-19

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vaccines and stated, "I am acknowledging now" since she had not been aware of all staff not being up to date with COVID-19 vaccines and she also confirmed that the staff were not being tested twice per week.

On 10/07/22 at 11:01 AM, Surveyor #1 interviewed the U.S. FOIA (b)(6) [redacted]) regarding agency staff's vaccination status before working at the facility. The U.S. FOIA (b)(6) confirmed there was no system in place to ensure that the staffing agencies were sending fully vaccinated staff who had been fit tested for N-95 masks.

On 10/07/22 at 11:52 AM, surveyor #2 had observed LPN #1 providing care on EX Order 26.4B1 [redacted] LPN #1 was wearing a black surgical mask during all observations. LPN #1 stated she had cared for the unsampled EX Order 26.4 floor resident, who was EX Order 26.4B1 and EX Order 26.4B1 on EX Order 26.4B1. LPN #1 stated she had worked at the facility for EX Order 2 months and confirmed she had not been fit tested for an N95 mask.

On 10/07/22 at 12:58 PM, the U.S. FOIA (b)(6) provided the facility line listing, which revealed a EX Order 26.4B1 unsampled EX Order 26.4B1 resident was identified on the EX Order 2 floor on EX Order 26.4B1.

On 10/07/22 at 1:01 PM, the U.S. FOIA (b)(6) confirmed that LPN #2 was not up to date with her COVID-19 vaccines, and the U.S. FOIA (b)(6) confirmed she had been unaware. The U.S. FOIA (b)(6) stated, "I will be honest with you" she did not know why LPN #2 "got through the system." The U.S. FOIA (b)(6) said there

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was no form she was aware of that the facility provided to staff for declining a COVID-19 vaccination. The U.S. FOIA (b)(6) stated, "from my understanding, everyone needs to be up to date on their vaccines." The U.S. FOIA (b)(6) noted that once she had a complete list of the unvaccinated staff, the staff would have to find another place to work if the staff refused to vaccinate.

On 10/11/22 at 8:49 AM, the U.S. FOIA (b)(6) provided a copy of the Resident/Employee Contact Tracing Record dated 1 EX Order 26.4B1. The document revealed that LPN #1 was identified as the nurse who cared for EX Order 26 residents who EX Order 26.4B1 EX Order 26.4B1, including Residents # 44 and #52, who EX Order 26.4B1 and the unsampled resident on EX Order 26.4B1; All EX Order 26 residents resided on the EX Order 26 floor. LPN #2 was identified as a close contact for EX Order residents, Resident #10 and an unsampled resident, on EX Order 26.4B1 who resided on the EX Order 2 floor.

On 10/11/22 at 12:53 PM, the facility U.S. FOIA (b)(6)) provided the survey team with Time Card detail for LPN #1 and LPN #2. LPN # 1 worked forty-seven shifts since the facility outbreak began on EX Order 26.4B1, which was revealed in the Time Card detail from EX Order 26.4B1 through EX Order 26.4B1. LPN #2 worked twenty shifts from EX Order 26.4B1 through EX Order 26.4B1.

The non-compliance remained on 10/12/22 for no actual harm with the potential for more than minimal harm that is not IJ based on the following:

Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to: a.) develop and

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implement a policy to track and document facility staff vaccination status to ensure all eligible staff were vaccinated by the required dates; and, b.) follow the facility policy for contingency plans by failing to ensure unvaccinated staff wore an N95 respirator mask (a tight-fitting mask that protected the wearer from air particles) to mitigate the potential spread of COVID-19.

This deficient practice was evidenced by the following:

On 09/26/22 at 12:02 PM, five days after the survey began on Ex Order 26.4B1, the U.S. FOIA (b) provided the Staff Vaccination Matrix (SVM) to the survey team. She confirmed it was completed over the weekend because they did not have staff vaccination cards.

On 09/26/22 at 2:18 PM, the U.S. FOIA (b)(6) provided an updated SVM to the survey team.

A review of the SVM revealed that there were 94 total staff, 85 completely vaccinated staff, four partially vaccinated staff, two staff granted an exemption, and three staff temporary delay/new hires. Of the 94 total staff, 29 staff did not receive the booster dose. The SVM revealed that 62 staff of the 94 were up to date (received all recommended COVID-19 vaccines, including any booster dose (s) when eligible) with the vaccination requirement.

A review was completed of the National Healthcare Safety Network (NHSN) data regarding the facility's reported percentage of fully vaccinated staff for the week ending 09/04/22. The facility reported the ratio of staff fully vaccinated was 100%. A review of the

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facility-provided SVM revealed that 95.7% of staff were vaccinated.

On 10/04/22 at 2:10 PM, Surveyor #3 interviewed the U.S. FOIA (b)(6)), who stated she had a medical exemption. When asked what PPE she had to wear in the building, she said she wore a surgical mask, but she was told she had to wear an N95 if she had to go into a EX Order 26.4B1 room.

On 10/05/22 at 11:26 AM, Surveyor #3 observed the SC, wearing a surgical mask, on the EX Orde floor at the nurses' station, conversing with one resident and one staff member.

On 10/05/22 at 1:00 PM, Surveyor #3 requested testing for LPN#3, who was listed as a temporary delay per CDC/new hire on SVM from the U.S. FOIA (b)(6)). The U.S. FO gave the surveyor a copy of LPN #3's vaccination card, which showed she was fully vaccinated and boosted. Therefore, no testing was required.

On 10/06/22 at 8:40 AM, the U.S. FOIA (b)(6) provided an updated SVM to the survey team.

On 10/06/22 at 9:34 AM, Surveyor #3 observed the U.S. FOIA (b)(6)) (listed on the SVM as completely vaccinated but had not received the booster dose) touring the facility on the EX Order floor with the Life safety surveyor. The U.S. FOIA (b)(6) wore a surgical mask.

On 10/06/22 at 12:15 PM, Surveyor #4 interviewed CNA #1 while working on the Ex Order floor. CNA #1 stated she received NJ Ex Order 26.4b1 n. She wore a surgical mask and stated that this was what she had to

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	315455	A. BUILDING _____ B. WING _____	C 10/12/2022

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AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

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wear in the building unless she cared for residents with COVID, then she would wear "goggles, an N95, and a gown."

A review of the SVM revealed CNA#1 was listed on the SVM as completely vaccinated but had not received the booster dose.

On 10/06/22 at 12:42 PM, Surveyor #4 interviewed TNA #1, who stated she had two vaccinations but needed a booster that was due in [redacted] and was going to get the booster soon. She wore a surgical mask, and she stated that she could wear a surgical mask. She said she would need to wear an N95, a gown, gloves, and a face shield with Covid residents. TNA# 1 stated that right now, on the [redacted] floor, it was "okay" for her to wear a surgical mask.

A review of the SVM revealed TNA#1 was listed on the SVM and was listed as partially vaccinated.

On 10/06/22 at 1:50 PM, in the presence of the survey team, Surveyor #3 interviewed the [redacted]. The [redacted] reviewed the facility's policy, "COVID-19 Management (A Policies)," and confirmed that all staff who are exempt or not up to date should be wearing an N95, but they are not. She stated that staff is being told that they must be up to date and that it is mandated. The [redacted] noted that staff would be removed from the schedule if they refused and did not have an approved exemption.

At that time, the [redacted] stated that they should have a list of all employees, copies of their vaccination cards, and a spreadsheet to track how many doses staff had received. She stated

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that new hires should have had to show their vaccination card. Surveyor #3 asked if employees could decline the COVID vaccine without an approved exemption. The U.S. FOIA (b)(6) stated "that if that was the case, they should not be employed in healthcare ."She said employees could not sign a declination form for the COVID-19 vaccine. She further stated that the Centers for Disease Control mandated at the Federal and State levels that everybody in healthcare must be up to date. Surveyor #3 reviewed the SVM and the vaccination cards with the U.S. FOIA (b)(6), who acknowledged that there were inconsistencies.

On 10/06/22 at 2:09 PM, in the presence of the survey team, the U.S. FOIA (b)(6) stated, "I totally acknowledge staff are not up to date, tracking employees was not current, but we weren't aware until I took over the US FOIA (b)(6) role." She then acknowledged that staff that was exempt or were not up to date were not being tested the way they should be during a COVID-19 outbreak, which was twice weekly.

On 10/06/22 at 02:45 PM, in the presence of the survey team, Surveyor #3 made the U.S. FOIA (b)(6), the U.S. FOIA (b)(6) and the Ex Order aware of the above concerns with employees not being boosted, employee vaccination not being tracked, and with employees that are exempt or not up to date wearing proper personal protection equipment according to the facility policy.

A review of the SVM received on Ex Order 26.4B1 from the Ex Order 26.4B1 which revealed the "vaccination list, who is not up to date" (IP List) received Ex Order 26.4B1, staff vaccination cards and interviews revealed the following:

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1. The U.S. FOIA (b)(6) was listed on the SVM as up to date, on the U.S. FOIA (b)(6) list as needing booster, vaccination card #1 (name redacted) lot # Ex Order 26.4B1 Ex Order 26.4B1 ; (name redacted) lot # Ex Order 26.4B1 Ex Order 26.4B1 [another facility name] post-acute vaccination card # 2 1st (name redacted) [pharmacy name] and 2nd dose (name redacted) [pharmacy name], no date, boosted (name redacted) Ex Order 26.4B1 generation pharmacy. On Ex Order 26.4B1 , in the presence of the survey team, the U.S. FOIA (b)(6) stated he was up to date on his vaccines and provided proof.

2.U.S. FOIA (b)(6) #1 was listed on the SVM as up to date, on the U.S. FOIA (b)(6) list as needing a booster, vaccination card: (name redacted), Ex Order 26.4B1 . On Ex Order 26.4B1 AM, Surveyor #3 interviewed US#1, stating she was up to date on her vaccines.

3. Housekeeper (HSK) #1 was listed on the SVM as completely vaccinated and needs a booster dose. On the IP list, nothing was recorded. Vaccination card: (name redacted) NJ Exec Order 26.4b1 . Surveyor #3 interviewed HSK #1, who stated he was up to date on his vaccines.

4. LPN #4 was listed on the SVM as up to date, on the U.S. FOIA (b)(6) list as needing booster, vaccination card: (name redacted) NJ Ex Order 26.4b1 53 AM, Surveyor #3 interviewed LPN #4, who stated she was u NJ Ex Order 26.4b1

5. Behavior Aide (BA) #1 was listed on the SVM as NJ Ex Order 26.4b1, on the U.S. FOIA (b)(6) list as needing a booster, vaccination card: (name redacted), NJ Exec Order 26.4b1

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F 888	Continued From page 353 On 10/05/22 at 11:28 AM, Surveyor #3 interviewed BA #1, who stated she was [redacted] On 10/12/22 at 9:56 AM, Surveyor #3 observed CNA#1 on the 2nd floor wearing a surgical mask. During an interview at that time, CNA#1 stated, "I was told yesterday I need to [redacted] today." On 10/12/22 at 1:46 PM, Surveyor #3 observed the SC on the [redacted] floor wearing a surgical mask. On 10/12/22 at 2:00 PM, in the presence of the survey team, Surveyor #3 made the [redacted] aware that CNA#1 and the SC were observed wearing only surgical masks, as mentioned above. They both acknowledged that the facility's policy was if not up to date or exemptions, staff should have been wearing an N95. A review of the facility's policy, "COVID-19 Management (All Policies)," revised on 5/31/2022, revealed it is the policy of this facility to follow CDC and DOH [Department of Health] guidelines for the management of the COVID-19 (Sars-COV-2). The policy addressed Staff COVID-19 Vaccination and Testing Requirements, Procedure: Employee Vaccinations for COVID-19 (per DOH order summary action). This facility will track and securely document the COVID-19 vaccination and/or testing status of all staff, including vaccination booster doses. Staff who need an exemption form can request it from Human Resources or their Department Head. Procedure:	F 888		

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F 888	Continued From page 354 3. All employees of this facility must be fully vaccinated, including booster vaccinations, as they are mandated or have an approved medical exemption. 4. For Staff who are partially vaccinated (one dose for multi-dose vaccine schedule or those who are eligible for the booster vaccines as it is mandated): Use of NIOSH-approved N95 or equivalent for source control. 5. Providing all personnel who decline to be vaccinated a written affirmation for their signature, which signifies that they were offered the opportunity for a COVID-19 vaccination but declined. For employees, the reason for declination must fall into a medical reason or religious reason. 7. Upon request from the DOH, the following must be presented: a. number and percentage of personnel that have been vaccinated for COVID-19, b. Number and percentage of personnel for which medical exemptions have been granted, c. The total number of covered personnel. 8. For staff who are not vaccinated do not fall into the exemption or are temporarily delayed in obtaining the vaccine as it is mandated and staffing is in crisis levels. a. This facility will communicate the staffing crisis to the appropriate government agency and will attempt to place identified staff members who aren't fully vaccinated in non-resident areas and to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g. assigning to residents who are not immunocompromised, unvaccinated). 9. This facility will require staff who have not completed their primary vaccination series (including ...been granted an exemption or who have a temporary delay) to follow addition CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in	F 888		

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F 888	Continued From page 355 areas that are restricted from resident access, even if the facility or service site is located in a county with low to moderate community transmission. 10. Any employee who refuses testing and is not fully vaccinated per the current guidelines will not be permitted to work in this facility. N.J.A.C. 8:39-9.3(c);19.1(b); 19.4(a)	F 888		
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to ensure corridors were equipped with firmly secured handrails on 1 of 3 floors (second floor) and was evidenced by the following: On 09/21/22 at 12:21 PM, the surveyor in the presence of a second surveyor was touring the second floor and observed the handrails from the elevator door located in front of the second floor conference room to be unsecure. The surveyors observed the handrail from the elevator to the corner of the low side corridor was visibly leaning outward. The surveyor was able to touch the handrail and it was observed to have almost completely separated from where it was screwed into the wall. The surveyors observed the attached corner handrail, that was meant to hold two handrails together, which was visibly partially separated from the two handrails causing another handrail on the low side corridor to become unsecured. The surveyors next observed the	F 924	1. Corrective Action: Upon identification, Handrails in the following locations were secured: - Handrail from elevator door located in front of the second-floor conference room - Handrail from the elevator to the corner of the low side elevator - Attached corner handrail - Handrail from the elevator toward the high side corridor 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: An audit was completed by the maintenance director to assure all handrails within the facility were properly affixed to the wall Weekly audits of handrail on all floors will be conducted by the maintenance director	12/5/22

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F 924	Continued From page 356 handrail from the elevator towards the high side corridor was visibly leaning outward with a corner handrail piece which was partially unattached to the loose handrail. On 09/21/22 at 12:23 PM, the U.S. FOIA (b)(6) [redacted] was observed on the Ex Order 26.4B floor. The two surveyors showed the handrails to the U.S. FOIA (b)(6). At that time, the U.S. FOIA (b)(6) confirmed the handrails were loose. He stated all handrails should be secured "so no one gets hurt." He further stated he performed walking rounds daily and he had not identified the loose handrails earlier that day. A review of the Centers for Medicare and Medicaid Services (CMS) Reference S&C-07-07 dated 12/21/06, included but was not limited to "the purpose of the handrail requirements is to assist residents with ambulation and/or wheelchair navigation. They are a safety device as well as a mobility enhancer for those residents who need assistance." On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-31.2(e)	F 924	and/or designee to identify any handrails that may have come loose and have them immediately remedied. Findings from the weekly audits will be brought to the Quality Assurance and Process Improvement committee. 4. How Will These Actions Be Measured: The results of the monthly reviews will be submitted to the Safety and Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	476002	A. BUILDING: _____ B. WING _____	C 10/12/2022

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 12 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	a. Staffing coordinator was educated on New Jersey state certified nursing assistant staffing requirements. b. Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will use staffing agencies and offer additional shifts to current staff. c. Identification of Others d. All residents have the potential to be affected by the deficient practice. Systematic changes e. Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and	12/5/22

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

Electronically Signed | 11/11/22

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 09/04/2022 to 09/10/2022 and 09/11/2022 to 09/17/2022, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -09/04/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -09/05/22 had 10 CNAs for 103 residents on the day shift, required 13 CNAs. -09/06/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -09/07/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/08/22 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. -09/10/22 had 10 CNAs for 100 residents on the day shift, required 13 CNAs.	S 560	referral bonuses are being utilized to continue to be competitive in the marketplace. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. The facility administrator/designee will continue to document all recruitment and retention efforts weekly. Quality monitoring f. The administrator/designee will review staffing schedules weekly to ensure g. Adequate staffing for all shifts. The results of these reviews will be submitted to h. the Quality Assurance Performance Improvement Committee monthly for 6 months. The first of which will take place in December 2022. Based i. on the audit results, a decision will be made regarding the need for continued j. submission and reporting	

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S 560	Continued From page 2 -09/11/22 had 11 CNAs for 100 residents on the day shift, required 12 CNAs. -09/12/22 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -09/13/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/14/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/15/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -09/16/22 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. On 10/05/22 at 12:01 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the required minimum direct care staff to resident ratios. She added that she did not know them "off the top of my head" but that she had a "cheat sheet." The surveyor asked the SC if the facility was meeting the required minimum direct care staff to resident ratios. She stated that she thought the facility was meeting the ratios most days. She added that sometimes it was difficult on the weekend. On 10/07/22 at 10:52 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was aware of the required minimum direct care staff to resident ratios. The surveyor then asked the LNHA if the facility was meeting the required minimum direct care staff to resident ratios and he stated that to his understanding the facility had been meeting the required ratios. A review of the facility provided policy titled, "Staffing", with a reviewed date of 05/05/22, included the following: Under Policy Statement	S 560		

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S 560	Continued From page 3 Our facility provides adequate staffing to meet needed care and services for our resident population. Under Policy Interpretation and Implementation 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. The policy did not include the required minimum direct care staff to resident ratios.	S 560		
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.)	S 830		12/5/22

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S 830	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to obtain a Criminal Background (CB) check prior to the date of hire for new employees. This deficient practice was identified for 1 of 5 newly hired employees reviewed and was evidenced by the following: A review of the five randomly selected newly hired employee files included the following: An Occupational Therapist Assistant, who was hired on [redacted], had a CB ordered on [redacted] and reported on [redacted] On 10/04/22 at 11:31 AM, in the presence of another member of the survey team, the surveyor interviewed the Director of Human Resources (DHR) regarding a newly hired employee's CB. The DHR stated that she would order the CB before the employee's start date. On 10/07/22 at 10:52 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the when a CB should be done for a newly hired employee. The LNHA stated that the CB should be done before the date of hire. On 10/07/22 at 11:31 PM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA) regarding the when a CB should be done for a newly hired employee. The	S 830	IMMEDIATE ACTION: Director of Human resources was immediately in serviced by regional human resources regarding the regulation that criminal background checks must be completed prior to the date of hire for a new employee. a. Identification of Others All residents have the potential to be affected by the deficient practice Systematic changes A monthly audit (random sample) of new hires will be completed by the Administrator and/or designee to assure that all new hires have had their criminal background checks completed prior to the date of hire QUALITY MONITORING Audit results will be reported to the Quality Assurance and Performance Improvement committee monthly x 6 months for review and further recommendations. The first of which will take place in December 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476002	A. BUILDING: _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

(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 830	Continued From page 5 RLNHA stated that the CB should be done prior to hire. A review of the facility provided policy titled, "Hiring" with a reviewed date of 11/21/21, included the following: Under Policy Interpretation and Implementation 8. The following steps will be followed when accepting applications from outside the facility: ... f. The HR Director will extend an offer of employment to the chosen applicant. Such offer will contain any relevant contingencies or disclaimers; g. The HR Director will then conduct any applicable investigations and determine whether the applicant is legally eligible to work in the United States; and h. An offer of employment may be revoked and employment may be terminated if an investigation reveals that an applicant made misrepresentations about or failed to disclose any fact which might indicate that the applicant is not qualified for the position in question ... 10. Where appropriate, background investigations may be conducted on persons making application for employment with this facility and on current employees.	S 830		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing	S1405		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 6 assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of five recently hired employee files, it was determined that the facility failed to ensure that 5 of 5 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: A review of the five randomly selected newly hired employee files included the following: A Temporary Nursing Assistant, who was hired on EX Order 26.4B1 had an examination dated EX Order 26.4B1 An Occupation Therapy Assistant, who was hired on EX Order 26.4B1, had an examination dated EX Order 26.4B1 An Assistant Director of Nursing, who was hired on EX Order 26.4B1, had an examination dated EX Order 26.4B1 A Housekeeper, who was hired on EX Order 26.4B1, had an examination dated U.S. FOIA (b)(6).	S1405	Director of Human resources was immediately in serviced by regional human resources regarding the regulation that employee physicals must be completed no more than 2 weeks prior to the date of hire for a new employee. a. Identification of Others All residents have the potential to be affected by the deficient practice Systematic changes A monthly audit (random sample) of new hires will be completed by the Administrator and/or designee to assure that all new hires have had their employee physicals completed no more than 2 weeks prior to the date of hire QUALITY MONITORING Audit results will be reported to the Quality Assurance and Performance Improvement committee monthly x 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476002	A. BUILDING: _____ B. WING _____	C 10/12/2022

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S1405	Continued From page 7 An Activity Aid, who was hired on EX Order 26.4B1, had an examination dated EX Order 26.4B1. On 10/04/22 at 11:39 AM, in the presence of another survey team member, the surveyor interviewed the Director of Human Resources (DHR) regarding the process to obtain physicals (examination) for newly hired employees. The DHR stated that newly hired employees had at least 30 days to bring in their physical form and that the physical could be from within the year. She added that the employees had the option of having their own physician perform the physical or have the physician here perform it. The surveyor then asked the DHR if the physicals of the 5 newly hired employees were performed 2 weeks prior or upon their hire date. The DHR confirmed that they were not. She then added that the Director of Nursing usually would "take care" of the "medical stuff." On 10/07/22 at 10:52 AM, during surveyor interview, the Licensed Nursing Home Administrator stated that his "practice" was for the physical to be performed upon hire. He added that he was not sure of what the facility's policy was. On 10/07/22 at 11:31 AM, during surveyor interview, the Regional Licensed Nursing Home Administrator stated that newly hired employees' physicals should be performed 2 weeks prior or upon hire. A review of the facility provided policy titled, "Medical Examinations (Physicals)" with a reviewed date of 5/2/22, included the following: Under Policy Statement Each potential employee, after receiving a conditional offer of employment, and each current	S1405	months for review and further recommendations. The first of which will take place in December 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 8 employee whose job position necessitates such must undergo physical examinations. Under Policy Interpretation and Implementation 2. Each potential employee who has received a conditional offer of employment will be required to undergo a physical examination and answer any inquiries related to his/her medical status. The cost of such examination will be borne by the facility.	S1405		
S2340	8:39-31.6(n) Mandatory Physical Environment (n) The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain a three-day minimum emergency food supply. This deficient practice would affect all residents and was evidenced by the following: On 10/05/22 at 9:57 AM, the surveyor requested from the Director of Dining Services (DDS) to provide a copy of the facility's three day emergency food supply menu. At this time, the DDS provided the surveyor of a copy of the menu, and they both proceeded to the emergency food supply storage for inspection. The surveyor and the DDS observed the following items listed on the menu were not in storage:	S2340	Upon identification of missing food items in the three-day emergency food supply, the menu was revised to reflect what was currently in stock. Director of dining services was educated of the importance of having the menu items on the emergency food supply menu available and the need to inventory all incoming food orders. a. Identification of Others All residents have the potential to be affected by the deficient practice Systematic changes A monthly audit, completed by the director of food services, will be	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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S2340	Continued From page 9 1. Canned chicken or mayonnaise for chicken salad. 2. Ravioli in sauce. 3. Canned tuna or mayonnaise for tuna salad. 4. Chili con carne. At the time of observation, the surveyor interviewed the DDS who confirmed the items were not in the emergency supply and the emergency food supply was separate from the day to day food supply. The DDS stated that she ordered everything on the emergency food supply menu in June of 2022, and she did not take inventory to ensure the facility had the items needed. On 10/05/22 at 10:30 AM, the surveyor informed the Regional Licensed Nursing Home Administrator (LNHA), who was currently overseeing the facility's LNHA and the facility, and the Regional Nurse about the missing items from the emergency food supply observed. On 10/12/22 at 12:40 PM, the Regional LNHA and Regional Nurse acknowledged these findings. NJAC 8:39- 31.6(n)	S2340	completed to assure that emergency food supply orders match with the listed items on the emergency food menu. QUALITY MONITORING Audit results will be reported to the Quality Assurance and Performance Improvement committee monthly x 6 months for review and further recommendations. The first of which will take place in December 2022.	

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
315455 Y1	A. Building B. Wing Y2	2/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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 F0657	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/21/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2022	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315455 Y1	A. Building B. Wing Y2	1/26/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0033	Correction	ID Prefix E0034	Correction	ID Prefix E0037	Correction
Reg. # 483.73(c)(4)-(6)	Completed	Reg. # 483.73(c)(7)	Completed	Reg. # 483.73(d)(1)	Completed
LSC	12/05/2022	LSC	12/05/2022	LSC	12/05/2022
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2022	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315455 Y1	A. Building B. Wing Y2	2/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0657	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/21/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
476002 Y1	A. Building B. Wing Y2	1/26/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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	Correction	ID Prefix S0830	Correction	ID Prefix S1405	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-9.3(b)	Completed	Reg. # 8:39-19.5(a)	Completed
LSC	12/05/2022	LSC	12/05/2022	LSC	12/05/2022
ID Prefix S2340	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-31.6(n)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/05/2022	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
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FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2022	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING **01** B. WING _____	**10/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE** **TRENTON, NJ 08638**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/06, 07/2022 and Avant Rehabilitation and Care Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Avant Rehabilitation and Care Center s a three story, Type I Fire Resistant building that was built in January 1998. The facility is divided into 7 smoke zones.	K 000		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations on 10/06/2022 in the presence of facility Management it was determined that the facility failed to ensure that 1 of 6 exit access stairwell doors tested were	K 311	1. Corrective Action: Fire rated exit access door next to room #334, it was immediately fixed on 10/7/22. Audit was completed of fire rated exit	12/5/22

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

Electronically Signed | 11/11/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING **01** B. WING _____	**10/12/2022**

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K 311	Continued From page 1 capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 10/06/2022 starting at 9:42 AM, a tour of the building in the presence of the U.S. FOIA (b)(6) [redacted] was performed. Along the tour the surveyor performed a closure test of the six (6) 1-1/2 hour fire rated exit access doors leading into the stairwells. At 10:20 AM, during a closure test of one (1) fire rated exit access door next to Resident room #334 when the door was opened to a 90 degree opening to the doors frame and allowed to self-close the door did not positive latch into their frame as required by code to maintain the fire rated construction. This test was repeated two additional times with the same results. The stairwell door would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The [redacted] confirmed the findings at the time of observations. The US FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	access doors to assure that they positively latched. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Monthly audits will be completed by the maintenance director and/or designee to assure that fire rated exit access doors positively latch. 4. How Will These Actions Be Measured: The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101	K 351		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING **01** B. WING _____	**10/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE** **TRENTON, NJ 08638**

(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 351	Continued From page 2 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: Based on observation and review of facility provided documentation on 10/06/2022 , it was determined that the facility failed to properly install 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 National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 10/06/2022 during the survey entrance at 09:13 AM, a request was made to the	K 351	1. Corrective Action: Escheon caps were installed on the sprinkler heads located on the third floor Secured Unit oxygen storage room, third floor clean utility room and third floor clean utility room on 10/7/22. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Audit was completed of sprinkler heads escheon caps to assure sprinkler heads proper placement of escheon caps. Monthly audits will be completed by the maintenance director and/or designee to assure that sprinkler heads have proper	

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	315455	A. BUILDING **01** B. WING _____	**10/12/2022**

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K 351	Continued From page 3 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 layout identified there were three (3) floors in the facility. Starting at 9:40 AM, in the presence of the facility U.S. FOI a tour of the facility was conducted. Along the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following locations: 1) At 9:52 AM, the surveyor observed inside the third floor Secured Unit oxygen storage room one fire sprinkler head. This fire sprinkler had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 2) At 10:00 AM, the surveyor observed inside the third floor Clean Utility room one sprinkler head had no evidence of an escheon cap leaving a 1/2 of an inch gap around the sprinkler head. 3) At 12:38 PM, the surveyor observed inside the third floor Clean Utility room one sprinkler head had no evidence of an escheon cap leaving a 1/2 of gap around the sprinkler head. With the opening's in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the room and not activate the fire sprinkler system. The U.S. FOIA confirmed the findings at the time of observations. The U.S. FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on	K 351	placement of escheon caps. 4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 351	Continued From page 4 10/07/2022 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 355 SS=D	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 and review of facility documentation on 10/06/2022 in the presence of facility management, it was determined that the facility failed to: 1) Perform and document on the tag attached to the fire extinguisher a monthly visual examination for 1 of 16 fire extinguishers, 2) Install portable fire extinguishers with-in the required height for 1 of 16 fire extinguishers 3) Maintain one (1) portable fire extinguishers in proper working condition, in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 7.3 Maintenance. - 7.3.1.1 All Fire Extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when	K 355	1. Corrective Action: On 10/7/22, the fire extinguisher located near the exit doors leading to the outside resident smoking area was mounted to the proper height and visual inspection completed and documented on the tag attached to the extinguisher. On 10/7/22 fire extinguisher was replaced next to the resident room #115. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Audit was completed of Fire extinguishers and their attached tags to ensure compliance. Monthly audits will be completed by the maintenance director and/or designee to assure that Fire extinguishers and their attached tags to ensure compliance.	12/5/22

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K 355	Continued From page 5 specifically indicated by an inspection or electronic notification. According to NFPA 10- 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. Reference #2 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour on 10/06/2022 in the presence of the facility Maintenance Director (MD) the surveyor observed and inspected sixteen (16) portable fire extinguishers in various locations with the following, 1) At 12:18 PM, the surveyor observed one "ABC- type" fire extinguisher near the exit doors leading to the outside Resident smoking area that appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the to the center of the pressure indicating needle of the extinguisher 5 feet 8 inches. The surveyor also observed that the fire extinguisher was last annually inspected June 2022 with no evidence of a monthly visual inspection being performed and documented on the tag attached to the extinguisher for July 2022,	K 355	4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 355	Continued From page 6 August 2022 and September 2022. 2) At 12:27 PM, One "ABC- type" fire extinguisher next to Resident room #115 pressure indicating needle was in the "RED" discharge zone on the gauge. The surveyor also observed on the tag attached to the extinguisher had a monthly visual examination documented for 10/01/2022. The US FOIA confirmed the findings at the time of observations. The US FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 374		12/5/22

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K 374	Continued From page 7 Based on observations and review of facility provided documentation on 10/06/2022, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 3 of 7 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 10/06/2022 during the survey entrance at 09:13 AM, a request was made to the 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 that there are two (2) sets of corridor double smoke doors on the 3rd. floor, are two (2) sets of corridor double smoke doors on the 2nd. floor and three (3) corridor smoke doors on the 1st. floor. Starting at 9:40 AM, in the presence of the facility U.S. FOI a tour of the facility was conducted. The surveyor performed closure tests of the seven (7) sets of smoke barrier doors in the corridors with the following results, 1) At 9:54 AM, one set of double smoke doors between the third floor Day room and Resident room #329, when both doors were release from	K 374	1. Corrective Action: On 10/7/22 the double smoke doors located between the third-floor day room and resident room #329, resident room #207, Resident room #108 were fixed to assure that the smoke barrier doors close leaving only the minimum clearance necessary for proper operation. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put Into Place: Audit was completed of smoke barrier doors to assure all close to resist the transfer of smoke. Monthly audits will be completed by the maintenance director and/or designee to assure that smoke barrier doors close to resist the transfer of smoke. 4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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K 374	Continued From page 8 their magnetic hold open devices and allowed to self close into their frame, this revealed one door did not close into its frame, it was not resistant to the transfer of smoke. The surveyor observed an approximately 34 inch opening between the two doors. This test was repeated two additional times with the same results. 2) At 11:07 AM, one set of double smoke doors next to Resident room when #207 when both doors were release from their magnetic hold open devices and allowed to self close into their frame, this revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 1/2 of an inch between the meeting edges. The surveyor measure and recorded a 1/2 of an inch gap between the meeting edges. This test was repeated two additional times with the same results. 3) At 12:25 PM, one set of double smoke doors next to Resident room when #108 when both doors were release from their magnetic hold open devices and allowed to self close into their frame, this revealed it was not resistant to the transfer of smoke. The surveyor observed a gap greater than 3/8 of an inch between the meeting edges. The surveyor measure and recorded a 3/8 of an inch gap between the meeting edges near the bottom of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The [redacted] confirmed the findings at the time of	K 374		

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K 374	Continued From page 9 observations. The U.S. FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/06, 07/2021, in the presence of facility management it was determined that the facility failed to maintain elevator emergency communications for 2 of 3 elevators tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the	K 531	1. Corrective Action: Upon identification that elevator #1 and #2 emergency telephones were not working properly, the elevator company was immediately called and repaired both telephones. 2. Identification of other residents or	12/5/22

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K 531	Continued From page 10 following: During the survey entrance at 9:13 AM, a request was made to the U.S. FOIA (b)(6)), how many elevators are in the building. The U.S. FOI told the surveyor that there are three (3) elevators. On 10/06/2022 starting at 9:40 AM, during a tour of the building in the presence of the facility U.S. FOIA (b)(6) at 9:42 AM a test of elevator #1 emergency telephone was performed. When the surveyor tested the emergency phone it did not function properly. On 10/07/2022 during a tour of the building with the U.S. FOIA (b)(6)) at 11:57 AM a test of elevator #1 emergency telephone was performed. When the surveyor tested the phone it did not function properly. At 12:12 PM a test of elevator #2 emergency telephone was performed. When the surveyor tested the phone it did not function properly. An interview was conducted during the two observations with the US FOIA (b). He acknowledged and confirmed that the emergency communication telephones in elevators #1 and #2 did not function. The U.S. FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Monthly audits will be completed by the maintenance director and/or designee to assure that Emergency telephones in elevators #1, #2 and #3 work properly. 4. How Will These Actions Be Measured: Results of monthly audit will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		12/5/22

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K 918	Continued From page 11 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/06/2022 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for	K 918	K918 SS=E Electrical Systems □ Essential Electric Systems 1. Corrective Action:	

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K 918	Continued From page 12 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: On 10/06/2022 during the survey entrance at 09:13 AM, a request was made to the U.S. FOIA (b)(6)) if the facility had an emergency generator. The U.S. FOI said, yes we have one. During the building tour with the facility U.S. FOIA at 12:38 PM an inspection of the emergency generator was performed. At this time the surveyor asked the U.S. FOI, where is the remote emergency shut off for the generator. The U.S. FOI told the surveyor, There is no remote emergency shut off. The surveyor observed that the emergency shut off was located on the generator's control panel. The U.S. FOIA confirmed the findings at the time of observations. The U.S. FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/07/2022 at approximately 12:50 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Upon identification that the Emergency Generator System was not equipped with a remote manual stop station, 2 quotes were obtained to purchase and installed on 11/10/22. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: The deficient practice has the potential to affect all residents. 3. Measures Put into Place: Education will be provided to management/supervisors on the generator emergency stop procedure upon installation of the stop button on 11/10/22. Education completed on 11/11/22. 4. How Will These Actions Be Measured: Monthly audit in conjunction with monthly generator checks will be completed to assure integrity of Emergency Generator System will be completed by the Maintenance Director and/or designee. The results of these reviews will be submitted to the Safety and Quality Assurance and Process Improvement Committee monthly Meeting for 6 months. The first of which will take place in December 2022. Based on the results of these audits, a decision will be made regarding the need for continued	

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K 918	Continued From page 13	K 918	submission and reporting.	

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
315455 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/26/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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	12/05/2022	LSC K0351	12/05/2022	LSC K0355	12/05/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	12/05/2022	LSC K0531	12/05/2022	LSC K0918	12/05/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/12/2022	☐ YES ☐ NO