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	315463	A. BUILDING _____ B. WING _____	C 05/08/2023

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MEADOWBROOK RESPIRATORY AND NURSING CENTER	38 FRENEAU AVENUE MATAWAN, NJ 07747

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F 000	INITIAL COMMENTS NJ Complaint #: 162479 Survey Date: 5/8/23 Census:114 Sample: 23 + 3 +1 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 610	1. A conclusion of the investigation was	6/9/23

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

Electronically Signed | 05/19/2023

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

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F 610	Continued From page 1 pertinent facility documents, it was determined that the facility failed to thoroughly investigate an injury of unknown origin to rule out abuse and neglect for a resident identified on [redacted]. This deficient practice was identified for 1 of 6 residents reviewed for accidents (Resident #14), and was evidenced by the following: On 4/26/23 at 11:24 AM, the surveyor observed Resident #14 in their room. The resident was lying in bed with the head of the bed elevated, with the bed in the lowest position and a [redacted] on the floor next to the bed. On 4/26/23 11:41 AM, the surveyor interviewed Resident #14 who stated he/she [redacted] and could not [redacted] The surveyor reviewed the medical record for Resident #14. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in [redacted], with diagnoses that included [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated a [redacted] A review of the individualized comprehensive care	F 610	completed; the interdiciplinary team concluded that [redacted] The resident remains in the facility and has not had any additional incidents. 2. All residents have the potential to be affected. 3. Incident reports to be reviewed at clinical meeting the next business day. Interdisciplinary team will write a conclusion note for each summarizing investigation and findidngs, including how abuse and neglect are ruled out. Nursing staff educated on thorough and complete incident report investigations. 4. Director of Nursing or designee will review two incident reports weekly after they are completed for 3 months to ensure all statements and supporting documentation are present, including interdisciplinary note showing conclusion and findings of the investigation. Results will be reported to the Administrator and Quality Assurance Performance Improvement committee.	

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plan dated [NJ Exec Order 26.4b], included a focused area that the resident was at risk for [NJ Exec Order 26.4b1] [redacted]. Interventions included to position bed in lowest position at bedtime or when in bed; [NJ Exe] [redacted] and reorient as needed.

A review of the Progress Notes included a Nurses Note dated [NJ Exec Order 2] 9:35 PM, that the Licensed Practical Nurse (LPN) wrote the resident was observed on the floor in [NJ Exec Order 26.4b1] [redacted] that was not there previously. Informed my supervisor; called the resident's representative, and contacted the physician. [NJ Exec Order 26.4b1] [redacted] started until resident was sent to the hospital for a [NJ Exec Order 26.4b1] [redacted]

On 5/1/23 at 1:19 PM, the survey team received incident/accident reports from the Director of Nursing (DON) who confirmed the reports provided were original, complete, and contained all documents.

On 5/3/23 at 12:02 PM, the surveyor reviewed an "Incident Report" and "Fall Investigation" for Resident #14, both dated [NJ Exec Order 2] which revealed the following:

The "Incident Report" was completed by the LPN on 3/13/23 at 9:46 PM, included the Certified Nursing Aide (CNA) alerted the LPN to go to the resident's room where she found the resident on the floor [NJ Exec Order 26.4b1] [redacted]

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NJ Exec Order 26.4b1 . The report also included two written statements; one from the CNA and one from the Nursing Supervisor/Registered Nurse (NS/RN). The CNA's statement indicated she had entered Resident #14's room to provide care and found the resident NJ Exec Order 26.4b1 and proceeded to notify the nurse. The statement provided by the NS/RN indicated she had last seen Resident #14 during her rounds, and the resident was NJ Exec Order 26.4b Then around 10:24 PM, the NS/RN stated the resident was noted NJ Exec Order 26.4b1 and upon assessment by herself, identified a NJ Exec Order 26.4b1 The resident's physician was notified, and the physician ordered the resident be sent to the hospital for evaluation. The report did not include at what time and where the resident was last seen, toileted, or possible causes to why the resident was on the floor.

A review of the resident's "Fall Investigation" completed by the DON on NJ Exec Order 2, included that the resident was NJ Exec Order 26.4b1 The form also indicated the incident had occurred in the resident's room and was an unwitnessed event with the possible cause of the event that the resident NJ Exec Order 26.4b1. The report indicated that the resident was unable to provide an explanation; the resident was NJ Exec Order 26.4b and stated, NJ Exec Order 26.4b1 ." There was no evidence of what time and where the resident was last seen; was the resident in bed prior to the

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incident; when the resident was last toileted; if anyone was observed going into the resident's room; how the resident NJ Exec Order 26.4b1 or NJ Exec Order 26.4 [redacted]; if the resident's roommate was ambulatory or interviewed; or a summary or conclusion for what occurred to rule out abuse or neglect.

On 5/03/23 at 1:02 PM, the surveyor asked the DON if there were any additional information, or a conclusion related to the investigation for the NJ Exec Order 26.4b1 The DON stated she would check and get back to the surveyor.

On 5/3/23 at 2:04 PM, the DON provided a summary of the investigation for Resident #14's NJ Exec Order 26.4b1 The DON stated she had taken so long to provide the investigation summary because she had to "type the conclusion, since the surveyor had asked for it." The surveyor at this time asked for clarification if the conclusion was already completed at the time of the incident or the DON just typed one as previously stated. The DON confirmed she just typed a conclusion upon surveyor inquiry because she thought the surveyor wanted a summary and conclusion, and it was not part of the initial report prepared on NJ Exec Order 26 The DON stated after an unwitnessed fall, a clinical meeting was held where they discussed the root cause as to why the person fell and then came up with new interventions to put in place to prevent further accidents. As a result of the NJ Exec Order 26.4b1 [redacted] the resident sustained NJ Exec Order 26.4b1 [redacted] and the resident was NJ Exec Order 26.4b1 at the time and was attempting to get out of bed to see their parents. The DON stated even though the resident was NJ Exec Order 26.4b [redacted], there was truthfulness in what they said. The DON stated she did not

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believe this was a case of abuse or neglect, that she only typed up a summary report if she had to report the incident to the New Jersey Department of Health (NJDOH). The DON acknowledged the entire investigation should be kept complete, including all interviews, conclusions, and documentation in one report.

On 5/4/23 at 10:18 AM, the surveyor interviewed the CNA who stated on [redacted], she was walking by Resident #14's room to care for another resident when she saw Resident #14 on the [redacted]. The CNA stated she did not [redacted] and believed the resident had slipped out of bed because he/she [redacted] and sometimes tried to climb out of bed.

On 5/4/23 at 10:41 AM, the surveyor attempted to interview the LPN via telephone who did not answer. The surveyor left a message to return call.

On 5/4/23 at 10:42 AM, the surveyor interviewed the NS/RN who was the Nursing Supervisor on [redacted] at the time of Resident #14's fall. The NS/RN stated she was familiar with Resident #14, and that the resident was [redacted] and always tried to get out of bed. The NS/RN stated she was alerted by the LPN that the resident was [redacted] so she went to Resident #14's room and found [redacted]. The NS/RN stated she did an initial assessment, identified a [redacted], and the LPN called the resident's physician. The NS/RN was unsure if the resident had been sent to the hospital, that her shift ended at 11:00 PM. The NS/RN stated she filled out an individual statement form and believed the CNA and the

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LPN had as well. The DON was responsible for the final investigation.

On 5/4/23 at 12:07 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON who stated there was a misunderstanding that there was additional information regarding the investigation for Resident #14's NJ Exec Order 26.4b1 The LNHA stated the interdisciplinary care team met after a fall and discussed the incident, investigated the root cause, and developed interventions to prevent further accidents. The LNHA confirmed this was not included in the incident report or the resident's medical record; that it was a discussion with the team. The LNHA confirmed the purpose of an investigation was to find the cause of the incident to prevent it from happening again, and to rule out abuse and neglect. The LNHA confirmed an incident report should be complete by showing what happened and summarized to show how the facility ruled out abuse and neglect. The LNHA confirmed the incident report could have included more information including a summary of events to paint the whole picture.

A review of the facility's "Accidents and Incidents-Investigating and Reporting" policy dated revised July 2017, included...the following data, as applicable, shall be on the Report of Incident/Accident form:...c. The circumstance surrounding the accident or incident...incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities."

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F 610	Continued From page 7 A review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy dated revised September 2020, included all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management.... NJAC 8:39-4.1(a)5	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to communicate a recommendation for a decrease in the administration frequency for an NJ Exec Order 26.4b1) used on an as needed basis to the physician in accordance with professional standards of practice. This deficient practice was identified for 1 of 23 residents reviewed for standards of practice (Resident #28) and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	1. The order was changed on NJ Exec Order 26 to reflect the correct frequency. 2. All residents receiving controlled drug medications have the potential to be affected. 3. Nurses were educated on orders from consults, to verify with the attending MD and document if the attending MD approves the recommendation or not with rationale. Nurses were educated on carrying out orders promptly. 4. Director of Nursing or designee will audit 4 residents on controlled medications weekly for one month and	6/9/23

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responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

On 4/26/23 at 10:10 AM, the surveyor observed Resident #28 in the Second-Floor day room in a wheelchair. The resident was NJ Exec Order 26.4b1 [redacted] A staff member from the maintenance department made a nurse aware of the resident's behavior and the nurse then proceeded to take the resident to their room.

On 4/28/23 at 10:08 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated Resident #28 was NJ Exec Order 26.4b1 [redacted] The resident was NJ Exec Order 26.4b1 [redacted] and needed assistance to get around in the wheelchair. The UM/LPN stated the resident had recently started taking medication as needed for NJ Exec Order 26.4b1 [redacted] because he/she had been NJ Exec Order 26.4b1 [redacted] and was difficult to NJ Exec Order 26.4b1 [redacted], but the new medication had helped.

The surveyor reviewed the medical record for Resident #28.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 [redacted], with diagnoses which included NJ Exec Order 26.4b1 [redacted]

then as needed, to ensure any new orders and/or changes to existing orders have been carried out and have been properly documented. Findings will be reported to the Administrator and Quality Assurance Performance Improvement committee.

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NJ Exec Order 26.4b1

A review of the most recent significant change Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26 reflected a brief interview for mental status (BIMS) score of NJ E out of 15, which indicated a NJ Exec Order 26.4b1.

A review of the individualized comprehensive care plan reflected a focus area initiated NJ Exec Orde, for use of NJ Exec Order 26.4b1 related to NJ Exec Order 2 . Interventions included to give NJ Exec Order 26.4b1 as ordered by the physician; monitoring and documenting side effects and effectiveness; and NJ Exec Order 26.4b1 consultations as needed.

A review of the most recent Psychiatric Follow-Up Note included recommendations dated NJ Exec Order 26 to discontinue previous NJ Exec Order 26.4b order; start NJ Exec Order 26.4b1 by mouth every twelve hours as needed for thirty days with a stop date of NJ Exec Order 26.

A review of the Order Summary Report included a physician's order (PO) for the recommended change for NJ Exec Order 26.4b dated NJ Exec Order 2. This was fourteen days after the recommendation from the Psychiatric Nurse Practitioner (Psych NP).

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected the administration of this medication at this frequency was not started until NJ Exec Order 2.

On 5/2/23 at 12:23 PM, the surveyor re-interviewed the UM/LPN who stated the

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process for recommendations made by a specialist were the nurses or the UM/LPN called the resident's primary physician with the recommendation and if the primary physician agreed with the recommendation, then the nurse entered the new order into the electronic medical record.

At this time, the UM/LPN and the surveyor reviewed the most recent Psychiatric Follow-up Note dated [NJ Exec Order 26]. The UM/LPN reviewed the recommendation made by the Psych NP dated [NJ Exec Order 26], to decrease the as needed frequency of the [NJ Exec Order 26.4b] from every eight hours to every twelve hours and she acknowledged that it had not been ordered until [NJ Exec Order 26]. The UM/LPN stated the Physician did not want to decrease the frequency yet; that she did not agree with the recommendation and did not want to decrease the frequency. The UM/LPN further stated she had not documented that the Physician disagreed with the Psych NP's recommendation. The UM/LPN continued that on [NJ Exec Order 26], she spoke with the Psych NP again regarding the recommendation to decrease the frequency of the [NJ Exec Order 26.4b], as the resident had a [NJ Exec Order 26.4b1] The Psych NP agreed, so the UM/LPN again spoke with the Physician who then agreed to the recommendation. When the surveyor asked if there was documentation regarding this conversation on [NJ Exec Order 26], the UM/LPN stated there was not.

On 5/4/23 at 12:55 PM, the surveyor interviewed via telephone the Psych NP who stated when she made a recommendation for a resident, the nurse reached out to the primary physician and if they agreed, the nurse entered the order. The Psych NP stated the primary physicians usually agreed

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with her recommendations. The Psych NP stated that she decreased the frequency of Resident #28's as needed [NJ Exec Order 26.4] from every eight hours to every twelve hours and increased the duration to thirty days because the nurses' documentation reflected the resident had fewer behaviors and had only received the [NJ Exec Order 26.4b] typically once or twice a day according to the MAR and therefore warranted a decrease. The Psych NP acknowledged the last time she had seen Resident #28 was on [NJ Exec Order 26], and on [NJ Exec Order 26], the UM/LPN approached her for an updated [NJ Exec Order 26.4b] prescription for every twelve hours as needed. The Psych NP stated the UM/LPN did not specify why there was a delay for the new order; she was not aware that the Physician had disagreed with her recommendation from [NJ Exec Order 26], and had assumed it had been an oversight on the UM/LPN's part.

On 5/4/23 at 1:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated psychiatry came to the facility on Fridays and would make recommendations. The nurse would then contact the primary physician for approval, and once the primary physician approved the recommendation, then the nurse entered the new order into the computer. The DON continued if the primary physician denied the recommendation, it should be a documented in the Progress Notes with a rationale as to why they disagreed with the recommendation. The DON acknowledged there was no documentation that the Physician disagreed with the Psych NP's recommendation for [NJ Exec Order 26.4b], and she could not speak to why the order to decrease the frequency of the [NJ Exec Order 26.4] had been delayed fourteen days.

On 5/4/23 at 1:38 PM, the surveyor interviewed

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F 658	Continued From page 12 via telephone the Physician who stated when the Psych NP made a recommendation, she typically followed their recommendations. The Physician stated Resident #28 was seen by psychiatry for [NJ Exec Order 26.4b], and she could not recall being contacted on [NJ Exec Order 26.4b], regarding a decrease in the frequency of the [NJ Exec Order 26.4b], and she did not disapprove of any recommendations made by the Psych NP so there would have been no reason for a delay. The Physician stated the recommendation may have been an oversight by the nurse. On 5/8/23 at 9:38 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Director of Clinical, and survey team acknowledged that recommendations should be communicated at the time with the physician, and if the physician chose to disagree with the recommendation, the nurse documented at the time that they spoke to the physician who disagreed with the recommendation. The LNHA acknowledged there was no documentation that the UM/LPN spoke to the Physician on [NJ Exec Order 26.4b], who disagreed with the recommendation, or that the UM/LPN spoke to the Physician on [NJ Exec Order 26.4b]. A review of the facility's "Medication and Treatment Orders" policy dated July 2016, did not include the process of how to proceed with a recommendation or order made by a specialist requiring primary physician approval. NJAC 8:39-27.1(a)	F 658		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		6/9/23

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F 695	Continued From page 13 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to maintain proper infection control practices during NJ Exec Order 26.4b1 care. This deficient practice was identified for 2 of 2 residents observed for NJ Exec Order 26.4b1 care (Resident #16 and #70), and was evidenced by the following: 1. On 4/26/23 at 10:21 AM, the surveyor observed Resident #16 in their room in bed. The resident had a NJ Exec Order 26.4b1 which was attached to a NJ Exec Order 26.4b1 The surveyor reviewed the medical record for Resident #16. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, and had diagnoses which included NJ Exec Order 26.4b1 .	F 695	1. Resident #16 and #70 did not have any negative outcome and remain in the facility. 2. all residents receiving tracheostomy care have the potential to be affected. 3. Respiratory Therapists and Nurses were educated on proper infection control during tracheostomy care and the policy on tracheostomy care was updated, to include changing gloves between removing and replacing the disposable inner canula. 4. The Infection Preventionist will observe two trach care procedures weekly for one month and then as needed to ensure proper infection control is taking place. Findings will be reported to the Administrator and Quality Assurance Performance Improvement Committee.	

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A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2 reflected that the resident had a brief interview for mental status (BIMS) score NJ E out of 15, which indicated a NJ Exec Order 26.4b1. A further review of "Section G" reflected that the resident was totally dependent for all activities of daily living (ADLs). A review of "Section O" reflected the resident received the following NJ Exec Order 26.4b1

A review of the Order Summary Report dated as of NJ Exec Orde, included the following physician's orders (PO):

A PO dated NJ Exec Order 2, NJ Exec Order 26.4b1; to change NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every day shift.

A PO dated NJ Exec Order 2, NJ Exec Order 26.4b1: change NJ Exec Order 26.4b1, NJ Exec O, NJ Exec Order 26.4b1 and/or NJ Exec as needed.

On 4/28/23 at 9:10 AM, the surveyor observed the Respiratory Therapist Supervisor (RTS) provide NJ Exec Order 26.4b1 for Resident #16 and observed the following:

The RTS gathered the NJ Exec Ord supplies from the NJ Exec Order 26.4b1 cart which included a NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, alcohol pads, and an NJ Exec Or, and placed them on the shelf of the television stand that was not sanitized.

The RTS used alcohol-based hand rub (ABHR)

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and donned (put on) a pair of gloves and proceeded to open the NJ Exec Order 26 and the NJ Exec Order 2 and emptied the NJ Exec into the NJ Exec Order 2 that was inside the NJ E. The RTS then NJ Exec Order 26.4b1 the resident's NJ Exec Or, which was a NJ Exec Order 26.4b1, and without changing his gloves and sanitizing the overbed table, he moved the NJ Exec Order 26 onto the overbed table. The RTS then proceeded to remove the NJ Exec Orde that was around the resident's NJ Exec Order 26.4b. The RTS used the cleaning brush from the NJ Exec Order 26 to clean around the NJ Exec Order 26.4b1, and then used the cotton tipped applicator to clean the outer part of the NJ Exec Or.

The RTS without changing his gloves or performing hand hygiene, opened the NJ Exec Or package and replaced the NJ Exec Order 26.4b1 of the NJ Exec Or and reconnected the NJ Exec Order 26.4b to the NJ Exec Or. The RTS doffed (removed) the gloves and without performing hand hygiene, donned a new pair of gloves and replaced the NJ Exec Order 26.4b1 dressing around the NJ Exec Orde.

The RTS with the same gloved hands opened a NJ Exec Order 26.4b1 and removed a marker from his pocket, dated the equipment and then replaced the equipment on the NJ Exec Order 26.4b1 He doffed the gloves and used ABHR.

On 4/28/23 at 9:45 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that during NJ Exec Order 26.4b1 and changing of the NJ Exec Order 26.4b1 good handwashing would be needed.

On 4/28/23 at 11:35 AM, the surveyor interviewed the RTS who stated he did not have to change his gloves during NJ Exec Order 26.4b1 because his gloves were

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not visibly soiled, so he therefore did not have to change his gloves after removing the used [NJ Exec Orde] and cleaning the [NJ Exec Orde] prior replacing the [NJ Exec Or] [redacted] and [NJ Exec Orde] because his gloves were not "visibly" dirty. At this time, the RTS provided the surveyor with the respiratory therapy policy which indicated gloves were only changed when visibly soiled.

On 4/28/23 at 12:56 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated she was the staff educator as well. The ADON stated that [NJ Exec Order 26.4b1] was a sterile procedure, and the [NJ Exec Order 26.4b] came sterile for that reason so infection control practices like changing gloves, hand hygiene, and cleaning bedside surfaces that you performed care on was important.

On 5/1/23 at 2:16 PM, the surveyor via telephone interviewed the Ventilator Unit/Medical Director (VU/MD), who stated general [NJ Exec Order 26.4b1] was done every twelve hours and dressing changes could be done on an as needed bases. The VU/MD further stated the [NJ Exec Order 26.4b1] replacement was a sterile procedure, and the [NJ Exec Order 26.4b1] would be a clean procedure. The VU/MD stated he would expect the staff to use standard personal protective equipment (PPE) protocol throughout the dressing change which included removing gloves and performing hand hygiene after touching something dirty or cleaning prior to putting on clean [NJ Exec Orde] or changing the [NJ Exec Order 26.4b1] because gloves could be contaminated without being visibly soiled and there was no way to determine.

On 5/3/23 at 2:52 PM, the surveyor informed the

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Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), ADON, and the Regional Director of Clinical (RDC) the NJ Exec Order 26.4b1 observation for Resident #16.

On 5/8/23 at 9:38 AM, the LNHA in the presence of the DON, RDC, and survey team stated the facility updated the policy for NJ Exec Order 26.4b1 to include changing gloves after changing the NJ Exec Order 26.4b1

2. On 4/26/23 at 11:48 AM, the surveyor observed Resident #70 in their room in bed with the head of the bed elevated. The resident had a NJ Exec Or which was attached to a NJ Exec Order 26.4b1.

The surveyor reviewed the medical record for Resident #70.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, and had diagnoses which included NJ Exec Order 26.4b1

A review of the most recent quarterly MDS dated NJ Exec Order 2, reflected that the resident had NJ Exec Order 26.4b with a NJ Exec Order 26.4. A further review of "Section G" reflected that the resident was totally dependent for all activities of daily living (ADLs). A further review of "Section O" reflected the resident received the following NJ Exec Order 26.4b1

A review of the Order Summary Report reflected dated as of NJ Exec Orde, included the following physician's orders (PO):

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A PO dated [NJ Exec Order 26.4b], NJ Exec Order 26.4b1 [redacted] are change daily.

A PO dated [NJ Exec Order 26.4b] NJ Exec Order 26.4b1 [redacted]

A review of the individualized comprehensive care plan dated [NJ Exec Order 26.4b], included a focus that the resident was NJ Exec Order 26.4b1. The goal of the care plan reflected the resident would be on the most appropriate [NJ Exec Order 26.4b] and setting to maintain NJ Exec Order 26.4b1. The interventions included to hand wash for thirty seconds before and after resident contact.

On 4/28/23 at 9:50 AM, the surveyor observed the Respiratory Therapist (RT) provide [NJ Exec Order 26.4b1] for Resident #70 and observed the following:

The RT gathered the [NJ Exec Order 26.4] used alcohol-based hand rub (ABHR) and donned gloves. The RT then opened the kit and an [NJ Exec Ord] [redacted] and placed them both on the overbed table that was not sanitized.

The RT placed the sterile waterproof drape (barrier) over the resident's chest and removed the sterile gloves from the [NJ Exec Order 26] and donned the sterile gloves over her already gloved hands and removed the [NJ Exec Order] from around the [NJ Exec Or] and placed the [NJ Exec Order] on the corner of the sterile drape.

The RT then removed the outer glove from her double gloved right hand and removed from her pocket with her right gloved hand, a vial of [NJ Exec Order 2] [redacted] and then donned the previously removed glove back on her right hand. She then

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proceeded to squeeze the NJ Exec Order 26.4b1 into the NJ Exec Order 26.4b1 in the NJ Exec Order 26; she removed the NJ Exec Order 26.4b1 from the NJ Exec Orde and without changing gloves of performing hand hygiene, replaced the NJ Exec Orde with a new NJ Exec Or . She then squeezed NJ Exec Order 26.4b1 onto the NJ Exec Order 26.4b1 from the NJ Exec Order 26 and wiped each side of the NJ Exec Orde to clean.

The RT with the same gloved hands removed a NJ from the tray under the resident's NJ Exec Order 26.4b, opened the package, and placed the NJ Exec Orde around the cleaned NJ Exec Order of the NJ Exec Or. The RT with the same gloved hands disconnected the NJ Exec Order 2, turned the knob on the wall to the NJ Exec Order 2, and opened and replaced the NJ Exec Order 26.4b1. The RT without changing gloves or performing hand hygiene, removed the stethoscope from around her neck, listened to the resident's lung sounds and without sanitizing the stethoscope, replaced the stethoscope back around her neck. The RT gathered the used supplies, placed them into the garbage, removed her gloves, and exited the room and performed hand hygiene using ABHR in the hallway.

On 4/28/23 at 9:45 AM, the surveyor interviewed the IP/RN who stated that during NJ Exec Order 26.4b1 and changing of the NJ Exec Order 26.4b1 good handwashing would be needed.

On 4/28/23 at 10:10 AM, the surveyor interviewed the RT who stated she was nervous and that she would usually not remove a glove and then put it back on and that she should have used disinfectant wipes to clean her stethoscope. The RT further stated when she replaced the NJ Exec Or that should have been a sterile

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procedure meaning she should have doffed her gloves, performed hand hygiene, and then donned a pair of sterile gloves.

On 4/28/23 at 12:56 PM, the surveyor interviewed the ADON who stated she was the staff educator as well. The ADON stated that NJ Exec Order 26.4b1 was a sterile procedure, and the NJ Exec Order 26.4b1 came sterile for that reason so infection control practices like changing gloves, hand hygiene, and cleaning bedside surfaces that you performed care on was important.

On 5/1/23 at 2:16 PM, the surveyor via telephone interviewed the VU/MD who stated general NJ Exec Order 26.4b1 was done every twelve hours and NJ Exec Order 26.4b1 could be done on an as needed bases. The VU/MD further stated the NJ Exec Order 26.4b1 replacement was a sterile procedure, and the NJ Exec Order 26.4b1 would be a clean procedure. The VU/MD stated he expected the staff to use standard PPE protocol throughout the NJ Exec Order 26.4b1 which included removing gloves and performing hand hygiene after touching something dirty or cleaning prior to putting on clean NJ Exec Order 26.4b1 or changing the NJ Exec Order 26.4b1 because gloves could be contaminated without being visibly soiled and there was no way to determine.

On 5/3/23 at 2:52 PM, the surveyor informed the LNHA, DON, ADON, and RDC the NJ Exec Order 26.4b1 observation for Resident #70.

On 5/8/23 at 9:38 AM, the LNHA in the presence of the DON, RDC, and survey team stated the facility updated the policy for NJ Exec Order 26.4b1 to include changing gloves after changing the NJ Exec Order 26.4b1.

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F 695	Continued From page 21 A review of the facility's "Tracheostomy Care" policy dated revised 9/28/22, included...perform hand hygiene per facility; put exam gloves on both hands; mask and eye wear should be worn if there is a likelihood of splashes and splattering; suction tracheostomy per facility policy; remove old dressing; pull soiled glove down over the hand, and soiled dressing and roll glove over dressing; discard both in appropriate receptacle. Perform hand hygiene... A review of the facility's "Hand Hygiene" policy dated revised 3/2020, included...facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors ...facility staff, visitors, and volunteers must perform hand hygiene procedures in the following circumstances: wash hands with soap and water ...in between glove changes. Alcohol-based hand hygiene products can and should be used to decontaminate hands...before putting on sterile gloves for the purpose of performing procedures for which aseptic technique is required. After removing personal protective equipment...the use of gloves does not replace hand hygiene procedures... NJAC 8:39-25.2(b), (c)4	F 695		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		6/9/23

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F 758	Continued From page 22 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 23 the appropriateness of that medication. 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 ensure: a.) non-pharmalogical interventions were attempted prior to the administration of an NJ Exec Order 26.4b1 ; and b.) specific target behaviors were monitored prior to the administration of an NJ Exec Order 26.4b1 for a resident who received an NJ Exec Order 26.4b1 since NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #47), and was evidenced by the following: On 4/26/23 at 11:47 AM, the surveyor observed Resident #47 sitting in a wheelchair in their room eating lunch. Resident #47 stated they had a NJ Exec Order 26.4b1 twice a week. The surveyor reviewed the medical record for Resident #47. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26. reflected the resident had a brief interview for mental status (BIMS) score of NJ E out of 15, which indicated an NJ Exec Order 26.4b1. A further review of	F 758	1. Both residents remain in the facility and have no negative outcomes. 2. All residents receiving psychotropic medications have the potential to be affected. 3. Nurses were educated by the assistant director of nursing and the pharmacy consultant on documentation for prn psychotropic medications- behaviors exhibited, what the resident verbalizes, non drug interventions attempted. Education included documentation on the behavior monitoring forms and correct filing and storage of the behavior monitoring forms. 4. The Director of Nursing or designee will audit four residents weekly for one month who are receiving prn psychotropic medications to ensure proper documentation of indication for use, as well as correct documentation on the behavior monitoring forms, and accessiblity of the behavior monitoring forms. Findings will be reported to the Administrator and the Quality Assurance Performance Improvement committee.	

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the MDS indicated the resident had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on four out of the last seven days during the seven day look-back period.

A review of the individualized comprehensive care plan included a focus area initiated NJ Exec Order 26 and last revised on NJ Exec Order 26 that the resident used NJ Exec Order 26.4b1 with regards to a diagnosis of NJ Exec Order 26.4b1 as manifested as getting NJ Exec Order 26.4b1 about NJ Exec Order 26.4b1 , on NJ Exec Order . Interventions included to administer medication dose as ordered; encourage frequent family visits for emotional support; encourage resident to verbalize his/her feelings/emotions; possible gradual dose reduction as needed; NJ Exec Order 26.4b1 consultation as needed; monitor adverse effects of medications; monitor and document target behaviors; give NJ Exec Order 26.4b1 as ordered; monitor and document for side effects and effectiveness; and redirect resident NJ Exec Orde

A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) included the following physician's order (PO):

A PO dated NJ Exec Order 26 and discontinued NJ Exec Order for NJ Exec Order 26.4b1 give one tablet by mouth every eight hours as needed (PRN) for NJ Exec Order 2 for fourteen days.

A PO dated NJ Exec Orde and discontinued on NJ Exec Order 26, for NJ Exec Order 26.4b1; give one tablet every twelve hours PRN for NJ Exec Order 26 for thirty days.

A PO dated NJ Exec Order 26 and discontinued NJ Exec Order 26, for

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NJ Exec Order 26.4b1; give one tablet every eight hours PRN for NJ Exec Order 26.

A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected that the resident received NJ Exec Order 26 on NJ Exec at 10:23 AM and 8:21 PM; NJ Exe at 8:17 PM; NJ Exe at 10:52 AM; NJ Exec at 9:54 AM; NJ Exe at 4:07 AM; NJ Exe at 9:59 AM; NJ Exec O at 10:51 AM; NJ Exec O at 9:27 AM; NJ Exec O at 8:01 PM; NJ Exec O at 8:57 AM; NJ Exec O at 11:27 PM; NJ Exec O at 10:28 AM and 9:11 PM; NJ Exec O at 10:36 AM; and NJ Exec O at 9:15 AM. A further review revealed the resident received NJ Exec Order 26.4b on NJ Exec O at 9:17 AM and 10:29 PM; NJ Exec O at 9:17 AM and 8:18 PM NJ Exec O at 10:16 AM and 8:42 PM; and NJ Exec O at 9:37 AM.

A review of the corresponding Progress Notes revealed electronic MAR [eMAR] - Administration Notes dated NJ Exec Orde at 2:22 PM; NJ Exec Orde at 11:17 PM; NJ Exec Orde at 12:30 AM; NJ Exec Orde at 11:35 AM; NJ Exec Orde at 11:13 AM; NJ Exec Order 26 at 12:36 AM; NJ Exec Order 26 at 10:12 AM; NJ Exec Order 26 at 8:25 AM; NJ Exec Order 26 at 12:33 PM; NJ Exec Order 26 at 3:31 PM; NJ Exec Order 26 at 4:01 PM; NJ Exec Order 26 at 4:22 AM; NJ Exec Order 26 at 12:47 PM; NJ Exec Order 26 at 9:45 AM; NJ Exec Order 26 at 9:31 AM; NJ Exec Order 26 at 12:17 AM; NJ Exec Order 26 at 8:42 PM; NJ Exec Order 26 at 1:11 PM; NJ Exec Order 26 at 9:36 PM; and NJ Exec Order 26 at 9:43 PM, that an as needed [prn] medication was administered and effective. The note did not include what the resident was exhibiting or verbalizing that warranted the use of the NJ Exec Order 26.4b1 or documented evidence of non-pharmalogical interventions attempted prior to administering the NJ Exec Order 26.4b1.

A further review of the Progress Notes revealed eMAR - Administration Notes dated NJ Exec Orde at 3:00 PM and NJ Exec Orde at 4:48 AM, that NJ Exec Order 26.4b1

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tablet to administer one tablet every twelve hours was effective. The note did not include the NJ Exec Order 26.4b1 [redacted]. Further, there was no documentation of non-pharmalogical interventions attempted.

An additional review of the Progress Notes revealed an eMAR - Administration Note dated [redacted] at 11:02 AM, that [redacted] tablet to administer one tablet every eight hours for [redacted] was effective. The note did not include the NJ Exec Order 26.4b1 [redacted] Further, there was no documentation of non-pharmalogical interventions attempted.

A review of the [redacted] OSR included an additional PO dated [redacted] with an end date of [redacted], for NJ Exec Order 26.4b1 [redacted] give one tablet by mouth every twelve hours as needed for [redacted] for sixty days.

A review of the corresponding [redacted] MAR reflected the resident received [redacted] on [redacted] at 9:19 PM; [redacted] at 9:07 AM and 9:06 PM; [redacted] at 10:27 AM; [redacted] at 8:45 PM; [redacted] at 8:34 PM; [redacted] at 9:47 AM and 8:56 PM; [redacted] at 9:24 AM; [redacted] at 9:05 PM; [redacted] at 9:08 PM; [redacted] at 8:58 AM; [redacted] at 9:53 AM; [redacted] at 9:23 AM; [redacted] at 7:52 AM; [redacted] at 9:38 AM; [redacted] at 10:41 AM; [redacted] at 8:38 PM; [redacted] at 9:06 AM; [redacted] at 9:42 PM; [redacted] at 9:14 PM; [redacted] at 7:34 PM; [redacted] at 9:04 AM; and [redacted] at 10:34 PM.

A review of the corresponding Progress Notes revealed eMAR - Administration Notes dated [redacted]

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at 10:32 PM; NJ Exec at 9:12 PM; NJ Exec at 9:57 PM; NJ Exec at 5:57 PM; NJ Exec at 9:32 AM; NJ Exec at 9:44 PM; NJ Exec at 7:20; NJ Exec at 9:08 PM; NJ Exec at 9:48 AM; NJ Exec at 10:10 AM; NJ Exec at 1:47 PM; NJ Exec at 8:48 PM; NJ Exec at 1:44 PM; NJ Exec at 8:59 PM; NJ Exec at 1:53 PM; NJ Exec at 9:19 PM; and NJ Exec at 7:37 AM. The note did not include what the resident was NJ Exec Order 26.4b1 [redacted] or documented evidence of non-pharmalogical interventions attempted prior to administering the NJ Exec Order 26.4b1.

A review of the Psychiatric Initial Evaluation dated NJ Exec Order 2, included a NJ Exec Order 26.4b1 evaluation was requested for a resident with a history of NJ Exec Order 2 and NJ Exec Order 26.4b1 The resident reported feeling NJ Exec Order 26.4b1" and reported taking NJ Exec Orde at home for many years. Plan was to continue as needed NJ Exec Order 26.4b1 for an NJ Exec Order 2 with an end date of NJ Exec Orde. Monitor and document resident's mood and behavior; report any concerns to Psychiatry.

A review of a Psychiatric Follow-up Note dated NJ Exec Orde, included resident was acclimating to the facility well; nurses reported NJ Exec Order 26.4b1. The resident was NJ Exec and NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 and reported NJ Exec Order 26.4b1 The plan was to renew NJ Exec Order 26.4b1 every twelve hours as needed for thirty days for NJ Exec Order 2 with an end date of NJ Exec Order 2. Monitor and document resident's mood and behavior; report any concerns to Psychiatry.

A review of a Psychiatric Follow-up Note dated NJ Exec Order 2, included resident had a history of NJ Exec Order 2 and NJ Exec Order 26.4b1 with reported NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The plan was to decrease NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every eight

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hours for NJ Exec Order 2 with an end date of NJ Exec Order 26 Monitor and document resident's mood and behavior; report any concerns to Psychiatry.

A review of a Psychiatric Follow-up Note dated NJ Exec Order 26. included resident reported NJ Exec Order 26.4b1 ; denies feeling NJ Exec Order 26.4b1 or NJ Exec Order 26.4b and reported occasional periods of NJ Exec Order 26 The plan was to discontinue previous order of NJ Exec Order 26.4b1 every eight hours as needed, and start NJ Exec Order 26.4b1 every twelve hours as needed for NJ Exec Order 26 with an end date of NJ Exec Order 26. Monitor and document resident's mood and behaviors; report any concerns to Psychiatry.

On 5/2/23 at 10:59 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated the process for a resident on NJ Exec Order 26.4b1 such as an NJ Exec Order 26.4b1, was to review the medication and monitor and document on the behavior monitoring sheet specific to that medication what was the resident's target behaviors and non-pharmalogical interventions that nurses were required to complete every shift. The UM/LPN continued that the behavior monitoring sheets were located in the behavior monitoring binder and at the end of the month, the behavior monitoring sheets were filed in the resident's paper medical chart.

On 5/2/23 at 1:34 PM, the surveyor observed Resident #47 in their room eating lunch. The resident stated he/she was not feeling well today.

On 5/2/23 at 2:10 PM, the surveyor asked the UM/LPN where Resident #47's NJ Exec Order 26.4b1 behavior monitoring sheet was. The UM/LPN confirmed the sheets were not in the resident's

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paper medical chart or in the binder. The surveyor then asked where the resident's [NJ Exec Orde] behavior monitoring sheet was, and the UM/LPN confirmed it was not in the resident's medical record. At this time the surveyor and UM/LPN reviewed the resident's [NJ Exec Order 26.4b1] "Behavior Monitoring Form" for [NJ Exec Order 2] which indicated the behavioral symptom code for the medication was NJ Exec Order 26.4b1 with no intervention codes listed. The sheet was also only completed for the day shifts on [NJ Exec Orde] and [NJ Exec Orde], which both days revealed the resident had [NJ Exec Order 26.4b1] that shift; and the [NJ Exec Order 2] evening and night shift were not completed. The UM/LPN confirmed the sheets should have been filled out completely for all shifts.

The surveyor continued to review the medical record.

A review of the [NJ Exec Order 26.4b1] MAR revealed the resident received a [NJ Exec Order 26.4b1] tablet on [NJ Exec Orde] at 8:30 AM, however there was [NJ Exec Order 26.4b1] on the "Behavior Monitoring Form" for [NJ Exec Order 26.4b1] that justified the use of the [NJ Exec Order 26.4b1] at that time.

A review of the corresponding Progress Notes included an eMAR - Administration Notes dated [NJ Exec Orde] at 12:46 PM, that a [NJ Exec Order 26.4b1] tablet; give one tablet every twelve hours for [NJ Exec Order 2] was administered and effective. The note did not include what the resident was [NJ Exec Order 26.4b1] There was also no documentation of attempted non-pharmalogical interventions.

A review of the "Certified Consultant Pharmacist

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Monthly Progress Notes" dated reviewed NJ Exec Order 26.4b1 indicated that nursing must denote a behavior daily from each time an as needed NJ Exec Order was used.

On 5/3/23 at 8:45 AM, the UM/LPN provided the surveyor with Resident #47's NJ Exec Order 26.4b1 "Behavior Monitoring Form." The surveyor asked where the form was located and the UM/LPN stated it was found "somewhere, sometimes misplaced." The surveyor then asked where the NJ Exec Order 26.4b1 "Behavior Monitoring Form" was, and the UM/LPN stated he could not locate it yet, but he would continue looking.

The surveyor reviewed the NJ Exec Order 26.4b1 "Behavior Monitoring Form" for NJ Exec Order provided by the UM/LPN which indicated the behavioral symptom code was NJ Exec Order 26.4b1 with no intervention codes. A further review revealed the resident had NJ Exec Order 26.4b1 and there were no non-pharmalogical interventions attempted for the month. (This did not correspond with the twenty-four doses of NJ Exec Order that were administered to the resident for the month in accordance with the NJ Exec Order 26.4b1 MAR).

On 5/3/23 at 10:12 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) stated he was unaware of the "confusion" with obtaining the resident's "Behavior Monitoring Form" that the Consultant Pharmacist (CP) had the sheets. The LNHA continued that in early NJ Exec Order the facility identified that staff were not documenting the monitoring of the behaviors and they were working on it. At this time, the surveyor requested Resident #47's NJ Exec Order 26.4b1 "Behavior

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Monitoring Form." The DON confirmed that the sheet should be located on the resident's paper medical chart; that medical records should be maintained on the paper chart for at least three months.

On 5/3/23 at 10:44 AM, the DON informed the surveyor that the facility cannot locate the [redacted] "Behavior Monitoring Sheet" and that she did "not want to lie."

On 5/3/23 at 1:27 PM, the surveyor interviewed via telephone the CP who stated that she started working at the facility since February 2023 and noticed there was no system for monitoring NJ Exec Order 26.4b1. The CP continued that there was a lot of documentation needed to administer an as needed NJ Exec Order 26.4b1 which included what the specific behavior occurring was and what specific non-pharmalogical intervention was attempted such as redirect but specifically how by offering a snack, activity, or toileting for example. The CP stated there should be a nurse's note documenting what occurred at that time that warranted the use of that medication. The CP stated every month she reviewed the NJ Exec Order 26.4b1, and the facility scanned a copy of the "Behavior Monitoring Form" for her to review. The CP confirmed at this time, the facility was "lacking in documentation for the necessary use" of as needed [redacted]; that yesterday she completed an audit and the as needed documentation was still "bad and at the very least should match." The CP stated if an as needed medication was administered, a nursing note should document what transpired; that [redacted] and [redacted] was not a reason.

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On 5/4/23 at 9:38 AM, the surveyor interviewed the LNHA who stated the CP sent a pharmacist to the facility today to inservice staff that every time an as needed NJ Exec Order 26.4b1 was administered, the nurse needed to document the reason the resident needed it and what was occurring at the time. The LNHA confirmed the facility did not have a separate policy for the use of as needed NJ Exec Order 26.4b1, that it was included in the medication administration policy.

On 5/4/23 at 10:13 AM, the surveyor interviewed Resident #47 who stated he/she was NJ Exec Order 26.4b1 that they went for testing yesterday. The resident continued that he/she was unsure of the medications they received, and the surveyor would have to speak to their nurse. The surveyor asked the resident if he/she received NJ Exec Orde at the facility and the resident stated that he/she did not have to ask for NJ Exec Orde that they received it routinely daily in the morning and at night NJ Exec Or each time. The resident stated at home, they took NJ Exec Orde three times a day, but that prescription was on NJ Exec Order 26 so he/she assumed the higher dosage here evened out.

On 5/4/23 at 10:31 AM, the surveyor interviewed the resident's LPN who stated the resident was generally NJ Exec Order 26.4b1", and was a NJ Exec Order 26.4b1 The LPN continued that the resident had NJ Exec Order 26.4b1, but sometimes could be a NJ Exec Order 26.4b1." The LPN stated the resident did not have a standing order for routine NJ Exec Order ; that was given as needed. The LPN stated she asked the resident if he/she wanted the NJ Exec Orde every morning and if he/she did, then she administered it. The LPN

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continued sometimes on NJ Exec Order 26.4b1 (Monday and Friday) the resident could get NJ Exec Order 26.4b1 about the transportation arriving and she tried to calm them down and reassure that the transportation would arrive. The surveyor asked what the process was for administering an as needed NJ Exec Order 2 and the LPN responded that she evaluated the level of NJ Exec Order 26.4b1 or sometimes will administer as a precautionary measure. The surveyor asked if the nurse needed to document anything, and the LPN stated that she documented the medication was administered and if effective; that she did not have to document the behavior or if the resident requested the medication.

On 5/4/23 at 11:34 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated the resident was NJ Exec Order 26.4b1 [redacted]

On 5/8/23 at 9:38 AM, the LNHA in the presence of the DON, Regional Director of Clinical (RDC), and survey team acknowledged the surveyor's concerns regarding the documentation of the use of as needed NJ Exec Order 2

A review of the facility's "Behavioral Assessment, Intervention and Monitoring" policy dated revised March 2019, included the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care...the facility will comply with regulatory requirements related to the use of medication to manage behavioral changes...the nursing staff will identify, document, and inform the physician about specific details

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F 758	Continued From page 34 regarding changes in the individual's mental status, behavior, cognition, including: a. onset, duration, intensity and frequency of behavioral symptoms...interventions will be individualized and part of overall care environment...non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. When medications are prescribed for behavioral symptoms, documentation will include: rationale for use; potential underlying causes of behavior; other approaches and interventions tried prior to use of antipsychotic medications; potential risk versus benefits of medications; specific target behaviors and expected outcomes; dosage; duration; monitoring for efficacy and adverse consequences... NJAC 8:39-27.1(a)	F 758		
F 761 SS=D	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 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		6/9/23

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F 761	Continued From page 35 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain medication carts free from unmarked and unwrapped medications, and ensure a shift to shift narcotic accountability count was completed for 1 of 3 medication carts observed (Second-Floor high-side) on 1 of 2 nursing units (Second-Floor); and b.) ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 1 of 6 forms provided. The evidence was as follows: 1. On 4/27/23 at 12:45 PM, in the presence of the Licensed Practical Nurse (LPN), the surveyor inspected the Second-Floor nursing unit high-side medication cart and observed inside the top drawer, two tablets in a small plastic cup, unmarked. At this time, the LPN informed the surveyor that she was not sure what the medications were and removed them from the cart for destruction. The LPN stated that they must have been left by the previous nurse as she had not noticed the	F 761	1. The loose pills were removed from the medication cart and destroyed. The DEA form was compared to the packing slip and declining sheets and no discrepancies were noted. 2. All residents have the potential to be affected. 3. Nurses were educated to ensure all medication is being stored properly and to check their medication carts for any issues. The Director of Nursing was educated on properly completing all required fields on the DEA form. 4. The Director of Nursing or designee will check each med cart once weekly for one month and then as needed as part of daily rounds, to ensure no medication storage issues. The Administrator will review the DEA forms monthly for three months to ensure completeness. Findings will be reported to the Admninistrator and Quality Assurance Performance Improvement committee.	

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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 761	Continued From page 36	F 761		

unlabeled medications until the surveyor brought it to her attention. The LPN acknowledged that unlabeled medications should not be stored in medication carts.

At this time, the surveyor reviewed the "Controlled Drugs-Count Record", (a shift-to-shift accountability form for reconciliation of Narcotics) and observed that the LPN had not signed the form. The LPN acknowledged that she should have signed the form.

2. On 4/28/23 at 9:00 AM, the surveyor reviewed six of DEA 222 forms. A review of the order form numbered 222011599 and dated 3/24/23, revealed that Section 5 was not completed according to the Instructions for DEA 222 forms. Controlled Substance Receipt reflected the purchaser filled out this section on its copy of the original order form.

On 4/28/23 at 10:55 AM, the surveyor interviewed the Director of Nursing (DON) and together they reviewed the findings of the inspection of the Second-Floor high-side medication cart and DEA 222 forms. The surveyor showed the DON the "Controlled Drugs-Count Record" which reflected that the incoming LPN had not signed the sheet on 4/28/23 at 7:00 AM, which indicated the count had not been done. The DON stated she was "very strict with narcotics" and "the form should have been signed by two nurses before leaving the shift." The oncoming and outgoing nurses counted and signed ensuring the narcotic counts were correct. The DON further stated that she was responsible for completing the DEA 222 forms and acknowledged she should have completed Section 5, but that she "overlooked it."

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F 761	Continued From page 37 On 5/8/23 at 9:38 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Director of Clinical, and survey team acknowledged the above concerns. A review of the facility's "Storage of Medications" policy dated revised November 2020, included ...the facility stores all drugs and biological's in a safe, secure, and orderly manner. A review of the facility's "Controlled Substances" policy dated revised April 2019, included...controlled substances are reconciled upon receipt, administration, disposition... controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together....any discrepancies are documented and reported to the director of nursing services immediately. NJAC 8:39-29.4(h)	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was	F 804	1. Department heads, manager on duty and supervisors are ensuring that trays	6/9/23

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F 804	Continued From page 38 determined that the facility failed to ensure safe and appetizing temperatures of food for 4 of 5 entree meals observed during 2 of 2 meal observations (breakfast and lunch). This deficient practice was evidenced by the following: On 4/28/23 at 10:00 AM, the surveyor conducted a Resident Council meeting which included four residents (Resident #26, #31, #63, and #64). All four residents informed the surveyor that all meals served at the facility were cold. Resident #26 stated that the residents had been complaining for months at their council meetings to the facility about the cold food. On 5/3/23 at 11:32 AM, the surveyor informed the Dietary Supervisor (DS) they wanted to observe the lunch meal for the day including food temperatures. The surveyor asked the DS to calibrate two digital thin probe thermometers in their presence; which the DS completed using an ice bath, and the thermometers reached 32 degrees Fahrenheit (F). On 5/3/23 at 11:33 AM, the surveyor observed the DS using one of the thermometers calibrated to 32 F and took the following temperatures for the lunch meal: Chicken stir fry 184 F Rice 195 F Carrots 140 F Gravy 144 F Puree chicken 180 F Puree carrots 181 F Mashed potatoes 173 F Ground chicken 161 F Ground carrots 177 F Sliced turkey (alternative regular meal option) 116	F 804	are passed to residents timely to ensure they receive food that is palatable and appetizing. 2. all residents have the potential to be affected. 3. all staff were educated on the importance of passing trays promptly when they arrive on the unit. managerial staff were assigned to assist with tray pass. manager on duty and supervisor were educated to assist and ensure a prompt tray pass on the weekends. 4. The Registered Dietitian will observe tray pass four times weekly for one month on different shifts to ensure tray pass is happening quickly. The dietitian will check temperatures of a test tray after all other trays have been passed two times weekly on alternating shifts for one month to ensure temperatures are in acceptable range. Findings will be reported to the Administrator and Quality Assurance Performance Improvement committee.	

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F 804	Continued From page 39	F 804		

F; the DS stated she needed to return to the oven to increase the temperature
Soup, pre-portioned and not stored on a heating element, 144 F
Fat-free milk 36 F
Whole milk 36 F
Fruit cup 35 F

On 5/3/23 at 11:44 AM, the DS stated that the facility's plate warmer, a device used to heat the plates prior to serving was broken, and the facility was utilizing plastic insulated domes and pellets (plate liner). The DS informed the surveyor that hot food should be served at 135 F or higher.

On 5/3/23 at 11:47 AM, the surveyor observed the DS remove the sliced turkey from the oven, and she obtained a temperature of 148 F.

On 5/3/23 at 12:14 PM, the surveyor was informed that the last meal for the 2-East nursing unit was plated, and the surveyor requested and observed plated three test tray meals which included a regular texture, alternative regular texture, and ground texture meals. The regular meal contained chicken stir fry, rice, milk, juice, coffee, and fruit; the alternative regular meal included sliced turkey, rice, and carrots; and the ground meal contained chicken, carrots, and mashed potatoes.

On 5/3/23 at 12:17 PM, the surveyor observed the Dietary Aide (DA) leave the kitchen with the meal cart for the 2-East nursing unit. At this time, the surveyor, Dietary Director (DD), and DS accompanied the DA with a thin probed thermometer calibrated to 32 F.

On 5/3/23 at 12:18 PM, the DA arrived on 2-East

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F 804	Continued From page 40	F 804		

nursing unit with the meal cart and left the meal cart on the nursing unit.

On 5/3/23 at 12:19 PM, staff began serving the meal trays.

On 5/3/23 at 12:27 PM, the surveyor observed the last meal tray was served to the resident. The surveyor asked the DD and DS at what temperature should food be served at, and they both responded hot food should be 135 F or higher and cold food should be 40 F or lower. At this time, the DD in the presence of the DS and the surveyor obtained the following temperatures from the sample trays:

Regular meal texture:
Chicken stir fry 118 F
Rice 121 F
Fruit cup 46 F
Milk 46 F
Juice 43 F

Alternative regular meal texture:
Sliced turkey 109 F
Rice 116 F
Carrots 106 F

Ground meal texture:
Chicken 110 F
Mashed potatoes 122
Carrots 114

At this time, both the DD and the DS confirmed the above temperatures were not acceptable.

On 5/4/23 at 7:24 AM, the surveyor informed the DS they wanted to observe the breakfast meal for the day including food temperatures. The

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F 804	Continued From page 41	F 804		

surveyor asked the DS to calibrate two digital thin probe thermometers in their presence; which the DS completed using an ice bath, and the thermometers reached 32 F.

On 5/4/23 at 7:33 AM, the surveyor observed the DS using one of the thermometers calibrated to 32 F and took the following temperatures for the breakfast meal:

French toast 142 F
Sausage 183 F
Ground bacon 180 F
Puree eggs 160 F
Puree sausage 140 F, DS stated will put in oven to make hotter
Ground toast 150 F
Hard-boiled eggs 162 F
Oatmeal, pre-portioned in insulated bowls with lids not stored on a heating element, 183 F
Fat-free milk 33 F
Juice 28 F
Coffee 168 F

At this time, the DD stated she was aware of residents' complaints of cold food, so the facility purchased enclosed meal carts and tried to encourage managers on the floors to deliver meal trays because food sat on the units waiting to be served to the residents.

On 5/4/23 at 8:27 AM, the surveyor was informed the last meal was completed for the 2-West nursing unit, and the surveyor requested a regular texture and puree texture meal test tray. The regular texture meal consisted of French toast, sausage, oatmeal, coffee, whole milk, and juice; and the puree texture meal consisted of pureed eggs, pureed sausage, and pureed toast.

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F 804	Continued From page 42	F 804		

On 5/4/23 at 8:38 AM, the DA left the kitchen with the 2-West nursing unit's meal cart. At this time, the surveyor, DD, and DS accompanied the meal to 2-West nursing unit.

On 5/4/23 at 8:39 AM, the meal truck arrived on the 2-West nursing unit, and staff began delivering trays at 8:40 AM.

On 5/4/23 at 8:44 AM, the surveyor was informed the last meal tray was delivered and the DS obtained the following temperatures that were below 135 F and above 41 F:

Regular texture meal:
French toast 125 F
Sausage 118 F
Oatmeal 112 F
Juice 44 F
Whole milk 42 F

Puree texture meal:
Pureed eggs 132 F

At this time, the DD and DS confirmed the above temperatures were not acceptable.

On 5/4/23 at 9:40 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the facility was aware of residents' complaints of cold food, and the facility was in the process of improving which included ordering enclosed meal carts. The LNHA stated he did not attend resident council minutes unless invited by the residents, but he stated that he received grievances about the cold food.

A review of the facility's undated "Resident

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F 804	Continued From page 43 Nutrition Services" policy included...to minimize the risk of foodborne illness, the time potentially hazardous foods remain in the "danger zone" (41 F to 135 F) will be kept to a minimum...food will be served palatable, attractive and at a safe and appetizing temperature. NJAC 8:39-17.4(a)(2)	F 804		
F 812 SS=D	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 facility documentation, it was determined that the facility failed to maintain kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following:	F 812	1. The cutting boards were replaced. 2. All residents have the potential to be affected. 3. Food Service director and kitchen staff	6/9/23

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F 812	Continued From page 44 On 4/26/23 at 9:26 AM, the surveyor toured the kitchen with the Dietary Director (DD), Dietary Supervisor (DS), and Registered Dietitian (RD). The surveyor observed the following: The cutting board on the steam table tray line was discolored black, brown, and reddish with the plastic peeling off and deeply pitted. The DD stated that the facility used that cutting board to cut food such as sandwiches on the tray line during meal service. The DD stated that the dietary staff first wrapped the board in aluminum foil and plastic wrap prior to cutting food on it. The surveyor asked if that practice was acceptable, and the DD and the DS stated they thought yes. The RD at this time confirmed wrapping the cutting board was not acceptable practice and the cutting board should not be used. On a drying rack hanging, one medium green, two medium yellow, two medium red, one medium light blue, one large green, one large light blue, and one large brown cutting boards all discolored and deeply pitted. The DD confirmed at this time the cutting boards should not be used because bacteria growth could occur in the pitting. The DD stated the facility had not changed the cutting boards in at least six months, and the RD confirmed the cutting boards should not be used and needed to be discarded. At this time, the surveyor asked the DD if the facility had a policy on maintaining kitchen equipment. The DD stated she would look for one. On 5/8/23 at 9:38 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of	F 812	were educated on cutting board sanitation and when to replace them by the Registered Dietitian. The cutting boards that were discolored and/or pitted were replaced. 4. The Registered Dietitian will conduct sanitation audits of the kitchen once weekly for three months and then monthly and as needed after that. Sanitation audit will include checking the condition of cutting boards. Findings will be reported to the Administrator and Quality Assurance Performance Improvement Committee.	

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F 812	Continued From page 45 the Director of Nursing (DON), Regional Director of Clinical, and survey team acknowledged the above findings. A review of the undated facility provided "Care and Use of Equipment" inservice education included proper use and care of equipment is very important to everyone's safety and productivity in the kitchen...cutting boards - one for vegetable and one for meats. Wash and sanitize between each use and between each food you cut...look for potential problems and report them to your supervisor immediately...The policy did not include when to replace cutting boards.	F 812		
F 842 SS=D	NJAC 8:39-17.2(g) 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;	F 842		6/9/23

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F 842	Continued From page 46 (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; (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	F 842		

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F 842	Continued From page 47 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: Based on observation, interview, review of the medical record, and other facility documentation, it was determined that the facility failed to maintain an accurate, complete, and easily accessible medical record. This deficient practice was identified for 1 of 22 resident medical records reviewed (Resident #88), and was evidenced by the following: 1. On 4/26/23 at 12:10 PM, the surveyor observed Resident #88 sitting outside their room eating lunch. The surveyor attempted to interview the resident at this time who was NJ Exec Order 26.4b1 The surveyor reviewed the medical record for Resident #88. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26 reflected the resident had a brief interview for	F 842	1. There was no negative outcome for resident #88 and resident remains in the facility. 2. all residents have the potential to be affected. 3. nurses were educated by the assistant director of nursing on neurochecks - frequency, duration, and keeping on the resident's medical record. Nurses were educated by the assistant director of nursing on resident records being accurate and accessible. nurses were educated by the assistant director of nursing on completion of and filing of behavior monitoring sheets. 4. The Director of Nursing or designee will audit five fall incident reports monthly for three months to ensure neurochecks were completed if indicated and are complete, accurate and accessible in the medical record. The director of nursing or designee will audit all behavior monitoring log books weekly for one month and then monthly after that to ensure all behavior monitoring forms are present and complete. Findings will be reported to the	

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F 842	Continued From page 48 mental status (BIMS) score of a [redacted] out of 15, which indicated a NJ Exec Order 26.4b1. A further review of the MDS reflected the resident had a NJ Exec Order 26.4b1 [redacted], and a NJ Exec Order 26.4b1 since admission. On 5/1/23 at 1:19 PM, the surveyor received from the Director of Nursing (DON) all incident and accident reports for Resident #88. The DON confirmed at this time that the reports provided were the original and complete accident reports. A review of NJ Exec Order 26.4b1 included on [redacted] at about 9:45 AM, the primary nurse reported to the supervisor that the resident was noted NJ Exec Order 26.4b1 [redacted] ..Immediate action taken included NJ Exec Order 26.4b1 [redacted] initiated. A review of the "Neurological Record" included in the investigation was dated [redacted] and timed 5:00 AM; 5:15 AM; 5:30 AM; 6:00 AM; 7:00 AM; 8:00 AM; 9:00 AM; 10:00 AM; 11:00 AM; 1:00 PM; 3:00 PM; 5:00 PM; 7:00 PM; and 9:00 PM. The top portion of the vital signs and [redacted] was completed until 7:00 AM; the portion NJ Exec Order 26.4b1 [redacted] at 5:00 AM only; and the portion labeled [redacted] was completed until 8:00 AM. A review of a NJ Exec Order 26.4b1, included on [redacted] at about 11:00 PM, resident was heard calling for help. Upon arrival, resident was noted NJ Exec Order 26.4b1 [redacted] Resident was noted with	F 842	Administrator and the Quality Assurance Performance Improvement committee.	

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dried NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 ...Immediate action taken included NJ Exec Order 26.4b1 initiated. A further review of the incident report did not include the "Neurological Record."

A review of a NJ Exec Order 26.4b1, included on NJ Exec Order 26 at approximately 11:00 PM, resident was observed on the NJ Exec Order 26.4b1 . Resident's bed was NJ Exec Order 26.4b1, and so was the floor around [his/her] bed. Resident had NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 ..Immediate action taken included NJ Exec Order 26.4b1 initiated. A further review of the incident report did not include the "Neurological Record."

A review of a NJ Exec Order 26.4b1 included on NJ Exec Order 26 at approximately 1:30 PM, resident was NJ Exec Order 26.4b1 of the wheelchair. Resident was asked what happened, and responded NJ Exec Order 26.4b1." NJ Exec Ord ...Immediate action included NJ Exec Order 26.4b1 initiated. A further review of the incident report did not include the "Neurological record."

On 5/2/23 at 10:19 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) who stated when completing an incident report for an NJ Exec Order 26.4b1, the nurses initiated NJ Exec Order 26.4b1 The LPN continued NJ Exec Order 26.4b1 were completed every fifteen minutes, then every thirty minutes, then every hour, every two hours, and finally every four hours for twenty-four hours

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and documented on the "Neurological Record." The LPN stated when the twenty-four hours was completed, the "Neurological Record" was filed on the resident's paper medical chart. At this time, the LPN showed the surveyor a "Neurological Record" that was filed on another sampled resident's paper medical chart.

The surveyor reviewed Resident #88's paper medical chart which did not include "Neurological Records" for the NJ Exec Order 26.4b1 [redacted]

On 5/3/23 at 11:14 AM, the surveyor interviewed the resident's Registered Nurse (RN) who stated the process for an NJ Exec Order 26.4b1 included to complete NJ Exec Order 26.4b1 for twenty-four hours that was documented on the "Neurological Record." The RN stated that the "Neurological Record" was kept on the resident's paper medical chart. The RN stated she could not recall the last time Resident #88 [redacted], she thought maybe two weeks ago.

On 5/3/23 at 11:21 AM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated for NJ Exec Order 26.4b1, the nurse completed NJ Exec Order 26.4b1 every fifteen minutes for the first hour, then thirty minutes for the next hour, every hour for four hours, and then every two hours for eighteen hours to total twenty-four hours. The UM/LPN provided the surveyor with a copy of the facility's undated "Neuro Check" policy. The UM/LPN continued NJ Exec Order 26.4b1 were documented in the nurse's notes as well as on the "Neurological Record" that was kept on the resident's paper medical chart. At this time, the UM/LPN accompanied by the surveyor reviewed Resident #88's paper medical chart and the

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UM/LPN stated the "Neurological Record" was not on the resident's chart, and he would have to follow-up with the Licensed Nursing Home Administrator (LNHA) to find out where the record could be.

A review of the facility provided undated "Neuro Check" policy included every fifteen minutes for one hour; every thirty minutes for one hour; every hour for four hours, and every two hours for eighteen hours to total twenty-four hours.

On 5/3/23 at 12:41 PM, the Director of Nursing (DON) provided the surveyor with Resident #88's "Neurological Records" dated [NJ Exec Order 2] and [NJ Exec Order 2]. The DON stated the records were found in the twenty-four hour nursing report. At this time, the surveyor asked the DON if this was all the "Neurological Records" for the resident, and the DON responded she would have to check.

On 5/3/23 at 12:47 PM, the Assistant Director of Nursing (ADON) provided the surveyor with additional "Neurological Records" dated [NJ Exec Order 2] to [NJ Exec Order 2] and [NJ Exec Order 2] to [NJ Exec Order 2]. The surveyor asked the ADON where these "Neurological Records" were located, and the ADON stated they were found in the investigation reports within the nurse's statements.

On 5/3/21 at 12:51 PM, the surveyor reviewed the facility's original investigation files provided by the DON still in the possession of the survey team. When the surveyor compared the "Neurological Record" dated [NJ Exec] that was included in the facility's original investigation file (NR #1) and compared it to the "Neurological Record" dated [NJ Exec] (NR #2) provided by the DON, the surveyor observed the following discrepancies:

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At 5:00 AM, the NJ Exec Order 26.4b1 was [redacted] on NR #1 and NJ Exec Order 26.4b1 the temperature was NJ Exec Order 26.4b1 on NR #1 and [redacted] on NR #2; and [redacted] on NR #1 and [redacted] on NR #2.

At 5:15 AM, the NJ Exec Order 26.4b1 on NR #1 and NJ Exec Order 26.4b1 on NR #2; the temperature was [redacted] on NR #1 and [redacted] on NR #2; the NJ Exec Order 26.4b1 on NR #1 and [redacted] on NR #2; the NJ Exec Order 26.4b1 [redacted] were not completed on NR #1, but completed on NR #2.

At 5:30 AM, NR #1 was completed for the vital signs, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1, but there was no documentation for 5:30 AM on NR #2.

At 5:45 AM, NR #1 was not documented, but the vital signs, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, [redacted], and NJ Exec Order 26.4b1 were completed on NR #2.

At 6:00 AM, the NJ Exec Order 26.4b1 on NR #1 and NJ Exec Order 26.4b1 on NR #2; the temperature was [redacted] on NR #1 and [redacted] on NR #2; the NJ Exec Order 26.4b1 on NR #1 and [redacted] on NR #2; the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, [redacted], and NJ Exec Order 26.4b1 were not completed on NR #1, but completed on NR #2.

At 6:30 AM, the NJ Exec Order 26.4b1 on NR #1 and NJ Exec Order 26.4b1 on NR #2; the temperature was [redacted] on NR #1 and [redacted] on NR #2; the NJ Exec Order 26.4b1 on NR #1 and [redacted] on NR #2; the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1,

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NJ Exec Order 2[illegible], and NJ Exec Order 26.4b1 were not completed on NR #1, but completed on NR #2.

At 7:00 AM, the NJ Exec Order 26.4b1 on NR #1 and NJ Exec Order 26.4b1 on NR #1; the temperature was NJ Exec Orde on NR #1 and NJ Exec Orde on NR #2; the NJ Exec Order 26.4b1 on NR #1 and NJ Exec on NR #2; the NJ Exec Order 26.4b1 were not completed on NR #1, but completed on NR #2.

NR #1 was not completed for 8:00 AM, 9:00 AM, 10:00 AM, 11:00 AM, 1:00 PM, 3:00 PM, 5:00 PM, 7:00 PM, or 9:00 PM on NR #1, but was completed on NR #2 except for the BP at 3:00 PM, 5:00 PM, 7:00 PM, and 9:00 PM. Both NR #1 and NR #2 were not completed for twenty-four hours per facility policy.

On 5/3/23 at 2:48 PM, the surveyor asked the ADON in the presence of the LNHA, DON, and Regional Director of Clinical (RDC) where she had located the "Neurological Records" for NJ Exec Order 2[illegible] to NJ Exec Order 2[illegible] and NJ Exec Order 2[illegible] to NJ Exec Order 2[illegible], and the ADON confirmed in the incident report. The surveyor than asked the Administration team how the records could be located in the files the survey team currently had, and the ADON responded it was in a different incident binder. At this time, the DON confirmed the surveyor had the completed incident reports. The surveyor then reviewed the NR #1 and NR #2 with the LNHA, who stated NR #1 was just the initial "Neurological Record" and NR #2 was when it was completed. The LNHA acknowledged the information on NR #1 and NR #2 did not all match, and could not speak to it.

On 5/4/23 at 10:25 AM, the DON informed the

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surveyor that the ADON had not located the additional "Neurological Records" in an incident binder because the facility did not have an incident binder and she, the DON only had the incident reports. The DON stated the additional "Neurological Records" must have been found in the twenty-four hour report, but acknowledged when the records were completed, they were to be filed in the resident's paper medical chart and confirmed the four "Neurological Records" were not filed on Resident #88's chart as should have been. The DON could not speak to the conflicting documentation on NR #1 and NR #2.

On 5/4/23 at 2:26 PM, the surveyor informed the LNHA, DON, ADON, and RDC their concerns and requested a copy of the facility's policy for maintaining medical records.

On 5/8/23 at 9:38 AM, the LNHA in the presence of the DON, RDC, and survey team stated the facility did not have a policy for maintaining active resident's medical records. The LNHA stated that the paper chart should contain at least three months of records. The LNHA acknowledged that medical records should be maintained accurate, complete, and easily accessible.

2. On 4/26/23 at 12:10 PM, the surveyor observed Resident #88 sitting outside their room eating lunch. The surveyor attempted to interview the resident at this time NJ Exec Order 26.4b1.

The surveyor reviewed the medical record for Resident #88.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included

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NJ Exec Order 26.4b1

A review of the admission MDS dated NJ Exec Order 26. reflected the resident had a BIMS score of a NJ E out of 15, which indicated a NJ Exec Order 26.4b1 A further review of the MDS reflected the resident received NJ Exec Order 26.4b1 on 7 of 7 days during a seven day look back period.

A review of the individualized comprehensive care plan included a focused area initiated NJ Exec Orde, for use of NJ Exec Order 26.4b1 with regards to NJ Exec Order 26.4b1 as manifested by NJ Exec Order 26.4b1 Interventions included to administer medication dose as ordered; encourage resident to verbalize his/her feelings; for possible gradual dose reduction as needed; monitor adverse side effects of medication; monitor and document target behaviors; and redirect resident during NJ Exec Order 26.4b1.

A review of the NJ Exec Order 26.4b1 Order Summary Report (OSR) included a physician's order (PO) dated NJ Exec Order 2, for NJ Exec Order 26.4b1 tablet; give one tablet every eight hours as needed for NJ Exec Order 2.

A review of the NJ Exec Order 26.4b1 OSR included a PO dated NJ Exec Orde, for NJ Exec Order 26.4b1 tablet; give one tablet by mouth every twelve hours as needed for NJ Exec Order 2 for fourteen days.

On 5/2/23 at 10:59 AM, the surveyor interviewed the UM/LPN who stated the process for a resident on NJ Exec Order 26.4b1 was to

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monitor and document on a behavior monitoring sheet specific to that medication what was resident's target behaviors and non-pharmalogical interventions that nurses were required to complete every shift. The UM/LPN continued that the behavior monitoring sheets were located in the behavior monitoring binder and at the end of the month, the behavior monitoring sheets were filed in the resident's paper medical chart. At this time, the surveyor and the UM/LPN reviewed the behavior monitoring binder, and the UM/LPN confirmed the resident's NJ Exec O behavior monitor sheet was not located in it, as well as their NJ Exec O sheet was not located in the binder's side pocket with the other resident's sheets. The surveyor and the UM/LPN reviewed the resident's paper medical chart, and the UM/LPN acknowledged the resident's chart did not include NJ Exec Order 26.4b1 behavior monitoring sheets.

On 5/2/23 at 1:50 PM, the UM/LPN provided the surveyor with the resident's NJ Exec Order 26.4b1 "Behavior Monitoring Form" for NJ Exec Order 26.4b1 NJ Exec Order 2 and NJ Exec Order 26.4b1 The UM/LPN stated they were located in a "lab book." The surveyor then asked where the resident's NJ Exec Order 26.4b1 form were, and the UM/LPN proceeded to the behavior binder and showed the surveyor monitoring sheets for NJ Exec Order 26.4b1 at time of bed, NJ Exec Order 26.4b1 tablet two times a day, NJ Exec Orde , and NJ Exec Order 26.4b1 . The NJ Exec Order 2 and NJ Exec Order 26.4b1 sheets were not completed for the NJ Exec Orde evening or night shift; and the two NJ Exec Order 26.4b1 sheets were not completed for the NJ Exec Orde evening shift.

On 5/2/23 at 2:00 PM, the surveyor asked the DON in the presence of the UM/LPN where the

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resident's NJ Exec Order 26.4b1 "Behavior Monitoring Form" was, and she responded to ask the UM/LPN. At this time, the surveyor asked the UM/LPN who confirmed it was not in the resident's paper chart, that maybe the Consultant Pharmacist (CP) had it.

On 5/3/23 at 8:45 AM, the surveyor asked the UM/LPN where the resident's NJ Exec Order 26.4b1 "Behavior Monitoring Form" that was requested yesterday, and the UM/LPN stated he was still trying to locate.

On 5/3/23 at 10:12 AM, the LNHA in the presence of the DON stated he was unaware of the "confusion" with obtaining the resident's "Behavior Monitoring Form" that the CP had the sheets. The LNHA continued that in early NJ Exec Orde the facility identified that staff were not monitoring behaviors and was working on it. At this time, the surveyor requested Resident #88's NJ Exec Order 26.4b1 "Behavior Monitoring Form". The DON confirmed that the sheet should be located on the resident's paper medical chart; that medical records should be maintained on the paper chart for at least three months.

On 5/3/23 at 10:44 AM, the DON informed the surveyor that the facility cannot locate the NJ Exec Orde "Behavior Monitoring Sheet"; that she did not want to "lie."

On 5/3/23 at 1:27 PM, the surveyor interviewed via telephone the CP who stated that she started working at the facility since NJ Exec Order 26.4b1 and noticed there was no system for monitoring NJ Exec Order 26.4b1. The CP continued that there was a lot of documentation needed to administer an as needed NJ Exec Order 26.4b1

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F 842	Continued From page 58 which included what the specific behavior occurring was and what specific non-pharmalogical intervention was attempted. The CP stated every month she reviewed the NJ Exec Order 26.4b1, and the facility scanned a copy of the "Behavior Monitoring Form" for her to review. On 5/8/23 at 9:38 AM, the LNHA in the presence of the DON, RDC, and survey team stated the facility did not have a policy for maintaining active resident's medical records. The LNHA stated that the paper chart should contain at least three months of records. The LNHA acknowledged that medical records should be maintained accurate, complete, and easily accessible. NJAC 8:39-35.2(d)	F 842		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 10 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. There was no negative outcomes. Efforts to recruit staff are underway. 2. all residents have the potential to be affected. 3. Advertisements for open Certified Nursing Assistant (CNA) positions are posted on the online job sites Indeed and Apploi. A job fair has been scheduled for June 7. Agency contracts are already being utilized and a new contract was signed. Referral and sign on bonuses have been advertised inside and outside the facility. A CNA trainin program is bringing students to the facility for clinical practice.	6/9/23

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

Electronically Signed | 05/19/23

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MEADOWBROOK RESPIRATORY AND NURSING CEN	38 FRENEAU AVENUE MATAWAN, NJ 07747

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 4/26/23 at 10:12 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) and Regional Director of Clinical informed the surveyor that the facility had improved with staffing. The LNHA continued that the facility used Agency staff as needed to cover shifts. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 4/9/23 to 4/15/23 and 4/16/23 to 4/22/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 4/11/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs. 4/12/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs.	S 560	4. Administrator will review staffing ratios daily to ensure complinace with required CNA ratios. Findings and results of efforts to recruit staff will be reported at the Quality Assurance Performance Improvement committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556200	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CEN	38 FRENEAU AVENUE MATAWAN, NJ 07747

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S 560	Continued From page 2 4/13/23 had 12 CNAs for 111 residents on the day shift, required 14 CNAs. 4/14/23 had 13 CNAs for 111 residents on the day shift, required 14 CNAs. 4/15/23 had 9 CNAs for 111 residents on the day shift, required 14 CNAs. 4/16/23 had 10 CNAs for 111 residents on the day shift, required 14 CNAs. 4/17/23 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. 4/19/23 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. 4/20/23 had 10 CNAs for 113 residents on the day shift, required 14 CNAs. 4/22/23 had 11 CNAs for 115 residents on the day shift, required 14 CNAs. NJAC 8:39-5.1(a)	S 560		

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
315463 Y1	A. Building B. Wing Y2	6/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	38 FRENEAU AVENUE MATAWAN, NJ 07747

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 F0610	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	06/09/2023	LSC	06/09/2023	LSC	06/09/2023
ID Prefix F0758	Correction	ID Prefix F0761	Correction	ID Prefix F0804	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	06/09/2023	LSC	06/09/2023	LSC	06/09/2023
ID Prefix F0812	Correction	ID Prefix F0842	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed
LSC	06/09/2023	LSC	06/09/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/8/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
556200 Y1	A. Building B. Wing Y2	6/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	38 FRENEAU AVENUE MATAWAN, NJ 07747

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	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/09/2023	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		
5/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315463	A. BUILDING **01** B. WING _____	**05/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/26/23. The facility was found to not be in compliance with 42 CFR 483.73.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2),	E 041		6/9/23

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

Electronically Signed | 05/19/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 1 §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	E 041		

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E 041	Continued From page 2 (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on record review and interview with facility staff, the facility failed to ensure its emergency preparedness policy plan included how the facility would maintain generator power/fuel during an emergency. This deficient practice had the potential to affect all 114 residents. Findings include: A review of the facility Emergency Preparedness policy, from a red binder titled "Emergency Preparedness" provided by the Maintenance	E 041	1. Fuel provider has been secured to provide generator fuel in an emergency and the policy has been updated. 2. all residents have the potential to be affected. 3. Maintenance director has been educated on the need for emergency fuel supply and the vendor has been secured to provide it and policy updated.	

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E 041	Continued From page 3 Director, revealed the facility policy lacked a reference to a plan to maintain its fuel/operational power systems during an emergency. An interview with the Maintenance Director on 04/26/23 at 3:35 PM revealed he had not had time to update the manual for emergency fuel suppliers. The generator at the time of the survey had a fuel supply. The facility also had 18 residents on life support at the time of the survey. NJAC 8:39-31.2(e)	E 041	4. Maintenance director or designee will review the Emergency Preparedness binder monthly for 3 months and then as needed to ensure all emergency policies are in place. Results of audit will be reported to the Administrator and Quality Assurance Performance Improvement Committee. The QAPI committee meets quarterly and as needed.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/26/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. Spring Hills Post Acute-Matawan was constructed in 2000. The facility is two stories with concrete flooring and concrete steel deck roofing and block bearing walls with metal studs and an aluminum siding and brick exterior. Spring Hills is therefore a type II (222) facility with a complete sprinkler system and smoke detection in all corridors. The facility has a 200 KW (kilowatt) diesel stand by generator. The generator also serves the assisted living area. The facility lacked documentation of the percentage of load used when testing. The facility has 114 occupied beds.	K 000		

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K 000	Continued From page 4 The facility has six smoke zones and 18 residents in a ventilator unit in bedrooms 119 to 129.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency lighting was provided for the generator transfer switch in accordance with NFPA 101 "Life Safety Code" (2012 Edition) Section 7.9.2.4. and NFPA 110 "Standard for Emergency and Standby Power Systems" (2010 Edition) Sections 7.3.1 and 7.3.2. This deficient practice had the potential to affect all 114 residents. Findings include: An observation on 04/26/23 at 11:55 AM revealed the electrical closet contained one generator transfer switch lacked battery operated emergency lighting for the transfer switch for the 200 KW stand by diesel generator. An interview with the Maintenance Director at the time of the observation confirmed the electrical closet which contained the transfer switch, lacked battery powered emergency lighting and stated he did not know it was a requirement. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	1. Emergency lighting was installed in the electrical closet. 2. All residents have the potential to be affected. 3. Maintenance director was educated on the requirements for emergency lighting and the vendor installed the needed emergency light. 4. Maintenance director or designee will audit four emergency lights weekly for one month and then as needed and report findings to the Administrator and Quality Assurance Performance Improvement committee. The QAPI committee meets quarterly and as needed.	6/9/23
K 321	Hazardous Areas - Enclosure	K 321		6/9/23

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K 321 SS=E	Continued From page 5 CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews with facility staff, the facility failed to ensure that two of two hazardous area soiled linen room doors self-closed in accordance with NFPA 101 (2012 edition) Life Safety Code, section 19.3.2.1.3. This deficient practice had the potential to affect 49 of	K 321	1. Self closing hinges were ordered and will be installed on both doors. 2. All residents have the potential to be affected.	

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K 321	Continued From page 6 114 residents. Findings include: An observation on 04/26/23 at 10:00 AM of corridor bedroom door 109 revealed the room did not have and self-closing door and was used for storage and contained over 125 boxes of personal protective equipment in cardboard boxes. An observation on 04/26/23 at 11:50 AM of the nursing supply closet in the corridor near bedroom 236 revealed the room did not have a self-closing door and contained over 150 cardboard boxes of nursing supply storage. An interview with the Maintenance Director at each observation verified the doors were not self-closing. He indicated he had been employed at the facility for five months as Maintenance Director and the storage and door status had been during that time. NJAC 8:39-31.2(e)	K 321	3. The maintenance director was educated on the need for self closing doors and the parts were ordered and will be installed. 4. Maintenance director or designee will check four self closing doors weekly for one month and then as needed and report findings to the Administrator and the Quality Assurance Performance Improvement Committee. The QAPI committee meets quarterly and as needed.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders,	K 341		6/9/23

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K 341	Continued From page 7 and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that one of 138 photo electric smoke detectors was greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect four residents in one central smoke zone on the second floor. Findings include: An observation of a smoke detector in the beauty salon on the second floor on 04/26/23 at 11:20 AM revealed the smoke detector was 18 inches from a heating and cooling air diffuser as measured by the Maintenance Director. A review of the facility alarm reports, from the black binder provided by the Maintenance Director on 04/26/23 at 1:45 PM, under the fire alarm tab revealed a report dated 01/05/23 and 10/22/21 titled "Fire Alarm Visual Inspection and Testing Form" that did not address or indicate a problem with smoke detectors installed too close to air diffusers. An interview with the Maintenance Director at the time of the observation verified the measurement	K 341	1. Vendor is scheduled to move the smoke detector. 2. All residents have the potential to be affected. 3. Maintenance Director was educated on placement of smoke detectors and the vendor was scheudled to move the detector. 4. Maintenance director or designee will audit four smoke detectors weekly for proper placement for one month and then as needed. Findings will be reported to the Administrator and Quality Assurance Performance Improvement Committee. The QAPI committee meets quarterly and as needed.	

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	315463	A. BUILDING **01** B. WING _____	**05/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

(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 341	Continued From page 8 taken as accurate and stated he did not realize this was a requirement. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to complete a smoke detection sensitivity test and make necessary alarm system repairs for all 138 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 114 residents. Findings include: A review of fire safety records, located in an untitled black binder provided by the Maintenance Director on 04/26/23 at 1:45 PM at the fire alarm tab, revealed the most recent fire alarm inspection titled "Fire Alarm Visual Inspection and Testing Form," on 01/05/23 and prior reports of 10/22/21, did not include a smoke detection	K 345	1. Vendor has been secured to conduct the smoke sensitivity testing and the shunt trip was repaired. The smoke sensitivity test was completed 5/30/23. 2. All residents have the potential to be affected. 3. Maintenance director was educated on the need for smoke sensitivity testing and a vendor was secured to do the testing. The shunt trip was repaired. 4. Maintenance director or designee will audit records of life safety inspections monthly for three months and then as needed to ensure all required inspections are complete. Results of the audits will be reported to the Administrator and Quality	6/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315463	A. BUILDING **01** B. WING _____	**05/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

(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 345	Continued From page 9 sensitivity test. Further review of fire safety records located in an untitled black binder provided by the Maintenance Director on 04/26/23 at 1:45 PM at the fire alarm tab revealed the most recent fire alarm inspection titled "Fire Alarm Visual Inspection and Sensitivity Form," on 01/05/23, indicated under the section "Elevator" page 3 of 4 read a statement "shunt trip did not work." An observation on 04/26/23 from 10:00 AM to 12:10 PM revealed the facility had smoke detection in all corridors every 30 feet and all bedrooms. The facility did not have a self-testing fire alarm system. An interview with the Maintenance Director on 04/26/23 at 3:45 PM revealed the facility did not have a smoke detector sensitivity test for the past two years and the facility does not have a smart alarm system. Additionally, the Maintenance Director did not have records to indicate the shunt trip had been repaired since the last fire alarm inspection dated 01/05/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	Assurance Performance Improvement Committee. The QAPI committee meets quarterly and as needed.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 741		6/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315463	A. BUILDING **01** B. WING _____	**05/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

(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 741	Continued From page 10 area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure safe ash trays and a metal self-closing container were provided in accordance with NFPA 101 (2012 edition) Life Safety Code (2012 Edition) Section 19.7.4. This deficient practice had the potential to affect four smokers. Findings include: Observations on 04/26/23 at 10:15 AM of the central enclosed outside courtyard which served as the smoking area revealed four Styrofoam cups full of water and used cigarette butts sitting on four different tables. No self-closing metal containers were noted anywhere in the smoking area. One smoking tower was noted near the	K 741	1. Metal closed ash trays were purchased and put in the smoking area. Styrofoam cups were removed and smokers educated. Resident 77 was not a smoker on admission. Upon learning he had started smoking the facility assessed him for safety and foudn him to be a safe smoker. He signed the facility smoking contract and his lighter is held at the reception desk according to facility policy. 2. All residents have the potential to be affected. 3. All smokers were educated on not using sytrofoam cups to hold or extinguish cigarettes and educated on the use of	

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	315463	A. BUILDING **01** B. WING _____	**05/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

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K 741	Continued From page 11 area near the gazebo. At 10:25 AM on 04/26/23, Resident 77 (R77) was observed in his wheelchair in the smoking area courtyard smoking a cigarette near the gazebo. He was alone and without staff present. Interview with R77 revealed he had his own cigarettes and lighter on his person. He was using the smoking tower to flick his ashes. He flicked in the direction of the tower, but the ashes flew into the air. R77 deposited the cigarette in the smoking tower. A review of the facility policy titled "Smoking Policy and Procedure," revised on 11/30/22 and retrieved off the computer from the Administrator, revealed the policy lacked references to safety while smoking such as safe use of ash trays at all times, extinguishing cigarettes in ash trays only, disposing of all ashes and cigarette butts when finished smoking, and how, when, and where to dispose of such cigarette butts. The policy also lacked a reference to final disposal of all cigarette butts at the end of the day or smoking session. The policy also indicated under section of "Policy" "the organization is a non-smoking facility and will permit residents to smoke in designated outside areas only." In addition, item 7 of the smoking policy indicated that residents would not be permitted to possess cigarette lighters and must be kept at the reception desk. An interview with the Maintenance Director at 10:15 AM on 04/26/23 revealed his understanding was that each resident retrieves cigarettes and lighters from the front desk or nursing station and returns each when finished smoking. An interview with the Director of Nursing (DON) on 04/26/23 at 11:10 AM indicated that residents	K 741	closed metal ashtrays. All smokers were reminded of facility policy of holding lighters at the reception desk. 4. Maintenance director or designee will check the smoking area daily for one month for compliance and then as needed. Housekeeping will check the smoking area daily as part of their regular cleaning schedule and will monitor for compliance. Findings will be reported to the Administrator and Quality Assurance Performance Improvement Committee. The QAPI committee meets quarterly and as needed.	

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K 741	Continued From page 12 receive the cigarettes and lighter on request at the reception desk and are returned when completed. Each person is assessed, and privileges are granted accordingly. Additionally, the DON stated she was not aware R77 was a smoker. R77 was not on the original smoking list provided to this surveyor from the DON on 4/26/22 at 11:10 AM. NJAC 8:39-31.2(e), 31.6(e)	K 741		
K 907 SS=E	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of records, the facility failed to ensure that the category 1 medial gas system had been maintained and tested in accordance with NFPA 99 (2012 edition) Health Care Facilities Code	K 907	1. East Coast Biomedical Service was contracted to provide this service. The service was completed 6/2/23. No residents were affected.	6/9/23

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MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

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K 907	Continued From page 13 Including all Gas and Vacuum System Requirements sections 5.1.14.2.1. and 5.1.14.2.2.2 through 5.1.15. This deficient practice had the potential to affect 18 residents on the Vent Unit. Findings include: Observations on 04/26/23 between 10:20 AM and 10:40 AM revealed a central oxygen supply system in bedrooms 119 through 129 for 18 residents for life support. The oxygen storage tanks were observed on the exterior of the building. A review of the facility's untitled blank binder or white untitled binder containing fire safety and inspection records, provided to the surveyor from the Maintenance Director on 04/26/23 at 1:45 PM, revealed that there was no information regarding the testing and maintenance of the category 1 medical gas system used at the facility. An interview with the Director of Nursing on 04/26/23 at 11:10 AM confirmed that bedrooms 119 through 129 used medical gas supplied from the central oxygen system to sustain life for 18 residents. An interview with the Maintenance Director and Administrator on 04/26/23 at 4:30 PM revealed that no documentation of maintenance or documentation of manufacture's requirements were available at the time of the survey. The facility called a local company for support and to produce such documentation, but no documents were available regarding the testing and maintenance of the system at the exit	K 907	2. All residents have the potential to be affected. 3. A vendor was contractd to provide the service and the maintenance director was educated on the need to have this service in place. 4. Maintenance director or designee will review the service records monthly for 6 months then as needed to ensure compliance. Findings will be reported to the Administrator and Quality Assurance Performance Improvement Committee. The QAPI committee meets quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315463	A. BUILDING **01** B. WING _____	**05/08/2023**

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MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

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K 907	Continued From page 14 conference. NJAC 8:39-31.2(e) NFPA 99	K 907		
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure that it provided a Type I essential electrical system (EES) in accordance with NFPA 99 (2012 edition) Health Care Facilities Code Including all Gas and Vacuum System Requirements sections 6.3.2.2.10.1, 6.4.2.2.1.1, 6.4.2.2.1.2, 6.4.2.2.1.3, 6.4.2.2.1.4. This deficient practice had the potential to affect all 18 residents on life support who reside in affected bedrooms 119 to 129. The	K 915	The facility is requesting a time limited waiver with an estimated completion date of 5/8/2024. We need to obtain estimates for vendors for the work, obtain necessary permits from the local and state applicable agencies, and have the work completed. The changes needed are extensive and necessitate quotes from different vendors, permits, and the work itself will take considerable time.	6/14/23

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MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

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K 915	Continued From page 15 generator also serves a 127 bed certified unit and a 70 bed assisted living unit. Findings include: An observation on 04/26/23 at 11:55 AM of the electrical closet near stairwell three revealed the facility has one transfer switch for the entire facility establishing a Type II or Type III EES, not a Type I EES. A review of generator maintenance records, from the white untitled binder provided by the Maintenance Director on 04/26/23 at 1:45 PM at the generator tab revealed there are no records indicating what percentage of load is being used during load testing. An interview with the Director of Nursing on 04/26/23 at 11:10 AM verified the facility has 18 residents on life support in bedrooms 119 through 129. An interview with the Maintenance Director at the time of the observation verified the facility has only one transfer switch. Further interview at this time revealed the Maintenance Director and facility does not know the total load of the certified building combined with the Assisted Living building or if greater or less than 120 KW (kilowatt). NJAC 8:39-31.2(e) NFPA 99	K 915	Residents are being kept safe in that staff - nurses and aides, respiratory therapists, department heads were educated to inform the supervisor and maintenance director immediately if there is any loss of power. this was initated on 4/26/243. the ventilators have battery backup ranging from 8-15 hours. The generator vendor has stated they can have an emergency generator up and running within 4-8 hours if needed. the maintenance director and his designee are monitoring the issue daily and will report any concern to the administrator and quality assurance performance improvement committee. The committee meets quarterly and as needed.	

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	315463	A. BUILDING **01** B. WING _____	R **06/15/2023**

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MEADOWBROOK RESPIRATORY AND NURSING CENTER	**38 FRENEAU AVENUE** **MATAWAN, NJ 07747**

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{E 000}	Initial Comments Facility non-compliant with K915. Facility is requesting a time-limited waiver. SA recommends approval.	{E 000}		
{K 000}	INITIAL COMMENTS	{K 000}		

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

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.

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
315463 Y1	A. Building B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	38 FRENEAU AVENUE MATAWAN, NJ 07747

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 E0041	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/09/2023	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	
5/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315463 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/15/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK RESPIRATORY AND NURSING CENTER	38 FRENEAU AVENUE MATAWAN, NJ 07747

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	06/09/2023	LSC K0321	06/09/2023	LSC K0341	06/09/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	06/09/2023	LSC K0741	06/09/2023	LSC K0907	06/09/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0915	06/14/2023	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	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/8/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO