STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315054	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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F 000	INITIAL COMMENTS Standard Survey C/O # NJ163533, NJ163173, NJ163585, NJ165142, NJ166987, NJ159883, NJ167046, NJ161095 Census: 158 Sample Size: 32 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		1/15/24

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

Electronically Signed | 12/15/2023

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, safe and sanitary environment. This was identified for 3 of 4 units and was evidenced by the following: During the initial tour of [redacted] hall on 11/14/2023 at 10:58 AM the surveyor observed the following; -privacy curtain between the beds in room [redacted] had dark stains on it. -The floor at foot of [redacted] bed had a dark orange/brown stain. -The floor was observed to have brown pieces of debris scattered on it. -There was no foot board on [redacted] bed. On 11/15/23 at 9:23 AM, the surveyor observed the radiator cover between rooms [redacted] on [redacted] hall in disrepair, with chipped paint. Multiple doorways into resident rooms on [redacted] hall observed with chipped paint.	F 584	F-584 (E) Safe/ Clean/Comfortable/Homelike Environment It is the practice of the facility to maintain a safe, clean, comfortable, and homelike environment allowing residents to use his or her personal belongings to the extent possible. Corrective Action: 1. The facility Governing Body met to review the facilities policies and procedures for maintaining a safe, clean, comfortable, and homelike environment, specifically regarding routine cleaning and disinfection within the facility. 2. On 11/23/2023 the facility Environmental Services Director/Designee conducted a facility-wide audit on rooms to assess the cleanliness of each resident: privacy curtain, room floors, door jams, radiators, baseboards, and common areas trash	

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F 584	Continued From page 2 During a tour of A hall on 11/17/2023 at 9:19 AM, the surveyor observed the following: -A Hall door jams where they meet floor were observed to have dark areas for rooms NJ EX Order. 264b1 NJ EX Order. 264b1, and NJ EX -The privacy curtain in room 12 was observed to have dark stains. On 11/17/2023 at 9:24 AM, the surveyor observed A hall soiled linen room threshold to be stained and appears dirty. On 11/17/2023 at 9:28 AM, the surveyor observed on NJ hall, the threshold on the shower room and tub room NJ to be black with underlying white color. On 11/17/2023 at 9:35 AM, the surveyor observed the radiator NJ hall with dust, debris in top cover between rooms NJ EX Order. 264b1 On 11/17/2023 at 9:45 AM, the surveyor observed that on NJ unit all rooms had debris and dark stains where the door casing meets the floor. The lower walls were observed with dark marks, and stains. On 11/17/2023 at 09:48 AM in the hallway between NJ EX O and NJ EX Ch units by NJ EX Order. 264b1 room, the floor was observed with dark stains where the floor meets the baseboards with dark debris and stains on the baseboard itself. The radiator cover behind the smoke door at the end of NJ EX hall was observed with dust in top cover. On 11/17/2023 at 9:56 AM, the surveyor observed dark marks on the floor by the doctor's office door, under the chart rack on NJ EX Ch hall.	F 584	cans and immediately began. a. Specifically addressing, i. The Privacy Curtains in NJ EX C , by removing and replacing them with a fresh set of privacy curtains. ii. The foot of bed NJ NJ was washed and a new foot board was place at the foot of the bed . iii. The floors in room NJ EX C were swept and then stripped & waxed to ensure that all brown pieces of debris were removed and orange/brown stains noted were removed. iv. The threshold of the shower room on B-hall was scrapped and cleaned to ensure all dark stains and spots were removed. v. The Radiator covers in Rooms NJ EX , NJ EX C and NJ EX were dusted and disinfected to ensure the absence of any dust or debris. The facility Maintenance Director/ Designee repainted the tops of the radiators NJ EX Order. 264b1 to ensure the absence of any paint chippings vi. In response to surveyors noting door jams on a-hall to be black and filled with debris, the door jams on A hall were assessed by the Environmental Services Director who began cleaning and scrapping all the door jams on the unit to include rooms NJ EX Order. 264b1 , and NJ EX . vii. The housekeeping for rom NJ EX Ch removed the dirty privacy curtain from the room and replaced with a clean privacy curtain . viii. The soiled linen room of NJ hall was reviewed and the Environmental Services Director/ Designees began scrapping an cleaning the threshold area to ensure the	

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F 584	Continued From page 3 On 11/20/2023 at 9:24 AM, the surveyor observed the baseboards where they meet the floor on [redacted] hall to have dark stains throughout the length of the hallway along with dust. On 11/20/2023 at 9:26 AM, the surveyor observed a large trash can at the nurse's station for [redacted] hall that had dark spots on the lower end facing the hallway. On 11/20/2023 at 9:27 AM, the surveyor observed that on [redacted] hall the baseboards where they meet the floor have dirt and dark marks throughout the length of the hall. The surveyor observed that all the corners of door jams where they meet the floor were observed with dark marks on [redacted] hall. During an interview with the surveyor on 11/17/2023 at 1:20 PM, the Director of Environmental Services (DEVS) said the process for cleaning rooms is a daily schedule and most housekeepers work 7-3. We work around trays being delivered. We clean all surfaces, fixtures, includes counter, windowsill, soap dispenser, toilet, sink, floor. We do a dry sweep the we use micro fiber wiping pads. We use [redacted] to a room [redacted] for the bathroom, [redacted] for living space. After used we put pads in dirty linen bag as they are washable. Also, empty trash and rebag. When asked how often resident rooms are cleaned, the DEVS replied they are cleaned daily. The surveyor questioned if there are any type of deep cleaning done in resident rooms and the DEVS said a schedule is posted and we deep clean the room that coincides with the date of the month (example room [redacted] all units done on the	F 584	absence of any darks spots or debris . ix. A review was conducted on all rooms on B-hall by the Environmental Services Director/ designee who immediately began addressing dark stains that were noted by surveyors to have been by the door casings where the door meets the floor. x. The Environmental Service Director/ designee as well as maintenance director reviewed, cleaned, and painted all radiators on the unit to ensure that all were free of dust, debris, darks spots and chipped paint. xi. The Environmental Service Director/ Designee reviewed the hallways on [redacted] unit a [redacted] unit closest to the Rainbow Room corners and threshold where the floor meets the baseboards and began addressing the concern by scrapping and washing all corners and baseboards. Any baseboards beyond cleaning were discarded and replaced by a member of maintenance. xii. The Environmental Services Director/ Designee began cleaning the [redacted] nurses station with particular focus on the floors by the MD office and underneath the chart rack as mentioned. xiii. The Environmental Service Director/ Designee reviewed the hallways on [redacted] unit corners where the floor meets the baseboards and began addressing the concern by scrapping and washing all corners and baseboards. Any baseboards beyond cleaning were discarded and replaced by a member of maintenance. xiv. The Environmental Services Director/ Designee conducted a review of the trash	

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F 584	Continued From page 4 12th day of the month). This includes all high dusting, light fixtures, over the bed table and legs, walls are cleaned, corners behind doors windows are done with windowsills. The DEVS went on to say the privacy curtains are washed weekly from all the rooms. All rooms are done monthly. The housekeepers are responsible for the deep cleaning. The porters are responsible for the curtains. Beds, railing and mattresses are also cleaned. The DEVS said he was responsible to make sure resident rooms are deep cleaned. The DEVS went on to say that throughout the day, I am constantly on the floor, and I always do spot inspections and check carts, rooms etc. The surveyor asked what the process is for cleaning the hallways and floors in the hallways. The DEVS said "My porters are responsible for cleaning hallways. They dry sweep 1 uses traditional mop with water and auto scrubber that mops and scraps the floor. They are done daily." The DEVS went on to say "At the same time baseboards and corners are done." "The porters are responsible for walls, handrails, fixtures, and radiators. Porter is responsible for top grill of the radiator to clean. We spray with solution and wipe them down and brush for dust that gets caught in between." During an interview with the surveyor on 11/20/2023 at 11:17 AM, the Director of Maintenance (DOM) was asked what the process is for identifying areas of the facility that need repair, paint or replacement. The DOM said "usually we take a walk around and check rooms to see if anything needs to be painted or repaired. I jot it down." We have an electronic system and if the aides find if anything needs to be fixed they put it in the system. The DOM went on to say "I have 1 guy that does the painting, and the other	F 584	can on GH unit located at NS and conducted a power washing to ensure the absence of any darks spots or stains. 3. On 11/23/2023 the facility conducted a facility-wide audit on all resident rooms to assess all resident bed frames and doorways to ensure they are following the facilities policy on maintaining a safe, clean, comfortable, and homelike environment. a. Following completion of facility wide audit, the Director of Maintenance / Designee developed and initiated plan to repaint all resident doors as needed. b. Following completion of the facility wide audit, the Director of Maintenance / Designees developed and initiated plan to replace all missing an/or broken bed boards. Element 2: 1. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator, Director of Maintenance and Director of Environmental Service identified that, all resident could have the potential to be affected by this deficient practice. Element 3 1. The Director of Environmental Services/ Designee will conduct a weekly audit for the next 3 month on all resident rooms to ensure that each resident room has privacy curtains free and clear of any stains, rips or tears in the event any concerns arise it will be addressed immediately. 2. The Director of Environmental Services/ Designee will conduct a weekly	

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F 584	Continued From page 5 guy will assist if needed. Most of time I have 3 guys beside myself, and I may take care of it or one of the other guys would take care of it. The DOM confirmed "Yes, I would assign them." The surveyor asked if there are any type of environmental rounds performed and if so who is included in this. The DOM replied, "I do this once or twice a month, resident rooms, hallways, office, activity rooms, kitchen area dining rooms therapy." The DOM confirmed "Yes, it is just me." A review of a facility policy titled Routine Cleaning and Disinfection with a date reviewed/revised 02/2023 revealed under the Policy section It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Under the Policy Explanation and Compliance Guidelines section 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at time of discharge. 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. 14. Privacy curtains in resident rooms will be changed when visibly dirty by laundering or cleaning with an EPA (Environmental Protection Agency) registered disinfectant per the curtain and disinfectant manufacturer's instructions. NJAC 31.4(a)	F 584	audit for the next 3 months on all resident rooms to ensure that all resident doorway thresholds, room floors and baseboards are free and clear of any stains or debris in the event any concerns arise it will be addressed immediately. 3. The Director of Maintenance / Designee will conduct a weekly audit for the next 3 months on all resident rooms and common area bathrooms to ensure that all doorways are free and clear of any chips in paint in the event any concerns arise it will be addressed immediately Element 4 1. The Director of Environmental Services will submit findings from the audit on privacy curtains within the facility to the QA/QAPI committee, if further actions are deemed necessary the team will address. 2. The Director of Environmental Services will submit findings from the audit on resident doorway thresholds, room floors, radiators and baseboards within the facility to the QA/QAPI committee, if further actions are deemed necessary the team will address. 3. The Director of Maintenance will submit findings from the audit on the painting of resident room doors and common area bathroom doors to the QA/QAPI committee three (3) times annually , if further actions are deemed necessary the team will address.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		1/15/24

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§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

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F 656	Continued From page 7 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement a comprehensive, person-centered care plan to prevent NJ EX Order. 264b1 related injury for 1 of 34 residents reviewed (Resident #52). This deficient practice was evidenced by: On 11/14/2023 at 10:50 AM during initial tour, the surveyor observed Resident #52 resting in bed. There was no NJ EX Order. 264b1 on the floor. On 11/17/2023 at 08:10 AM, the surveyor observed Resident #52 resting in bed and watching TV. The NJ EX Order. 264b1 was not on the floor. During that time, the surveyor observed Resident #52's room and did not see the floor mat. The surveyor also observed a NJ EX Order. 264b1 placed underneath Resident #52, with gray cord extending on the floor and not connected to the powering device (a box with batteries which makes the alarm work). On 11/20/2023 at 08:38 AM, the surveyor observed Resident #52 sleeping in bed. The floor mat was not on the floor by Resident #52's bed. A review of Admission Record found in the Electronic Medical Record (EMR) indicated that Resident #52's diagnosis included, but were not limited to, NJ EX Order. 264b1 ,	F 656	F656: Develop/Implement Comprehensive Care Plan a. Element 1: " the Unit Manager/ Designee Place floor mat while resident #52 is in bed. " the Unit Manager/ Designee Place working bed alarm while resident #52 is in bed and check connection cord and powering device is always connected. " Registered Nurse /Licensed Practical Nurse /Certified Nurse Aide were educated and in-service by the facility educator on the importance of having floor mat and working bed alarm on residents on fall risk while in bed as stated in their care plan. b. All residents who are at risk of falling while in bed need a floor mat and bed alarm as ordered or stated in their care plan may have potential to be affected. c. The following measures were put into place to ensure this does not recur: " List obtained by unit managers of all residents ordered or care planned for bed alarm and floor mat. " The Unit Manager/ Designee Ensure all residents obtained from the list have floor mat and working bed alarm. " The Facility Educator / Designee " In-service Registered Nurse	

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F 656	Continued From page 8 NJ EX Order. 264b1 A review of a quarterly Minimum Data Set (MDS; an assessment tool) dated NJ EX Order. 264b1 revealed that Resident #52's Brief Interview for Mental Status (BIMS; a tool use to screen cognitive condition) was NJ EX Order. 264b1). A review of Resident #52's Care Plan (CP) located in the EMR revealed CP for f NJ EX dated NJ EX Order. 264b1 with "Focus: Actual f l r/t [related to] NJ EX NJ EX Order. 264b1 NJ EX Order. 264b1 " Furthermore, the CP indicated interventions for NJ EX Order. 264b1 initiated on NJ EX Order. 264b1 and floor mat to side of bed initiated on NJ EX Order. 264b1 to prevent injury. A review of Progress Notes found in the EMR and facility provided Incident Report revealed that Resident #52 had unwitnessed NJ EX without injury on NJ EX Order. 264b1 . A review of " NJ EX Risk Assessment 1.0 Revised" found in the EMR and dated NJ EX Order. 264b1 revealed that the resident was at NJ EX Order. 264b1 . On 11/17/2023 at 12:12 PM during interview with the surveyor, Certified Nurse Assistant (CNA#1) replied, "I usually help [resident's name] get washed and dressed. [Resident's name] needs lots of support with transfers" when asked about Resident #52' care needs. On 11/17/2023 at 12:17 PM during interview with the surveyor, Unit Manager/Licensed Practical Nurse (UM/LPN #1) stated, "Yes! [Resident's name] had one NJ EX Order. 264b1 . We put NJ EX Order. 264b1 on	F 656	/Licensed Practical Nurse /Certified Nurse Aide to check presence of NJ EX Order. 264b1 and working NJ EX Order. 264b1 that has an order or care planned while in bed on all shift. d. Audits will be conducted by the Director of Nursing / Designee on the presence of working and properly connected to powering device bed alarm and usage of NJ EX Order. 264b1 for residents that are ordered, and care planned NJ EX Order. 26 weekly x4, monthlyx3, quarterly x2. Findings will be reported to QA quarterly x2.	

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her/his bed to prevent her/him from getting out and [NJ EX Order] when asked about Resident #52's risk for falls or history of falls. At that time and in the presence of UM/LPN #1, the surveyor showed the [NJ EX Order: 26401] which was not connected to the powering device. The UM/LPN #1 lifted the mattress, checked around the room, but could not locate the powering device. At that time, UM/LPN #1 confirmed that the powering device was not present, and the cord extending from the [NJ EX] [NJ EX Order: 26401] should have been connected to the powering device in order to work. The UM/LPN #1 stated, "Yes, absolutely! The [NJ EX Order] should have the box [powering device]. It won't work without it."

On 11/20/2023 at 08:35 AM during interview with the surveyor, UM/LPN #1 replied, "Yes" when asked if documented care plan interventions should be followed in practice. During the same interview, UM/LPN #1 also said, "Yes" when asked by the surveyor if Resident #52's interventions outlined in the care plan ([NJ EX Order: 26401] [redacted] should be implemented when the resident is in bed.

On 11/20/2023 at 01:05 PM during interview with the surveyor, the Director of Nursing (DON) stated, "If we put care plan, we should be putting interventions as well, and we follow it. We put it in TAR [treatment administration record] and POC [point of care; documentation system] if it is needed for the aides" when asked about expectations for care planning. During the same interview, the DON said, "Yes" when asked if care planned intervention such as [NJ EX Order: 26401] and [NJ EX Or] [NJ EX] should be followed in practice. Furthermore, the DON stated, "[NJ EX Order: 26401], because when they [residents] try to get out of bed, we respond to the

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F 656	Continued From page 10 NJ EX Order. 264b1 is needed to prevent injury from NJ EX O when asked by the surveyor why it was important to have a NJ EX Order. 264b1 at the bedside and a functioning NJ EX Order. 264b1. The DON also stated, "If it's defective, it is not going to work. We aren't going to hear it" when asked by the surveyor why it was important to ensure that NJ EX Order. 264b1 is not defective or malfunctioning. A review of policy titled NJ EX Ord Prevention/Management" and revised on 2/2021 revealed under section "Approaches to Managing NJ EX Ord and NJ EX Order. 264b1" that "Staff will identify and implement relevant interventions to try to minimize serious consequences of f NJ EX Order.	F 656		
F 684 SS=D	N.J.A.C. 8:39-11.2(f); 27-1(a) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ163585 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to provide the needed care and services in accordance to	F 684	F684: Quality of Care a. Our immediate corrective action was to: " Educate Registered Nurse #3 on the importance of placing orders immediately as ordered by the physician.	1/15/24

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F 684	Continued From page 11 professional standards of practice that met the resident's physical needs by not obtaining laboratory diagnostics, specifically a [redacted] test as ordered by the physician for the next day. The deficient practice was discovered for 1 of 3 residents (Resident # 355) investigated for Change of Condition. The deficient practice was evident by the following: A review of Resident # 355's Electronic Medical Record (EMR) revealed that he/she had diagnoses of but not limited to a [redacted] NJ EX Order. 264b1). A review of Resident # 355's Physician Orders revealed an order to "Send to ER [Emergency Room] re: critical lab result [redacted] " and that the resident is a " [redacted] " (provide [redacted] NJ EX Order. 264b1). A review of Resident # 355's EMR revealed a "Routine Nursing Progress Note" dated [redacted] that revealed, "PACE MD called to order CBC [redacted] NJ EX Order. 264b1 t] lab for next morning then follow up on the result." The EMR did not reveal any orders for a [redacted] test for [redacted] and showed no laboratory results under "Results" in the EMR at all for [redacted] as the previous progress note revealed the physician ordered a [redacted] for that morning. A follow-up review of Resident # 355's EMR revealed that the next [redacted] test was	F 684	" " Registered Nurse /Licensed Practical Nurse in-service on placing orders immediately as ordered by the physician and notify. b. All residents that have laboratory orders from the physician may have potential to be affected. c. The following measures were put into place to ensure this does not recur: " the facility nurse educator conducted one on one education and In-service with all Register Nurses and Licensed Practical nurses on staff to ensure all orders from the physician must be placed, on facility documentation system point click care , immediately and request of laboratory service place on Laboratory Company Website. " The former Laboratory Company was replaced with New Laboratory Company to ensure laboratory request are done at the date and time it was requested by the physician. d. Audits will be conducted by the Director of Nursing/ Designee on laboratory follow-up orders and results weekly x4, monthly x3, quarterly x2. Findings will be reported to QA quarterly X2.	

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obtained on [redacted] at 06:30 AM. The result revealed that Resident # 355's [redacted] was [redacted]. The reference range for [redacted] according to the laboratory results was [redacted] through [redacted]. Once the physician was notified of the [redacted] t, and order was given to send the resident to the Emergency Room. The previous [redacted] test obtained from Resident # 355 on [redacted] resulted in a [redacted] count of [redacted]

On 11/17/2023 at 12:08 PM during an interview with the surveyor, the Unit Manager/Registered Nurse (UM/RN) # 2 replied, "Yes." when the surveyor asked if a physician orders labs for the following morning, do they get added as an order.

On the same date at 12:45 PM during an interview with the surveyor, the UM/RN # 3 replied, "Yes, definitely." when asked by the surveyor if a resident has a change of condition and the physician orders labs for the next morning, does an order for that need to be added to the EMR.

On 11/21/2023 at 1:17 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) replied, "That would be reasonable." when the surveyor asked is it reasonable to believe that if the labs were completed on [redacted], the elevated [redacted] may have been discovered earlier.

On 11/22/2023 at 10:21 AM during an interview with the surveyor, the Director of Nursing (DON) replied, "She [RN/LPN # 3] forgot to put the physician's order for [redacted] to the [EMR]."

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F 684	Continued From page 13 A review of the facility-provided policies titled, "Physician Orders" and "Venipuncture for Lab Draws" did not contain pertinent information about laboratory orders. N.J.A.C. § 8:39-11.2 (b)	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Resident #133 Based on observation, interview, review of the medical record (MR) and review of other pertinent facility documents, it was determined that the facility failed to consistently ensure communication with a contracted [NJ EX Order. 264] facility according to facility policy and procedure. This deficient practice was evidenced for 1 of 1 resident (Resident #133) investigated for [NJ EX Order. 264]. This deficient practice was evidenced by the following: On 11/16/2023 at 09:06 AM Resident #133 stated to the surveyor that they had attended [NJ EX Order. 264] for approximately (1) year and is transported via the facility contracted transportation service. Resident #133 stated that he/she had no issues with transportation. Resident #133 also stated that he/she does not take a communication binder when attending [NJ EX Order. 264] and does not recall	F 698	F698: Dialysis a. Our immediate corrective action was to: • A communication binder was created and sent to scheduled dialysis times with resident upon subsequent dialysis appointment and thereafter. • Nursing educated and instructed to check residents' [NJ EX Order. 264] access upon return from treatment. • Information was obtained from [NJ EX Order. 264] center for resident #133 for dates NJ EX Order. 264b1 , [NJ EX Order. 264b1], and [NJ EX Order. 264] . • Educate RN/LPN in the unit where resident #133 is located, to ensure that communication form is signed by the receiving nurse in the unit and form is filled out by [NJ EX Order. 264] center. If the form is not completed by the [NJ EX Order. 264] center, nurse must call to have information fax or	1/15/24

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F 698	Continued From page 14 staff checking his/her [redacted] site upon return to the facility. According to the Admission Record, Resident #133 was admitted to the facility with the following but not limited to diagnoses: NJ EX Order. 264b1 [redacted]. According to the [redacted] quarterly Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #133 had a Brief Interview for Mental Status Score of [redacted] indicating intact [redacted] status. Section [redacted] of the MDS revealed that Resident #133had an NJ EX Order. 264b1 [redacted] According to Section [redacted] Resident #133 received [redacted] while a resident at the facility. A review of the Order Summary Report, dated [redacted] revealed the following physician orders for Resident #133: "Assure retrieval of [redacted] communication book post [redacted] treatment. If center did not return book, call center for communication. Every day shift every NJ EX Order. 264b1. Order date: [redacted]" "Resident receives NJ EX Order. 264b1, NJ EX Order. 264b1 4 AM at [facility name]." "Send completed communication form to [redacted] center with patient on scheduled days. Every	F 698	emailed to the unit. b. Any resident that goes to [redacted] center has the potential to be affected. c. The following measures were put into place to ensure this does not recur: • In-service nursing staff RN/LPN the importance of having [redacted] form filled out by [redacted] center and to ensure to sign the form when received and if form is not filled out by the [redacted] center to call and have the center Fax or email information needed on the form. • DON/ADON informed nurse manager from [redacted] centers to educate their nursing staff on completing communication form. d. Audits will be conducted by the Nursing Administration on completion of communication form, weekly x4, monthly x3, quarterly x2. Findings will be reported to QA quarterly x2.	

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F 698	Continued From page 15 night shift every NJ EX Order. 264b1." A review of Resident #133's comprehensive care plan revealed a care plan Focus: "Renal insufficiency related to NJ EX Order. 264b1, NJ EX Order. 264b1. Date Initiated: NJ EX Order. 264b1. Care planned Interventions included: "Coordinate NJ EX Order. 26 care with the NJ EX Order. 26 treatment center. Date Initiated: NJ EX Order. 264b1 On 11/20/2023 at11:23 AM the surveyor reviewed Resident #133's dialysis communication book that is sent with the resident on NJ EX Order. 26 treatment days. The communication form was reviewed for the following dates: NJ EX Order. 264b1 [redacted], NJ EX Order. 264b1 and NJ EX Order. 264b1. The following NJ EX Order. 26 communication forms were not completed by the dialysis center: NJ EX Order. 264b1 [redacted] and NJ EX Order. Order. 26 On 11/20/2023 at 11:35 AM the surveyor interviewed the Licensed Practical Nurse (LPN#1), assigned to Resident #133's unit. The surveyor asked what the procedure was for Resident #133's NJ EX Order. 264 communication book/form. LPN #1 stated, "We fill it out before the resident leaves, for any medications provided, vitals, and any new pertinent issues. Then dialysis sends it back with the resident. They do pre and post vitals and weights and any medications provided. Upon arrival back from NJ EX Order. 26 the assigned nurse reviews the communication form." LPN #1 further stated, "We will review for any new requests. If NJ EX Order. 26 does not complete the form the assigned nurse will call NJ EX Order. 26 and get the required information."	F 698		

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The surveyor asked LPN #1 what they would do if a resident returned from the [redacted] treatment center with a blank communication form for "Information from the [redacted] Center.?" LPN #1 replied, "If the form is blank for the [redacted] section the nurse should call just to make sure there are no changes."

On 11/20/2023 at 12:02 PM the surveyor conducted an interview with the facility Director of Nursing (DON). The surveyor asked the DON what the purpose of the [redacted] communication book/form. The DON replied, "The purpose of the communication book is to have open dialogue between the facility and the [redacted] center." The surveyor then asked the DON what should be done if the [redacted] communication form is received blank from the [redacted] treatment center. The DON stated, "If the form comes back blank, the assigned nurse or supervisor is responsible for contacting [redacted] to get the necessary information." During another interview on [redacted] at 10:48 AM the facility DON told the surveyor, "They (nurse) call the [redacted] center and if there is no recommendation then they just sign the MAR (medication administration record)." The surveyor asked the DON if the receiving nurse should contact the [redacted] center if a [redacted] communication form is received blank from the [redacted] center. The DON told the surveyors, "Yes, it should be done (contact the [redacted] center) upon return to the facility to get the necessary information even if there are no new recommendations. The receiving nurse assigned to the [redacted] resident should sign the [redacted] communication form upon return to the facility to ensure that the form was reviewed."

The surveyor reviewed the facility provided policy

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F 698	Continued From page 17 and procedure with subject: [redacted] Services, revised date: [redacted] The following was revealed under the Interpretation and Process heading: 5. Resident will be sent with communication book to each treatment to assure collaborative care. 6. Transport company will return communication book to charge nurse. 7. The resident's nurse will review the communication book upon return from treatment for evaluation and any recommendations/treatments that had occurred at the dialysis center.	F 698		
F 812 SS=F	N.J.A.C. 8:39-27.1 (a) 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	F 812		1/15/24

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F 812	Continued From page 18 standards for food service safety. This REQUIREMENT is not met as evidenced by: FACILITY F812 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/14/2023 at 9:20 AM the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. Upon entry to the walk-in refrigerator a previously opened box contained shelled eggs. The box was open, and the eggs were exposed. The box was sitting on the floor of the walk-in refrigerator. 2.- In addition, a bulk bottle of Ranch dressing and a bottle of bulk BBQ sauce were previously opened. The bottles did not have an open or use by date. A pan contained Jello and was covered with clear plastic wrap. The pan of Jello was undated, and the plastic wrap did not completely cover the Jello, exposing it to the air. 3. On a middle shelf of the walk-in refrigerator a white plastic bin contained what appeared to be oranges. The oranges were in the process or were turned brown and several of the oranges had a fuzzy white mold-like substance on the exterior of the orange.	F 812	F-812 (F) Food Procurement, Store/Prepare/ Serve-Sanitary It is the practice of this facility to maintain a food safety program that ensures the safe management of food procurement, storage, preparation, and sanitary serving within the facility. Corrective Action 1. The Facility governing body met to review the facilities policies and procedures for Food Safety, specifically regarding the food procurement, storage, preparation, and sanitary serving of food within the facility. 2. On 11/14/2023 the Food Service Director/ Designee removed the box of exposed eggs from the floor. The Food Service Director/ Designee provided education to all Dietary Aides regarding the facility policy for proper procurement and storage of food. 3. On 11/14/2023 the Food Service Director /Designee conducted sanitation and stored away the meat slicer an stand up mixer. The Food Service Director/ Designee provided education to all dietary staff on policy and procedure for proper sanitation and storage of kitchen supplies. 4. On 11/14/2023 the Food Service Director/ Designee conducted and audit on all food storage containers to ensure serving utensil had not been accidentally left inside their storage bins. All dietary aides and cooks were provided with education on facility policy and procedure for proper storage of food.	

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F 812	Continued From page 19 4. In the walk-in freezer, a previously opened box of Tyson Chicken filet had no dates. The box was opened and the bag inside the box that contained the chicken filets was opened and the chicken filets were exposed. 5. In the reach-in refrigerator, a previously opened bottle of lemon juice had no open or use by date. On the same shelf a clear plastic take-out style container appeared to contain a salad. The container had no dates. 6. In the food prep area a cleaned and sanitized meat slicer and stand-up mixer were not in use. The meat slicer and stand-up mixer were not covered and were exposed. 7. In the dry storage area a bulk container contained a previously opened bulk bag of rice. The bulk container did not have the clear plastic cover in place and the bag of rice was opened and exposed to the air. In addition, the bag of was observed to contain a clear plastic 4-ounce portion control cup and a plastic dessert dish in the rice used to access the rice for food production of resident meals. On 11/16/2023 from 11:24 AM to 11:42 AM the surveyor accompanied by the Licensed Practical Nurse (LPN # 5) observed the following on the G/H unit pantry: 1. In the pantry refrigerator (2) containers of Nepro (a liquid supplement designed for patients with renal disease) that were brought to the facility by a resident family had a manufacturer's use by date "10CT2022." A plastic take out style container with a clear plastic lid contained an	F 812	5. On 11/16/2023 The Director of Nursing/Designee provided education to all nursing staff on the facility policy for date and labeling of pantry refrigerator items . 6. On 11/21/2023 the Food Service Director/designee audit all food storage areas to ensure that all items undated items have been removed from kitchen and discarded. All Dietary aides educated on proper protocol for storage of food within the facility. 7. On 11/21/20223 the Food Service Director/ Designee conducted an audit of all can within the kitchen storage to identify whether they had dents on them an immediately transferred them to labelled dented cans storage cart. All dietary aides were provided education on proper protocol and location of dented cans to avoid future occurrences. 8. On 11/21/2023 the Food Service Director/ Designee conducted an audit of the dry storage room to identify an address any improperly stored plate and dishware in the dry storage room. The Food Service director purchased covers for all 7 compartment storage carts to ensure items stored on it are always covered. All dietary staff were provided in-service and education on the new protocol for storage of plates and dishware in the dry storage room. 9. On 11/21/2023 the Infection Preventionist conduct a competency and education on hand washing with Cook # 1 mentioned in 2567 to ensure Cook # 1 comprehension of the facility hand hygiene policy and procedure. On	

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F 812	Continued From page 20 unidentified food. The container had no name and no dates. In addition, a plastic take out container of tortellini in rosa sauce had no dates. An unopened container of Low Fat Cottage Cheese had a "BEST IF USED BY" date of "09/22/23." LPN #5 agreed that the unit nursing staff is responsible for monitoring the dates of food products in the pantry and that all food products should have a date and name on them, per facility policy. On 11/16/2023 from 11:47 to 11:56 AM the surveyor, accompanied by the Registered Nurse/Unit Manager (RN/UM#3) observed the following on the C/D Unit Pantry: 1. Inside the freezer there was an accumulation of ice build-up and unidentified yellow/orange food stains on the ice build-up. RN/UM #3: on interview agreed that the freezer required defrosting and sanitizing, and that maintenance would be responsible for that task. On 11/21/202 from 10:55 to 11:45 AM the surveyors, accompanied by FSD, observed the following in the kitchen: 1. In the dry storage room on the can good mobile storage rack the surveyor identified that a can of Cheddar Cheese Sauce and a can of Sauerkraut had significant dents on the seam. On interview the FSD stated, "I missed those." 2. In the middle of the dry storage room a wheeled (7) compartment dishware storage cart, used to store cleaned and sanitized dishware used for resident meals, The cart contained (2) racks of dessert plates and (1) rack of monkey dishes (a small bowel with a flat bottom). The	F 812	11/22/2023 the Infection Preventionist provide the entire Food Servies Department competency and education on proper hand hygiene protocol. 10. On 11/21/23 The Food Service Director and Infection Preventionist provided education of Dietary Aide # 1 on usage of hair Nets and Beard Guards within the kitchen. 11. On 11/16/23 the facility Maintenance Director /Designee conducted an audit on all refrigerator and freezers on the unit to ensure that they did not have an over accumulation of ice. Any freezer noted to have and over accumulation of ice was immediately thawed, sanitized, and returned to the unit. Identification of Others 1. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator, Food Service director and Infection Preventionist and identified that all resident are at risk of the deficient practice Systemic Changes 1. The Food Service Director/Designee will conduct daily opening/closing checklist audits for the next (3) three months of the facility walk in refrigerator to include but not limited to the review of department compliance with: proper concealment of items not in use, dating and labeling, and removal of all expired items and address concerns as needed. 2. The Food Service Director / Designee will conduct daily opening/closing checklist audits for the next (3) three months of the facility dry storage room to	

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F 812	Continued From page 21 plates and dishes were stored uncovered, not in the inverted position, and were exposed to contamination. 3. In the walk-in refrigerator on a top rack, a half pan contained what appeared to be grape jelly. The 1/2 pan was covered with plastic wrap. The pan had no dates. 4. In the walk-in freezer on an upper rack two (2) clear plastic containers with lids contained pesto, according to the FSD. The containers had no dates. 5. In the reach-in refrigerator on an upper shelf (2) 4-ounce portion control cups with lids were labeled "applesauce" and had a use by date of "11/15." On a shelf below a previously opened package of orange cheese slices were wrapped in plastic wrap. The cheese had no dates. 6. Prior to taking food temperatures before the lunch meal tray line the facility cook performed hand hygiene. Lunch Tray Line: John/Cook: Hand hygiene performed. The surveyor watched the cook turn on the faucet, wet their hands, apply soap, and perform hand washing for approximately 25 seconds. The cook then rinsed their hands under running water. After rinsing his hands, the cook turned off the faucet with a bare hand after completing hand washing. The cook then secured a hand towel from the dispenser and proceeded to dry their hands. The cook then threw the hand towel into the waste receptacle. On interview the FSD agreed that the cook should not turn off the faucet with their bare hand after completing hand washing. 7. During preparation for the lunch meal tray line	F 812	include but not limited to the review of the department's compliance with: proper storage of dented cans, proper storage of serving utensils, proper storage of plates and dishes to eliminate contamination exposure and address concerns as needed. 3. The Food Service Director/Designee will conduct daily opening/closing checklist audits for the next (3) three months of the facility walk in freezer to include but not limited to the review of department compliance with dating and labeling items, and address concerns as needed. 4. The Food Service Director/Designee will conduct weekly competencies and education with all dietary staff on policy and procedures for use of hair nets and beard guards withing the kitchen. 5. The Facility Maintenance Director/Designees will conduct weekly audits for the (3) three months on all pantry refrigerator to ensure all freezers do not have over accumulation of ice and address concerns as needed. 6. The Unit Manager/Designees will conduct weekly audits for the next (3) three months on all pantry refrigerators to ensure compliance with dating and labeling policy and address concerns as needed. 7. The Facility Infection Preventionist /Designee will conduct weekly audits for the (3) month on all dietary staff to ensure compliance with hand hygiene policy and procedure. Quality Assurance: 1. The Food Service Director/Designee	

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F 812	Continued From page 22 a kitchen staff was observed in the tray line area prior to the serving of the lunch meal. The staff had a lengthy beard. The staff had no beard guard, and the beard was exposed. The surveyor reviewed the facility policy titled Dating and Labeling Policy and Procedure, undated. The policy revealed the following under the PROCESS heading: 1. All food items must be labeled with either a manufacturer label or handwritten label. 2. All food products, upon receiving, must be dated with receiving date. 3. All prepared (individually wrapped) items will be dated with compliance of the 3-day rule and labeled with a "use on or by" date. Examples: Applesauce, Pudding, Sandwiches, Salads. **Note the day the item is prepped counts as the 1st day of usage.** 5. All bulk pre-packaged prepared items, i.e., mayonnaise, salad dressing, pickles, barbeque sauce, uncooked pastas, opened cake/brownie mixes, beef, or chicken base. bread crumb, bulk cheeses, sour creams, etc. will be marked with an "opened date" and discarded date of 30 days. Example: Open 5/10/22, Use by 6/10/22. 9. Any item which is found not properly dated and labeled shall be discarded. 10. All open boxes in the freezer of items that have not been cooked yet get an open date and a use by or use on date of 30 days. The surveyor reviewed the facility policy titled Hair	F 812	will submit findings from the opening/closing audit on the walk-in refrigerator within the facility to QAA committee quarterly, if further action is deemed necessary the team will address. 2. The Food Service Director/Designee will submit findings from the opening/closing audit on the walk-in freezer within the facility to QAA committee quarterly, if further action is deemed necessary the team will address. 3. The Food Service Director/Designee will submit findings from the opening/closing audit on the dry storage room within the facility to QAA committee quarterly, if further action is deemed necessary the team will address. 4. The Food Service Director/Designee will submit findings from educations and competencies results with dietary staff within the facility to QAA committee quarterly, if further action is deemed necessary the team will address. 5. The Director of Nursing/Designee will submit findings from the education and competencies completed with nursing staff on protocol for dating and labeling of items in the pantry refrigerator within the facility to QAA committee quarterly, if further action is deemed necessary the team will address. 6. The Maintenance Director/Designee will submit findings from pantry freezer audits for each unit within the facility to QAA committee quarterly, if further action is deemed necessary the team will address. 7. The Infection Preventionist/Designee will submit findings from the education	

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F 812	Continued From page 23 Nets and Beard Guards, undated. The following was revealed under the heading Beard Restraints: All facial hair that is longer than a 1/4 inch must be restrained through the use of a beard net. The surveyor reviewed the facility policy titled Dented Cans, undated. The following was revealed under the heading Procedure: "Place all dented cans in a clearly marked, specifically designated area away from other product so that the food service director can safely discard product and get a refund for said cans." The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, undated. The following was revealed under the heading Policy Interpretation and Implementation: 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, and the "use by" date. 7. The nursing staff is responsible for discarding perishable foods on or before the "Use by" date. 8. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates.) The surveyor reviewed the facility provided competency titled Hand Washing. The following was revealed under the Procedure section:	F 812	and competencies completed with dietary staff on hand hygiene within the facility to QAA committee quarterly, if further action is deemed necessary the team will address.	

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F 812	Continued From page 24 1. Turn on faucet and run water until a desired temperature is achieved. Hot water is unnecessarily rough on the hands. 2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) outside the stream of water. 3. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. 4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. 5. Discard towels into trash. 6. When possible, utilize lotions throughout the day to protect the integrity of the skin. N.J.A.C. 18:39-17.2(g)	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868		1/15/24

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F 868	Continued From page 25 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to have a Quality Assurance and Process Improvement Committee (QAPI) and Quality Assurance Assessment (QAA) that consisted of the minimum required members by failing to include the facility's Medical Director in any of the provided attendance sheets. The Medical Director's attendance was not documented on 10 of 10 attendance sheets provided by the facility. The deficient practice was evidenced by the following:	F 868	F-868 (D) QAA Committee It is the practice of this facility to maintain a quality assessment assurance committee consisting at minimum of the Director of Nursing, Medical Director, (3) three other staff members which includes the administrator and infection preventionist. Element 1 1. The facility Governing Body met to review the facilities policies and procedures for maintaining a Quality Assessment Assurance Committee, specifically regarding the need for the presence of the medical director at all	

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F 868	Continued From page 26 On 11/20/2023 at 12:24 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) said that the facility-provided Quality Assurance Meeting signature sheets are the same signature sheets for QAPI Committee. A review of the signature sheets the facility provided to the surveyor did not include the Medical Director's signature as proof of attendance to any meetings held during 2023, specifically from January through October. On 11/21/2023 at 11:24 AM during an interview with the surveyor, the Medical Director stated he attends the facility's QAPI meetings every three months. He further stated that if he has a prior commitment, he will follow up after. On 11/22/2023 at 10:21 AM during an interview with the surveyor, the LNHA said, "I don't have physical signatures but I do a review call afterwards with the Medical Director. It's hard to catch him..." A review of the facility provided policy titled, "Quality Assurance and Process Improvement" with a revised date of 6/2022 revealed under, "Committee Membership" that, "3. The following individuals will serve on the committee:... c. Medical Director..." The policy also revealed under the section titled, "Committee Reports and Records" that, "1. The committee shall maintain minutes of all regular and special meetings that include at least the following information:... b. the names of committee members present and absent..." N.J.A.C. § 8:39-23.1 (a) 3	F 868	Quality Assessment Assurance Committee meetings within the facility. 2. The facility cannot retroactively complete the QAA meeting sign in sheets; however, On 11/23/2023 the Administrator, Medical Director and Director of Nursing met to review the Q Quality Assessment Assurance Committee policy and procedures and identified dates for the QAA Meetings for the upcoming year to ensure the Medical Director is present to all QAA Meetings. Element 2 1. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator, Director of Nursing and Medical Director identified that, all residents could have the potential to be affected by this deficient practice. Element 3 1. The Administrator/ Designee will conduct a quarterly review of all QAA Meeting attendance sheets to ensures that the Medical Director was present and signed into all meetings. 2. The Administrator/ Designee will provide Virtual Access to all QAA meetings with record attendance to ensure that the Medical Director is able to attend any meetings he/she cannot be physically Element 4 1. The Administrator will submit findings from the audit on QAA meeting attendance within the facility to the QA/QAPI committee monthly/quarterly for the next three (3) quarters , if further actions are deemed necessary the team will address.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		1/15/24

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F 880	Continued From page 28 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to use appropriate hand hygiene and proper disinfection while providing [redacted] care to residents. The deficient practice was observed A.) for 1 of 1 resident (Resident # 85) investigated for NJ EX Order. 264b1 and B.) 1 of 2 residents (Resident #109) investigated for [redacted] Condition. The deficient practices were evident by the	F 880	F880 Infection Prevention and Control a. Our immediate corrective action was to: • Educate LPN #3 that perform wound care to Resident #85 on [redacted] Care Policy and Steps and Procedures on [redacted] Care. Given specific education on disinfecting the surface prior to placing items needed on [redacted] care and performing hand hygiene with soap and water or alcohol-based hand sanitizer in	

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F 880	Continued From page 29 following: A.) A review of Resident # 85's Electronic Medical Record (EMR) revealed a Nutrition Note in the progress notes dated 1[redacted] The Nutrition Note revealed that Resident # 85 had an unstageable pressure ulcer to the[redacted] area. A review of Resident # 85's Significant Change 5-Day Minimum Data Set (MDS) dated [redacted] revealed under section, '[redacted] that Resident # 85 was at [redacted] The MDS did not reveal that he/she had a [redacted] at that time. A review of Resident # 85's medical diagnoses located in the EMR revealed that Resident # 85 was diagnosed with but not limited to unspecified [redacted] A review of Resident # 85's EMR revealed under "Orders" that he/she had a physician's order for [redacted]. The order revealed to apply [redacted] topically every day shift for [redacted] care. The order further revealed to cleanse the [redacted] with [redacted]) moistened gauze and a clean, dry dressing daily and PRN (as needed). A review of Resident # 85's Care Plans located in the EMR revealed a Care Plan with a focus of, "Actual [redacted] related to [redacted], [redacted]."	F 880	between change of gloves. • Educate LPN #4 that perform wound care to Resident #109 on [redacted] Care Policy and Steps and Procedures on [redacted] Care. Given specific education on 1. Performing hand hygiene with soap and water or alcohol-based hand sanitizer prior to donning gloves at the start of the wound care and to perform hand hygiene between change of gloves. 2. Wipe equipment such as scissors before and after use with alcohol or disinfectant wipe. • A wound care competency was performed with both LPN #3, and LPN #4. b. Any resident who has orders of [redacted] care has the potential to be affected. c. The following measures were put into place to ensure this does not recur: • In-service all nursing staff RN/LPN on [redacted] Care Policy and Steps and Procedures on [redacted] Care. Specific instructions are given on Performing hand hygiene with soap and water or alcohol-based hand sanitizer prior to donning gloves at the start of the [redacted] care and to perform hand hygiene between change of gloves. Wipe equipment such as scissors before and after use with alcohol or disinfectant wipe. • Perform Competency on Steps and Procedures on [redacted] Care to all nursing staff RN/LPN. d. Audits will be conducted by the Infection Preventionist Nurse and Nursing Administration on Proper Steps and	

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F 880	Continued From page 30 On 11/16/2023 at 11:20 AM, Surveyor # 1 obtained permission from Resident # 85 to observe his/her [redacted] care. On the same date and time, Surveyor # 1 observed Licensed Practical Nurse (LPN) # 3 begin to prepare to perform [redacted] care on Resident # 85. At that time, LPN # 3 placed NJ EX Order. 264b1 unpackaged gauze, a wood applicator, and an NJ EX Order. 264b1 [redacted]) on the top surface of the nightstand next to Resident # 85's bed. LPN # 3 did not apply any disinfectant to the nightstand surface prior to placing the items onto it. On the same date and approximate time in the presence of Surveyor # 1, LPN # 3 donned disposable gloves and began to clean Resident # 85's [redacted] with gauze saturated with NJ EX Order. 264b1 Upon completion of cleaning the [redacted], LPN # 3 removed the disposable gloves and donned a new pair of disposable gloves and began to apply [redacted] to the [redacted] using the wood applicator. LPN # 3 did not perform hand hygiene with soap and water or alcohol-based hand sanitizer between the change of gloves. On the same date at 11:40 AM during an interview with Surveyor # 1, LPN # 3 replied, "Yes, we should have wiped it down" when Surveyor # 1 asked if anything should have been done to the nightstand surface. LPN # 3 also replied, "Yes, sorry about that." when Surveyor # 1 asked if she should have washer her hands in between changing gloves. On 11/21/2023 at 01:17 PM during an interview with Surveyor # 1, the Licensed Nursing Home	F 880	Procedures on Wound Care weekly x4, monthly x3, quarterly x2. Findings will be reported to QA quarterly x2. Should non-compliance be identified, re-education will be conducted and audits will continue to be conducted.	

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Administrator replied, "I would like that, yes." when the surveyor asked if the nurse providing [redacted] care should disinfect the surface that supplies will be placed upon. At that time, the Director of Nursing (DON) also replied, "Should be cleaned." The DON replied, "To make sure there is no contamination on the [redacted]." when Surveyor #1 asked what was the importance of doing that [disinfection].
During the same interview, the DON replied, "Yes, with either hand sanitizer or handwashing." when Surveyor # 1 asked should hand hygiene be completed between changing gloves.

A review of the facility provided policy titled, "[redacted] Care" with a revised date of 12/2021 revealed under "Steps in the Procedure" that, "1. Establish a clean field on the resident's overbed table. Place all items to be used during procedure on the clean field..." The policy also revealed under "Steps in the Procedure" that, "Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly or use ABHR [alcohol-based hand sanitizer]. 6. Put on gloves..."

N.J.A.C § 8:39-19.4

Resident #109

B.) On 11/14/2023 at 11:15 AM, Surveyor # 2 observed Resident #109 sitting on the side of the bed, [redacted] ver time) hanging on his/her [redacted] At that time, Resident #109 stated that he/she has a [redacted] applied to a

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NJ EX Order. 264b1 Resident #109 stated that he/she had the NJ EX Order. 264b1 dressing changed this morning.

A review of Resident #109's Electronic Medical Record (EMR) revealed that resident #109 was admitted to the facility with the following diagnoses including but not limited to:

NJ EX Order. 264b1 .

A review of Resident #109's Minimum Data Set (MDS), an assessment tool, dated NJ EX Order. 264b1, revealed that Resident #109 had a Brief Interview for Mental Status score of NJ EX Order, indicating NJ EX Order cognition. NJ EX Order. 264b1 and revealed that Resident #109 was at risk for NJ EX Order. 264b1

A review of Resident #109's EMR revealed that he/she had the following physician's order that revealed NJ EX Order. 264b1 to NJ EX Order. 264b1 area. Change NJ EX Order. 264b1 daily NJ EX Order. 264b1. Set NJ EX O NJ EX Order. 264b1). Cleanse NJ EX Order NJ EX Order. 264b1], apply NJ EX Order. 264b1." Resident #109 also had a physician order for the NJ EX Order. 264b1 site: "Monitor NJ EX Order. 264b1 every shift for signs/symptoms of infection, NJ EX Order. 264b1 every shift for NJ EX Order. 264b1."

A review of Resident #109' EMR under care plan

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revealed that he/she had a comprehensive care plan initiated on NJ EX Order. 264b1 for: NJ EX Order. 264b1 of NJ EX Order. 264b1 following a procedure other NJ EX Order. 264b1, NJ EX Order. 264b1 diagnosis." Interventions included: NJ EX Order. 264b1 will be resolved without complications. Administer medication per physician orders. Maintain precautions as ordered for NJ EX Order. 264b control. Obtain labs/diagnostic tests as ordered and notify physician of results. Obtain vital signs as indicated."

Resident #109 had a care plan initiated on NJ EX Order. 264b1 for NJ EX Order. 264b1. Interventions were as follows: Will show continued signs of healing through next review. Will show no signs of NJ EX Order. 264l through next review. Administer analgesia per physician orders (offer prior to treatment/therapy). Administer treatment per physician orders. NJ EX Order. 264b1. Application/Maintenance of NJ EX Order. 264b1. Obtain labs as ordered and report results to physician. Report evidence of infection such as NJ EX Order. 264b1, NJ EX Order. 264b1, etc. Notify physician as needed. Therapy evaluation and treatment as ordered. Weekly NJ EX Ord assessment.

On 11/21/2023 at 10:21AM Surveyor # 2 obtained verbal permission from Resident #109 to observe his/her NJ EX Order. care.

On the same date and approximate time, Surveyor # 2 observed Licensed Practical Nurse (LPN) # 4 begin to perform NJ EX Order. 26 care that included changing the NJ EX Order. 264b1. At that time, LPN #4 did not perform hand hygiene prior

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to donning gloves at the start of the NJ EX Order. 2 care. The surveyor then observed LPN #4 doffing gloves after removing the NJ EX Order. 264b1 and placing it in the trash. At that time, LPN #4 did not perform hand hygiene. LPN #4 donned a new pair of gloves, helped reposition resident #109, removed the gloves and then performed hand hygiene using soap and water. LPN #4 then donned a new pair of gloves and prepared to perform NJ EX Order. 2 care on Resident #109. Surveyor # 2 observed LPN #4 set up the NJ EX Order. 264b1 kit on the bedside table. At that time, LPN # 4 removed the gloves no hand hygiene was performed. LPN #4 then donned a new pair of gloves to perform the NJ EX Order. 2 care treatment. LPN #4 doffed the gloves once the wound care treatment was completed, no hand hygiene performed. LPN #4 then donned a new pair of gloves and started to clean up the bed side table. LPN#4 then doffed the gloves and performed hand hygiene.

During the wound care treatment this surveyor observed LPN #4 cut the NJ EX Order. 264b1 NJ EX Order. 264b1 dressing with scissors located on the bed side table. Prior to the use of the scissors, LPN #4 did not wipe the scissors clean with alcohol or a disinfectant wipe.

On the same date at 10:56 AM during an interview with the surveyor, when asked what is the expectation of hand hygiene when doing wound care, LPN #4 stated, "I would perform hand hygiene before starting the care, after removing the dirty dressing and after I am done with everything. The surveyor asked LPN #4 if hand hygiene should be performed between glove changes. LPN #4 stated, "Yes, every time you remove your gloves." The surveyor asked if

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the scissors that were used during NJ EX Order: 26 care were included in the NJ EX Order: 26401 kit. LPN #4 stated, "The scissors were from the treatment cart. They do not come in the NJ EX Order: 26401 kit." The surveyor asked LPN #4 if sanitized the scissors prior to using them for NJ EX Order: 26 care. LPN #4 stated, "I did not wipe them before cutting the NJ EX Order: 26401 dressing or before cutting the NJ EX Order ."

On 11/21/2023 at 1:17 PM the surveyor asked the facility Director of Nursing (DON) what are your expectations for staff for hand hygiene while performing NJ EX Order: 2 care. The DON said, "They should wash their hands before and after the procedure. If they are visibly soiled and in between glove changes. If they remove their gloves, they need to also do hand hygiene with either hand sanitizer or by washing them." The surveyor asked the DON should hand hygiene be done in between glove changes. The DON stated, "Yes, they should be cleaned with either hand sanitizer or hand washing." This surveyor then asked the DON, when providing wound care should instruments such as scissors be cleaned prior to use. The DON said, "Yes, they must wipe the instruments prior to using them with wipes."

On 11/22/2023 at 09:33 AM, a review of the facility policy and procedure for Wound Care, revised on 12/2021, revealed the following under the Purpose section: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Under the Preparation section of the policy, it included the following: 1) Verify that there is a physician's order for this procedure. 2) Review the resident's care plan to assess for any special needs of the resident. a) For example, the resident may have PRN orders for pain medication to be

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F 880	Continued From page 36 administered prior to wound care. 3) Assemble the equipment and supplies as needed. Under the Procedure section it included the steps of the procedure as follows, Steps in the Procedure: 1) Establish a clean field on resident's overbed table. Place all items to be used during the procedure on the clean field. Arrange the supplies so they can easily be reached. 2) Wash and dry your hands thoroughly or use ABHR (alcohol-based hand rub) 3) Position patient 4) Put on exam gloves. Loosen tape and remove dressing. 5) Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly or use ABHR. 6) Put on gloves... 13) Dress wound. Pick up sponge with paper and apply directly to area. Mark tape with initials, time, and date and apply to dressing. 14) Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly or use ABHR. 15) Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed. 19) Wash and dry your hands thoroughly or use ABHR	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		1/15/24

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F 883	Continued From page 37 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 38 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to ensure documentation in the resident's medical record of the information provided regarding the benefits and risks of immunization and the administration or the refusal of the vaccine, specifically the [redacted] vaccination (vaccine used to [redacted]). This deficient practice was identified for 3 of 5 residents (Resident # 135, Resident #63, & Resident # 109) reviewed for immunization status. This deficient practice was evidenced by the following: 1.) A review of the Electronic Medical Record (EMR) revealed that Resident #135 had diagnoses including but not limited to: [redacted] Resident #135 is over the age of [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate	F 883	[redacted] a. Our immediate corrective action was to: • Offer and give [redacted] Vaccine to Resident # 135 and Resident #63 and document in our EMR Immunization record. • Completed the [redacted] and [redacted] Vaccination Information and Permission Form and [redacted] Vaccination Information and Permission Form for Resident # 109. Resident #109 received all her vaccinations, given by her PCP in the community. Resident #109 Vaccination for [redacted] and [redacted] was updated and recorded in our EMR Immunization Record. • In-Service Nursing Staff RN/LPN in the unit where Resident #135, Resident #63 and Resident # 109 resides on Policy and Procedures for [redacted] and [redacted] Vaccination and [redacted] Vaccination. Specific instructions given on completing Vaccination and Permission Forms and offering after given consents	

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F 883	Continued From page 39 care, dated NJ EX Order. 264b1 indicated a BIMS of NJ EX Order indicating NJ EX Order. 264b1. Section NJ EX Order. 2 indicated Resident 135's NJ EX Order. 264b1 vaccine was not up to date and that the vaccine was not offered. A review of the physician orders from admission to present did not reveal an order for the NJ EX Order. 264b1 vaccine. A review of the Medication Administration Records (MARS) of NJ EX Order. 264b1 through NJ EX Order. 264b1 did not indicate that the NJ EX Order. 264b1 vaccine was given. On 11/16/2023 at 12:20 PM, during surveyor #1 interview with Resident #135, he/she said they were not offered the NJ EX Order. 264b1 vaccine and stated that he/she would take it if it were offered. On 11/16/2023 at 11:50 AM, during surveyor #1 interview with Licensed Practical Nurse (LPN) #2, when asked if Resident #135 was offered the NJ EX Order. 264b1 vaccine she stated she did not see it in the electronic medical record. On 11/16/2023 at 1:45 PM, during surveyor #1 interview with Unit Manager / Registered Nurse (UM/RN #1), she stated that Resident #135 consented to the NJ EX Order. 264b1 vaccine and Infection Preventionist (IP) was in the process of administering it. On 11/20/2023 at 12:48 PM, during surveyor #1 interview with UM/RN #1 she stated that when a new admission comes in, nursing asks the resident or power of attorney (POA) if the resident has had immunizations and if not, if the resident would like them. If the resident would like an immunization, they sign consent, and it is given (if	F 883	by resident or POA. b. Any new admission or resident that gave consent for vaccination have potential to be affected. c. The following measures were put into place to ensure this does not recur: • In-Service Nursing Staff RN/LPN on Policy and Procedures for Pneumonia and NJ EX Order. 26 Vaccination and NJ EX Order. 2 Vaccination. Specific instructions given on completing Vaccination and Permission Forms and offering after given consents by resident or POA. • Infection Preventionist will check on new admission resident NJ EX Order. 264b1 and NJ EX Order. 264b1 Vaccination Information and Permission Form and NJ EX Order. 2 Vaccination Information and Permission Form. IP nurse will request and offer Vaccine and record in our EMR Immunization record section. d. Audits will be conducted by Nursing Administration on Completion of NJ EX Order. 264b1 and NJ EX Order. 264b1 Vaccination Information and Permission Form and NJ EX Order. 2 Vaccination Information and Permission Form and Offering Vaccine if resident or POA gave consent, record vaccination information into our EMR Immunization record section. Audits will be done weekly x4, monthly x 3, quarterly x2. Findings will be reported to QA quarterly x2.	

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seasonally appropriate). For the NJ EX Order. 264b1 vaccine specifically, the resident's medical record and age are checked to see if they qualify and if they do qualify, the records are checked and the resident and/or POA are asked if they have had it previously and if yes, it is documented in the medical record as historical. She provided a paper copy of the consent signed on [redacted] by Resident #135, which indicated he/she consented to the [redacted], the [redacted] vaccine, and the [redacted] vaccine. UM/RN#1 also stated she is not sure why the NJ EX Order. 264b1 vaccine had not been administered yet and would have to ask the Infection Preventionist.

On 11/20/2023 at 1:28 PM, during surveyor #1 interview with IP, he stated that this is his fourth week at this facility, and he has audited all charts to see who is due for vaccines. He also stated he was working on the NJ EX Order. 264b1 vaccines on [redacted] & [redacted] halls today and was currently ordering them from the pharmacy.

On 11/21/2023 at 1:32 PM, during surveyor #1 interview with the Director of Nursing (DON), she stated that when a new resident is admitted, the nurse reviews if they've had vaccines. If vaccines were received, they are put in the medical record, and if vaccines had not been received, the resident is asked if they want it, and they then sign a refusal or consent. If the resident consents, the nurse lets the physician know of request, the order is obtained, and the vaccine is given. She further stated that all residents are offered the NJ EX Order. 264b1 vaccines.

On 11/22/2023 at 10:27 AM, during surveyor #1 interview with the DON, she stated that for some reason the NJ EX Order. 264b1 vaccine was missed

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for Resident #135, and it was not given. Resident #135 was given the NJ EX Order. 264b1 vaccine today (NJ EX Order. 264b1).

A review of Infection Control Policy NJ EX Order. 264b1 Vaccination" revised date of Jan 2023, revealed under policy section: The purpose of the policy is to minimize the risk of residents acquiring NJ EX Order. 264b1. The procedure section included:
7. The consent form is filed in the resident's medical record and is not to be thinned off of the chart.
8. The Infection Prevention Nurse/designee will review the records for consents
9. The Infection Prevention Nurse or RN designee will administer the vaccine
11. Administration of the NJ EX Order. 264b1 vaccine is documented in the medical chart and includes the date given
12. Administration of the vaccine is also documented in the medical chart. This documentation includes date, lot number of the vaccine and it's expiration date (Lot number and expiration date are found on the vaccine's packaging.)
2) A review of Resident #63's Electronic Medical Record (EMR) revealed that resident #63 was admitted to the facility with the following diagnoses including but not limited to: Infection of amputation of stump, Diabetes NJ EX Order. 264b1 Resident #63 is over the age of NJ EX O

A review of Resident #63 Minimum Data Set (MDS) an assessment tool used to facilitate care, dated NJ EX Order. 264b1, revealed that the resident has a Brief Interview for Mental Status Score of NJ EX Order,

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indicating intact cognition.

A record review of Resident #63's paper medical record revealed a Pneumonia and Influenza Vaccination Information and Permission Form, signed, and dated by resident #63 on [redacted] giving permission for the [redacted] vaccine. No immunization records were found in the paper medical record.

A review of Resident #63's MDS, dated [redacted], section [redacted] revealed that Resident #63's [redacted] vaccination is not up to date. Further, it revealed that the [redacted] vaccination was documented as "not offered."

On 11/17/2023 at 11:20 AM, during an interview with the surveyor, Resident #63 was asked if the facility offered him/her the [redacted] vaccines when he/she was admitted to the facility. Resident #63 stated, "Yes, I was offered the [redacted] vaccine." Resident #63 stated he/she also had [redacted] vaccines for [redacted] already. At that time, the surveyor asked Resident #63 if the facility had you fill out documentation, such as a vaccination information and permission form. Resident #63 replied, "I believe I did sign the form." Resident #63 denied being offered the [redacted] vaccine.

A review of Resident #63's EMR under "Immunizations" did not yield any information that Resident #63 received the [redacted] vaccination.

A review of resident #63's progress notes revealed that there were no documented progress notes in reference to the [redacted] vaccination being offered or that resident #63 had

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	315054	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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declined the vaccination.

3) A review of Resident #109's EMR revealed that Resident #109 was admitted to the facility with the following diagnoses including but not limited to: NJ EX Order. 264b1 [redacted]. Resident #109 is over the age of [redacted].

A review of Resident #109's MDS, dated [redacted] revealed that Resident #109 had a Brief Interview for Mental Status Score of [redacted], indicating intact cognition. Section [redacted] indicated that Resident #109's NJ EX Order. 264b1 [redacted] vaccinations were "not offered."

A review of Resident #109's paper medical record which revealed the NJ EX Order. 264b1 Vaccination Information and Permission form for resident #109 was blank. The form reveled that Resident #109 had his/her name at the top with the admission date adjacent to it. It did not have any check offs for permission or the do not wish boxes for the [redacted] vaccine or the [redacted] vaccines. The line for patient signature and the line for responsible party signature was left blank. Also, the date was not written adjacent to the line. No immunizations records were in the paper medical record under the "immunizations" tab.

On 11/17/2023 at 10:25 AM during an interview with the surveyor, Resident #109 was asked if the facility offered him/her the NJ EX Order. 264b1 [redacted] vaccines when he/she was admitted to

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the facility. Resident #109 stated, "No, I already had the vaccinations done in [redacted]." Resident #109 was then asked if the facility had him/her fill out documentation such as a vaccination information and permission form. Resident #109 stated, "No, I do not remember filling out or signing that form."

A review of Resident #109's progress notes in the EMR did not reveal any reference to [redacted] and [redacted] vaccinations being offered to the resident or if Resident #109 had declined the vaccinations.

On 11/17/2023 at 10:05 AM, during an interview with the surveyor, when asked what is the process for new admissions and immunizations? Unit Manager/Registered Nurse (UM/RN #2) stated "We will ask them upon admission if they were vaccinated. If they can't tell us, such as being nonverbal then we would contact family and ask them if they know. Sometimes the admission department will find out if they have had their vaccinations if they are a new admission." When asked where current immunizations can be found, UM/RN #2 said, "They will be documented in our system under the immunizations tab." The surveyor then asked UM/RN #2, if all residents were offered the [redacted] vaccines. She stated, "Yes. The person doing the admission assessment would offer it to them. If They decline initially then the infection control and/or unit manager can follow up with them to see if they have changed their mind and would like to receive it." UM/RN #2 was asked if there is a form that the residents fill out upon admission stating if they would like to be offered the [redacted] vaccines UM/RN #2 replied, "Yes, we use a form that they can check off if they

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F 883	Continued From page 45 would like to receive it or decline it." The surveyor then asked if they decline to receive the immunizations would you document it anywhere? UM/RN #2 said, "If they declined, you would go to the immunization tab and check off that they declined. You would also document it in the progress notes stating they were offered and declined." On 11/21/2023 at 1:45 PM during an interview with the facility Director of Nursing (DON), the surveyor asked what is the facility process for new admissions and immunizations? The DON stated, "The nurse will review or question the resident as to if they have been vaccinated. If they received it prior to admission, we would then document it in the EMR. If they give consent for the immunizations the nurse will notify the doctor. The doctor will then order it." When asked if all residents are offered the influenza and [redacted] vaccines upon admission the DON stated, "Yes. They will fill out a consent form. On the consent form they will either check off decline or accept. If the physician gives the ok to give the vaccine the nurse will put the order in." The surveyor then questioned if a blank consent form indicated that vaccines were not offered. The DON said, "There may be another consent form signed that isn't in the chart. The infection control department may have it." The surveyor then asked the DON if it should be documented in the EMR under "Immunizations" if a resident had received vaccinations prior to admission. The DON, stated, "Yes". N.J.A.C. 8:39-19.4(i)	F 883		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2)	F 919		1/15/24

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F 919	Continued From page 46 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure resident call devices where within reach of the residents for 2 of 32 sampled residents, (Resident #99 and Resident #201). This deficient practice was evidenced by the following: 1.) During the initial tour of the facility on 11/14/2023 at 10:58 AM, Resident #99 was observed lying in bed and the call bell was observed on the floor, under the overbed table and under a can out of the reach of the resident. Resident did not respond when asked if he/she uses the call bell. On 11/15/2023 at 9:22 AM, Resident #99 was observed to be lying in bed and the call bell was observed to be inside the top drawer of the dresser that was next to the bed. The call bell was not in reach of the resident. On 11/20/2023 at 8:29 AM, Resident #99 was observed lying in bed and the call bell was observed to be draped over top of the dresser. The call bell was out of reach of the resident.	F 919	F919 Resident Call System a. Our immediate corrective action was to: • Keep the call bell for Resident #99 and Resident #201 within reach. • In-service RN/LPN/CNA in the unit where Resident # 99 and Resident #201 reside on our Policy and Procedure on Call Bell. Given specific instructions on keeping call bell within resident reach. b. All residents have the potential to be affected. c. The following measures were put into place to ensure this does not recur: • In-Service Nursing Staff RN/LPN/CNA on our Policy and Procedure on Call Bell. Given specific instructions on keeping call bell within all residents reach. • Ensure RN/LPN/CNA during their shift round on checking that call bell are within all their residents reach. • All residents call bell must be securely clipped within reach for ease of accessibility. • Assure that all residents call bell is	

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F 919	Continued From page 47 A review of the Admission Record revealed Resident #99 was admitted with diagnoses including but not limited to: [redacted] A review of the most recent Minimum Data Set (MDS) and assessment tool used to facilitate care dated [redacted] revealed Resident #99 had NJ EX Order. 264b1 cognition. A review of the Care Plan revealed a Focus area of Risk for [redacted] characterized by history [redacted], multiple risk factors related to: [redacted]. Under the Goal section No [redacted] with [redacted] through the quarter. Interventions included but were not limited to: call bell in reach. 2.) During the initial tour of the facility on 11/14/2023 at 10:47 AM, Resident #201 was observed lying in bed. Resident #201's call bell was observed to be on the floor at the foot of bed out of reach of the resident. When asked if he/she uses the call bell, Resident #201 was asking about [redacted]. A review of the Admission Record revealed Resident #201 was admitted to the facility with diagnoses including but not limited to: NJ EX Order. 264b1 NJ EX Order. 264b1 that [redacted] A review of the most recent MDS dated	F 919	always in reach for ease of use. d. Audits will be conducted by the Nursing Administration on Call bell are kept within resident reach weekly x4, monthly x3, quarterly x2. Findings will be reported to QA quarterly x2.	

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F 919	Continued From page 48 NJ EX Order: 264b1 revealed Resident #201 had a Brief Interview for Mental Status score of NJ EX Order: indicating NJ EX Order: NJ EX Order. 264b1 A review of the Care Plan did not include documentation as to placement of the call bell. During an interview with the surveyor on 11/20/2023 at 8:30 AM, Certified Nursing Assistant (CNA #1) was asked by the surveyor, where the surveyor would expect a call bell to be when I walk in a resident room. CNA #1 replied on the bed. Hooked onto the bed in their reach. During an interview with the surveyor on 11/20/2023 at 9:55 AM, Unit Manager/Registered Nurse (UM/RN #3) was asked where the surveyor would expect a call bell to be when I walk in resident room. UM/RN #3 responded the call bell should be right next to them where they can reach, clipped to them so they can easily access it. During an interview with the surveyor on 11/21/2023 at 1:23 PM, the Director of Nursing (DON) was asked where the surveyor would expect a call bell to be when I walk in a resident room. The DON replied it should be near the patient and reachable whether in bed or chair arm distance away. A review of a facility policy titled Call Bells with revised date of 12/2021, revealed under the policy section .... Staff is to assure that the call bell is in reach for ease of use.	F 919		
F 925 SS=E	NJAC 8:39-29.1(a) Maintains Effective Pest Control Program	F 925		1/15/24

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F 925	Continued From page 49 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain an effective pest control program so that the facility is free of pests by failing to remove insect traps filled with carcasses from a resident's room and failing to remove dead insect carcasses from a resident dining area. The deficient practice was observed for 1 of 8 residents (resident # 71) and 1 of 2 Dining Areas under the Environmental Task. The deficient practiced was evidenced by the following: On 11/14/2023 at 10:37 AM during the initial tour, the surveyor met Resident # 71 in his/her room. At that time, the resident said he/she that insects were observed in the room on multiple occasions. At that time, the surveyor observed two insect traps underneath the baseboard heater. The traps mechanism for action was a sticky substance that prevents the insects from moving out of the trap. The traps were filled with insect carcasses. The majority of the insects in the trap appeared to be but not limited to NJ EX Order. 264b1 On 11/15/2023 at 8:15 AM, the surveyor observed what appeared to be a live NJ EX Order. 264b1 climbing the wall in the G/H Dining/Lounge room where the surveyors were stationed for the survey. On 11/15/2023 at 12:48 PM, the surveyor again	F 925	F- (E) Maintains Effective Pest Control Program It is the practice of this facility to maintain an effective pest control program so that the facility is free of pests and rodents. Element 1 1. The facility Governing Body met to review the facilities policies and procedures for maintaining an effective Pest Control Program; specifically, regarding the removal of insect traps. 2. On 11/22/2023 the facility maintenance director/designee conducted a review of Resident #71 room an removed and replaced all of the used insect traps in resident #71 room . 3. On 11/22/2023 the facility Maintenance Director/ designee conducted a review of facility rainbow room and address any concerns related to fly carcasses noted by surveyors. 4. On 11/22/2023 the facility Maintenance Director/Designee conducted an audit on all resident rooms and common areas to ensure all were free of insect traps which contained the NJ EX Order. 264b1 . Element 2 1. An assessment of the risk this deficient practice could have on residents at this facility was completed by the Administrator and Maintenance Director	

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F 925	Continued From page 50 observed the insect traps in Resident # 71's room in the same location as the day before. The traps contained numerous insect carcasses. On 11/16/23 09:40 AM, during an interview with the surveyor, Registered Nures/Unit Manager (RN/UM #1) said if we see any bugs or pests, we notify maintenance and the pest company comes. She further said that when the pest company does spray, all residents are taken off the unit and they spray. She concluded by saying we stay off the unit for two to three hours that it is more frequent than every two to three months. On 11/17/2023 at 12:31 PM while in the dining room referred to as the NJ EX Order: 26461", the surveyor observed numerous carcasses of flying insects on top of the baseboard heater. The insects were observed at the same time that residents were eating lunch in the room. On 11/20/2023 at 11:19 AM during an interview with the surveyor, the Maintenance Director said the facility is treated for pests once a week. He explained that the facility uses a communication log book where staff can write where they observed insect activity. The Maintenance Director further explained that either the pest control company, housekeeping, or himself remove the insect traps from resident rooms. On 11/21/2023 at 09:05 AM during an interview with the surveyor, Resident # 71 stated that, "They need to remove these traps." At that time, the surveyor again observed the insect traps in the room under the baseboard heater. On the same date at 01:17 PM during an interview with the surveyor, the Licensed Nursing	F 925	identified that, all residents could have the potential to be affected by this deficient practice. Element 3 1. The Maintenance Director/Designee will conduct weekly audits on all resident rooms and common areas to ensure that they are free and clear of used insect traps. Element 4 1. The Maintenance Director /Designee will submit findings from weekly audits on all resident rooms and common areas within the facility to QAA committee monthly and QAPI committed quarterly (every 3 months), if further action is deemed necessary the team will address.	

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F 925	Continued From page 51 Home Administrator stated, "Once they notice, the Housekeeper should be checking that [insect traps] and taking that away. She further revealed that the Housekeeper for each unit is responsible for removal of insect traps. The surveyor reviewed the facility-provided Pest Control invoices. The invoice dated for [redacted] revealed that the [redacted]" was treated for [redacted] The invoice further revealed that insect activity was mainly around the heaters. A review of the facility policy titled, "Pest Control" with an effective date of 6/2019 revealed under "Policy Interpretation and Implementation" that, "5. Maintenance services assist, when appropriate and necessary, in providing pest control services." N.J.A.C. § 8:39-31.5	F 925		

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	060106	A. BUILDING: _____ B. WING _____	C 11/22/2023

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S 000	Initial Comments C/O # NJ163533, NJ163173, NJ163585, NJ165142, NJ166987, NJ159883, NJ167046, NJ161095 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: C/O # NJ163533, NJ163173, NJ163585, NJ165142, NJ166987, NJ159883, NJ167046, NJ161095 Based on interviews 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 14 of 14 day shifts for the period of 12/11/2022 to 12/24/2022, 21 of 21 day shifts, 1 of 21 evening shifts in total staff for residents and 2 of 21 evening shifts deficient in Certified Nurse Aides for the period of 03/26/2023 to 04/15/2023, 7 of 7	S 560	S-560 (F)- Mandatory Access to Care It is the practice of this facility to comply withs as applicable Federal, State, and Local laws, rules, and regulations related to minimum direct care staff to resident ratios as mandated by the state of New Jersey. Corrective Action 1. The Facility cannot retroactively correct the deficient practice sited. 2. The facility Governing Body met to review the facilities policies and procedures for maintaining minimum direct care staff to resident ratios.	1/15/24

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

Electronically Signed | 12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 day shifts, 1 of 7 evening shifts for total staff for residents, 1 of 7 evening shifts deficient in CNAs for the period of 06/18/2023 to 06/24/2023, 7 of 7 day shifts and 1 of 7 overnight shifts for the period of 08/20/2023 to 08/26/2023, and 14 of 14 days shifts for the period of 10/29/2023 to 11/11/2023. Findings include: A.) 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 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. 1.) The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows for the period 12/11/2022 to 12/24/2022: -12/11/22 had 12 CNAs for 153 residents on the day shift, required at least 19 CNAs. -12/12/22 had 10 CNAs for 153 residents on the day shift, required at least 19 CNAs.	S 560	Identification of Others 1. An assessment of the risk this deficient practice could have on residents at this facility was completed by the administrator, Director of Nursing, and Staffing Coordinator, HR Manager and it was found that all residents could have the potential to impacted by this deficient practice. Systemic Changes : 1. The Facility Director of Nursing , Administrator , HR Manager initiated the following employee recruitment programs for the clinical department : 1) Sign on with new agencies 2) Offer agency staff bonuses 3) Offer our staff bonuses 4) Job Fair 5) Referral bonuses for our staff 6) Local C N A school to provide courses for new hire. 2. The Human Resources Director/ Staffing Coordinator will track all new hires within nursing department on a monthly basis and address concerns as needed I. Quality Assurance . A. The Human Resource Director/designee will aggregate findings from these rounds monthly and review the findings with the administrator quarterly on an ongoing basis. B. The Huma Resources Director /designee will provide a report of his/her findings to the QA committee for action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEAL	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -12/13/22 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs. -12/14/22 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs. -12/15/22 had 11 CNAs for 150 residents on the day shift, required at least 19 CNAs. -12/16/22 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs. -12/17/22 had 14 CNAs for 148 residents on the day shift, required at least 18 CNAs. -12/18/22 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs. -12/19/22 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs. -12/20/22 had 10 CNAs for 149 residents on the day shift, required at least 19 CNAs. -12/21/22 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -12/22/22 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -12/23/22 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -12/24/22 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. 2.) The facility was deficient in CNA staffing for residents on 21 of 21 day shifts, deficient in total staff for residents on 1 of 21 evening shifts, and deficient in CNAs to total staff on 2 of 21 evening shifts as follows for the period of 03/26/2023 to 04/15/2023: -03/26/23 had 9 CNAs for 154 residents on the day shift, required at least 19 CNAs. -03/27/23 had 10 CNAs for 153 residents on the day shift, required at least 19 CNAs. -03/28/23 had 8 CNAs for 151 residents on the day shift, required at least 19 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 -03/29/23 had 9 CNAs for 151 residents on the day shift, required at least 19 CNAs. -03/30/23 had 11 CNAs for 151 residents on the day shift, required at least 19 CNAs. -03/31/23 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs. -04/01/23 had 10 CNAs for 151 residents on the day shift, required at least 19 CNAs. -04/02/23 had 13 CNAs for 157 residents on the day shift, required at least 20 CNAs. -04/02/23 had 14 total staff for 157 residents on the evening shift, required at least 16 total staff. -04/02/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -04/03/23 had 10 CNAs for 157 residents on the day shift, required at least 20 CNAs. -04/04/23 had 10 CNAs for 157 residents on the day shift, required at least 20 CNAs. -04/05/23 had 10 CNAs for 159 residents on the day shift, required at least 20 CNAs. -04/06/23 had 12 CNAs for 159 residents on the day shift, required at least 20 CNAs. -04/07/23 had 12 CNAs for 159 residents on the day shift, required at least 20 CNAs. -04/08/23 had 9 CNAs for 158 residents on the day shift, required at least 20 CNAs. -04/09/23 had 12 CNAs for 156 residents on the day shift, required at least 19 CNAs. -04/10/23 had 7 CNAs for 156 residents on the day shift, required at least 19 CNAs. -04/11/23 had 9 CNAs for 156 residents on the day shift, required at least 19 CNAs. -04/12/23 had 9 CNAs for 156 residents on the day shift, required at least 19 CNAs. -04/12/23 had 10 CNAs to 27 total staff on the evening shift, required at least 13 CNAs. -04/13/23 had 13 CNAs for 153 residents on the day shift, required at least 19 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEAL	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -04/14/23 had 10 CNAs for 153 residents on the day shift, required at least 19 CNAs. -04/15/23 had 12 CNAs for 153 residents on the day shift, required at least 19 CNAs. 3. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in CNAs to total staff on 1 of 7 evening shifts as follows for the period of 06/18/2023 to 06/24/2023: -06/18/23 had 11 CNAs for 160 residents on the day shift, required at least 20 CNAs. -06/19/23 had 11 CNAs for 160 residents on the day shift, required at least 20 CNAs. -06/19/23 had 14 total staff for 160 residents on the evening shift, required at least 16 total staff. -06/19/23 had 6 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -06/20/23 had 13 CNAs for 157 residents on the day shift, required at least 19 CNAs. -06/21/23 had 13 CNAs for 157 residents on the day shift, required at least 19 CNAs. -06/22/23 had 11 CNAs for 157 residents on the day shift, required at least 20 CNAs. -06/23/23 had 9 CNAs for 157 residents on the day shift, required at least 19 CNAs. -06/24/23 had 9 CNAs for 157 residents on the day shift, required at least 20 CNAs. 4. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows for the period of 08/20/2023 to 08/26/2023: -08/20/23 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/20/23 had 11 total staff for 163 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S 560	Continued From page 5 the overnight shift, required at least 12 total staff. -08/21/23 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/22/23 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/23/23 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/24/23 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/25/23 had 8 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/26/23 had 7 CNAs for 163 residents on the day shift, required at least 20 CNAs. 5. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows for the period of 10/29/2023 to 11/11/2023: -10/29/23 had 11 CNAs for 149 residents on the day shift, required at least 19 CNAs. -10/30/23 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. -10/31/23 had 10 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/01/23 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/02/23 had 11 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/03/23 had 11 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/04/23 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/05/23 had 13 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/06/23 had 12 CNAs for 158 residents on the day shift, required at least 20 CNAs. -11/07/23 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/08/23 had 15 CNAs for 155 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060106	A. BUILDING: _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 6 day shift, required at least 19 CNAs. -11/09/23 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/10/23 had 13 CNAs for 155 residents on the day shift, required at least 19 CNAs. -11/11/23 had 12 CNAs for 152 residents on the day shift, required at least 19 CNAs. A review of the facility policy titled, "Staffing" with a revision date of 2/2021 revealed under, "Policy Interpretation and Implementation" that, "1. Our facility maintains adequate staffing on each shift to ensure that our resident' needs and services are met ..." The policy further revealed under the same section that, "2. Nursing Assistants both are available on each shift to provide the needed care and services for each of our residents/patients." and lastly that, "3. Staffing patterns will be developed based on state guidance."	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060106 (Y1)	A. Building B. Wing (Y2)	1/16/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315054	A. Building B. Wing	1/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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 F0684 Reg. # 483.25 LSC	Correction Completed 01/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/22/2023	☐ 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
315054 Y1	A. Building B. Wing Y2	1/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADYS CENTER FOR REHABILITATION & HEALTHCARE	1100 CLEMATIS AVE PLEASANTVILLE, NJ 08232

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 F0584	Correction	ID Prefix F0656	Correction	ID Prefix F0698	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(l)	Completed
LSC	01/15/2024	LSC	01/15/2024	LSC	01/15/2024
ID Prefix F0812	Correction	ID Prefix F0868	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	01/15/2024	LSC	01/15/2024	LSC	01/15/2024
ID Prefix F0883	Correction	ID Prefix F0919	Correction	ID Prefix F0925	Correction
Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.90(g)(1)(2)	Completed	Reg. # 483.90(i)(4)	Completed
LSC	01/15/2024	LSC	01/15/2024	LSC	01/15/2024
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	
11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO