STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315483	A. BUILDING _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	**456 RAHWAY AVENUE ELIZABETH, NJ 07202**

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F 000	INITIAL COMMENTS	F 000		

Survey Date: March 17, 2022

Census: 87

Sample:18 + 11 = 29

A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.

During a Recertification Survey conducted on 3/17/2022, it was determined that effective 03/03/22, the facility was found to have been in wide-spread system failure resulting in Immediate Jeopardy cited at F678 at a s/s of an L.

The Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 03/03/22, including the Immediate Jeopardy Template. A revised Immediate Jeopardy Template was provided to the Facility Administrator on 03/04/22.

The Facility failed to:

-ensure staff initiate an emergency response system, failed to called 911 and failed to utilized the facility defibrillator when a resident was found unresponsive.

-ensure a system was in place to appropriately track and maintain cardiopulmonary resuscitation (CPR) certifications to ensure that staff maintained the appropriate CPR certification.

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/12/2022

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

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F 000	Continued From page 1 On 03/08/2022, the Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy and determined that the Immediacy of the Jeopardy could be removed, effective 03/08/2022. The facility submitted an acceptable removal plan on 03/08/22 at 8:30 AM. The survey team verified the removal plan onsite on 03/08/22 at 9:30 AM, which removed the immediacy. The non-compliance for F678 remained as of 3/9/22, for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to maintain resident call bells that were accessible and within reach of all residents. This deficient practice occurred for 1 of 18 residents reviewed (Resident #259) and was evidenced by the following: On 02/28/22 at 10:48 AM, the Surveyor observed Resident #259 lying in bed with heel booties on. The surveyor observed a flat tap call bell draped over the resident's bed side rail and was within	F 558	F558 Immediate Corrective Actions The call bell was immediately placed within reach of Resident # 259 on their stronger functional side. The Aide who failed to properly place the call bell within reach was counselled and re-educated. Identification of Other Residents All residents have the potential to be affected by this practice Systemic Changes Nursing staff received re-education to	4/30/22

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F 558	Continued From page 2 the resident's reach. On 03/01/22 at 8:36 AM, the Surveyor observed Resident #259 lying in bed and was wearing heel booties. The Surveyor interviewed Resident #259 at that time who stated that he/she was "not good" because he/she could not reach the remote control for the bed. The surveyor observed that Resident #259's bed remote that was hanging off of the bed and it was touching the floor. The surveyor then asked Resident #259 where his/her call bell was so he/she could call the nurse for help. Resident #259 then shrugged his/her shoulders. The Surveyor then observed Resident #259's flat tap call bell which was draped over the cord at the area where the call bell was attached to the wall. The call bell was not within Resident #259's reach. At 8:44 AM, in presence of another Surveyor, the Surveyor interviewed Resident #259's Certified Nursing Aid (CNA). The Surveyor asked the CNA how a resident would call for help if needed. The CNA stated that the resident would press the call bell. The surveyor then asked the CNA if she had made rounds on the residents that morning. The CNA stated that she made rounds and checked Resident #259 this morning but that she had not performed morning care yet. The Surveyor then asked the CNA what the reason was that the call bell was hanging on the wall and was not within Resident #259's reach. The CNA stated that she moved the call bell out of reach because the call bell kept "going off." She then stated that she should not have moved the call bell out of reach. At 8:55 AM, in the presence of another Surveyor, the Surveyor asked the Licensed Practical Nurse (LPN) to observe the location of Resident #259's	F 558	ensure placement of call bells are within reach of resident at all times when in bed or room . Monitoring of Corrective Action Charge nurse makes daily rounds and checks to assure residents can easily access their call bells when in their rooms . Call bell audits will be conducted by the Unit Manager weekly for 4 weeks and then monthly for 2 months . Results of the audits will be provided to the DON who will report findings in aggregate to the QAPI committee quarterly for further action as appropriate .	

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call bell. The LPN confirmed that the call bell was draped over the cord on the wall and not within Resident #259's reach. The LPN then stated that sometimes when staff change the resident, they move the call bell and forget to move it back. The surveyor then told the LPN what the CNA told the surveyors. The LPN then placed the call bell within Resident #259's reach. She then stated that the call bell should always be with the resident.

A review of Resident #259's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 01/20/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #259 was [redacted].

On 03/02/22 at 12:09 PM, the surveyor interviewed the Director of Rehabilitation Physical Therapist (DORPT) regarding Resident #259's call bell. The DORPT stated that Resident #259 had a special tap bell because the resident could not use his/her hands properly. He then stated that the staff should place the call bell on the bed next to the resident on the resident's stronger side. He added that the call bell should not be placed on the siderail of the bed.

On 03/10/22 at 9:55 AM, the Surveyor informed the Director of Nursing (DON) about the location of Resident #259's call bell. The DON stated that sometimes the staff forget to place the call bell back after care. The surveyor then shared the interview the Surveyor conducted with the CNA.

On 03/11/22 at 11:04 AM, the DON stated that the CNA had documented a statement that she had

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F 558	Continued From page 4 left the room of Resident #259 for a minute to get something. The surveyor then asked the DON if a call bell was not working properly what should the staff do. The DON stated that the staff should report it to the Maintenance Department and provide the resident with another device to call for help. A review of the facility provided Job Description for Certified Nursing Assistant (CNA) included the following: 11. Enforces safety measures and protects residents from injury by: ...placing the call bell within reach of the resident ... A review of the facility provided policy titled "Answering Call Bells" with a reviewed date of 10/2021, which included the following: Policy: Call bells must be answered promptly and properly. Objective: 1. To promptly meet needs of the resident ... Procedure: ... 7. Check to see that call bell is within reach before you leave ... 11. Call bells to be answered immediately and promptly. 12. Call bell must be within reach of all residents. 13. Call bell must be accessible to the unaffected side of a paralyzed resident. N.J.A.C. 8:39-31.8(c)(9)	F 558		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or	F 563		5/15/22

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her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.
(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;
(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;
(iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and
(v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the facility visitation process did not restrict visitation as per executive directive from Center for Medicare Services (CMS) QSO-20-39-NH revised 11/12/2021. This deficient practice was identified for 1 of 18 residents (Resident #5) reviewed. The deficient practice was evidenced by the following:

Immediate Corrective Actions
Resident #5 and The family member of resident #5 was provided with a copy of the facility visitation protocol and informed of their right to refuse antigen testing per the current protocol in compliance with DOH and CMS requirements .
The process for visitation was reviewed and clarified to reflect NJDOH executive directive and CMS requirements. The SW

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F 563	Continued From page 6 On 02/28/22, at 9:45 AM the surveyor toured the second floor of the facility. Resident #5 approached the surveyor and requested information regarding visitation. On 02/28/22 at 10:28 AM, during the entrance conference with the Administrator (LNHA) and the Director of Nursing (DON), the DON stated that visitors must be tested for COVID-19. The LNHA interjected, and stated, that the visitor was not forced to test. On 03/03/22 at 8:08 AM, upon the Survey team entrance to the facility, the Receptionist was interviewed regarding the process for a visitor upon entrance. The Receptionist stated they [visitor] signed in and "they have to do a rapid" [COVID-19 test]. The Survey team observed boxes of COVID-19 rapid tests located at the reception desk. When inquired as to what happened when a visitor refused to test, the Receptionist stated that no one had ever refused. She stated the Social Worker (SW) had sent out a notice to the families about the rapid test and they signed an informed consent. On 03/03/22 at 12:47 PM, Resident #5 stated that he/she would like to visit with his/her family, but the facility required a COVID test prior to visitation and the family refused to comply. Resident #5 stated that due to his/her EX Order 26 § 4b1 [redacted] and could not wash properly. Resident #5 stated that his/her daughter who was a certified nurse aide would come and assist at times with care. Resident #5 stated that due to	F 563	, Activities Director and receptionist were re-educated on visitation requirements in compliance with CMS and NJDOH guidance . Identification of Other Residents All residents have the potential to be affected by this practice . Systemic Changes Visitation protocol was reviewed and clarified to assure visitors have the option to refuse antigen testing and still be permitted to visit their family member residing at the facility . The facility family and resident COVID 19 notification process was reviewed to assure residents and visitors receive proper notification of visitation process including their right to refuse antigen testing prior to visitation . Monitoring of Corrective Actions The SW will audit family and resident notification letters monthly for the next three months to assure proper notification was received in compliance with DOH and CMS requirements and discuss findings with the administrator . Results of the audits will be presented in aggregate at the quarterly QAPI committee by the social worker for further action as appropriate .	

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the restriction imposed by the facility the family member had not been able to visit him/her.

The surveyor reviewed Resident #5's medical record which revealed the following:

Resident #5 was admitted to the facility with diagnoses which included, EX Order 26 § 4b1 [redacted]. The Quarterly Minimum Data Set dated 01/15/22 (MDS), an assessment tool used to identify and prioritize care, revealed that Resident #5 was able to make his/her needs known. Resident #5 scored EX O [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident was EX Order 26 § 4b1 .

On 03/04/22 at 9:56 AM the Surveyor reviewed the facility provided notice sent out by the facility. The notice provided, dated 01/18/22, confirmed that visits were scheduled daily from 10:30 AM -11:30 AM on the first-floor dayroom.

On 03/04/22 at 10:05 AM, Resident #5 told the surveyor that the family had not been in to visit since January because of the new requirements for testing. During the last visit, the Administrator told the family that based on directives received from the Department of Health (DOH) visits must be scheduled and family must have a COVID-19 test upon entrance to the facility. Resident #5 stated that the Administrator did not provide the family with the directive and stated that he can impose the rules as he pleased for the facility.

On 03/04/22 at 10:15 AM, the Surveyor conducted a telephone interview with the family member (FM) of Resident #5. The FM stated that she was very frustrated about not being able to

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see her loved one as she would like to. The FM stated that during the last visit, the Director of Nursing (DON) and the Social Worker (SW) told her that she had to have a COVID test done prior to visiting. The FM refused to take a COVID test, and the FM had not been allowed to visit since that time.

On 03/04/22 at 11:15 AM, the Surveyor conducted a follow up telephone interview with the FM of Resident #5. The FM stated that she did not get a letter from the facility regarding the visitor restrictions. She stated that she visited last in January and was told that she had to be tested based on DOH directives. She further stated that when she asked for the DOH directive, she was informed that the facility did not have to provide her with any proof. She stated that when she visited in January the facility attempted to administer a COVID-19 test to her without her consent.

On 03/04/22 at 11:30 AM, the Surveyor interviewed the SW. The SW stated that families were notified in writing monthly of the facility's visitation. The SW stated that Resident #5's family had not contacted anyone at the facility to request a visit and that the Activity Director (AD) oversaw scheduling visits.

On 03/04/22 at 11:35 AM, the Surveyor interviewed the Administrator (LNHA) about the referenced directive. The LNHA stated that the directive was from DOH. He further stated that visitors must have a COVID-19 rapid test to be able to visit with family. When inquired about the current guidelines distributed by Centers for Medicare and Medicaid Service, the LNHA provided the Surveyor, at a later time (12:55 PM),

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with the Executive Directive No. 21-021 dated 11/24/2021. The Directive which revealed under " Visitor Testing" section (i) (ii) the following was revealed:

"Consistent with QSO-20-39-NH, facilities in counties with substantial or high level of community transmission are encouraged to offer testing to visitors. If they do not, facilities should encourage that visitors be tested on their own within 2-3 days before coming to the facility. Non -CMS certified facilities should follow this same recommendation.
visitors are not required to be tested or vaccinated as a condition of visitation".

On 03/04/22 at 11:45 AM, the Surveyor interviewed the AD. The AD confirmed that visits were by appointment only and visitors must sign the consent. The AD further explained that all visitors were to have their temperature taken, a COVID-19 questionnaire screening, must wear masks, and have a COVID-19 test administered upon entrance. She further stated that visits were handled by the SW and her role was only to schedule the visits. She stated the visits were scheduled daily in an activity room on the first floor for one hour. She stated she was told by the SW that was an administrative decision.

On 03/04/2022 at 12:30 PM, the surveyor reviewed the facility provided consent form, dated 06/20/20. The content indicated that the center [referring to the facility] reserves the right to limit the length of any visit, the days on which visits will be permitted, the hours during a day when visits will be permitted, and the number of times during a day or week a resident may be visited.

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On 03/04/2022 at 12:19 PM the SW provided a letter dated 01/18/2022 that was forwarded to the family and friends. The following were noted:

We hope that this letter finds you and yours in good health.
We appreciate your understanding and patience as we make every effort to keep our resident safe during this COVID-19 pandemic.
While we recommend no visitation at this time, we are pleased to inform you that we will be allowing in-person, in-door visitation in our First Floor Day Room.
We need you to note the following guidelines and procedures for the visits-

1. Visits will be scheduled and by appointment only. Please call our recreation department in advance at #908 [-000-0000]; extension [#0000] or by email.
2. Visitation will be scheduled daily between 10:30-and 11:30 AM.
3. During your visit, you should always wear a face covering mask and maintain social distancing and infection control standards.
4. Upon your arrival at the lobby, you will meet with a staff member who will assist with your COVID-19 screen.
5. Please do not visit if you are sick, having elevated temperature, viral symptoms or not feeling well.
6. You are asked to notify the facility ASAP if you test positive for COVID-19 or exhibit any symptoms of COVID-19 within 14 days of your visit.

On 03/06/22 at 12:45 PM, the Surveyor conducted an interview with the DON. The DON stated that the SW handled visitation in the facility

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and the AD was responsible to schedule the visits. The DON stated there was no COVID in the facility and they tried to keep all residents safe.

On 03/06/22 at 12:55 PM, the Surveyor conducted a subsequent telephone interview with the FM. The FM stated that she had not visited since January. She stated she was notified of the visit's requirement upon the last visit and she was not allowed to return upstairs since she refused the COVID-19 test. She stated she did not receive a letter from the facility regarding the visit requirements from the DOH.

On 03/08/22 at 9:13 AM, the surveyor interviewed the SW. The SW stated that all residents were provided with a Resident Bill of Rights and a meeting was held and the Bill of Rights was explained. The SW stated that those who were not in attendance received a copy and a packet was also sent to the family. The SW was asked to elaborate further regarding the visitation process. She stated that she emailed a copy of the letter to all families. The SW stated that any resident that was unable to go downstairs would have to comply with testing. She stated that based on what she knew the family should be allowed to visit. The Surveyor inquired if the families were clear on the rules and requirements about the visitation rules, and the SW stated that the information was sent monthly to the families.

On 03/09/22 at 8:03 AM, upon entrance to the facility, the Survey team inquired regarding visitation and the Receptionist stated that visits were by appointment only.

On 03/10/22 at 9:50 AM, the Surveyor

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interviewed the AD regarding visitation time and duration. She stated that visits were scheduled daily from 10:30 AM -11:30 AM downstairs so social distancing could be observed. She stated that the room used for visits also was used as a resident activity room for the first floor. The AD stated they could not infringe more on resident rights due to the utilization of the room for visitation instead of the activities room.

According to the Executive Order QSO-20-39-NH revised 1/2021 CMS is providing clarification to recent guidance for visitation (see CMS memorandum QSO-20-39-NH REVISED 11/12/2021). While CMS cannot address every aspect of visitation that may occur, we provide additional details about certain scenarios below. However, the bottom line is visitation must be always permitted with very limited and rare exceptions, in accordance with residents' rights. In short, nursing homes should enable visitation following these three key points:

Adhere to the core principles of infection prevention, especially wearing a mask, performing hand hygiene, and practicing physical distancing.
Don't have large gatherings where physical distancing cannot be maintained; and
Work with your state or local health department when an outbreak occurs.

Centers for Medicare and Medicaid Services (CMS) Reference: QSO-20-39-NH revised 11/12/2021 reflected the following information regarding visitation in nursing homes:

While CMS guidance has focused on protecting nursing home residents from COVID-19, we

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recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends.

In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

Facilities must always allow indoor visitation and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.
Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Also, facilities should avoid large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the

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same time and physical distancing cannot be maintained. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident ' s room or designated visitation area. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission.

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident ' s room. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

The Admission Packet provided by the facility on 03/01/22 revealed a copy of the Resident's Bill of Rights which revealed:
Residents must be informed of all rights as follows:
11. Resident may associate and communicate privately with persons of his or her choice, may join with other residents, individuals within or outside of the facility to work for improvements in resident care...
16. The resident is assured of established daily visiting hours.

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F 563	Continued From page 15 19. The resident is allowed privacy for visits with family, friends, clergy, social workers, or for professional or business purposes. NJAC 8:39-4.1(a) 23	F 563		
F 609 SS=D	NJAC 8:39-4.1(a) 23 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		5/15/22

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F 609	Continued From page 16 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) report to the New Jersey Department of Health (NJDOH) an allegation of resident to resident abuse, and b.) develop the facility's "Policy on Resident Abuse" policy in accordance with federal and state requirements for the timing of reporting such allegations of abuse to the state agency. The deficient practice was identified for 1 of 2 investigations of reportable incidents reviewed (Resident #258) and was evidenced by the following: On 02/28/22 at 11:34 AM, the Surveyor reviewed Resident #258's electronic Progress Notes (ePN) which included the following note dated 02/08/22 at 6 PM: Resident reported to writer that resident across the hall from his/her room hit him/her on the left forehead with a cane when he/she went to the residents' room at 5pm to approach him for taking his snacks from the TV room.	F 609	F609 Element One □ Corrective Actions " The incident involving Resident #258 was reported to the NJDOH on 4/8/2022. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by this practice. Element Three □ Systemic Changes " Staff received re-education regarding reporting of allegations of abuse as required. " All incidents are discussed during morning operations meetings to ensure proper investigations are completed timely to rule out and prevent abuse or neglect and reported as required within regulatory timeframes and in compliance with facility policies.	

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F 609	Continued From page 17 On 03/01/22 at 11:00 AM, the Surveyor requested the Director of Nursing (DON) provide the Surveyor with any incidents that were required to be reported to the state agency for the month of February. At 1:41 PM, the DON stated that the facility only had one incident that was required to be reported to the state agency for the month of February. The DON stated that the incident occurred yesterday (02/28/22) and that they would be faxing it to the agency today. On 03/02/22 at 10:05 AM, the Surveyor requested that the DON provide any incidents or investigations that occurred in the last 3 months for Resident # 258. At 12:15 PM, the Director of Social Services provided the Surveyor with a one-page document titled, "Incident Interview" dated 02/09/22 which included a summary of the incident that occurred between Resident #258 and an unsampled resident. At 12:29 PM, in the presence of the survey team, the Surveyor inquired to the DON if Resident #258's allegation of abuse was reported to the NJDOH. The DON stated that it was not reported. She added that the investigation concluded that the incident was not witnessed and that the incident was fabricated. The surveyor then inquired to the DON if any allegation of abuse, whether it happened or not, was required to be reported. The DON stated that any allegation of abuse should be reported. On 03/11/22 at 11:23 AM, in the presence of the survey team, the DON and the Licensed Nursing	F 609	" The DON/designee/Administrator are notified immediately of any allegations of abuse and notify regulatory agencies as required. The DON completes the required reportable event form and reviews all incident investigation documents to determine the cause of incidents and actions that need to be taken to prevent further incidents. Element Four □ Quality Assurance Incidents are reviewed daily Monday through Friday at morning operations meetings. The DON/designee reviews incident investigations to rule out abuse and/or neglect and to ensure timely notification of NJDOH as required. Tracking of incidents is being conducted weekly for the next month then monthly going forward by the DON/designee. Findings are discussed with the Administrator and reported quarterly in aggregate to the QAPI committee for action as appropriate.	

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Home Administrator (LNHA) confirmed that Resident #258's allegation of abuse was not reported to the NJDOH and that the allegation should have been reported. The surveyor then asked the LNHA when an allegation of abuse should be reported to the NJDOH. The LNHA stated that an allegation of abuse should be reported immediately.

The facility did not provide any documented evidence that Resident #258's allegation of abuse was reported to the DOH.

A review of the undated facility provided policy titled "Policy on Resident Abuse" included the following:
It is the policy of this facility to protect all residents from physical or mental abuse; involuntary seclusion, neglect or misappropriation of personal property and to investigate and report all alleged or suspected incidents of resident abuse to the appropriate regulatory agencies ...
An employee witnessing any form of abuse is required to promptly report the incident to the charge nurse. Any staff member failing to report these incidents will be subject to disciplinary action which may include immediate discharge.

The administrator will report the incident to the department of health and the Ombudsman's office within 72 hours.
The investigation and its outcome will be reported to the above agencies ...
VII. Reporting
All violations and alleged or suspected incidents of any form of abuse/neglect will be reported to appropriate state agencies within 72 hours ...

A review of the facility provided policy titled,

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F 609	Continued From page 19 "Accident/Incident Reports" with a revised date of 10/2021, included the following: Policy All accidents and incidents occurring on the facility's premises must be reported. An incident is any occurrence not consistent with the routine operation of the Facility, normal care of the resident, a happening involving visitors, malfunctioning equipment, or observation of a condition which might become a safety hazard ... All DOH reportable events will be reported to the appropriate jurisdiction. N.J.A.C. 8:39-5.1(a)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record reviews and review of	F 610	F610	4/30/22

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F 610	Continued From page 20 pertinent documents, it was determined that the facility failed to complete a thorough and timely investigation for an allegation of abuse. This deficient practice was identified for 2 of 3 residents reviewed for abuse (Resident #60 and Resident #258). The deficient practice was evidenced by the following: During the initial tour of the facility on 02/28/22 at 10:23 AM, the Surveyor observed Resident #60 who was awake and alert and was lying in bed. The Surveyor observed a reach extender (handheld mechanical tool used to increase the range when grabbing objects) located on the bed and was next to the resident. Resident #60 stated that he/she was moved to that room last night following an altercation with the former roommate. Resident #60 stated, "[referred to the roommate] touched me inappropriately, and I hit him/her with the reacher" on the shoulder. On 02/28/22 at 12:50 PM, the Surveyor reviewed the nurse Progress Notes and was unable to locate documentation regarding the 02/27/22 incident. On 03/01/22 at 9:15 AM, the Surveyor observed Resident #60 in bed resting. At 9:50 AM, during a second interview with the Surveyor, Resident #60 recounted the same story and stated that the nurses were aware of the incident. Resident #60 stated, "I called for help, put the call light on, and three nurses came to the room to assist". A review of Resident #60's clinical record revealed: According to the Admission Face Sheet, Resident #60 was admitted to the facility with diagnoses	F 610	Element One □ Corrective Actions " The incident that occurred with Resident #60 was re-investigated by the DON and Administrator and witness and staff statements obtained. " The staff involved in the incident occurring with Resident #60 received re-education regarding the Abuse and Neglect policy to include timely reporting of allegations of abuse, completion of investigation documents including written witness statements, resident assessment, and progress notes that reflects results of resident assessment, notification of responsible party and physician, and actions taken to protect the resident. " The incident that occurred with Resident #258 was re-investigated by the DON and Administrator and witness and staff statements obtained. " The staff involved in the incident involving Resident #258 received re-education regarding reporting allegations of abuse, timely completion of investigation documents including written witness statements, resident assessment, and progress notes that reflects results of resident assessment, notification of responsible party and physician, and actions taken to protect the resident. Identification of at Risk Residents All Residents have the potential to be affected by these practices.	

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F 610	Continued From page 21 which included, EX Order 26 § 4b1 [redacted] The Quarterly Minimum Data Set (MDS) ,a resident assessment document, dated 02/25/22 revealed that Resident #60 scored EX O[redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident was EX Order 26 § 4b1 [redacted]. Section E of the MDS which addressed behavior indicated that Resident #60 had no behaviors. 03/01/22 at 9:53 AM, the Surveyor interviewed the Social Worker (SW) regarding the incident. The SW stated that Resident #60 requested to be moved and whe was not aware of any verbal or physical altercation. On 03/01/22 at 10:15 AM, the Surveyor conducted a follow up interview with the SW regarding the incident. At that time, she had no information to offer and stated she would visit the resident and investigate the matter. On 03/01/22 at 1:50 PM, the SW provided an undated form titled, "Incident Interview" which revealed the following: "It was reported by nursing that on 02/27/22 in the evening, there was an argument between Resident #60 and their roommate, Resident #60 was moved to Room 201. SW and DON interviewed the residents- Resident #60 reported that he/she was in bed when his/her roommate came to him/her and stated that "I stole [his/her] money" and that "I have [his/her] bank account". He/She reported that he/she looked for the money "on my butt"	F 610	Element Three □ Systemic Changes Staff received re-education related to the facility policies and regulations for conducting timely investigations to rule out abuse or neglect, obtaining witness statements, and documenting the results of resident assessment and actions taken because of an incident in the medical record including notification of the responsible party and physician, and revision as appropriate of the resident care plan. Element Four □ Quality Assurance Incidents are reviewed daily Monday through Friday at morning operations meetings. The DON/designee reviews incident investigations to rule out abuse and/or neglect and to ensure timely notification of NJDOH as required. Trend analysis of incidents is being conducted weekly for the next month then monthly going forward by the DON/designee. Findings are discussed with the Administrator and reported quarterly in aggregate to the QAPI committee for action as appropriate.	

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and "under my pillow" and admitted "I hit [him/her] on the shoulder [he/she] did not hit me, three nurses came". Resident #60 also stated to the SW that "[referring to the roommate] was looking for a driver license...
The roommate was interviewed and stated that "I really don't know; no one told me anything" and denied any "wrong doing".

A review of the 24 hour nursing report, dated 02/27/22, revealed the following "the roommate constantly standing by Resident #60's bed stated [he/she] took his/her money, bank account and car's key. All evening the roommate refused to stay on [his/her] side of the bed." By 10: 00 PM, Resident #60 was moved to another room.
"Today during an interview with the roommate, [he/she] said that [he/she] hit [him/her] on the shoulder, as per the staff's report they did not witness any physical altercation". (The facility did not immediately initiate and document an investigation regarding an allegation of abuse or the allegation of misappropriation.)

The surveyor attempted to interview the nurse who worked on 02/27/22 on the 3:00 PM -11:00 PM shift, via telephone and the nurse could not not be reached on 3 occasions. The surveyor attempted to interview the roommate on 03/01/22 at 10:30 AM, the roommate was very confused and was unable to proceed with the interview.

The clincal record was reviewed by the Surveyor, which included the Progress Notes (PN). The clinical record not reveal any documented entries, or documentaiton regarding the incident for 02/27/22 and 02/28/22.

An entry was entered in the PN by the DON on

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03/01/22 at 12:58 PM which revealed "On 2/28/22 Staff reported the [Resident and his/her] roomate had an argument on 2/27. Roommate [initials] reported that [roommate's initials] alleged that [roommate's initials] stole [his/her] money, bank account and [his/her] car key and standing next to [him/her] demanding for it. [Resident] was not leaving from [his/her] space, [roommate's initials] admitted that [he/she] hit [his/her] roommate on the shoulder, and called staff for help. There was no documentation that the family and the physician were notified on 02/27/22 following the incident. (This was documented two days after the incident).

A PN dated 03/01/22 at 15:37 (3:37 PM) by the SW revealed "On 2/28/22 Staff reported a verbal exchange between [the reisdent and room mate] that took place the evening before." "[The Resident] said that [his/her] roommate took [his/her] money and [his/her] bank account.,."In an initial interview with the roommate, yesterday, [he/she] did not mention any physical action." (This interview was not documented and was two days after the initial report documented on the 02/27/22 nursing report).

On 03/03/22 at 9:20 AM, the Surveyor observed Resident #60 in the room. Resident #60 elaborated further regarding the incident and stated that the roommate claimed that he/she was looking for a car key and he/she was all over his/her bed and then made contact with him/her. Resident #60 indicated that he/she activated the call light, yelled for help and "three nurses" came to the room, and he/she told them what had happened.

On 03/03/22 at 9:45 AM, during an interview with

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the DON regarding the incident, the DON stated that she agreed the "documentation was lacking.", and confirmed the incident was not entered in the clinical record. The DON submitted a written note and 2 written statements from the nurse and the Certified Nursing Assistant. None of the entries revealed that Resident #60 was involved in a physical altercation. The DON did not provide documented evidence that both residents were interviewed and assessed at the the time of the incident.

On 03/03/22 at 12:15 PM, the Surveyor conducted an additional interview the DON regarding the investigative process. She stated that the incident should have been entered into the Progress Notes. She did not provide information regarding the time that she was made aware of the incident. The DON did not provide a rationale regarding why the incident was not domented in the clinical record when the incident occurred.

An interview with the SW on 03/04/22 at 11:30 AM, revealed that the DON forwarded an email regarding the incident. When asked to provide a copy of the e-mail she indicated that she could not locate the e-mail on the phone. The SW went on to state that the nurse did not document the incident in the clinical record nor contact her. The facility did not initiate an investigation until 03/01/22 when the surveyor brought it to their attention.

During an interview on 03/08/22 at 11:43 AM the Surveyor interviewed a Licensed Practical Nurse (LPN) regarding the process following any incident. The LPN stated she worked at the facility for ten years. The LPN stated that the

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process was for the nurse on duty to enter the incident into the PN, notify the Physician, family and notify the DON. The LPN further stated that if the information was not entered following the incident, the DON must be notified and a late entry should be added into the clinical record.
2. On 02/28/22 at 10:34 AM, the Surveyor observed Resident #258 sitting in a wheelchair.

A review of Resident #258's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]

On 02/28/22 at 11:34 AM, the Surveyor reviewed Resident #258's electronic Progress Notes (ePN) which included the following note dated 2/8/22 at 6 PM: Resident reported to writer that resident across the hall from his/her room hit him/her on the left forehead with a cane when he/she went to the residents' room at 5pm to approach him/her for taking his/her snacks from the TV room. Left forehead assessed and no redness, no raised area and non tender to touch. Resident stated he/she does not need writer to do anything, "stated that's too much paper work." Writer reassured resident to check his/her forehead again for any injury.

On 03/01/22 at 11:00 AM, the Surveyor inquired to the DON and requested to provide any incidents that were required to be reported by the facility to the Department of Health (DOH) state during the month of February 2022.

At 1:41 PM, the DON stated that the facility only

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had one reportable incident in February. She added that the incident happened yesterday (2/28/22) and that she was faxing it today to the DOH.

On 03/02/22 at 8:27 AM, the Surveyor interviewed Resident #258. Resident #258 stated that the unsampled resident was a thief and that the unsampled resident hit him/her with a cane on 2/8/22.

On 03/02/22 at 10:05 AM, the Surveyor asked the DON for any incidents or investigations that occurred in the last 3 months for Resident # 258.

At 12:15 PM, the Director of Social Services (SW) provided the surveyor with a one-page document titled, "Incident Interview" dated 02/09/22 which included a summary of the incident that occurred between Resident #258 and an unsampled resident. The unsigned document did not indicate who completed it and it revealed: It was reported by Resident #258 today that yesterday 02/08/22 at around 7 PM, he/she left a box of crackers on the table in the day room and went to his/her room. Resident #258 then saw that the unsampled resident took the box to his/her room. Resident #258 asked the unsampled resident for the box but the unsampled resident refused to give it, so Resident #258 went into the unsampled resident's room to get the box, and the unsampled resident hit Resident #258 with a cane. Resident #258 said the nurses were busy at that time, but Resident #258 later told the nurse. The SW and translator spoke to unsampled resident who admitted that he/she took the crackers and ate them, when asked why unsampled resident said "I don't know". Unsampled resident denies hitting anyone. DON

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immediately responded to the scene and did not witness any physical altercation. Assigned nurse was near the day room and did not witness any physical altercation. SW offered a room change to Resident #258 but resident declined. Resident #258 has a hx (history) of fabricating stories about staff and/or residents. Both residents were advised to call the staff for assistance as needed and that they are not allowed to use physical or verbal abuse towards each other.

At 12:29 PM, in presence of the survey team, the Surveyor questioned the DON if the "Incident Interview" was the completed thorough investigation. The DON stated that this was the incident that was reported to us. She added that at the time of the incident Resident #258 did not report that he/she was hit by the other resident. She stated that the next morning Resident #258 reported to her that he/she was hit by the other resident. The DON then stated when she spoke with Resident #258, the resident told her that he/she spoke to a Nurse after the incident and told the Nurse. The DON added that she called the Nurse and that the Nurse told the DON that she checked Resident #258 and that he/she had no marks. The surveyor asked the DON if the Nurse had made a written statement. The DON stated that the Nurse told her verbally and that she did not document it. The Surveyor inquired if there was anything else documented regarding the investigation. The DON stated that they did not have anything else "written up." The DON stated that the Nurse investigated the incident on 02/08/22 but that the nurse did not report it to us. The surveyor asked the DON if the investigation done by the Nurse was documented. The DON stated that the investigation done by the Nurse was not documented. The DON stated that the

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Nurse checked with other residents that were in the area but that she did not document the interviews. The DON confirmed that the Nurse should have taken statements from the residents and documented it. The DON was unable to provide documentation of a completed thorough investigation that included statements from residents and staff.

On 03/9/22 at 10:18 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that a full thorough investigation was not completed at the time of the allegation of abuse, and that on 03/08/22 the facility had added documentation to the investigation.

On 03/11/22 at 11:26 AM during a pre-exit conference with the Administrator and the DON, and in the presence of the survey team, the DON stated that all allegations of abuse should be investigated and reported immediately.

A review of the undated facility provided policy titled "Policy on Resident Abuse" included the following:
It is the policy of this facility to protect all residents from physical or mental abuse; involuntary seclusion, neglect or misappropriation of personal property and to investigate and report all alleged or suspected incidents of resident abuse to the appropriate regulatory agencies ...
An employee witnessing any form of abuse is required to promptly report the incident to the charge nurse. Any staff member failing to report these incidents will be subject to disciplinary action which may include immediate discharge.
II. Training:
All orientees regardless of department and affiliation receive an individual orientation on

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identifying and reporting abuse with handout defining types of abuse and how to report to supervisors ...
IV. Identification:
Immediate incident reporting and investigation of all falls, bruising, tears, increased depression, fearful behaviors.
Monitoring of incidents by supervisors, Director of Nursing and the administrator.
Anyone witnessing o(r) suspecting any type of abuse towards a resident by any individual (including staff, family, friends, and other resident) will immediately report the incident to the supervisor on duty.
V. Investigation
The supervisor will immediately assure the safety of the resident and assess for the need for medical attention ...
The supervisor will notify the administrator, the director of nursing and the nurse consultant of the incident.
An incident report will be completed and the supervisor will obtain the statement of all witnesses or persons involved. A statement should also be obtained from the resident if possible ...
The administrator will report the incident to the department of health and the Ombudsman's office within 72 hours.
The incident investigation checklist will be used as a tool to ensure all documents are received and all areas are properly investigated.
The investigation and its outcome will be reported to the above agencies ...
A file will be kept in the administrator's office of each instance of actual suspected abuse.
VI. Protection
All residents involved in an investigation are monitored closely to avoid further disruption of

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daily quality of life.
Intervention by the social worker with resident and family.
Immediate removal of "threat" whether employee, other resident, social circumstance or physical hazard to provide security and safety ...
VII. Reporting
All violations and alleged or suspected incidents of any form of abuse/neglect will be reported to appropriate state agencies within 72 hours ...
Any employee who has reasonable cause to believe a resident has been abused in any manner will repo(r)t the alleged incident to their supervisor, the director of nursing or the administrator.

A review of the facility provided policy titled, "Accident/Incident Reports" with a revised date of 10/2021, included the following:
Policy
All accidents and incidents occurring on the facility's premises must be reported. An incident is any occurrence not consistent with the routine operation of the Facility, normal care of the resident, a happening involving visitors, malfunctioning equipment, or observation of a condition which might become a safety hazard.
Purpose
To provide a safe and helpful environment for residents, visitors, an(d) employees.
Process
1. Reporting of Accident/Incidents:
1.1 Regardless of how minor an accident or incident may be, it must be reported to the department Supervisor and appropriate documentation completed on the shift that the accident or incident occurred;
1.2 Employees witnessing an accident or incident involving a resident, employee, or visitor must

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report such occurrence to his or her immediate supervisor immediately. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance;
1.2.1 Any unwitnessed accident or incident must be investigated for potential abuse, neglect, negligent treatment, misappropriation or exploitation.
1.3 The supervisor must be informed of all accidents or incidents so that medical attention can be provided, if necessary ...
4. Documentation an Investigation Action:
4.1 The charge nurse and/or the Department Director/Supervisor must document the incident and conduct an immediate investigation of the accident or incident.
4.2 The specified Accident/Incident Form will be used (f)or residents, employees, and visitors.
4.3 Witnesses, if any, will also be documented (on) the report. The address an(d) telephone number of the witnesses will also be documented.
4.4 Every attempt will be made to ascertain the cause of the accident/incident.
4.5 The administrator and Director of Nursing will be made aware o(f) all such incidents occurring in the facility and will review completed reports. If any accident is of a serious nature, medically or suspected abuse, neglect, negligent treatment, misappropriation o(r) exploitation, it shall be reported by telephone immediately regardless of time or day ...
4.5.2 The administrator is responsible for coordinating the investigation an(d) assuring that appropriate action is taken. Conducts interviews, collects written statements from all staff or visitors involved in the situation.
4.6 Completed accident/incident reports and investigation forms must be submitted within 24 hours to the administrator and the Director of

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to review and	F 657	F657 Immediate□ Corrective Actions The care plan of Resident #208 was	4/30/22

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revise a resident's Care Plan for antibiotic use with infection. This deficient practice was identified for 1 of 20 residents (Resident #208) reviewed for Care Plans and was evidenced by the following:

1) On 02/28/22 at 9:41 AM, the Surveyor toured the first floor unit and observed Resident #208 lying in bed. Resident #208 pulled up his/her bed sheet and pointed at their feet. The Surveyor observed both feet were swollen and red in color.

On 03/03/22 at 8:22 AM, Resident #208's direct care Licensed Practical Nurse (LPN) stated the resident needed help with getting to the bathroom, care, tube feeding, also was ordered pleasure foods, and encouragement to keep feet elevated because of swelling.

On 03/03/22 at 9:10 AM, the direct care Certified Nursing Assistant (CNA) stated the resident needed total care, was incontinent, and that his/her feet were swollen and dent when they are touched.

A review of the resident's medical record revealed the following:

The Admission Record revealed that Resident #208 was recently admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted].

The Admission Minimum Data Set (MDS - an assessment tool), dated [redacted], revealed a Brief Interview for Mental Status (BIMS) of [redacted]/15 which indicated EX Order 26 § 4b1 [redacted]; activities of daily living (ADL)s revealed the resident required

immediately reviewed and updated as appropriate to reflect current health status.
Identification of other residents
All residents have the potential to be affected by this practice.
Systemic Changes
Staff received re-education regarding including entering new infections/ antibiotic orders on the 24-hour report.
The 24-hour report is reviewed and new infections / antibiotic orders are discussed during morning clinical meetings and care plans updated to reflect resident health status.
Monitoring Of Corrective Actions
Weekly for the next four weeks then monthly for the next three months the MDS Coordinator will provide the DON/designee with an audit of 5 charts to substantiate updating care plans when there is new infection. The DON/designee will report MDS audit findings at the quarterly QAPI committee meeting for action and further guidance as appropriate.

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F 657	Continued From page 34 extensive staff assistance. The Physician's Orders Sheet (POS) revealed an order dated 3/2/22 for EX Order 26 § 4b1 [redacted] The February 2022 Medication Administration Record (MAR) revealed that Resident #208 had been administered the EX Order 26 § 4b1 as ordered. A review of the March 2022 MAR revealed that Resident #208 had been administered the EX Order 26 § starting on 3/2/22 at 10 PM. A review of the Care Plan (CP), on-going and included resolved/canceled areas, included but was not limited to the following: a Problem area dated 3/4/22 resident on EX Order 26 § 4b1 [redacted] On 03/09/22 at 9:01 AM, the MDS Registered Nurse (RN) was in the conference room with the survey team. The MDS RN stated things to incorporate on the CP EX Order 26 § 4b1 [redacted] She stated the purpose of the CP was for all the staff, CNAs, Nurses, Social Worker (SW), family	F 657		

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members to be involved and to updated as needed. The MDS RN stated the Interdisciplinary Care Team would speak about the residents during morning meeting and the CP would be updated. The MDS RN stated the nurses, SW, recreation department, and rehabilitation department, are all supposed to review and make changes as they occur and they all have access to make the changes in the computer. She further stated she had never seen the CP policy and had worked at the facility for 7 months.

On 03/09/22 at 9:06 AM, the MDS RN stated if an antibiotic was started on a resident, it would be discussed during morning meeting and placed on the CP. The MDS RN stated it was important for antibiotics to be on the CP in order to monitor them for their effectiveness and any side effects.

On 03/09/22 at 10:22 AM, the DON stated there was an initial CP done within 48 hours and again within the next 14 days. She stated the purpose of a comprehensive care plan was so staff were aware and involved "for patient safety". The DON stated she would expect to see problems, goals, and interventions and if a problem were identified in between quarterly reviews, the CP would be changed as soon as possible "immediately". The DON stated the staff reviews the 24 hour report daily and would update the CP. The weekend supervisor can also update the CP. She further stated again that the facility should have an immediate update of the CP with changes that occur.

A review of the facility provided, "Resident Assessment Instrument", policy revised 12/10, included but was not limited to the assessment

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coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: b. when there has been a significant change in the resident's condition. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.

On 03/04/22 at 11:35 AM, the facility provided, "Job description Unit Coordinator / Charge Nurse (Registered Nurse / LPN), not dated, which included but was not limited to: 8. communicates to the direct care staff daily, on an ongoing basis regarding resident care needs and changes to the plan of care; 9. assumes overall responsibility for the completion of report, and any other documents, according to facility policy.

On 03/04/22 at 11:35 AM, the facility provided, "Job Description - Staff Nurse", not dated, which included but was not limited to: Care Plan and Assessment Functions: review care plans daily to ensure that appropriate care is being rendered; inform the charge nurse of any changes that need to be made on the care plan; ensure that your nurses' note reflect that the care plan is being followed; review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs; and ensure that your assigned nursing assistants are aware of the resident care plans and that they are being used in administering daily care to the resident.

On 03/09/22 at 9:55 AM, the Licensed Nursing

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F 657	Continued From page 37 Home Administrator (LNHA) provided the, "Care Plan - Interdisciplinary Team", policy revised 2008, which included but was not limited to: Our facility's Care Planning / Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning / Interdisciplinary Team which includes but is not limited to the following personnel: h. the Director of Nursing k. others as appropriate or necessary to meet the needs of the resident. On 03/10/22 at 12:18 PM, the above concerns were brought to the attention of the LNHA and DON. The facility had no additional information to provide. NJAC 8:39-11.2(e)(f)(h)(i); (2)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to: 1.) follow professional standards of practice and facility policy when altering a Medication Administration Record (MAR) and Physician's Order (PO) sheet, and 2.) ensure physician ordered medications were administered and entered correctly into the	F 658	Element One □ Corrective Actions " The medication administration records (MARs) for Residents#258 was immediately clarified and rewritten. " The pregabalin order for Resident #258 was clarified with the physician and	4/30/22

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MAR. This deficient practice was identified for 2 of 7 residents (Resident #258 and #5) reviewed during a medication administration observation and was evidenced by the following:

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."

Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

1) On 03/01/22 from 8:04 AM to 8:16 AM, the Surveyor observed the Licensed Practical Nurse (LPN) on the first floor during the medication administration. The LPN administered medications to Resident #258. As the LPN was signing for the administration of the medications, the surveyor observed six medications and the duplicative order discontinued on the MAR.

" The DON investigated the discrepancy in Resident#5□s [EX Order 26 § 4b] administration documentation vs. drug on hand.

" The nurse who did not document administering [EX Order 26 § 4b] on 2/11/22 was counseled and re-educated.

" The nurse who check marked [EX Order 26 § 4b] on the MAR without explanation on 2/25/22 was counseled and re-educated.

" The nurse who signed but did not administer [EX Order 26 § 4b] on 3/1/22 was counseled and re-educated.

Element Two □ Identification of at Risk Residents

All residents may be affected by these practices.

Element Three □ Systemic Changes

" Nursing was re-educated on facility medication administration (MAR) policies.

" Nursing staff received re-education to assure the MAR/TAR is signed for the administration of medications.

" Nursing staff were re-educated to document medication refusals and policy to document discontinued medications on the MAR.

" Staff nurses were re-educated on shift

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F 658	Continued From page 39 administration time, with lines drawn through them. The surveyor observed that of the six medications, only one had the word duplicate written. The crossed through medications and times did not have any staff signatures or discontinue dates noted. A reconciliation review of the 03/22 MAR completed by the Surveyor revealed the following order discrepancies: a) Order dated 01/18/22 EX Order 26 § 4b1 [redacted] This order had a single hand written line through the medication and another line through the times. Nothing was noted in the "D/C date" section or anywhere else on the MAR and no staff signature or date. b) Order dated 11/30/21 EX Order 26 § 4b1 [redacted] This order had two lines hand written through the medication and one line handwritten through the times. There was nothing noted in the "D/C date" section or anywhere else on the MAR and there was no staff signature or date. c) Order dated 01/18/22 EX Order 26 § 4b1 [redacted]	F 658	to shift chart review and monthly medical reconciliation. " The consultant pharmacist was engaged is auditing all charts making notations of missing signatures on the MARs or TARs as part of the monthly audits. Element Four □ Quality Assurance " Monthly for the next three months the DON/Nurse supervisor /designee will audit 10 charts to ensure the MARs and Treatment Administration Record are properly completed and there are no missing signatures for ordered medications. The DON will provide the audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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EX Order 26 § 4b1 [redacted] This order had three handwritten lines through the medication. There was nothing noted in the "D/C date" section or anywhere else on the MAR and there was no staff signature or date.

d) Order dated 01/28/22 EX Order 26 § 4b1 [redacted] This order had two handwritten lines through the medication and one line through the times. There was nothing was noted in the "D/C date" section or anywhere else on the MAR and there was no staff signature or date.

e) Order dated 10/5/21 EX Order 26 § 4b1 [redacted] This order had one line through the medication with the word duplicate written next to it. There was an "X" written over each of the plotted medication time as well. There was nothing noted in the "D/C

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date" section and there was no staff signature or date.

A review of the Physician Order (PO) sheet for Resident #258, revealed the following:

EX Order 26 § 4b1 [redacted], one dated 10/5/21 and the other 02/17/22 and neither order was noted as being a duplicate order.

On 03/01/22 at 8:16 AM, the LPN stated that the orders on the MAR that are crossed off should have been noted with "D/C or Duplicate and signed." The LPN stated the nurse on the 3 PM to 11 PM shift was responsible to do the recaps (reconciliation of the orders plotted on the MAR) and should have fixed the orders and it was not the 7 AM to 3 PM shifts job to do that. She further stated that the supervisor reviewed the MARS as well.

On 03/02/22 at 10:00 AM, the Registered Nurse (RN) Supervisor observed the MAR and TAR with the surveyor and acknowledged it was incorrect and confusing for staff. She stated the orders should have been clarified and any discontinued or changed medication orders must be yellowed

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out (highlighted with yellow marker), noted in the D/C section, or document the change. The RN Supervisor stated staff should never write over the times because it would be too confusing, and if there was a duplicate order but different dates, the staff must call to clarify the order and replot it on the MAR. She stated she was not sure why it (MAR) was not "caught" and fixed.

On 03/02/22 at 10:05 AM, the Director of Nursing (DON) was observed to be standing behind the first floor nurses station. The DON was shown the MAR and stated she would look for a policy for recaps on the MAR and TAR. The DON stated the duplicate orders should have been crossed out and noted correctly on the MAR.

2. A review of the medical record for Resident #5 revealed that the resident was admitted to the facility with diagnoses which included, diabetes mellitus, depression, hypertension.

Review of the Physician orders sheet reflected an order for EX Order 26 § 4b1 [redacted]
The order was transcribed into Resident # 5's March 2022 MAR and plotted to be administered daily at 9:00 AM.

On Tuesday 03/01/22, a review of the MAR following medication Administration on the second floor, revealed that the LPN signed the MAR which indicated that she administered [redacted] to Resident #5.

During an interview with the LPN on 03/01/22 at 11:30 AM, the LPN stated that she signed the MAR in error. She informed the Surveyor that

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prior to the administration of the last dose, she ordered a box that contained four [redacted]. The LPN escorted the Surveyor to the medication room and showed the Surveyor the sealed box which contained four [redacted] stored and was stored in the refrigerator. Upon further inspection, the Surveyor also noted that one syringe of [redacted] remained in the refrigerator. A review of the February 2022 MAR showed that on Friday 02/11/22, the nurse did not sign for [redacted]. The back of the MAR did not reflect that Resident #5 refused [redacted] on 02/11/22.

On 02/25/22 a check mark was noted on the front of the MAR and there was no comment documented on the back of the MAR. The nurse did not indicate if [redacted] was administered, and the administration site was not entered on the MAR.

An interview with the provider pharmacy on 03/03/22 at 11:15 AM, revealed that [redacted] was delivered on 02/18/22 and the pharmacist stated "only" two doses of [redacted] should remain. At that time, the Surveyor along with the LPN noted "5" doses of [redacted] were stored in the refrigerator. The pharmacist indicated that if "5" doses were available, and based on her calculation, the medication had not been administered.

During an interview with the LPN on 03/03/22 at 12:50 PM, she stated that she did not work on 02/11/22 so she could not comment on the amount of [redacted] that was available in the refrigerator.

On 03/10/22, at 12:50 PM, the DON was made aware of the above concerns. The DON told the

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surveyor that she reviewed the February 2022 MAR and confirmed that [redacted] had not been administered as ordered. The DON indicated that she did not investigate further.

The Surveyor showed the March 2022 MAR to the DON where both observed that [redacted] was plotted to be administered daily instead of weekly. The DON indicated that the nurses would be in-serviced.

A review of the facility's policy titled, "Charting and Documentation", revised 10/2021, received from the Assistant Director of Nursing on 03/08/22 at 1:02 PM, revealed the following under Policy Statement:

All services provided to the resident, or any changes in the resident's medical condition, shall be documented in the resident's medical record. Under policy Interpretation and Implementation the following were noted:
All observations, medications administered, services performed, etc.,must be documented in the resident's clinical record.

On 03/01/22 at 1:39 PM, the facility provided, "Correcting the medical record" procedure, revised 11/11 which included but was not limited to: 1- if the medical record needs to be altered, the correction must be done appropriately; otherwise the accuracy of the entire record will be called into question. 7- Prohibited conduct includes but is not limited to - making corrections or modifications to a resident's medical record, including medication administration records and treatment administration records without dating, signing or initialing the entry. (The policy was not followed by the staff.)

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On 03/02/22 at 10:38 AM, the facility provided, "Transcribing Physician Orders in Medical record", policy and procedure, dated 1/1/06 and revised 3/22, which included but was not limited to Policy: accurate recording of resident orders (including medication, treatment and ancillary orders) will be ensured. Physician Order Sheet Form: e) when the POS are delivered to the facility it is the nursing departments responsibility to check for accuracy of these sheets. 3-C) if orders have been discontinued or changed, they must be changed not only on the order sheet but also on the medication and treatment sheet. to discontinue an order, cross it out and indicate D/C in the right hand margin with your initials and the date the D/C order was written. 4-D) to change an order, the order as it is currently written should be D/C'd and the entire order incorporating the change should be written as a new order. 6-A) the nurse noting a medication order (new order, changed order, D/C'd order) shall indicate by bracketing the order or orders, marking the order "NOTED", and recording the time, date, and signing full name and title. The nurse who noted an order shall have the responsibilities of transcribing the order onto the medication administration record. (The policy was not followed by the staff.)

On 03/04/22 at 11:35 AM, the DON provided the facility, "Job Description-Staff Nurse", undated, which included but was not limited to: Charting and Documentation: sign and date all entries made in the resident's medical records. Drug Administration Functions: prepare and administer medications as ordered by the physician; review medication orders for completeness of information, accuracy in the transcription of the

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F 658	Continued From page 46 physician's order, and adherence to stop order policy. On 03/04/22 at 11:35 AM, the DON provided the facility, "Job Description Unit Coordinator/ Charge Nurse (Registered Nurse/LPN)", undated, which included but was not limited to: receives and verifies the accurate transcription of physician's orders and ensures that these orders are implemented accurately and professionally. Assumes overall responsibility for the completion of report, and any other documents, according to facility policy. Supervises all licensed nursing personnel to assure satisfactory performance of duties according to their job descriptions and facility policies. On 03/10/22 at 12:18 PM, the above concerns were again discussed with the Licensed Nursing Home Administrator and the DON. No additional information was provided. NJAC 8:39-27.1(a), 29.2(d)	F 658		
F 678 SS=L	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and document review, it was determined that the facility failed to ensure: 1.) the emergency response system was activated to call a "code",	F 678	F678 Element # 1 Immediate Corrective Actions An investigation into the events of 2/12/22 surrounding the care of Resident #7 was	5/15/22

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F 678	Continued From page 47 2.) 911 was enacted, 3.) the EX Order 26 § 4b1 [redacted] was utilized for a resident who was found unresponsive (Resident #7) and was a full "code" status (all resuscitation procedures will be provided when a person stops breathing or heart stops beating). This deficient practice occurred for 1 of 3 residents (Resident #7) reviewed for unexpected deaths and 4.) failed to ensure a system was in place to appropriately track and maintain cardiopulmonary resuscitation (CPR) certifications to ensure that staff maintain the appropriate CPR certification. The facility's system wide failure to appropriately track and maintain appropriate cardiopulmonary resuscitation certifications, and provide the required emergency response, posed a serious and immediate threat to the health, safety, and wellbeing of all residents who resided in the facility. A serious adverse outcome had occurred and was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 03/04/22 at 1:50 PM. The IJ situation began on 02/12/22 at 8:00 AM when Resident #7 was found unresponsive and was identified by the survey team during an on-site survey on 03/03/22. The facility submitted an acceptable removal plan on 03/08/22 at 8:30 AM. The removal plan was verified, as implemented, by the survey team on 03/08/22 at 9:30 AM. Evidence as follow: On 03/02/22 at 12:51 PM, the surveyor reviewed the closed medical record for Resident #7, which revealed: A Licensed Practical Nurse (LPN #1)	F 678	initiated and completed by the Administrator and DON on March 3, 2022. Staff were interviewed and statements were obtained from those involved in the care and treatment of Resident # 7 on 2/12/22. Staff involved in the treatment of Resident #7 on 2/12/22, including the licensed nurses, certified nursing assistants, and nursing supervisors were counseled by the DON and then re-educated regarding the facility code policy including announcing and responding to a code, immediately calling 911, assessment of the resident, actions to take based on assessment findings, role responsibilities and process for requesting EMS services, use of the AED, and documentation of all actions and responses during a code with accurate times, actions taken during the code and resident outcome. Education also included review of the policy and procedures with additional documentation requirements. Basic Life Support classes were immediately held to certify nursing staff. Staffing was reviewed to ensure that at least two certified nursing staff members were present on each shift going forward. Element # 2 Identification Of other residents All Residents have the potential to be affected by this practice. Element # 3 Systemic Changes The policy and procedures related to initiating a code were reviewed by facility administration and nursing management and approved .	

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F 678	Continued From page 48 documented a Nurse's Note (NN) on 02/12/22 at 16:05 (4:05 PM). The NN revealed that during rounds at 7:00 AM, Resident #7 was awake and verbal. Then by 8:00 AM, LPN #1 went to give Resident #7 medications, and the resident was unresponsive, no pulse, "body a little cold CPR was done and no response, body was getting cold [SIC]." The RN PP (Director of Nursing) pronounced dead. The Admission record for Resident #7 revealed the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted] The Annual Minimum Data Set (MDS, assessment tool), dated 11/29/21, revealed under the Prognosis section that the resident was not checked off having a chronic disease that may result in a life expectancy of less than 6 months. The Care Plan for Resident #7 was reviewed. A Problem listed was Advance Directives - Resident had an Advance Directive/Proxy dated 12/14/20. The Goal was Resident #7 will continue to be informed and educated of the rights to make Advance Directives/Proxy, change it as needed, and their "wishes will be followed and respected," Dated 12/14/20. The Physician's Order, signed by the Physician on 01/30/22, did not reveal an order for 'do not resuscitate.' On 03/03/22 at 9:07 AM, the surveyor interviewed LPN #1, the nurse assigned to care for Resident	F 678	Nursing staff, including licensed nurses, nursing management, nursing supervisors and certified nursing assistants received re-education that included a thorough review of the code policy and procedures to follow. Education included announcing and responding to a code, immediately calling 911, assessment of the resident, actions to take based on assessment findings, process to initiate CPR if required, use of the defibrillator as appropriate, process for contacting EMS, and documentation of all actions taken in the medical record with the time of each action at the conclusion of the code. Nurses received re-education regarding their role when a code is called to ensure the facility procedures are followed and to ensure code response, code stat actions are properly implemented and when required contact with EMS is timely. Education also included supervisory review of all code documentation . All codes will be reviewed at AM clinical meetings by the DON ,ADON , Unit managers to ensure policy and procedure has been followed . A tracking tool was implemented that includes all staff CPR certification and renewal dates . This tool will be maintained by the receptionist and proof of certification/recertification maintained in the employee file .Monthly at a minimum , receptionist will review the tracking tool with the staff educator to assure CPR classes are scheduled as needed . Staffing coordinator maintains a list of	

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F 678	Continued From page 49 #7 on 02/12/22. LPN #1 confirmed she was assigned to Resident #7 on 02/12/22. LPN #1 stated the resident was okay, and then in the next twenty minutes, the resident "went bad" and that the resident was unresponsive. When she went to see Resident #7 prior, she stated that she had spoken with the resident, and Resident #7 said they were going to eat breakfast. The surveyor inquired as to what was she did when the resident was found unresponsive and asked if 911 was activated. LPN #1 stated, "we did not call 911", that she went in to give the resident medications, and the resident was already gone. LPN #1 stated she was shocked, she called for help from another nurse (LPN #2), and she stated, "I did everything I was supposed to do." LPN #1 stated to refer to her NN; all the information was in her notes. On 03/03/22 at 9:38 AM, the surveyor interviewed the DON regarding the process that is to be followed if a resident was found unresponsive. The DON stated that if a person was unresponsive, the nurse would check the resident and complete a nursing evaluation. The DON stated that if the resident was a full code, 911 would be called. The DON stated she remembered Resident #7 and that she was called in on the weekend to pronounce (confirm death) Resident #7. The DON stated she was told that Resident #7 had no vital signs, and prior, the resident was alert and oriented, and ambulatory. On 03/03/22 at 9:50 AM, the surveyor interviewed LPN #2. LPN #2 stated she was told by LPN #1 that Resident #7 had a problem. LPN #2 stated the resident was not on her assignment, and she had been across from Resident #7's room at the nurses' station. LPN #2 stated that LPN #1 called	F 678	staff currently certified in Basic Life Support and utilizes the list to ensure required number of certified staff members are scheduled each shift . A mock code will be held quarterly within the facility. Element # 4 Monitoring of Corrective Actions Current Basic Life support certified staff numbers will be reported at quarterly QAPI committee meetings . The chart of residents who have coded will be reviewed weekly x 4 and monthly for the next 3 months by the DON/designee .The DON will provide audit findings in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate .	

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her into the room, and they both started CPR on Resident #7. The surveyor inquired to LPN #2 if she would call 911, and she stated, "of course" I would call 911. The surveyor asked LPN #2 if either nurse utilized an AED. LPN #2 stated, "no," we did not use the AED because no one went and got it. LPN #2 stated she did as much CPR as she could because she was tired and had a shoulder problem. The surveyor inquired to LPN #2 if there was any documentation or a form filled out to record what was happening with Resident #7. LPN #2 stated that no form was filled out and the resident did not have a pulse, but they were still a "a little warm." The surveyor inquired again about the AED. LPN #2 stated she went into Resident #7's room, and there was no AED. It was located on the first floor. LPN #2 stated that LPN #1 called her in and that there were only three nurses in the whole building. LPN #2 stated she did not know if LPN #1 had called a "code" overhead and stated that she and LPN #1 were the only nurses there during the code.

On 03/03/22 at 9:59 AM, the surveyor interviewed a Registered Nurse, Nursing Supervisor (RN#1), at the first-floor nurses station. The surveyor asked RN #1 about the small red machine enclosed in a glass case and attached to the wall. RN #1 stated it is an AED, and it is used when a resident codes or was in distress. She stated we should have one on each floor but that the facility only had one. RN #1 stated that the staff would page code overhead if a resident codes or was in distress. RN #1 stated that all the nurses would go to the code, and the first floor nurse would bring the AED to the code.

On 03/03/22 at 11:00 AM, the LHNA provided the surveyor a copy of the facility's "Emergency

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Procedure-Cardiopulmonary Resuscitation' policy, Revised 10/2021. The Policy revealed:
Policy Statement: Personnel have completed training on initiating cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for sudden cardiac arrest.
General Guidelines:
1. Sudden cardiac arrest [SCA] is a loss of heart function due to abnormal heart rhythms (arrhythmias). Cardiac arrest occurs soon after symptoms appear. It is a leading cause of death among adults.
2. A "heart attack" refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest. Typically heart attacks are less sudden than SCA.
3. Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS includes recognizing presentations of SCA.
4. The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse.
5. Early delivery of a shock with a defibrillator plus CPR within 3-5 minutes of collapse can further increase the chances of survival.
6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless:
a. it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and external defibrillation exists for that individual; or
b. there are obvious signs of irreversible death (e.g., rigor mortis).
7. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer

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CPR.
8. If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives.
Preparation for Cardiopulmonary Resuscitation:
1. Obtain and/or maintain American Red Cross or American Heart Association certification in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel.
2. The facility's procedure for administering CPR shall incorporate the steps covered in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care of facility BLS training material.
3. Provide periodic Mock Codes (simulations of an actual cardiac arrest) for training purposes.
4. Select and identify a CPR Team for each shift in the case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue effort directing other team members during the rescue effort.
5. The CPR Team in this facility shall include at least one nurse, one LPN/Licensed Vocational Nurse (LVN), and two CNAs who have received training and certification in CPR/BLS.
6. Maintain equipment and supplies necessary for CPR/BLS in the facility at all times...
Emergency Procedure-Cardiopulmonary Resuscitation:
1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR.
a. Instruct a staff member to activate the emergency response system (code) and call 911.

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b. Instruct a staff member to retrieve the automatic external defibrillator.
c. Verify or instruct a staff member to verify the DNR or code status of the individual.
d. Initiate the basic life support (BLS) sequence of events...
6. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with compression-ventilation ratio of 30:2.
7. When the AED arrives, assess for need and follow AED protocol as indicated.
8. Continue with CPR/BLS until emergency medical personnel arrive.

The facility did not call a "code," contact 911 or utilize the AED per the facility policy.

On 03/03/22 at 11:27 AM, the surveyor, in the presence of the survey team, interviewed the DON about completing mock codes per the facility policy. The DON stated they have not mock codes recently, and she did not provide any further information related to mock codes. The DON stated the facility educated staff on CPR, and the surveyor requested copies of LPN #1 and LPN #2's CPR certification.

On 03/03/22 at 11:53 AM, the surveyor conducted an additional interview with LPN #2 in the presence of the survey team. The surveyor inquired about the facility process if a resident is found unresponsive. LPN #2 stated when someone is unresponsive, you would start CPR and call 911. The surveyor inquired if LPN #1 had called 911. LPN #2 stated that she didn't know if LPN #1 called 911. LPN #2 stated if they have a code, they would call a code "STAT" overhead. Furthermore, LPN #2 stated there were only three

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nurses on staff in the building that day and no Registered Nurse, "I didn't hear her call." LPN #2 stated, "we do mock fire drills, but not mock codes." LPN #2 stated when a code occurred that, the nurses were supposed to document it in the nurses' notes. LPN #2 stated she had CPR certification and knew how to use it. LPN #2 stated that Resident #7 had no pulse when she went into Resident #7's room, and then LPN #1 exited Resident #7's and LPN #2 began CPR completed a blood pressure and there was no reading, and stated LPN #1 talked to the DON and decided to stop CPR. LPN #2 stated they didn't have enough staff, and there was no supervisor on that weekend.

On 03/03/22 at 12:00 PM, the DON provided the surveyor with a "Community & Workplace Certification, Basic Life Support, Adult, Child & Infant CPR, and AED" for LPN #1, and the DON did not provide a CPR certification for LPN #2. The surveyor inquired as to the CPR training at the facility. The DON stated the facility does a CPR class at the facility, American Heart Association (AHA). The DON reviewed the CPR card provided to the surveyor for LPN #2, and the surveyor inquired how the certification met the American Heart Association training standards. The DON did not provide an explanation and stated she didn't have LPN #2's CPR card.

On 03/03/22 at 1:42 PM, the surveyor interviewed the LNHA and DON in the presence of the survey team. The surveyor informed the DON and LHNA regarding the findings; 911 was not activated, a "code" was not called, and the AED was not utilized for Resident #7 when the resident became unresponsive. The DON confirmed that the staff should have utilized the AED and called

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911. The DON further stated that three nurses were working that day, and the process should have been enacted. The surveyor asked the DON regarding the ability of LPNs to assess a resident or are LPNs able to pronounce death. The DON acknowledged the LHNA and stated that LPNs could not pronounce death or assess a resident.

On 03/04/22 at 8:59 AM, the LHNA and DON were interviewed by the surveyor, in the presence of the team, regarding the facility's process of tracking the nursing staff CPR certifications. The DON stated the in-service coordinator should be tracking the CPR certifications, but she was unsure if it was up to date. The DON provided a copy of 7 Employee BLS certifications. The CPR cards provided to the surveyors included 5 AHA "Provider Basic Life Support" cards, including a copy of LPN #2's card. A second copy of the "Community & Workplace Certification, Basic Life Support, Adult, Child & Infant CPR and AED" for LPN #1, and two cards for "National CPR Foundation, Provider Card." The survey team requested to see the tracking system at that time. The DON stated the In-service Coordinator/Assistant Director of Nursing (IC/ADON) would provide it. Furthermore, the DON added, there had not been CPR training because of COVID.

On 03/04/22 at 9:31 AM, the IC/ADON provided the surveyor, in the presence of the survey team, a "Plaza Healthcare and Rehab Center BLS (Basic Life Support) Log," with 20 names listed and 18/20 of the names had an "X" next to it. The surveyor inquired about the list provided by the IC/ADON and how the IC/ADON would know when the CPR certification expired. The IC/ADON stated she did not have expiration dates on it, and

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she just knew when they expired, and she would put an X next to the staff's name if they had the CPR certification. She stated that was how she tracked it, and she knew if they had the certification by when the facility offered the CPR training. She stated that some staff would forward a card if they had the training elsewhere. There were 12 more employee names on the "Plaza Healthcare and Rehab Center BLS (Basic Life Support) Log" than copies of CPR cards provided by the facility.

On 03/04/22 at 10:03 AM, the surveyor interviewed the receptionist/staff coordinator (R/SC) in the presence of another surveyor. She stated her responsibilities included putting staffing out, doing the state nursing report, room rosters, and updating admission and discharge charts. She stated she had to schedule a nurse on each shift that was CPR certified. The surveyor inquired how the R/SC would know what nurses were CPR certified. The R/SC stated the IC/ADON had a list of CPR certified staff and stated if the CPR certification was done outside of the building, the staff would bring it in. The surveyor showed the R/SC the undated list of BLS certifications provided by the IC/ADON and inquired to the R/SC if that was the list she utilized. The R/SC stated she utilized a different list with the staff name and the expiration date. The surveyor inquired to the R/SC if a specific type of CPR certification was required. The R/SC stated she was unaware of the type of CPR certification required for nursing staff. She completed a schedule every four weeks and did not look at the CPR certified list every time she completed a schedule; she looked at it every few months. The R/SC provided the surveyors with a list of all "Active Employees, Nursing," which

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included 12 LPNs, 41 Certified Nursing Assistants (CNA), and 8 Registered Nursed (RN).

On 03/04/22 at 10:28 AM, the IC/ADON provided the surveyor with two more CPR cards. Her AHA "Provider Basic Life Support" CPR card included one AHA "Provider Advanced Cardiovascular Life Support Card." There were 10 more names on the Plaza Healthcare and Rehab Center BLS Log than CPR cards provided. The DON was not listed on the list.

On 03/04/22 at 11:11 AM, the surveyor interviewed the DON in the presence of another surveyor. The surveyor asked the DON why she was listed as the 7:00 AM- 3:00 PM (day shift) RN on the day that Resident #7 became unresponsive. She stated she was not in the building that day, and she was on call. The DON stated that the facility did "not" have a charge nurse on the schedule that day. She stated that they usually would, but she would be on call if they don't have enough staff. Asked why she was not in the building on 2/12 since she was scheduled from 7-11, the DON stated that she was on call that day and confirmed that she was on the list as the RN.

On 03/04/22 at 12:01 PM, the R/SC provided the surveyor with a copy of an undated Plaza Healthcare and Rehab Center BLS (Basic Life Support) Log (Log) that she would utilize to make the schedule. The Log revealed 19 nursing staff with an X next to 18/19 nursing staff. In the column next to the "X" was an "Issue Date," and next to that, "Renew By." Five out of the nineteen nursing staff did not have a date listed in the "Issue Date" and "Renew By" columns. The surveyor reviewed the Log provided by the DON

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on 03/03/22 at 12:00 PM and compared it to the nursing staff schedule for the date Resident #7 required CPR. Both LPN #1 and LPN #2 were on the R/SC's list as having had BLS training. The LPN (only nurse) assigned to the 1st floor on the same date was not listed as having BLS training. On the day Resident #7 coded, five out of thirty-four nursing staff scheduled were listed on the R/SC's list as having had BLS training.

On 03/04/22 at 1:32 PM, the surveyor, in the presence of two other surveyors, conducted a telephone interview with the Medical Director (MD), who was also the attending Physician for Resident #7. The surveyor inquired if she was aware that all of the nursing staff were not CPR certified. She stated she was not aware and assumed that the supervisors knew CPR. The surveyor asked the MD if it was important for nursing staff to have current, appropriate CPR certification. The MD responded, "yes, they should," and all nurses should have CPR certification. The MD stated that she was not aware that all staff did not have appropriate or current CPR certification.

Review of the Unit Coordinator/Charge Nurse (Registered Nurse/LPN) Job Description indicated that it is the Unit Coordinator/ Charge Nurse responsibility to direct, monitor, and supervise all staff assigned to the unit, to ensure Quality of Care and Quality Life for each resident, to exercise good judgment and to respect confidential matters. The direction of staff will ensure that care and services will be delivered in compliance with all Federal, State, and local requirements and facility policies and procedures. Evaluates emergencies and determine the immediate measures to be implemented

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F 678	Continued From page 59 according to standards of practice. Communicated all emergencies to the Director of Nursing/ADON and/or designee. Scope of Supervision: Responsible for all nursing staff assigned to the unit and coordinate quality of care and quality of life for every resident residing on the units all shifts. NJAC 8:39-4.1 (31)iii, 9.6 (g)	F 678		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review and review of other pertinent facility documentation it was determined that the facility failed to consistently perform interventions designed by an Occupational Therapist to promote range of motion and positioning for 2 of	F 688	F688 Immediate Corrective Actions Resident #259 and Resident #159 were re-evaluated for therapy needs by the rehabilitation department. Residents currently on a restorative	4/30/22

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F 688	Continued From page 60 2 residents (Resident #159 and #259) who were reviewed for positioning and mobility. The deficient practice was evidenced by the following: On 02/28/22 at 10:16 AM during tour, the Surveyor interviewed Resident #159 who was sitting up in bed. Resident #159 stated that he/she wanted to be able to walk, however he/she did not receive rehabilitation and wanted to know why. He/she stated that he/she got of bed to chair daily and did not walk. The surveyor reviewed Resident # 159's medical record which revealed the following: The Admission Record (AR) indicated that Resident #159 was admitted to the facility with the diagnoses which include but not limited to, EX Order 26 § 4b1 The quarterly Minimum Data Set (MDS) an assessment tool dated 01/06/22, indicated that Resident #159 was cognitively intact and required complete care of two staff members for transfers and bed mobility. The MDS also indicated that the resident was non-ambulatory and required complete care with activities of daily living (ADLs) and was free from pressure ulcers and skin impairments. There was documentation on the MDS that indicated that the resident had limitations with range of motion on one side of the upper body and both sides of the lower body. On 03/01/22 at 10:30 AM, the Surveyor interviewed the Director of Rehabilitation Physical Therapist (DORPT) who stated that Resident #159 had been in the facility for a few years and had been non-ambulatory. The DORPT revealed that the resident was on a restorative nursing	F 688	program were rescreened for appropriateness of current plan of care. Identification of at Risk Residents All residents that are at risk for decreased mobility and function have the potential to be affected by this practice. Element Three Systemic Changes The existing restorative program was reviewed and revised to a functional program. CNAs will be re-educated in the changes and how to provide daily functional interventions of range of motion , splints and ambulation . Monitoring of Corrective Actions The rehab department will review restorative grid documentation for completion weekly for three weeks then monthly for the next three months. Findings of these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate .	

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program (RNP) and that the Director of Nursing (DON) was responsible for oversight of the RNP. The DORPT stated that Resident #159 had a diagnosis of [redacted] and had not ambulated for a few years but could sit up in a w/c. He added that he was not aware that the resident ever refused RNP.

On 03/01/22 at 11:11 AM, the Surveyor interviewed the Restorative Certified Nursing Assistant (RCNA#1) who stated that she performed range of motion (ROM) on Resident #159's upper and lower body two times a week and bed mobility (turning and moving in bed) two times a week. The CNA showed the Surveyor the restorative book and provided the surveyor with Resident #159's restorative referral from the rehabilitation department. The restorative referral contained instructions on what type of restorative Resident #159 should receive to be able to maintain the resident's current level of functional mobility. The RCNA stated that there were times when restorative nursing could not be performed because the restorative CNAs had to take a patient assignment or when they had to take residents out for appointments. She then added that any assigned Certified Nursing Assistant (CNA) could also perform the restorative nursing for the residents when the restorative CNA was not available. The surveyor and the RCNA reviewed the form located in the restorative nursing book which was titled, "Restorative Nursing Program Attendance Grid (RNPAG)" the RCNA stated that there should be RCNA signatures slotted on the days that restorative nursing was provided to Resident #159. The RCNA did not have a response as to why there were no signatures on the RNPAG from 02/13/22 until 02/28/22 indicating that Resident #159

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received restorative nursing for ROM of upper and lower body and bed mobility. The RCNA stated that the resident did not have a history of refusal of RNP.

On 03/01/22 at 11:27 AM, the Surveyor interviewed the Registered Nurse (RN) who was providing care to Resident #159 who stated that she also did not know why the RNPAG was not signed by the RCNA from 02/13/22 until 02/28/22 that Resident #159 received RNP for ROM upper and lower body and bed mobility. She also indicated that if there were no signatures on the RNPAG then you would not know if the task was performed. "Signatures from staff would indicate that a task was performed."

The Surveyor reviewed the Occupational Therapy Discharge Summary (OTDS) dated 8/10/17, which indicated that discharge recommendations and RNP were to facilitate patient maintaining current level of performance and to prevent decline, development of the instruction in the following RNPs had been completed with the interdisciplinary team (IDT): ROM (active and passive) and bed mobility.

The Surveyor reviewed the restorative referral dated 8/11/17, which contained instructions that Resident # 159 would participate in RNP 6 days a week for EX Order 26 § 4b1 [redacted]

The Surveyor reviewed Resident #159's Care Plan (CP) dated 08/30/19 and revised on 01/27/20 which revealed the following

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information:

Resident #159 had limited EX Order 26 § 4b1 related to (r/t) EX Order 26 § 4b1 and was prescribed ROM/bed mobility exercises and was at risk for EX Order 26 § 4b1.

The bedside CNA Kardex Report (KR) dated 03/09/22, which indicated that Resident #159 was on a nursing rehab/restorative: active ROM program and bed mobility.

On 03/01/22 at 12:17 PM, the Surveyor interviewed Resident #159 who stated that he/she did not always receive restorative ROM exercises and was not happy about it. The resident also added that he/she did not think that he/she had a decline in functional level and stated that his/her skin was intact.

On 03/01/22 at 12:35 PM, the Surveyor interviewed the Director and Nursing (DON) who stated that she oversaw the Restorative Nursing Program. The DON reviewed the RNPAG with the surveyor from 02/13/22 until 02/28/22 and stated that there should have been RCNA signatures slotted on those dates from 02/13/22 until 02/28/22 to indicate that the resident received ROM to upper and lower body, as well as bed mobility. The DON confirmed that if there were no signatures, then you could not say for certain if the resident received the restorative nursing that was recommended by rehabilitation.

The Surveyor reviewed the skin assessments for February for 02/01/22, 02/08/22, 02/15/22, and 02/22/22 and there were no new skin impairments documented.

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The Surveyor interviewed the DORPT who stated that he evaluated Resident # 159 on 3/2/22 and indicated that the resident did not have any new contractures or change in ROM. The DORPT provided the surveyor with a physical therapy evaluation (PTE) dated 03/02/22 which indicated that the resident required skilled PT services to increase lower extremity strength and improve dynamic balance, increase functional activity tolerance, facilitate motor control, and enhance rehabilitation potential and develop and struct in restorative nursing program in or to enhance the resident's quality of life by improving ability to increase performance skills and functional task.

2. On 02/28/22 at 10:48 AM, the surveyor observed Resident #259 lying in bed and was wearing EX Order 26 § 4b1 on. Resident #259 stated that he/she wanted to get physical therapy.

The surveyor reviewed Resident #259's medical record which revealed the following:

A review of Resident #259's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 EX Order 26 § 4b1

A review of Resident #259's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/20/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Or out of 15, which indicated that Resident #259 was

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F 688	Continued From page 65 EX Order 26 § 4b1. Further review indicated that Resident #259 required complete care of 2 staff members for transfers and bed mobility. The MDS also indicated that the resident was non-ambulatory and required complete care with activities of daily living (ADLs) and was free from pressure ulcers and skin impairments. There was documentation on the MDS that indicated that the resident had limitations with range of motion on both sides of the upper body and both sides of the lower body. A review of the Occupational Therapy Discharge Summary signed and dated by the Occupational Therapist on 8/24/21, included the following: RNP: To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (Interdisciplinary Team): ROM (range of motion) (Active-Assisted/Passive) bed mobility and splint or brace care. On 3/1/22 at 12:05 PM, the Surveyor reviewed Resident #259's Restorative Nursing Program Attendance Grid for February 2022 which included the following: Under the procedures of PROM OR A/AA ROM (passive or active range of motion) and Ambulation/Bed Mob.(mobility), there was the number 15 documented on 2/2, 2/4, 2/8, 2/9, 2/10, 2/11, 2/12 and 2/13 which indicated Resident #259 received 15 minutes of the procedures on those days. There was a X documented on 2/1, 2/3, 2/5, 2/6 and 2/7 which indicated Resident #259 did not receive the procedures on those days. The remaining days of February (2/14 to 2/28) were blank.	F 688		

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A review of the Restorative Nursing instruction Form did not include a frequency of how many times a week it was to be performed.

At 12:08 PM, the Surveyor interviewed the RCNA#1 who stated that she or RCNA #2 worked with Resident #259 but that they sometimes would be pulled from their RNP functions to performed CNA functions. She added that they document the ROM exercises that they perform with a resident in a book but that it was hard to keep the book updated.

On 02/04/22 at 11:08, the Surveyor interviewed RCNA #2 who stated that he worked three days a week and that RCNA #1 worked the opposite three days in the week and that they performed RNP for the entire building (two floors). He added that in the past there was an aid for each floor. RCNA #2 stated that the RNP included ROM, splints, braces and ambulation. He added that each resident in the RNP is supposed to participate a minimum of six days and that he cannot get to each resident in the RNP every day. RCNA #2 stated that he had a personal notebook that he documented in to keep track of who received or did not receive RNP for each day and that at the end of the month would document it in the facility's Restorative Nursing Program Attendance Grid. The surveyor then asked RCNA#2 if Resident #259 received RNP every day. RCNA#2 stated that sometimes he was unable to get to Resident #259 because he would get pulled when someone called out, or if they needed him to escort a resident to a physician's appointment. He added that he felt bad when he could not get to the residents. The surveyor then asked RNCA#2 if he made anyone aware that the

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residents did not always receive RNP. He stated that he informed the Director of Nursing (DON) that it was not feasible to get to everyone daily.

RNCA#2 provided the Surveyor a document that had a list of the residents that were on RNP for splints, braces and/or ROM. Resident #259 was listed for knee brace and PROM (passive). The document also included the following: Everyday Monday-Sunday.

On 03/04/22 at 11:38 AM, the Surveyor asked the DON if she was aware that the Restorative Nursing Program Attendance Grid was not filled out from 02/14/22 to 02/28/22 and that the staff stated they fill it out at the end of the month. The DON stated that the staff should be signing the Attendance Grid on the same day and that it should not wait until the end of the month.

At 2:31 PM, the surveyor interviewed the DORPT who stated that residents on RNP are scheduled to have it 5-6 or 6-7 days a week. He added that the Attendance Grid should be filled out daily.

On 03/10/22 at 9:55 AM, the Surveyor asked the DON if she checked that the staff documented RNP. The DON stated that she did not check daily but that she tried to check weekly. The surveyor then asked the DON if RNCA #1 and RNCA#2 were only assigned to perform RNP. The DON stated that they get "pulled" sometimes. She added that the goal was RNP was to be done daily and documented.

The facility policy with a revised date 03/01/22 and titled, "Rehabilitative Nursing Care" indicated that rehabilitative nursing care is provided for each resident admitted. The policy also indicated

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F 688	Continued From page 68 that rehabilitative nursing care did not require a qualified professional therapist to render. The facility's rehabilitative nursing care program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence and to assure that there is no decline in physical function. Rehabilitative nursing care is performed daily for those who require such services and included but was not limited to: -Maintaining good body alignment and proper positioning. -Encouraging and assisting bedfast residents to change position at least every two hours day and night to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities. -Assisting residents with their routine ROM exercises. NJAC 8:39-27.1 (a)	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility 1.) failed to ensure: that the facility policy for Accident/Incident Reports was followed to determine the causal factor and to update interventions to prevent	F 689	Element One □ Corrective Actions Falls were reinvestigated to determine the root causes of Resident #57□s multiple falls.	5/15/22

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F 689	Continued From page 69 recurrent falls, for a visually impaired ambulatory resident who was identified as a high fall risk, and sustained multiple falls, including a fall that resulted in a head injury on 01/06/22, and 2.) failed to ensure; that the emergency crash cart (a set of trays /drawers /shelves on wheels) used for transportation and dispensing of emergency medications and equipment, was secured and not easily accessible to residents and non-licensed staff. The deficient practice occurred for 1 of 2 residents (Resident #57) reviewed for falls and for 1 of 2 crash carts inspected (2nd floor). The deficient practice was evidenced by the following: 1. On 02/28/22 at 10:41 AM, the Surveyor observed a resident wandering unassisted in the hallway, holding on to different wheelchairs that were in the hallway to move from locations. The surveyor alerted the staff of the resident, Resident #57. A Physical Therapist was in the other hallway assisting another resident. He escorted Resident #57 to the room and stated that Resident #57 was confused and communicated in Spanish only. The surveyor reviewed Resident #57's clinical record on 02/28/22 which revealed that Resident #57 had a history of falls. Further review of the clinical record, "Admission Record", revealed that Resident #57 was admitted to the facility with diagnoses which included, but were not limited to, hypertension, cerebral infarction due to embolism, and blindness one eye, unspecified eye, fracture and history of falling.	F 689	Care plan interventions were put in place to address root causes of falls. The emergency cart on the second floor was immediately locked. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes The Accident □ Incident policy was reviewed and revised . Nursing staff were re-educated about proper completion of incident reports and documentation per facility policy when a resident sustains a fall. Nurses were re-educated on the updated care plan of Resident #57. CNAs were re-educated on the plan of care for Resident #57. Falls are discussed at morning clinical meeting and care plan updated as appropriate. Nurses document daily emergency crash cart checks to ensure carts are locked. Element Four □ Quality Assurance Unit supervisor/designee will monitor that crash cart is secured daily . Crash cart audit findings will be reported at the quarterly QAPI meeting. The DON / ADON or designee will review	

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F 689	Continued From page 70 The Quarterly Minimum Data Set (MDS - an assessment tool) dated 01/17/22, revealed Resident #57 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS), which indicated [redacted]. A review of the facility provided Fall Scale, dated 01/17/22, revealed Resident #57 scored a 65 which indicated a high fall risk on the Morse Fall Scale. An interview with the Certified Nursing Assistant (CNA) who cared for Resident #57 on 03/09/22 at 9:15 AM, revealed that Resident #57 spoke Spanish only, needed assistance with care, and wandered at times. The surveyor reviewed Resident #57 's care plan and noted a fall Care Plan initiated on 12/14/19. The goal was for Resident #57 to be free from injury related to falls. A review of the on-going Resident Care Plan revealed a problem area of [redacted] Goals included will remain free from injury related to fall, date initiated 01/13/20 and will be free of falls through the review date, target date 05/05/22. Interventions included but were not limited to hand-held during ambulation and ensure wearing shoe properly. A review of the Certified Nurse Aide Care Card revealed under Mobility, that Resident #57 required staff assistance of at least [redacted] dated 09/22/20. The Resident Care Plan revealed the following: [redacted] on 12/14/19, [redacted] on 01/03/20, [redacted] on 09/22/20, [redacted] on 10/06/20, [redacted] on	F 689	all incidents daily at morning clinical meeting for three weeks then monthly for the next three months to ensure incident form, witness statements, and all other relevant documentation is obtained. Review will include documentation in the progress notes, investigation summary and updating of care plan interventions. Findings of these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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12/19/20 in room, 01/06/22- found on the floor in the hallway. (The facility did not identify the causal factor after each fall or implement meaningful interventions to minimize falls. The facility did not indicate/update the care plan how Resident #57 would be supervised to prevent further falls.)

On 03/09/22 at 10:21 AM, the Surveyor, in the presence of another surveyor, interviewed the DON regarding Resident #57's falls and the Care Plan interventions. The DON stated that the care plan should be implemented upon admission, quarterly, and on day 14 of admission to ensure proper care was delivered, identified, and any problems were addressed. The DON stated the care plans should be updated as soon as possible. The DON further stated for a resident identified as a risk for falls, the care plan should be revised after each fall and stated: "we don't leave it the same," and after each fall, interventions should be revised. The surveyor asked the DON if falls would be investigated; the DON stated, "if it is needed," we investigate. The surveyor asked the DON to clarify her statement regarding interventions needing to be revised after each fall. The DON stated they either revise the intervention or add something "new after a fall." They do not leave it the same.

On 03/04/22 at 11:35 AM, the facility provided, "Job Description - Staff Nurse", not dated, which included but was not limited to: Care Plan and Assessment Functions: review care plans daily to ensure that appropriate care is being rendered; inform the charge nurse of any changes that need to be made on the care plan; ensure that your nurses' note reflect that the care plan is being followed; review resident care plans for

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appropriate resident goals, problems, approaches, and revisions based on nursing needs; and ensure that your assigned nursing assistants are aware of the resident care plans and that they are being used in administering daily care to the resident.

On 03/09/22 at 9:05 AM, the Surveyor requested all investigations for Resident #57 and a timeline regarding the resident falls with interventions.

On 03/09/22 at 12:56 PM, the DON provided the Surveyor with the following investigations and a " Fall Investigation Summary." The Fall time line with interventions implemented after each fall was not provided. The Investigations did not include an investigation for 12/14/19 and 12/19/20.

The investigations revealed:

-A type-written Fall Investigation Summary dated 01/03/20. A Description of Event: A noise was heard in the hallway and found resident sitting on the floor with the rolling walker at his/her side. Right eye was discolored and blood noted between gum and teeth. No other injury noted and resident was able to walk with assistance post fall. Ice pack applied to head. MD gave order to tranfer to the hospital. Medical Data: Resident had EX Order 26 § 4b1 and did not realize his/her limitations and walked with the rolling walker on the unit. Resident has blindness to left eye. Investigation Summary: The Resident was found in the hallway and he/she lost his/her balance and fell. He/she was tired and wanted to sleep. The Resident was sent to the hospital and admitted with fractured rib related to fall. Plan: Staff to redirect resident to his/her room and offer rest when seen him/her walking in the hallway.

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-An Un-witnessed Incident report dated 09/22/20 at 13:31 (1:31 PM), Nursing Description: Resident was found on the floor sitting up right in his/her room next to his/her bed with one shoe on right foot. Immediate Action Taken: No visible injury noted, vital signs take, complained of pain to right femur. Mobility: Ambulatory with assistance. Staff to assist with shoe when seen looking for shoe. Offer toileting after and before meal and bedtime.

-An Un-witnessed Incident report dated 10/06/20 at 11:45 AM, Incident Description: Nursing Description: Resident was seen sitting on the floor in front of the room. Resident was assessed and no apparent injury, complained of pain to lower back. Mobility: Ambulatory with assistance. Immediate Action Taken. Resident to walk in hallway when seen getting up from bed or chair.

- An unsigned Investigation for Unknown Injuries, dated 11/26/21, Nature of Injury: EX Order 26 § 4b1 on Rt. [right] side forehead. Three nurses and three certified nurse aides have documented hand written statements on the form which revealed that none of the staff witnessed anything. Conclusion: No unusual occurances noted by staff. Resident does not recall anything due to cognitive impairment. Resident ambulatory and has unsteady gait. Refer to therapy.

-An Incident report dated 11/27/21 at 11:46 AM, Incident Description. Nursing Description: During change of shift and making rounds resident was noted with a small EX Order 26 § 4b1 on his/her right side. When resident was asked he/she was noted with a small EX Order 26 § 4b1 on right side of forehead. Resident thought bumped head and was not sure. Denied falling. Injury Type: "No injuries

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observed post incident" (The [redacted] was not listed).

An Investigation Summary dated 01/06/22 and signed by the Assistant Director of Nursing and Administrator revealed a Description of Event: at 01/06/22 at 1:00 PM, a Nurse heard a thud in the hallway and noted the resident lost his/her balance. The resident had a [redacted] on the right forehead and complained of [redacted] Resident had [redacted]. Results revealed [redacted], no bleeding. Plan:..keep in supervised area when possible. Staff will do rounds more frequently when the Resident is in bed.

-An Un-witnessed Incident report dated 01/06/22 at 15:40 PM (3:40 PM), Incident Description: Nursing Description: Resident noted lying in hall way floor. Noted bump on [redacted]. Resident Description: Stated while he/she was walking lost his/her balance. Injury Type: No injuries observed post incident (The bump was not listed). There was no witness to the fall. There was no staff statements that would indicate when Resident #57 was last seen/checked. Resident #57 was evaluated at the hospital and diagnosed with [redacted].

On 03/09/22 at 9:55 AM, the Licensed Nursing Home Administrator (LNHA) provided the, "Care Plan - Interdisciplinary Team", policy revised 2008, which included but was not limited to: Our facility's Care Planning / Interdisciplinary Team is responsible for the development of an

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individualized comprehensive care plan for each resident. 2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning / Interdisciplinary Team which includes but is not limited to the following personnel: h. the Director of Nursing k. others as appropriate or necessary to meet the needs of the resident.

On 03/09/22 10:30 AM, the Surveyor interviewed the DON, in the presence of another Surveyor. The surveyor inquired as to what is done after a resident falls. The DON stated that after each fall, we should look at the Care Plan and the fall interventions should be revised. The DON stated "we don't leave it the same". The DON then stated and confirmed that we either revise the interventions or add something "new after a fall" that they do not leave the interventions the same.

On 03/10/22 at 12:18 PM, the above concerns were brought to the attention of the LNHA and DON by the Surveyor, in the presence of the survey team. The facility had no additional information to provide which included the missing investigations and a timeline of resident falls including interventions added or revised as stated by the DON.

On 03/11/22 at 11:40 AM, the DON provided a revised care plan and could not provide the rationale for not having a previously updated care plan. Upon further inquiry, the DON stated that all staff should update the care plan.

2. On 02/28/22 at 12:20 PM, the surveyor observed the crash cart in the hallway on the second-floor unit. The top drawer was ajar, exposing some supplies. The seal to secure the

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crash cart was broken. Upon further inspection, the surveyor noted that the crash cart contained other supplies that should not be easily accessible. A pair of bandage scissors was observed in the top drawer. The second drawer contained syringes and needles. The 3rd drawer contained intravenous tubing, distilled water solution, 0.45 Normal saline solution, and multiple expired items.

That same day at 12:25 PM, the surveyor alerted the Licensed Practical Nurse (LPN) and inquired about the crash cart. The LPN indicated that the 11:00 PM -07:00 AM shift was responsible for checking the crash cart and ensure that the crash cart was secure. The LPN stated that she could not provide any information.

On 02/28/22 at 12:20 PM, the surveyors witnessed a verbal outburst in the common area of the hallway adjacent to the second-floor nursing station. Resident #60 picked up the lunch tray and threw it on the floor because he/she could not understand the roommate who was speaking in Spanish. The resident was very agitated. The social worker and other facility staff witnessed the verbal outburst.

That same day at 12:55 PM, the Director of Nursing (DON) arrived on the floor and observed the unlocked crash cart was in the common area. The DON revealed that the cart should not be left open for safety reasons. The DON stated that the crash cart should have been secured and locked at all times. Upon further inquiry, the DON revealed that the 2nd floor housed residents diagnosed with EX Order 26 § 4b1 and residents with behavior issues. The DON stated clearly that the crash cart was to be locked and secured at all

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times for safety.

The facility provided policy titled, "Crash Cart Policy" with a date of 09/05/21, indicated that the crash cart inventory and testing would be done by the 11:00 PM-7:00 AM floor nurse daily. When the crash was cart to be found to have a broken red tag, the 11:00 PM-7:00 AM nurse would conduct inventory of the existing contents and would refill the cart. The policy also indicated that expired items would be removed and replaced and that the crash carts must be locked whenever the cart was not in use. When the crash carts were opened to use, staff would keep the carts near them and always under direct supervision.

A review of the undated facility policy titled" Accident/Incident Reports" indicated that all accidents and incidents occurring on the facility's premises must be reported. An incident is any occurrence not consistent with the routine operation of the facility's normal care of the resident, a happening involving visitors, malfunctioning equipment, or observation of a condition that might become a safety hazard. Purpose: To provide a safe and helpful environment for residents, visitors, and employees.

1. Reporting of Accidents/ Incidents: Regardless of how minor an accident or incident may be, it must be reported to the department Supervisor and appropriate documentation completed on the shift that the accident or incident occurred. Employees witnessing an accident or incident involving a resident, employee, or visitor must report such occurrence to his or her immediate supervisor immediately. Do not leave an accident

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victim unattended unless it is absolutely necessary to summon assistance; Any unwitnessed accident/incident must be investigated for potential abuse, neglect, negligent treatment, misappropriation, or exploitation.
The supervisor must be informed of all accidents or incidents so that medical attention can be provided if necessary.
Documentation and Investigation Action:
The charge nurse/ and or the Department Director/ Supervisor must document the incident and conduct an immediate investigation of the incident or accident.
The specified Accident/ Incident Form will be used for residents, employees, and visitors.
Witnesses, if any, will also be documented in the report. The address and telephone number of the witnesses will be documented.
Every attempt will be made to ascertain the cause of the accident/ incident.
The Administrator and the Director of Nursing will be aware of such incidents occurring in the facility and will review completed reports. If any accident is of a serious nature, medically or suspected abuse, neglect, negligent treatment, misappropriation, or exploitation, it shall be reported by telephone immediately regardless of time or day.
The administrator will ensure that staff directly involved will be suspended pending a complete investigation, depending on the circumstances of the incident.
The administrator is responsible for coordinating the investigation and assuring that appropriate action is taken. Conducts interviews, collects written statements from all staff or visitors involved in the situation.
Completed accident/incident reports and

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F 689	Continued From page 79 investigation forms must be submitted within 24 hours to the administrator and the Director of Nursing. NJAC 8:39-29.4(e)(f)(g)(h) 27.1(a) 33.1(d) 11.2(2)(3)i	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to a) provide a resident a physician ordered routine pain medication within the acceptable time; b) administer a routine pain medication as ordered by the physician, and c) accurately document the administration of narcotic medication for 1 of 18 sampled residents (Resident #258). This deficient practice was evidenced by the following: On 03/02/22 at 8:27 AM, the Surveyor observed Resident #258 seated in a EX Order 26 § 4b1 in the resident's room. Resident #258 was moaning. Resident #258 stated that he/she did not receive	F 697	Element One □ Corrective Actions " The EX Order 26 § 4b1 order for Resident #258 was clarified with the physician and rewritten. " The telephone order from the physician for change in pain medication administration times for Resident #258 was documented on the physician order sheet. " A late entry progress note was written to document telephone physician communication and change in medication administration times for the pain medication ordered for Resident #258.	5/15/22

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F 697	Continued From page 80 the EX Order 26 § 4b1 that was ordered for 8 AM. Resident #258 stated that the facility "ran out" of the medication and that the medication was supposed to come "last night" from the pharmacy. Resident #258 then stated that the nurse was going to call the pharmacy at 8 AM and get the medicine "stat" (at once). At 8:41 AM, the Surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated that she called the pharmacy at 8 AM and that the pharmacy would have the medication delivered that afternoon. The surveyor asked the LPN why the medication was not refilled prior to the resident's receipt of the last remaining dose. The LPN stated that the refill order was sent to the pharmacy and that the pharmacy said there was an insurance problem. At 8:45 AM, the Surveyor reviewed Resident #258's Medication Administration Record (MAR) which included the following: A type written order for EX Order 26 § 4b1 [redacted] The last dose given on 3/2/22 was at 3 AM. The 8 AM dose was blank. A type written order for EX Order 26 § 4b1 [redacted] The 9 AM dose was given. At 10:08 AM, the Surveyor interviewed Resident #258 who stated that he/she still did not receive the EX Order 26 § 4b1). Resident #258 then stated that he/she received the other EX Order medication (EX Order 26 § 4b1) that was ordered, but that it does not help the pain. Resident #258 added that he/she was getting the EX Order 26 § 4b1 every four	F 697	" The nurse who on 3/1/22 at 11 pm did not sign the declining inventory sheet for Resident #258□s NJ Exec. Or medication at the appropriate time was immediately re-educated. " The nurse who documented narcotics on the declining inventory sheet was re-educated to plot correctly and clarify orders as appropriate. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes " The LPN assigned to give medications to Resident #258 on 3/2/22 was immediately re-educated on the facility medication administration policy including 1) timeliness of administration and documentation of physician notification when medication is unavailable and not administered and 2) educated to use backup narcotics when necessary and if medication is not available to call physician for alternative in a timely manner. Nursing staff received immediate re-education regarding the facility medication administration policy . Element Four □ Quality Assurance The unit supervisor or designee will review pain medication orders, MAR documentation, progress notes and	

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F 697	Continued From page 81 hours as needed but that the physician had changed it to every 5 hours at set times. At 10:29 AM, the Surveyor interviewed the Registered Nurse Supervisor (RN/S) who stated that the LPN had brought to her attention that Resident #258 did not have any of the medication EX Order 26 § 4b1 left. The RN/S stated that she called the Pharmacist (RPh) and that at first the RPh said that they did not have a refill but that when she looked again there was a refill. The RN/S then added that the pharmacy was bringing the medication "stat." The surveyor asked the RN/S if the facility had backup pain medication that was facility stock. The RN/S stated that they usually have a backup. The RN/S then asked the LPN if she checked to see if they had the medication in the backup facility stock. At 10:35 AM, the LPN stated that they did not have EX Order 26 § 4b1 s in the backup facility stock. She added that there was only EX Order 26 § 4b1 in the backup facility stock. The surveyor observed the declining inventory sheet which indicated there were EX Order 26 § [redacted] available. At 10:38 AM, the LPN then stated that she was going to wait to give the six EX Order 26 § 4b1 [redacted] to Resident #258 until his/her next scheduled dose at 1 PM. She added that she could only give the medication one hour before or one hour after the scheduled time. The RN/S then told the LPN that she should check Resident #258's pain level. At 10:41 AM, the LPN stated that Resident #258 was in pain and did not want to wait until the next scheduled dose. The LPN then called Resident #258's physician but was unable to reach the	F 697	declining inventory sheets for 5 residents for three weeks then monthly for the next three months. Findings of these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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physician and left a voicemail. The LPN then contacted the Director of Nursing (DON) and explained the situation to the DON.

At 10:55 AM, in the presence of the Surveyor, the DON told the LPN to give Resident #258 the medication EX Order 26 § 4b1 as she called the physician.

At 11:05 AM, the DON told the Surveyor that the facility had the medication in the backup supply and that it had been reordered but that it did not come yet. She added that the resident was going to receive it now. The surveyor then told the DON that the medication was scheduled to be given at 8 AM. The DON stated that the nurse should have offered the medication from the backup at 8 AM. The DON then stated that the LPN should not have waited that long. The surveyor then asked the DON what the LPN should have done if there was no backup medication in the facility stock. The DON stated that the LPN should have called the physician for an alternative medication order until the ordered medication arrived from the pharmacy.

At 11:14 AM, the LPN signed the declining inventory sheet for EX Order 26 § 4b1 and gave six of them to Resident #258.

At 1:00 PM, in the presence of the survey team, the Surveyor called and interviewed the RPh via speaker on the telephone. The RPh stated that the facility needed to request a refill for a medication. She then stated that the facility called and spoke to her at 9:40 AM and they asked for a refill for Resident #258's EX Order 26 § 4b1 medication. She added that the facility did not ask for it as a stat and that it was being sent on the next

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scheduled delivery. The RPh stated that the facility called at 10:41 AM and spoke to another pharmacist and the facility then asked for the delivery to be a "stat." The surveyor then asked the RPh if the facility had called the day before and spoke to her since the facility told the surveyor that they did. The RPh stated that she did not have a conversation with the facility the day before. She then added "I don't know why they keep using my name."

On 3/4/22 the Surveyor reviewed Resident #258's medical record.

A review of Resident #258's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted].

A review of Resident #258's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/13/2022, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #258 was EX Order 26 § 4b1.

A review of Resident #258's care plan, with an initiated date of 8/19/2019, indicated the resident had EX Order 26 § 4b1 [redacted].

A review of Resident #258's declining inventory sheet for EX Order 26 § 4b1 reflected that two tablets were administered at 2:30 PM and not at the 11PM time indicated on the MAR. Further

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review reflected that after the two tablets were administered at 6 PM on 3/2/22, two tablets were administered at 3 AM on 3/3/22. Then the next 2 tablets were administered at 11PM on 3/2/22. The tablets were not documented consecutively in the appropriate declining order.

A review of Resident #258's March MAR reflected that the nurse initialed that she administered EX Order 26 § 4b1 at 8 AM and 1PM on 3/2/22. The back of the MAR was blank. There was no indication that the 8 AM and 1PM doses were given at a different time.

A review of Resident #258's electronic Progress Notes reflected that there was no documentation that the physician was notified or that Resident #258 had a delay in receiving his/her pain medication.

A review of Resident #258's physician orders reflected that there was not a verbal order written by the DON to administer the EX Order 26 § 4b1 medication at a different time on 3/2/22.

On 03/08/22 at 10:28 AM, the Surveyor interviewed the LPN regarding the time the 1 PM dose was given on 3/2/22. The LPN stated that she gave the 1 PM dose at 2:30 PM since he/she got the previous dose late. She added that the medication did not come from the pharmacy until 2:30 PM. The surveyor then asked the LPN what the process was if a medication was not given at the scheduled time. The LPN stated that a note should be written on the back of the MAR to indicate a medication was given at a time that was different than the scheduled time. The LPN confirmed that for the 8 AM and 1 PM dose on 3/2/22 she just initialed the front of the MAR and

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that she did not write on the back of the MAR to indicate that the medication was given at a different time. The surveyor than asked the LPN if there was an order from the doctor to give Resident #258 the medication at a different time than every 5 hours. The LPN stated that the DON spoke to the physician and that the physician said we could give it. The LPN confirmed that the DON did not write the verbal order that she received from the physician in Resident #258's medical record.

At 10:45 AM, the Surveyor asked the DON if she had received an order from the physician to give Resident #258 the medication at a different time. The DON stated that she informed the physician about the situation what happened for the 8 AM dose and the physician ordered a different time but that she did not write the order. The DON stated that she should have written the physician's order in Resident #258's medical record. The surveyor then asked the DON if the incident with Resident #258's [redacted] medication should have been documented in the Progress Notes. The DON confirmed that there should have been a note documented. The surveyor then asked the DON if the LPN should have documented the time that the medication was given on the back of the MAR. The surveyor then asked the DON if the LPN should have given the scheduled 1 PM medication at 2:30 PM which was not 5 hours after the last dose given at 11:14 AM without the physician being informed. The DON stated that the LPN should have informed the physician and followed a physician's order. The surveyor then asked the DON about the process of the declining inventory sheet. The DON stated that when a narcotic medication was removed, that the nurse was to sign the declining

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inventory sheet for that medication before giving the medication to a resident. The nurse is also responsible to make sure the labeled number on the pill that they will be giving matched the same number on the declining inventory sheet. The surveyor asked the DON how a nurse could sign the declining inventory sheet at 3 AM on 03/02/22 and then a nurse could sign it after at 11 PM on 3/1/22. The DON stated that the nurse at 11 PM should have signed out the medication at the appropriate time and then the 3 AM nurse should have signed out the medication after the other nurse, not before.

On 03/10/22 at 9:42 AM, the Surveyor asked the RN/S how the facility determined the times a medication would be given if the physician did not indicate the times. The RN/S stated that the facility had set times. The surveyor then asked the RN/S about an order that was every 5 hours. The RN/S stated that it would depend on the facility times.

At 9:58 AM, the Surveyor asked the DON who would write the times on the MAR for a medication if the physician did not indicate the times the medication was to be given. The DON stated that the nurse who admitted the resident or received the order would write the times. The surveyor then asked the DON about Resident #258's EX Order 26 § 4b1 medication ordered every five hours. The DON stated that the resident told the nurse what times he/she needed the medication most. The surveyor then asked the DON if the time between the 11 PM and 3 AM dose was five hours apart as ordered by the physician. The DON stated that it was only four hours and that it was an issue, and stated that added that she wished someone would have brought that to her

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F 697	Continued From page 87 attention before the surveyor did. A review of the facility provided Job Description for Licensed Practical Nurse included the following: Chart all accidents/incidents involving the resident. Follow established procedures ... Prepare and administer medications as ordered by the physician ... Ensure that narcotic records are accurate for your shift ... Review medication orders for completeness of information, accuracy in the transcription of the physician's order and adherence to stop order policy. Notify the Charge Nurse and Nursing Office of all drug and narcotic discrepancies noted on your shift ... A review of the facility provided policy titled, "Medication Administration Schedule" with an effective date of 9/11/13 did not include a facility medication administration schedule for every five hours. A review of the facility provided policy titled, "Controlled Medication Count" with a revised date of 1/18/22, included the following: 5.) Medications will be signed out with a date, a time of administration, the nurse's initials and the residents name with the number of remaining tablets, capsules, milliliters. 6.) All residents who received a narcotic analgesic will have their MAR completed, the Pain flow sheet will be documented accordingly and a Nurse's note will be also completed on each of those residents. 7.) Any discrepancies are to be reported immediately to the Unit Manager/Supervisor and	F 697		

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F 697	Continued From page 88 the Director of Nursing. 8.) In re-ordering of EX Order 26 § 4b1 [redacted], once the declining count has reached the reddened area on the bingo card, the bingo card sticker is to be removed and faxed to the pharmacy for delivery. A follow up call to the pharmacy must be made by the nurse to ensure that fax request for EX Order 26 § 4b1 refill was received by pharmacy. All communications and follow-ups should be documented in the 24 hour report sheet. Staff nurse to notify supervisor/designee that they are awaiting narcotic/controlled medication delivery. Continual follow up should be made until medication is received or order changed by MD. 9.) If notified by pharmacy that signed script from MD is needed, follow up call to MD's office will be made by nursing. 10.) Alternative method of pain relief will be offered until Narcotic/Controlled medication is received or changed per Physician's order. A review of the facility provided policy titled, "Drug Administration" dated 1/1/06 included the following: H) If for any reason a medication that a physician has ordered is withheld it should be so noted on the Medication Administration Record and in the nurse's notes ... L) Medications are given at the time ordered, or within 60 minutes before or after the time designated for medication passes, or within 30 minutes before or after the ordered time of administration with regard to meals. A review of the facility provided policy titled, "8. Controlled Substances" dated 1/1/06 included the following: 2) Declining Inventory Forms ... D) When a controlled drug is administered to a	F 697		

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patient, in addition to following the proper procedure for charting medication, the declining inventory sheet must also be signed ...
5) A verifiable record system must be maintained for controlled substances.
A) A declining inventory sheet must be maintained for each controlled drug prescription in the facility.
B) When a dose of controlled drug is administered the appropriate space must be signed on the declining inventory form.
C) An inventory of controlled substances retained in each nursing unit must be made at the termination of each shift. Both the outgoing and incoming nurses who meet the criteria for handling controlled substances will sign this record.

A review of the facility provided policy titled, "5. Back-Up Medications" dated 1/1/06 included the following:
A supply of Back-up medications will be kept at each Facility to assist in having "stat" medications readily available when needed.

A review of the facility provided policy titled, "Reordering, Changing & Discontinued Medication Orders" with a reviewed date of 1/22, included the following:
B. Reorders/Refill orders ...
1.Refills can be requested by placing the refill strip portion of the mediation on the refill order form and faxing to the pharmacy. A white medication reorder form with printed bar code must be used for non-controlled medications.

A review of the facility provided policy titled, "Charting and Documentation" with a revised date of 10/2021, which included the following:

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F 697	Continued From page 90 Policy Statement All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation 1. All observations, medications administered, services performed etc, must be documented in the resident's clinical records ... 3. All incidents, accidents, or changes in the resident's condition must be recorded. A review of the undated facility provided policy titled, "Pain Management" included the following: Medicate the resident as ordered by the physician and continue non-pharmacological intervention in conjunction with medications. N.J.A.C. 8:39-29.2(d)	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to: a.) administer medications in accordance with physician orders to coordinate with dialysis days, and b.) follow-up on recommendations from the hemodialysis center for 1 of 2 residents who received dialysis treatments (Resident #3). The deficient practice was evidenced by the following:	F 698	F 698 Element One □ Corrective Actions " The physician was notified and issued revised orders to coordinate with dialysis days. " The care plan of Resident #3 was	5/15/22

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F 698	Continued From page 91 On 03/01/22 at 10:08 AM, the Surveyor conducted an interview with Resident #3 in the resident's room. The resident stated that he/she attended dialysis on Monday, Wednesday and Friday at 1:45 PM. Resident #3 stated he/she had been going to the dialysis center on Monday, Wednesday and Friday a few months ago. Resident #3 stated that prior to that, he/she used to go to dialysis on Tuesday, Thursday and Saturday. The Surveyor reviewed the medical record for Resident #3 and the following was revealed: A physician order script dated 12/22/21 revealed an order for EX Order 26 § 4b1 [redacted] on hemodialysis days. A "Pharmacist Note" dated 02/24/22 at 10:13 AM, located in the progress notes, revealed "Follow med [medication] times with dialysis". A Physician's Order sheet for February 2022 revealed and order for [redacted]	F 698	EX Order 26 § 4b1 to reflect changed hemodialysis schedule. " The recommendation of the dialysis treatment center regarding hypertension medications was reviewed with the physician and physician order modified. " The nurse caring for the resident post dialysis on 1/31/22 was counseled and re-educated. " The care plan of Resident #3 was modified to reflect changed hemodialysis schedule. Element Two □ Identification of at Risk Residents All residents on hemodialysis may be affected by these practices. Element Three □ Systemic Changes " Nurses were re-educated on the purpose of the hemodialysis communication record, need for full completion of form and review of hemodialysis center comments upon resident return from the center. " Nurses were re-educated that changes in hemodialysis schedule prompt review of medication orders by the physician and modification of care plan. Element Four □ Quality Assurance The DON / ADON or designee will review resident orders as to change in	

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F 698	Continued From page 92 The Care Plan Revealed a Problem: Resident #3 needs [EX Order 26 § 4b] [EX Order 26 § 4b1] due to [EX Order 26 § 4b1] (Tue-Thu-Sat.), Revised on 09/28/21. The Goal was Resident #3 will have no signs and symptoms of complications from [EX Order 26 § 4b] through the review date, revised on 10/15/21 with a Target date of 03/15/22. Interventions/Tasks included: Encourage resident to go for the scheduled [EX Order 26 § 4b] appointments. Resident receives [EX Order 26 § 4b] (Tuesday-Thursday-Saturday), Date Initiated, 09/16/21 and Revised, 10/26/21. The surveyor reviewed the Medication Administration Record (MAR) for January, 2022, and February, 2022, and a [EX Order 26 § 4b] book for Resident #7. The [EX Order 26 § 4b] book contained the [EX Order 26 § 4b] [EX Order 26 § 4b] Progress/Communication Notes for Resident #3, which included the dates that Resident #3 attended dialysis and [EX Order 26 § 4b] Center Nurse Communication back to the facility. The Documents revealed: 01/31/22 Resident #3 attended [EX Order 26 § 4b]. Treatment Problem: Yes circled, If yes, explain: "EX Order 26 § 4b1, (see note below). There was a note on the document that revealed "note: To SNF [Facility]-RN Please do not (underlined) give [EX Order 26 § 4b1] medications prior to [EX Order 26 § 4b1]] treatment. The MAR had an "X" on the same date for the [EX Order 26 § 4b1] which indicated it was not administrated. 02/02/22 Resident #3 attended [EX Order 26 § 4b]. The MAR had an "X" on the same date for the [EX Order 26 § 4b1] which indicated it was not administrated. The [EX Order 26 § 4b1] was administered at 5:00 PM. 02/04/22 Resident #3 attended [EX Order 26 § 4b].	F 698	hemodialysis schedule and hemodialysis communication records for action items weekly for three weeks then monthly for the next three months. Findings of these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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The MAR had an "X" on the same date for the EX Order 26 § 4b1 which indicated it was not administrated.
The EX Order 26 § 4b1 was signed off as administered at 8 AM and 5 PM.
02/07/22 Resident #3 attended EX Order 26 § 4b.
The MAR had an "X" on the same date for the EX Order 26 § 4b1 which indicated it was not administrated.
The EX Order 26 § 4b1 was signed off as administered at 8 AM and 5 PM.
02/09/22 Resident #3 attended EX Order 26 § 4b.
The MAR had an "X" on the same date for the EX Order 26 § 4b1 which indicated it was not administrated.
The EX Order 26 § 4b1 was signed off as administered at 8 AM and 5 PM.
02/11/22 Resident #3 attended dialysis.
The MAR had an "X" on the same date for the EX Order 26 § 4b1 which indicated it was not administrated.
The EX Order 26 § 4b1 was signed off as administered at 5 PM.
02/14/22 Resident #3 attended EX Order 26 § 4b
The MAR had an "X" on the same date for the EX Order 26 § 4b1 which indicated it was not administrated.
The EX Order 26 § 4b1 was signed off as administered on 8 AM and 5 PM.
02/16/22 Resident #3 attended EX Order 26 § 4b.
The MAR had an "X" on the same date for the EX Order 26 § 4b1 which indicated it was not administrated.
The EX Order 26 § 4b1 was signed off as administered on 8 AM and 5 PM.
02/18/22 Resident #3 attended EX Order 26 § 4b
The EX Order 26 § 4b1 was signed off as administered on 8 AM and 5 PM.
02/23/22 Resident #3 attended EX Order 26 § 4b.

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The [redacted] was signed off as administered on 8 AM and 5 PM.
02/25/22 Resident #3 attended [redacted].
The [redacted] was signed off as administered on 8 AM and 5 PM.
02/28/22 The Resident #3 attended [redacted].
The [redacted] was signed off as administered on 8 AM and 5 PM.

On 03/01/22 at 10:32 AM, the Surveyor interviewed the Licensed Practical Nurse who was assigned to Resident #3 (LPN). The LPN stated that Resident #3 went to dialysis on Monday, Wednesday and Friday. The LPN showed the surveyor the MAR for Resident #7, and stated that when she initialed the MAR, it indicated that the medication was administered.

On 03/02/22 at 9:07 AM, the Surveyor conducted a telephone interview with a Registered Nurse (RN) at the [redacted] center. The RN stated she was familiar with Resident #7's care. The RN stated she remembered the [redacted] treatment that Resident #3 had on 01/21/22 and referred to the note on the [redacted] communication form. The RN stated that Resident #3's [redacted] and the note was documented to the nursing facility. The RN stated when the resident's [redacted]

On 03/02/22 at 9:51 AM, the Surveyor conducted a telephone interview with the Consultant Pharmacist (CP) regarding note he wrote re: dialysis times. The CP stated the [redacted] should be given at [redacted]

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On 03/03/22 at 9:17 AM, the Surveyor interviewed the Director of Nursing (DON) regarding when the MAR would be reviewed for accuracy. She stated that the recapulations of the MARS were done monthly. The DON, in the presence of the Surveyor, reviewed the note written on the [EX Order 26 § 4b] communication form regarding holding BP medications 01/31/22 and the MD order for the [EX Order 26 § 4b1] with the DON. The DON stated the MD order was from the nephrologist (kidney doctor). The DON stated that whoever was the nurse at the time, whoever received the note from the [EX Order 26 § 4b] center and when they changed the days should have picked up the change that needed to be done. The surveyor inquired to the DON regarding if a nurse should have picked up the need to change the order and communication from [EX Order 26 § 4b]. The DON stated "absolutely" it should have been picked up. She stated she was not aware that this was a concern. The DON stated that the resident should not have received the [EX Order 26 § 4b1] medications on the dialysis days. The DON stated the nurses should have communicated with the physician regarding the [EX Order 26 § 4b] center recommendation, she reiterated that it should have been communicated with the doctor.

On 03/03/22 at 9:33 AM, the surveyor, the DON, in the presence of the surveyor checked the electronic medical record (EMR) and reviewed the nursing and physician progress note documentation from 01/27/22 through 02/02/22 and stated "I don't see anything". At 9:35 AM, the DON reviewed the physical medical record for Resident #3 and looked for physician documentation regarding the medication hold. The DON stated stated "it is not here" "absolutely" not and the DON stated it was

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common sense. Inquired to the DON, and reviewed the dialysis monitoring form, and inquired as to what the purpose of the dialysis monitoring form was. The DON stated the purpose was to ensure the resident received medications before and after hemodialysis as ordered and establish communication with the dialysis center.

On 03/09/22 at 8:57 AM, the surveyor interviewed Minimum Data Set Coordinator/ Registered Nurse (MDS) regarding the care plan process. The MDS stated she completed the initial care plan and that any changes made regarding medications, resident status, or if anything is reported, the care plan would be updated and reviewed the care plan after the morning meeting. The MDS stated the purpose of the care plan was for the residents plan of care and how we would manage them individually. The MDS stated it was the total plan of care for the residents including medications and restorative would be on the care plan. The Surveyor inquired as to if a resident was on dialysis would that be on the care plan. The MDS stated "yes" and she would expect to see the day and time that the resident attended dialysis. The MDS stated "yes" that usually the nurses, social worker, rehabilitation, or the dietitian would update the care plan if there was a change.

On 03/09/22 at 10:36 AM, the Surveyor, interviewed the DON about what the purpose of the resident care plan was. The DON stated "to ensure the patient gets the proper care" The DON stated, problems, goals and interventions should be changed "immediately, if there was a change.

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F 698	Continued From page 97 The facility form untitled with a revised date of 11/2021 indicated that residents would receive appropriate care and monitoring pre and post hemodialysis and to facilitate good communication between the facility and hemodialysis center. The policy indicated that the purpose of this policy was the following: -To assist the resident/patient in maintaining homeostasis pre and post hemodialysis. -To establish guidelines for communication with the dialysis center was to ensure continuity of care to resident requiring dialysis. -To ensure resident received medications before and after hemodialysis as ordered. -Ensure ongoing communication with dialysis and staff. NJAC 8:39-27.1(a)	F 698		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to conduct performance evaluations in a timely manner and to provide documented education for areas of improvement identified on the performance evaluations, for 4 of 5 Certified Nursing Assistants (CNA #1, #2, #3, and #5) reviewed. This deficient practice was evidenced	F 730	Element One □ Corrective Actions " Annual performance evaluation was conducted for CNA"s #1,2,3 and 5 . " The 90 day performance evaluation required for newly hired CNA #5 was conducted.	5/15/22

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F 730	Continued From page 98 by the following: On 03/02/22 at 8:13 AM, the Surveyor requested the CNA performance evaluations and education information from the Registered Nurse (RN) Staff Educator. On 03/02/22 at 10:11 AM, the RN Staff Educator provided the Surveyor with some CNA competencies and nothing else. The RN Staff Educator stated that the in-services she had provided the surveyor are the yearly education for all CNAs. The Surveyor explained there was missing information. The Surveyor explained to the RN Staff Educator that the survey team needed to review the performance evaluations and the educational information for the CNAs. On 03/03/22 at 8:35 AM, the facility had not provided the information on the CNA performance evaluations and education. On 03/03/22 at 1:56 PM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were in the conference room with the survey team. The Surveyor asked again for the CNA performance evaluations and education. On 03/04/22 at 8:07 AM, the Surveyor observed a folder left in the conference room that contained the performance reviews for the five CNAs with "areas targeted for improvement" but no corresponding education for the improvements was identified. A review of the facility provided, "CNA Certification Log", dated 2/28/22, included a hire date for all employed CNAs. The log contained the following hire dates for the 4 CNAs.	F 730	" Education was provided to CNAs #1, 2, 3 and 5 in the areas of targeted for improvement identified from their performance evaluations. " The performance record/ skills performance checklist was reviewed and updated. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes " A schedule was established for new hired 90 day performance evaluations. " Inservice education is provided in all CNAs whose evaluations are flagged areas of targeted areas for improvement. Element Four □ Quality Assurance The ADON/ Staff Educator or designee will maintain the schedule of annual performance evaluations and 90 day performance evaluations. Monthly reports will be made to the DON who will report status on timely completion of evaluations at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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CNA #1 09/14/2018
CNA #2 08/27/1987
CNA #3 03/05/2001
CNA #5 10/02/2021

A review of the facility provided, "Performance Evaluation-Certified Nursing Assistant", revealed the following annual review dates and evaluation keys:

CNA #1 had an annual performance review on 10/14/21, on month past the date of hire. CNA #1 was noted to have an objective partially met of "conducts periodic resident care and unit checks with appropriate documentation, along with charge nurse." The "areas targeted for improvement: educated the importance of documentation." The facility failed to provide the educational information specific to the performance evaluation.

CNA #2 had an annual performance review on 10/28/21, two months past the date of hire. CNA #2 was noted to have an objective partially met of "conducts periodic resident care and unit checks with appropriate documentation, along with charge nurse" and "verifies all residents have wrist bands, education, picture and door tags". The "areas targeted for improvement: educated the importance of documentation, also to report if missing door tags/name bands". The facility failed to provide the education information specific to the performance evaluation.

CNA #3 had an annual performance review on 11/12/21, eight months past the date of hire. CNA #3 was noted to have an objective partially met of "verifies all residents have wrist bands,

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F 730	Continued From page 100 medication, picture and door tags". The "areas targeted for improvement: educated to report if resident is missing wrist band, door tags". (The facility failed to provide the education information specific to the performance evaluation). CNA #5 had a 90 Day performance review on 12/6/21, one month short of the 90 Day review date. The facility failed to provide another performance evaluation at the 90-day mark from the date of hire. A review of the facility provided, "Policy and Procedure on Nurse Aide training and Performance review", revised 10/21, included but was not limited to the following: Policy - a program shall use a performance record/skills performance checklist which shall include: 1) a record of when the trainee performs the duties and skills and the determination of satisfactory or unsatisfactory performance. Procedure - nurse staff educator will provide the annual in-services as required by DOH [Department of Health]. Performance evaluations will be conducted 90 days after the start of employment and on an annual basis and as needed. On 03/10/22 at 12:18 PM, the above concerns were brought to the attention of the LNHA and the DON. The facility failed to provide any additional information.	F 730		
F 742 SS=D	NJAC 8:39-43.17(b) Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure	F 742		4/30/22

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F 742	Continued From page 101 that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and review of other pertinent facility documentation it was determined that the facility failed to provide consistent behavioral health services for attainment or maintenance of a resident's highest practicable well-being. This deficient practice was identified for 1 of 2 residents reviewed (Resident #61) and was evidenced by the following: On 02/28/22 at 12:20 PM, the Surveyor observed Resident #61 on the 2nd floor unit. The resident was agitated and loudly yelled for someone to get out of his/her room. On 02/28/22 at 12:21 PM, the Surveyor reviewed Resident #61's clinical record which revealed the following information: -The physician order sheet reflected that the Resident #61 was on the EX Order 26 § 4b1 [redacted] EX Order 26 -The Admission Record (AR) indicated that Resident #61 was admitted to the facility with the diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]	F 742	F 742 Element One □ Corrective Actions Resident #61 was immediately assessed by telehealth psychologist without change in orders. Element Two □ Identification of at Risk Residents All residents who need psychological services may be affected by these practices. Element Three □ Systemic Changes Facility has contacted a new vendor to provide psychology services for the residents . Element Four □ Quality Assurance The Social Worker and/or designee will audit psychologist visits monthly for follow up treatment for the next three months. Findings of these audits will be reported at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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EX Order 26 § 4b1

-The quarterly Minimum Data Set (MDS) and assessment tool dated 12/30/21, indicated that the resident was EX Order 26 § 4b1. Section E (Behavior section) of the MDS reflected that the resident had no behaviors and had no signs or symptoms of EX Order 26 § 4b1.

-The Care Plan (CP) dated 08/16/19 with a revised date of 07/05/21, indicated the resident periodically displayed the following behaviors: easily angered and will bang fist, loud sounds upset the resident and he/she will yell profanities and will argue with his/her peers, will refuse to see the dentist, podiatrist, or medical doctor (MD) at times. The CP did not indicate that the resident was receiving routine EX Order 26 § 4b1 sessions.

The Social Service note dated 02/28/22 at 12:49 PM, indicated that the resident became upset with the roommate because the roommate said something about him/her. According to the note the other resident was Spanish speaking and was out in the hallway.

The nurses note dated 2/28/22 at 16:18 PM indicated the following:
The resident was upset by the roommate and was very agitated because his/her roommate said something in Spanish that the resident could not understand. The resident also indicated that was hard to have someone in the room with you and you cannot communicate. The resident was seen by the EX Order 26 § 4b1 and the EX Order 26 § 4b1 wrote a new order for the medication EX Order 26 § 4b1

On 03/08/22 at 9:51 AM, the Surveyor

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interviewed the Licensed Practical Nurse (LPN) who revealed that she witnessed an incident which occurred on 06/24/21 in which Resident #61 attempted to [redacted] the roommate, was agitated, flaring his/her hands and staff had to separate the residents. During this incident Resident #61 hit staff multiple times, started hitting his/her head and was transferred to crisis. The LPN further added that Resident #61 had an altercation downstairs with another resident (did not specify a date) and based on what she observed that day, Resident #61 should be placed in a private room so that other residents should not be subject to his/her behavior.

On 03/09/22 at 9:57 AM, the Surveyor requested all investigations and interventions that were put in place to manage the resident behaviors.

The Surveyor was provided with a facility investigation dated 06/24/21, which indicated that Resident #61 had become upset with his/her roommate in which staff intervened that the resident started hitting staff. The roommate was moved into a different room and Resident #61 was sent to crisis. The surveyor reviewed the form titled, "Clinical Outreach Program for the Elderly (S-COPE)" dated 06/25/2021, which recommended that the resident be provided with EX Order 26 § 4b1 with a EX Order 26 § 4b1 to provide the client with a safe environment to express his/her experiences and obtain self-help tools.

The Surveyor reviewed the facility provided forms titled 'EX Order 26 § 4b1 (PS)" dated 07/09/21 at 9:30 AM to 9:46 AM which indicated that the resident would receive sessions every two weeks to engage in psychological services.

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F 742	Continued From page 104 According to the clinical records provided by the facility, the resident was not seen for PS until 09/11/21. During this session the documentation indicated that the resident's condition would deteriorate if the resident did not participate in EX Order 26 § 4b1 or if the treatment would discontinue and the recommendations indicated that the resident EX Order 26 § 4b1 require EX Order 26 § 4b1 to reduce EX Order 26 § 4b1 The next time the resident would receive EX Order 26 § 4b1 was 5 months later 02/20/22. The PS dated 02/20/22 also indicated that the resident would require EX Order 26 § 4b1 or the resident's condition would deteriorate if the resident did not participate in EX Order 26 § 4b1 or if the treatment would discontinue. This PS also indicated that the resident would receive EX Order 26 § 4b1 . On 03/11/22 at 10:04 AM, the Surveyor interviewed the EX Order 26 § 4b1 who stated that he was not the EX Order 26 § 4b1 " therapist, but the EX Order 26 § 4b1 therapist could provide more information. The surveyor was unable to reach the " EX Order 26 § 4b1 Therapist by phone. On 03/11/22 at 11:45 AM, during the pre-exit conference the DON indicated that the regular therapist was no longer working and that the resident would be evaluated the next day. NJAC 8:39-27.1 (a), 28.1 (c)	F 742		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		5/15/22

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Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of other pertinent facility documentation, it was determined that the facility failed to: 1.) ensure that expired medications and supplies were removed from two medication rooms and two unit emergency carts, and 2.) ensure the temperatures were monitored daily for 1 of 2 unit (1st floor) medication refrigerators. This deficient practice was identified for 2 of 2 units and was evidenced by the following:

1) On 03/01/22 at 9:01 AM, Surveyor #1 inspected the medication storage room on the

Element One □ Corrective Actions

" The medication room was cleaned. Expired medications and supplies and multiple bags of resident personal medications were removed from medication rooms and emergency crash carts.

" The nurses who worked the 3:00 PM to 11:00 PM shift on the 2nd floor on 2/27/22 at the time of the unsecured crash cart was re-educated and

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F 761	Continued From page 106 2nd floor. The surveyor observed that there were plastic bins in the medication storage room filled with supplies. Upon further inspection of the plastic bins, the surveyor observed that the bins had multiple individual bags of resident personal medications from multiple un-sampled residents who either discharged to home or who were deceased and were mixed in with with intravenous (IV) tubing supplies and dressings. The surveyor found the following: 1.) .9% sodium chloride (NaCl) IV 100 cc bag expired Oct 2020. 2.) .9% NaCl 100 cc IV bag expired 01/12/2021. 3.) Discharged residents' personal bottles of medication of Lasix (diurectic medication) expired 07/18/203, 2 bottles of Colace (stool softener) expired 07/08/2020 and 06/2020, 3 vials of IM injectable Haldol (antipsychotic) expired 06/08/2020, Tums (antiacid) expired 09/13/2019, Neurontin (neuropathic pain) expired 07/26/2020, Loratadine (antihistamine) expired 07/2020, Cilostazol (Platelet Aggregation Inhibitors) expired 06/2020, Metoprolol (blood pressure) expired 06/25/2020. On 03/01/22 at 9:13 AM, while Surveyor #1 was in the process of inspecting the medication storage room on the 2nd floor, the Director of Nursing (DON) was standing at the nurse's station and observed the Surveyor inspect the plastic bins that were full of IV supplies, individual bags of medications and dressing supplies. The Surveyor interviewed the DON at this time who stated that there should not be personal bottles of resident medications stored in the medication storage room. The DON looked at the names labeled on the medication bottles and revealed that those medications were from residents that	F 761	counseled. " The nurse who worked the 11:00 PM to 7:00 AM shift on the 2nd floor 02/27/2022 and did not secure the open crash cart was re-educated and counseled. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes " The Medication Storage Policy was reviewed with no updates. " Nurses received re-education in Medication Storage Policy and Discarding and Destroying Medications Policy. " Nursing staff were re-educated to send family members home with medications brought from home. " Nursing supervisor / designee make weekly rounds to check medication rooms to remove and destroy expired medications or medications of residents who are expired. " Nursing supervisor/ designee make weekly rounds to monitor completion of medication refrigerator temperature logs. Nursing staff received re-education about proper documentation of temperatures on the logs .	

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F 761	Continued From page 107 were either discharge or expired. She then stated that when a resident was admitted to the facility and brought their own medications from home, that the medication should be sent back home with the families. She also indicated that if a resident was sent home, then the medication from the pharmacy would be sent back as this was the policy of the facility. She stated that the nurses should be checking the medication room and returning expired or deceased residents' medication to the pharmacy. The DON stated that the Pharmacy Consult (PC) would come in monthly to check the medication room to assure that there were no expired medications and that medications were labeled correctly. She stated that the PC was in on 01/24/22 and checked the medication room. She was not notified of any discrepancies. The DON confirmed that there should not be expired medications or expired IV supplies mixed with supplies that were still in use. On 03/01/22 at 9:33 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who stated that when a resident expired or discharged out of the facility that medications should be returned to the pharmacy. She also stated that when residents or resident families brought in personal medications from home, that the resident's family was asked to take the medication back home and that the medication would be ordered from the facility pharmacy. She stated that there should not be resident personal bags of medications stored in the medication storage room. She also stated that the PC inspected the medication room monthly and should have taken resident personal medication, expired medications, and expired supplies out of the medication storage room. She also stated that the supervisors were responsible for making sure that the medication room was	F 761	" The Crash Cart Inventory form was modified to list expiration dates of emergency crash cart equipment. " 11-7 nursing staff was re-educated to check locked emergency crash cart and AED for function nightly. Element Four □ Quality Assurance The nursing supervisor or designee will review temperature logs and crash cart inventory forms for daily checks. The nursing supervisor and/or consultant pharmacist will audit medication rooms weekly x 4 and monthly x 2 months. Findings of these audits will be reported to the DON who will provide audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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clean and that expired medications or resident personal medications were not stored in the medication storage room.

On 03/01/22 at 9:38 AM, Surveyor #1 interviewed the Registered Nurse Unit Manager (RN/UM) who stated that she was relatively new to the facility and was still learning the facility policy and procedures. She added that from her experience working as a nurse in long term care, that resident personal medications should not be stored in the medication storage room and should be returned to the family to take home. She also stated that expired medications should not be kept in the medication storage room and should be returned to the pharmacy and that expired IV supplies should not be kept in with supplies that were in use.

On 02/28/22 at 12:26 PM, Surveyor #2 and Surveyor #3 noted a red crash (emergency) cart in the resident hallway with the top drawer open. Upon further observation revealed that the crash cart was not locked. The surveyor noted that that top drawer had a pair of bandage scissors, second drawer had syringes with needles ready to use such as 17 intramuscular syringes (IM), 1 100 count box of lancets, 24 count 25-gauge needles and 2 count of 22 syringe gauge needles. The 3rd drawer of the crash cart had 11 counts of IV tubing expired 4/2020, 1 sterile H20 (water) irrigation bottle expired 12/13/20 and normal saline .45% solution with an expiration date of 11/20/20.

On 02/28/22 at 12:34 PM, Surveyor #1, Surveyor #2 and Surveyor #3 interviewed the LPN that was in the hallway and inquired about the crash cart. The nurse stated that the 11:00 PM to 07:00 AM

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shift was responsible to check the crash cart and ensure that the crash cart was locked. The LPN stated that "anything could happen" regarding the crash cart being left open. The LPN could not provide further information, she told the surveyor to see the supervisor for further information.

2.) On 02/28/22 at 12:36 PM, Surveyor #4 and Surveyor #5 noted a red crash cart behind the 1st floor nurse's station desk. The RN Supervisor was behind the nurse's desk and reviewed the crash cart with the surveyors. The surveyors noted the top drawer had 14 individually wrapped alcohol pads all with an expiration date of 2/16, and a sealed needle pack that was visibly soiled; the second drawer had 3 IV start kits which expired 8/13/21, 1 IV administration set which expired 11/9/21; and the fifth drawer had 20 border gauze pads which had expired 12/17.

The surveyors also reviewed the 1st floor, "Crash Cart Inventory and Testing" logs. The first log was dated January 2022 and revealed that the inventory and testing will be done by "11-7 nurse." The log was blank on 1/1, 1/2, 1/6, 1/7, 1/8, 1/9, 1/18, 1/22, 1/25, 1/26, 1/27, 1/28, 1/30, and 1/31/22 = 14 of 31 days. The Defib [defibrillator] tested was blank 26 of 31 days. The second log was dated February 2022 and revealed that the inventory and testing will be done by "11-7 nurse." The log was blank on 2/6, 2/7, 2/15, 2/21, 2/27, and 2/28 = 6 of 28 days. The Defib tested was blank 19 of 28 days.

At that time, the RN Supervisor stated there should be no expired supplies in the crash cart with supplies in use and that the inventory and testing log should be signed every day.

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On 02/28/22 at 12:40 PM, the surveyors interviewed the DON who stated that the crash cart should have been secured and locked as residents could get to the cart and use supplies. The DON added that the crash cart should not be accessible. She also stated that the crash cart should be checked daily and that the staff was supposed to check the crash cart for expired items and then should lock the cart after daily inspection. The surveyors reviewed the form that was attached to the top of the crash cart labeled "Crash Cart Inventory and Testing (CCIT)". The DON stated that this form should be signed daily by the 11:00 PM to 7:00 PM nurse to verify that they checked the crash cart for expired items and that the nurse should lock the crash cart after they inspect the cart. The DON had no explanation as to why the CCIT was not signed by the 11:00 PM to 7:00 PM nurse on the following dates 02/11/222, 02/12/222, 02/18/222, 02/26/222, 02/27/222 and 02/28/222.

3) On 03/01/22 at 8:25 AM, Surveyor #4, in the presence of the RN/IP, reviewed the first floor medication storage room. Surveyor #4 observed that the medication refrigerator was locked, contained medications and vaccinations, and the temperature log was missing signatures.
Surveyor #4 and the RN/IP reviewed the following logs: November 2021 revealed no temperatures documented on 11/12, 11/13, 11/14, 11/20, 11/28, and 11/29/21 = 6 of 30 days.
December 2021 revealed no temperatures documented on 12/10, 12/11, 12/12, 12/13, 12/24, 12/25, 12/26, and 12/27/21= 8 of 31 days.
January 2022 revealed no temperatures documented on 1/1, 1/8, 1/9, 1/10, 1/22, 1/24,

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1/29, and 1/30/22= 8 of 31 days.
February 2022 revealed no temperatures documented on 2/5, 2/6, 2/7, 2/15, 2/19, 2/21, and 2/26/22= 7 of 28 days.

At that time, the RN/IP stated that the 11 PM - 7 AM nurse was responsible to document the temperatures of the medication refrigerator. She further stated it was important to ensure the integrity of the medications.

On 03/02/22 at 8:58 AM, Surveyor #1 conducted a telephone interview with Registered Nurse (RN) who worked the 11:00 PM to 7:00 AM shift on the 2nd floor 02/07/2022. The RN revealed that she was the only nurse with 62 residents. She stated that it was her responsibility to check the crash (emergency) cart on the 2nd floor. She stated that when she arrived for her shift, "The 3:00 PM-11:00 PM shift had moved the crash cart from its usual location near resident room #212 to the left hallway by the window and left it opened. "I have no idea why, so I left it that way." She revealed that the green lock tab was off the crash cart when she came in to start her shift on 2/27/22 at 11:00 PM-7:00 AM shift. The RN suddenly ended the interview by phone and stated that she needed to call the surveyor back. The RN did not return the surveyor's call.

On 03/02/22 at 9:50 AM, Surveyor #1 conducted a telephone interview with the Pharmacy Consultant (PC) for the facility who stated that he had been working in the facility for a "good number of years". He stated that his responsibility was to perform monthly resident chart review, periodic employee medication pass observation, inspect stock medications and medication cart for expiration dates and proper labeling and storage,

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and to inspect the refrigerator temps. He stated that if the medications were expired, they could spoil and not be effective or lose efficacy. He stated that that refrigerator temps needed to be in range 36-46 so that efficacy could remain intact. "We check the emergency medication kits, not the actual crash cart." He added that he came to facility a couple weeks ago and report was provided to the DON. He stated, "In general in was pretty good. I may not see everything because I look at stock medications. It is very tight and cluttered in the medication rooms." He also added that he did not investigate the plastic bins that were in the medication rooms so he could not speak on what was in those plastic bins.

The facility provided policy titled, "Medication Storage Policy" with a revised date of April 2007, indicated that the facility shall store all drugs and biologicals in a safe, secure and orderly manner. The policy also indicated the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals and that all such drugs shall be returned to the dispensing pharmacy or destroyed.

The facility provided policy titled, "Discarding and Destroying Medications" with a revised date of April 2007, indicated that medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by the resident, and/or medications left by the residents upon discharge) shall be destroyed.

The facility provided policy titled, "Crash Cart Policy" with a date of 09/05/21 indicated that the crash cart inventory and testing will be done by the 11:00 PM-7:00 AM floor nurse daily. When

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F 761	Continued From page 113 the crash cart to be found with a red tag, the 11:00 PM-7:00 AM nurse will conduct inventory of the existing contents and will refill the cart. The policy also indicated that expired items would be removed and replaced. The policy indicated that the crash carts at the facility must be locked whenever the cart was not in use and when the crash carts were opened to use, the staff would keep the carts right near them and always supervised the carts. The facility provided policy, "Policy for checking temperature for Refrigerator", dated 4/21, revealed Policy: to maintain medicine quality, both floor refrigerator temperature needs to be checked daily. Procedure: 11-7 shift assigned floor nurse will be checking the temperature daily to ensure refrigerator temp [temperature] is within normal range 36 to 46 degree. After checking the temp, needs to log in temp log and sign in and date it. Any abnormal temperature needs to be reported to maintenance department immediately. NJAC 8:39-29.4(e)(f)(g)(h)	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced	F 770		5/15/22

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F 770	Continued From page 114 by: Based on interview, and closed record review it was determined that the facility failed to order the appropriate physician ordered laboratory test for 1 of 2 closed medical records reviewed for physician orders (Resident #7) and was evidenced by the following: On 03/02/22 at 12:51 PM, the Surveyor reviewed the closed medical record for Resident #7 which revealed: A Licensed Practical Nurse (LPN #1) documented a Nurses Note (NN) on 02/12/22 at 16:05 (4:05 PM). The Admission record for Resident #7 revealed the resident was admitted to the facility with diagnoses which included, but were not limited to, EX Order 26 § 4b1 [redacted]. A Doctor's Progress note, dated 02/02/22 was reviewed which revealed EX Order [redacted] The Physician's Orders dated 02/02/22 revealed an order for a EX Order 26 § 4b1 on Friday and the order was noted on 02/02/22 and signed by a Registered Nurse. A NN dated 02/03/22, at 15:21 (3:21 PM) revealed a LPN #1 documented "EX Order 26 § 4b1 " and results pending. A Final laboratory report, dated 02/05/22, revealed Tests ordered: EX Order 26 § 4b1 [redacted] with the listed test results. On 03/10/22 at 11:50 AM, the Surveyor, in the presence of three other surveyors, conducted a telephone interview with Resident #7's Physician (MD). The Surveyor inquired if the MD was aware that the CMP was not ordered. The MD stated she did not keep track of the laboratory tests that	F 770	F 770 Element One □ Corrective Actions " The cancelled CMP lab order for Resident #7 was investigated. " The nurse who transcribed the wrong laboratory test (CBC) for Resident #7 on 2/2/22 was re-educated and counseled. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes " nurses were re-educated on the process for new orders .Nursing staff received re-education regarding ensuring lab orders are properly transcribed , ordered , completed and reported to physician as required . Element Four □ Quality Assurance The ADON/ Staff Educator or designee will audit 10 random lab test orders weekly x 4 then monthly x 2 months. Audit results will be reported to the DON who will report audit findings at the quarterly QAPI committee meeting for action and further guidance as appropriate	

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she ordered and the facility would give her the results. She stated that no one had informed her that the CMP was not completed.

On 03/11/22 at 9:52 AM, the Surveyor, interviewed the Registered Nurse, Charge Nurse (RN/CN) regarding what the facility's responsibility was for ordering physician ordered laboratory tests (lab). The RN/CN stated "we must" carry out lab orders. The surveyor showed the RN/CN the Physician's Orders dated 02/02/22 for Resident #7, and the RN/CN confirmed that she signed off the order for the CMP and PTH level. At 9:55 AM, the Surveyor accompanied the RN/CN to another floor to find the lab requisition form, and the RN/CN was unable to locate it. The RN/CN stated that if the laboratory did the wrong lab, that it "definitely" should have been noticed, and the MD should have been called. The RN/CN stated "catching it is the problem". At 10:04 AM, the RN/CN telephoned the Laboratory in the presence of the Surveyor and confirmed the CMP was not completed.

On 03/11/22 at 10:03 AM, the Surveyor discussed the concerns regarding the missing lab values with the Director of Nursing and requested a copy of the CMP if it was completed.

On 03/11/22 at 10:18 AM, the DON provided a copy of Resident #7's labs, dated 02/04/22. The lab was documented "Comprehensive Metabolic Panel Canceled (added in error), which was noted under the PTH lab and this notation was not included on the original MD signed lab copy that was located in Resident #7's closed medical record. The Surveyor inquired to the DON why that was printed on the lab. The DON acknowledged the lab was not done as ordered

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F 770	Continued From page 116 and does not know why it was canceled and it was not completed. The facility provided the Job Description Unit Coordinator (Registered Nurse/LPN) which revealed the Purpose: Unit Coordinator/Charge Nurse is responsible to direct, monitor and supervise all staff assigned to the unit, to ensure Quality of Care and Quality of Life for each resident, to exercise good judgement and to respect confidential matters. Direction of staff will ensure that care and services will be delivered in compliance with all Federal, State, and local requirements, as well as facility policies and procedures...#6 Receives and verifies the accurate transcription of physician's orders and ensures that these orders are implemented accurately and professionally. NJAC 8:39-27.1(a)	F 770		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review it was determined that the inactions in administration of the facility contributed to the facility failure to ensure: a.) the visitation process did not restrict visitation and complied with executive directive from Center for Medicare Services (CMS) QSO-20-39-NH revised 11/12/21,	F 835	F835 Element One □ Corrective Actions " Visitation process was revised in accordance with the executive directive from Center for Medicare Services (CMS) QSO-20-39-NH revised 11/12/21.	5/15/22

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F 835	Continued From page 117 b.) allegations of abuse were investigated and reported to the State Survey Agency (SSA), c.) the facility followed the facility Policy and Procedure (P&P) for Abuse Identification and Prevention, d.) a system for staff education and monitoring for Basic Life Support/CPR was in place after an adverse resident event occurred, e.) that nurse aides received the minimum required number of in-service hours and annual performance evaluations, f.) the facility developed quantitative and measurable goals for Quality Assessment and Performance Improvement (QAPI) , and g.) Antibiotic Stewardship was being conducted to track and monitor antibiotic use. This deficient practice was evidenced by the following: Reference 678L The Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 03/03/22, including the Immediate Jeopardy Template. A revised Immediate Jeopardy Template was provided to the Facility Administrator on 03/04/22. The Facility failed to: -ensure staff initiate an emergency response system, failed to call 911 and failed to utilize the facility defibrillator when a resident was found unresponsive. -ensure a system was in place to appropriately track and maintain cardiopulmonary resuscitation (CPR) certifications to ensure that staff maintained the appropriate CPR certification.	F 835	" The allegation of abuse relating to Resident #258 was investigated and reported to the NJDOH. " The allegation of abuse /misappropriation of funds of Resident #60 was investigated and reported to the NJDOH. " Accredited Basic Life Support courses to certify nursing staff in CPR were immediately scheduled and held. " The 90 day performance evaluation required for newly hired CNA #5 was conducted. " The annual performance evaluation of CNAs # 1,2,3 and 5 was completed. " Education was provided to CNAs #1, 2, 3 and 5 in the areas of targeted for improvement identified from their performance evaluations. Element Two □ Identification of at Risk Residents All residents have the potential to be affected by these practices. Element Three □ Systemic Changes " The Administrator reinstituted daily morning operation meetings with department directors held Monday thru□ Friday weekly. " The Administrator oversees daily	

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F 835	Continued From page 118 On 03/08/22, the Department of Health received an acceptable allegation for the Removal of Immediate Jeopardy and determined that the Immediacy of the Jeopardy could be removed, effective 03/08/22. The facility submitted an acceptable removal plan on 03/08/22 at 8:30 AM. The survey team verified the removal plan onsite on 03/08/22 at 9:30 AM, which removed the immediacy. The non-compliance for F678 remained as of 3/9/22, for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. (Reference: F563, F609, F610, F730, F867, F881) a.) The facility administrator (LNHA) failed to ensure that facility residents were able to have visitation in accordance with the regulatory guidance. On 03/08/22 at 11:08 AM, the Surveyor interviewed the LNHA about the current facility visitation process. The LNHA stated that visiting hours were based on when the recreation staff was in the facility. The LNHA stated the residents were allowed visitors and that was only by appointments. The LNHA stated that the visitation would occur only in a downstairs area and not allowed in the resident rooms. b.) Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to: report to the New Jersey Department of Health	F 835	nursing staffing to ascertain the facility is meeting staffing ratios and sufficient staff are on duty each shift trained in Basic Life Support. " The Administrator oversees investigations of alleged abuse and reports alleged abuse as per NJDOH regulations. " The Administrator oversees the annual performance evaluations of CNA staff. " The Administrator conducts facility QAPI committee meetings overseeing QAPI projects implemented to address the plan of Correction . A consultant was hired to work with the administrator , department directors , and staff to plan corrective actions ,implement system changes and develop monitoring processes to ensure sustained compliance with regulations . A work grid was developed based on the CMS 2567 dated 3/17/22 with accountability for each area assigned to core team members . Element Four □ Quality Assurance A QAPI compliance committee was formed to include the consultant , administrator , department directors , and will meet weekly until substantial compliance is achieved to assure all corrective actions and systemic changes have been completed as noted in this plan of correction . This is in addition to regularly scheduled quarterly QAPI	

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(NJDOH) an allegation of resident-to-resident abuse that occurred on 2/8/22 and b.) develop the facility's "Policy on Resident Abuse" policy in accordance with federal and state requirements for the timing of reporting such allegations of abuse to the state agency.

At 12:29 PM, in the presence of the survey team, the Surveyor inquired to the DON if Resident #258's allegation of abuse was reported to the NJDOH. The DON stated that it was not reported. She added that the investigation concluded that the incident was not witnessed and that the incident was fabricated. The Surveyor then inquired to the DON if any allegation of abuse, whether it happened or not, was required to be reported. The DON stated that any allegation of abuse should be reported.

On 03/11/22 at 11:23 AM, in the presence of the survey team, the DON and the Licensed Nursing Home Administrator (LNHA) confirmed that Resident #258's allegation of abuse was not reported to the NJDOH and that the allegation should have been reported. The Surveyor then asked the LNHA when an allegation of abuse should be reported to the NJDOH. The LNHA stated that an allegation of abuse should be reported immediately.

c.) Based on interview, record reviews and reviews of pertinent documentation obtained from the facility, it was determined that the facility failed to thoroughly and timely investigate and report an allegation of abuse to the State Agency. This deficient practice was identified for 2 residents, Resident # 60, and Resident #258.

"It was reported by nursing that on 02/27/22 in

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the evening, there was an argument between Resident #60 and the roommate, Resident #60 was moved to Room 201. The Social Worker (SW) and DIrector of Nursing (DON)interviewed the residents-

Resident #60 reported that he/she was in bed when his roommate came to him/her saying that "I stole his/her money" and that "I have his/her bank account". He/she reports that he/she looked for the money "on my but" and "under my pillow" and admitted "I hit him/her on the shoulder" he/she did not hit me, three nurses came".
Resident #60 also stated to the SW that "he/she [referring to the roommate] was looking for a driver license...
The roommate was interviewed and stated that "I really don't know; no one told me anything" and denied any "wrongdoing".

A review of the 24-hour Report dated 02/27/22 indicated the following "the roommate constantly standing by Resident #60's bed stated he/she took his/her money, bank account and car's key. All evening the roommate refused to stay on his/her side of the bed. By 10: 00 PM, Resident # 60 was moved to Room 201."
The facility did not investigate further to rule out any abuse /misappropriation of funds.

There was no late entry made regarding the incident in the clinical record on 02/27, 02/28. An entry was entered on 03/01/22 at 12:58 PM and indicated that a verbal exchange took place.

The surveyor reviewed the electronic progress notes. There was no documentation that the family and the physician were contacted on 02/27/22 following the incident.

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On 03/03/22 at 9:45 AM, during an interview with the DON regarding the incident, the DON stated that she agreed the documentation was lacking. The incident was not entered in the clinical record. The DON submitted a written note and 2 written statements from the nurse and the Certified Nursing Assistant. None of the entries revealed that Resident #60 was involved in a physical altercation. There was no documented evidence that both residents were interviewed and assessed.

On 03/03/22 at 12:15 PM, the surveyor again interviewed the DON regarding the process. She stated that the incident should have been entered in the Progress Notes. She would not elaborate on the time that she was made aware of the incident nor the rationale for the missing documentation in the clinical record.

On 03/11/22 at 11:26 AM during a pre-exit conference with the Administrator and the DON, the DON stated that all allegations of abuse should be investigated and reported immediately.

On 2/28/22 at 11:34 AM, the surveyor reviewed Resident #258's electronic Progress Notes (ePN) which included the following note dated 2/8/22 at 6 PM: Resident reported to writer that resident across the hall from his/her room hit him/her on the left forehead with a cane when he/she went to the residents' room at 5 pm to approach him/her for taking his/her snacks from the TV room. Left forehead assessed and no redness, no raised area and non-tender to touch. Resident stated he/she does not need writer to do anything, "stated that's too much paperwork." Writer reassured resident to check his/her forehead

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again for any injury.

On 3/1/22 at 11:00 AM, the surveyor asked the DON to provide any incidents that were required to be reported to the Department of Health (DOH) state during the month of February 2022.

At 1:41 PM, the DON stated that the facility only had one reportable incident in February. She added that the incident happened yesterday (2/28/22) and that she was faxing it today to the DOH.

On 3/2/22 at 8:27 AM, the surveyor interviewed Resident #258. Resident #258 stated that the unsampled resident was a thief and that the unsampled resident hit him/her with a cane on 2/8/22.

At 12:29 PM, in presence of survey team, the Surveyor asked the DON if the "Incident Interview" was the full thorough investigation. The DON stated that this was the incident that was reported to us. She added that at the time of the incident Resident #258 did not report that he/she was hit by the other resident. She stated that the next morning Resident #258 reported to her that he/she was hit by the other resident. The DON then stated when she spoke with Resident #258, the resident told her that he/she spoke to a Nurse after the incident and told the Nurse. The DON added that she called the Nurse and that the Nurse told the DON that she checked Resident #258 and that he/she had no marks. The surveyor asked the DON if the Nurse had made a written statement. The DON stated that the Nurse told her verbally and that she did not write it. The surveyor asked if there was anything else documented regarding the investigation. The

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DON stated that they did not have anything else "written up." The DON stated that the Nurse investigated the incident on 2/8/22 but that the nurse did not report it to us. The surveyor asked the DON if the investigation done by the Nurse was documented. The DON stated that the investigation done by the Nurse was not documented. The DON stated that the Nurse checked with other residents that were in the area but that she did not document the interviews. The DON confirmed that the Nurse should have taken statements from the residents and documented it. The DON could not provide documentation of a thorough investigation that included statements from residents and staff.

On o3o/9/22 at 10:18 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that a full thorough investigation was not completed at the time of the allegation of abuse, and that on 03/08/22 the facility added additional documentation to the investigation.

e.) Based on interview and review of pertinent facility documentation, it was determined that the facility failed to conduct performance evaluations in a timely manner and to provide documented education for areas of improvement identified on the performance evaluations, for 4 of 5 Certified Nursing Assistants (CNA #1, #2, #3, and #5) reviewed.

A review of the facility provided, "Performance Evaluation-Certified Nursing Assistant", revealed the following annual review dates and evaluation keys:

CNA #1 had an annual performance review on 10/14/21, one month past the date of hire. CNA

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#1 was noted to have an objective partially met of "conducts periodic resident care and unit checks with appropriate documentation, along with charge nurse". The "areas targeted for improvement: educated the importance of documentation". The facility failed to provide the educational information specific to the performance evaluation.

CNA #2 had an annual performance review on 10/28/21, two months past the date of hire. CNA #2 was noted to have an objective partially met of "conducts periodic resident care and unit checks with appropriate documentation, along with charge nurse" and "verifies all residents have wrist bands, education, picture and door tags". The "areas targeted for improvement: educated the importance of documentation, also to report if missing door tags/name bands". The facility failed to provide the education information specific to the performance evaluation.

CNA #3 had an annual performance review on 11/12/21, eight months past the date of hire. CNA #3 was noted to have an objective partially met of "verifies all residents have wrist bands, medication, picture and door tags. The "areas targeted for improvement: educated to report if resident is missing wrist band, door tags". The facility failed to provide the education information specific to the need identified in the performance evaluation.

CNA #5 had a 90 Day performance review on 12/6/21, one month short of the 90 Day review date. The facility failed to provide another performance evaluation at the 90-day mark from the date of hire.

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On 03/10/22 at 12:18 PM, the above concerns were brought to the attention of the LNHA and the DON. The facility failed to provide any additional information.

f.) Based on interview and document review, it was determined that the Quality Assessment and Performance Improvement (QAPI) committee failed to utilize the Facility Performance Improvement Plan to; a.) ensure a system for staff training and monitoring for Basic Life Support/CPR was in place after an adverse resident event occurred, and b.) follow the facility process to measure the utilize data acquired for pressure ulcer quality improvement and develop quantitative and measurable goals.

On 03/03/22 at 1:42 PM, the surveyor interviewed the LNHA and DON in the presence of the survey team. The surveyor informed the DON and LHNA regarding the findings; 911 was not activated, a "code" was not called, and the AED was not utilized for Resident #7 when the resident became unresponsive. The DON confirmed that the staff should have utilized the AED and called 911. The DON further stated that three nurses were working that day, and the process should have been enacted. The surveyor asked the DON regarding the ability of LPNs to assess a resident or are LPNs able to pronounce death. The DON acknowledged the LHNA and stated that LPNs could not pronounce death or assess a resident.

On 03/04/22 at 8:59 AM, the LHNA and DON were interviewed by the surveyor, in the presence of the team, regarding the facility's process of tracking the nursing staff CPR certifications. The DON stated the in-service coordinator should be tracking the CPR certifications, but she was

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unsure if it was up to date. The DON provided a copy of 7 Employee BLS certifications. The CPR cards provided to the surveyors included 5 AHA "Provider Basic Life Support" cards, including a copy of LPN #2's card. A second copy of the "Community & Workplace Certification, Basic Life Support, Adult, Child & Infant CPR and AED" for LPN #1, and two cards for "National CPR Foundation, Provider Card." The survey team requested to see the tracking system at that time. The DON stated the In-service Coordinator/Assistant Director of Nursing (IC/ADON) would provide it. Furthermore, the DON added, there had not been CPR training because of COVID.

(Refer 678L)

On 03/11/22 at 9:17 AM, the Surveyor reviewed the facility form titled "Pressure Ulcers-Quality Improvement Report" 4th quarter 2021 Reports. The report did not have root cause analysis, benchmarks, measurable goals or targets, Step-by-step interventions to correct the problem and achieve established goals; or perform a study act cycle, and a description of how the QAA committee will monitor to ensure changes yield the expected results.

On 03/11/22 at 10:41 AM, in the presence of the survey team, the Surveyor reviewed information concerning QAPI from data acquired for pressure ulcer quality improvement with the LNHA and DON. The LNHA and DON explained the process for QAPI to self-identify problems in the facility, however, could not provide information on how the facility is tracking and trending issues according to the facility policy and procedures. The LNHA stated that they needed to change the

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QAPI tool to include tracking, trending, and benchmarking and to include root cause analysis.

g.) Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to monitor and track resident antibiotic use for 3 of 3 months (January 2022, February 2022, and March 2022) reviewed for Antibiotic Stewardship.

On 03/08/22 at 10:44 AM, the Registered Nurse Infection Preventionist (RN/IP), in the presence of Surveyor #1 and Surveyor #2, stated the purpose of the facility Antibiotic Stewardship was to track trends in antibiotic use and facility infections. The RN/IP stated the information would be used to determine such things as if the antibiotic needed to be discontinued or if a culture or repeat laboratory test needed to be done. The RN/IP further stated that if a resident were on an antibiotic longer than needed or the wrong antibiotic, it could lead to being resistant to the antibiotic. She stated that the facility also had a monthly meeting for infection control. The RN/IP stated that as of this date, there were no residents on antibiotics in the facility. The RN/IP stated she checked the 24-hour reports daily to see who was on antibiotics and that she would discuss the antibiotic stewardship information with the medical director quarterly. She stated the information was also reviewed with the facility in the Quality Assurance meetings. The RN/IP reviewed the Antibiotic Stewardship logbook, acknowledged antibiotics were not being monitored or tracked since the beginning of 2022, and stated she had no reason to provide why the residents on antibiotics were not being tracked or monitored. The RN/IP stated she had spoken to

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the physician regarding Resident #206 having EX Order 26 § of the EX Order 26 § 4b1 and what was being done about it but had not documented that information anywhere. The RN/IP further stated she was not aware that Resident #208 had been ordered an EX Order 26 § 4b1 on 2/11/22.

The facility provided form titled. "Job-Description-Administrator" and dated 07/01/15 indicated that the Administrator directs the overall operations of the facility's activities, both internal and external, to provide excellent care to patients and residents. The Administrator is to coordinate these activities to ensure compliance with established standards. The policy indicated that the duty of the Administrator is as follows:
-Establishes polices pertaining to total patient care, personnel, medical staff, financial status, public relations, maintenance of the building and grounds. Explains such policies to the staff and other concerned parties. Reviews compliance and established policies by personnel and medical staff and periodically reviews policies and makes changes as found necessary.
-Prepares job descriptions and policy and procedure manuals for all departments.
-Reviews compliance of facility with national, state,
and local standards.
-Selects competent personnel to supervise activities of major departments.
-Meets with Department heads at regular intervals.
-Receives advise for major department heads on matters pertaining to department operations and external relationships and reviews and frequently checks competence of the workforce.
-Acts as liaison to the governing authority on

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F 835	Continued From page 129 behalf of the Medical Director, the staff, and the patients. -Interpretation of institution's philosophy and all policies to staff and other concerned parties. NJAC 8:39-9.2(a)	F 835		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and review of other pertinent facility documentation it was determined that the facility Medical Director (MD) failed to provide clinical oversight and guidance regarding resident care policies and procedures that affect resident care, medical care, and resident quality of life related to 1.) laboratory results 2.) staff training and certifications for basic life support/cardiopulmonary resuscitation (CPR) and 3.) antibiotic stewardship. This deficient practice was evidenced by the following: 1.) On 03/02/22 at 12:51 PM, the Surveyor reviewed the closed medical record for Resident #7 which revealed: A Licensed Practical Nurse (LPN #1) documented a Nurses Note (NN) on 02/12/22 at 16:05 (4:05 PM). The admission record for Resident #7 revealed the resident was	F 841	F841 Element One □ Corrective Actions " The medical director was informed by NJDOH surveyors of a laboratory test that was not performed on Resident #7. " The medical director was informed by NJDOH surveyors that not all staff were certified in Basic Life Support. " The medical director was informed by NJDOH surveyors that antibiotics had not yet been tracked for 2022. Element Two □ Identification of at Risk Residents All residents may be affected by these practices.	4/30/22

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F 841	Continued From page 130 admitted to the facility with diagnoses which included, but were not limited to EX Order 26 § 4b1 [redacted] A Doctor's Progress note, dated 02/02/22 was reviewed which revealed EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted] . The Physician's Orders dated 02/02/22 revealed an order for a EX Order 26 § 4b1 on Friday and the order was noted on 02/02/22 and signed by a Registered Nurse. A NN dated 02/03/22, at 15:21 (3:21 PM) revealed a LPN #1 documented " EX Order 2 [redacted] " and results pending. A Final laboratory report, dated 02/05/22, revealed Tests ordered: "EX Order 26 § 4b1 [redacted] with the listed test results. On 03/10/22 at 11:50 AM, the Surveyor, in the presence of three other surveyors, conducted a telephone interview with Resident #7's Physician (MD), who was also the medical director of the facility. The Surveyor inquired if the MD was aware that the CMP was not ordered. The MD stated she did not keep track of the laboratory tests that she ordered, and the facility would give her the results. She stated that no one had informed her that the CMP was not completed. 2.) On 03/04/22 at 8:59 AM, the LHNA and DON were interviewed by the Surveyor, in the presence of the team, regarding the facility tracking of the nursing staff CPR certifications. The DON stated the in-service coordinator should be tracking the CPR certifications, but she was not sure if it was up to date. The DON provided a copy of seven Employee BLS certifications. The cards provided	F 841	Element Three - Systemic Changes The medical director schedules weekly meetings with the DON and Administrator to discuss current facility issues. " The ADON/ Educator will report monthly infection surveillance and antibiotic use to the medical director. Element Four □ Quality Assurance The medical director will contribute to root cause analysis, corrective actions, and systems changes to improve care outcomes as a participant at quarterly QAPI meetings	

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included 5 AHA "Provider Basic Life Support" CPR cards which included a copy of LPN #2's card, a second copy of the "Community & Workplace Certification, Basic Life Support, Adult, Child & Infant CPR and AED" for LPN #1, and two cards for "National CPR Foundation, Provider Card". The survey team requested to see the tracking system at that time, and the DON stated the In-service Coordinator/Assistant Director of Nursing (IC/ADON) would provide it because she tracked the CPR cards, and there had not been a CPR training because of COVID.

On 03/04/22 at 9:31 AM, the IC/ADON provided the Surveyor, in the presence of the survey team, the facility "BLS (Basic Life Support) Log", with 20 names listed and 18/20 of the names had an "X" next to it. The Surveyor inquired about the list provided by the IC/ADON and how the IC/ADON would know when the CPR certification expired. The IC/ADON stated she did not have expiration dates on it, and she just knew when they expired and would put an X next to the staff's name if they had the CPR certification. She stated that was how she tracked it, and she knew if they had the certification by when the facility offered the CPR training. She stated that some staff would forward a card if they had the training elsewhere (There were 12 more employee names on the "Plaza Healthcare and Rehab Center BLS (Basic Life Support) Log", than copies of CPR cards provided by the facility).

On 03/04/22 at 1:32 PM the Surveyor, in the presence of two surveyors, conducted a telephone interview with the Medical Director (MD), who was also the attending physician for Resident #7. The surveyor inquired to the MD if she was aware that all the nursing staff were not

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CPR certified. She stated she was not aware and assumed that the supervisors knew CPR. The surveyor inquired to the MD if it was important for nursing staff to have current, appropriate CPR certification. The MD responded "yes, they should", and that all the nurses should have CPR certification. The MD stated that she was not aware that all of staff did not have appropriate or current CPR certification.

3.) On 03/10/22 at 11:50 AM, survey team conducted a telephone interview with the Medical Director (MD). The MD stated she was not too involved with infection control because the facility used to have an infectious disease doctor. She further stated she was not aware that antibiotic stewardship was not being tracked for 2022, and that it was definitely important so the facility could be aware and keep track that an antibiotic was given timely.

The facility provided the surveyors with a form dated 07/10/2017 and titled, "Medical Director Duties". The Medical Director (MD) duties included the following:
-The MD shall be a licensed physician and shall be responsible to coordinate medical care in the facility and provide clinical guidance and oversight regarding implementation of resident care polices.
-The MD shall collaborate with the facility leadership, staff and other practitioners and consultants to help develop, implement, and evaluate resident care policies and procedures that reflect the current standards of practice.
-The MD shall assist the facility in identifying, evaluating, and addressing medical and clinical concerns and issues that affect resident care, medical care, or quality of life.

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F 841	Continued From page 133 -The MD shall be responsible for integrated delivery of care and services, such as medical nursing, pharmacy, social, rehabilitative, and dietary services which included clinical assessments, analysis of assessment findings, care planning including preventative care, care plan monitoring and modification, infection control including isolation pr special care. -The MD shall be responsible for use and availability of ancillary services such and x-ray and laboratory. - The MD shall be responsible for formulation and facility implementation of advance directives and end of life care. -Shall ensure that systems to ensure that other licensed practitioners who may perform physician-delegated task act within the regulatory requirements and within the scope of practice defined by state law. -Identify facility or practitioner educations and information needs. -The MD shall coordinate and evaluate the medical care within the facility by reviewing and evaluating aspects of physician care and services and helping the facility identify, evaluate, and address health care issues related to the quality of life of the residents. -The MD shall address issues related to the coordination of medical care identified through the facility's quality assessment and assurance committee and quality assurance program, and other activities related to coordination of care. Cross reference: F678 Based on interview, record review and document review, it was determined that the facility failed to ensure: 1.) the emergency response system was activated to call a "code", 2.) 911 was enacted, 3.)	F 841		

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F 841	Continued From page 134 the automatic external defibrillator (AED) was utilized for a resident who was found unresponsive (Resident #7) and was a full "code" status (all resuscitation procedures will be provided when a person stops breathing or heart stops beating), and 4.) a system was in place to appropriately track and maintain cardiopulmonary resuscitation (CPR) certifications to ensure that staff maintain the appropriate CPR certification. F770 Based on interview, and closed record review it was determined that the facility failed to order the appropriate physician ordered laboratory test for 1 of 2 closed medical records reviewed for physician orders (Resident #7). F881 Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to monitor and track resident antibiotic use for 3 of 3 months (January 2022, February 2022, and March 2022) reviewed for Antibiotic Stewardship. N.J.A.C 8:39-23.1 (a), (b), (c).	F 841		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867		4/30/22

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F 867	Continued From page 135 Based on interview and document review, it was determined that the Quality Assessment and Performance Improvement (QAPI) committee failed to utilize the Facility Performance Improvement Plan to; a.) ensure a system for staff training and monitoring for Basic Life Support/CPR was in place after an adverse resident event occurred, and b.) follow the facility process to measure the utilize data acquired for pressure ulcer quality improvement and develop quantitative and measurable goals. This deficient practice was evidenced by the following: a.) (Refer to 678 L) b.) On 03/11/22 at 9:08 AM, the Surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the facility process for QAPI. The LNHA stated that the facility QAPI meeting is held quarterly, and attendance included the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the LNHA, Medical Director (MD), department heads, and vendors such as lab, x-ray, pharmacy consultants etc. He stated that concerns were brought to the QAPI committee's attention by conducting environmental rounds, department audits, food committee meetings, Resident Council, staff meetings and clinical morning meetings. He further added that through daily morning meetings the team discussed concerns and if those concerns were being addressed. He stated that "we" know how problems were improving though meetings, audits, and environmental rounds and then he stated that "now" we will be	F 867	F867 Element One □ Corrective Actions A tracking tool to monitor current status of staff trained in Basic Life Support was instituted. " The Pressure Ulcer Quality Improvement Report was reviewed and revised to include how performance improvement will be measured. Element Two □ Identification of at Risk Residents All residents may be affected by these practices. Element Three □ Systemic Changes " The facility Quality Assurance and Performance Improvement Plan was reviewed and revised as appropriate. " Leadership staff were re-educated in the QAPI process, i.e., root cause analysis, benchmarks, quantitative measurable goals, and performance improvement projects designed to correct the problem and achieve established goals. Element Four □ Quality Assurance Numbers of staff currently certified in BLS and status of skin performance improvement project will be reported at quarterly QAPI meetings .	

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developing QAPI through all the issues the state had found during inspection.

On 03/11/22 at 9:17 AM, the Surveyor reviewed the facility provided form titled "Pressure Ulcers-Quality Improvement Report" 4th quarter 2021 Reports. The report did not have root cause analysis, benchmarks, measurable goals or targets, Step-by-step interventions to correct the problem and achieve established goals; or perform a study act cycle, and a description of how the QAA committee will monitor to ensure changes yield the expected results.

On 03/11/22 at 9:28 AM, the Surveyor interviewed the DON who stated that she attended the quarterly QAPI with the LNHA and departments heads including the MD. She stated that to identify problems, that the facility had clinical morning meetings and that the nurses would bring issues to the DON. She also stated that the facility did random monitoring of problems. She stated that once the facility identified a problem that the facility would investigate and put a plan in place to identify, monitor and correct the problem. She also stated that the facility did tracking and trending to assure corrective action was happening.

On 03/11/22 at 9:38 AM, the Surveyor interviewed the Registered Nurse Supervisor (RNS) who stated that if she saw any concerns, she would report them in clinical morning meeting to make sure concerns got addressed and from there the QAPI committee wound develop a plan to assure that the issue got resolved. I am new here but I'm sure the facility is doing QAPI and addressing concerns.

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On 03/11/22 at 10:41 AM, in the presence of the survey team, the Surveyor reviewed information concerning QAPI from data acquired for pressure ulcer quality improvement with the LNHA and DON. The LNHA and DON explained the process for QAPI to self-identify problems in the facility, however, could not provide information on how the facility is tracking and trending issues according to the facility policy and procedures. The LNHA stated that they needed to change the QAPI tool to include tracking, trending, and benchmarking and to include root cause analysis.

The facility provided form titled, "Quality Assurance and Performance Improvement Plan" dated August 2021, indicated that the facility was committed to enhancing the quality of life by nurturing individuality and independence and that the purpose of QAPI was to take a proactive approach to continually improve the way they cared for residents, caregivers and other partners as to provide an exceptional environment were people are valued, care for and attain or maintain physical, mental and psychosocial well-being. According to the facility QAPI plan, QAPI focuses on systems, sets goals for performance and measures progress toward those goals. The plan indicated that the facility would aim for safety and quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents by ensuring that their data collection tools, and monitoring systems were in place and were consistent for proactive analysis. The plan further indicated that the facility would utilize the best available evidence (such as data from the MDS and CASPER reports, national benchmarks, published best practices and clinical guidelines, etc..) to define and measure goals. The plan indicated that the facility would be using

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F 867	Continued From page 138 performance indicators to monitor a wide range of care processes and outcomes and would review findings against benchmarks or goals that the facility had established for performance. It would also include tracking, investigation and monitoring adverse events every time they occur, and action plans would be implemented through the plan, do study act cycle or improvement to prevent recurrences. NJAC 8:39-9.2(a), 33.1(a), 33.2(b), 33.2(c)(13), 33.2(d) & 33.3	F 867		
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;	F 880		5/19/22

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F 880	Continued From page 139 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 140 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure: 1.) staff wore the required personal protective equipment (PPE) in resident rooms that required transmission-based precautions (TBP), and 2.) staff performed hand hygiene in accordance with the Centers for Disease Control and Prevention (CDC) and per the facility policy. This deficient practice was identified for 2 of 2 residents (Resident #206 and #209) reviewed for TBP, and identified for one staff member during the medication pass administration. The evidence was as follows. 1. a.) On 02/28/22 at 10:15 AM, Surveyor #1 observed Resident #206 lying in bed and a yellow pocket holder with personal protective equipment (PPE) was hanging on the door. There was no signage on the door to see the nurse or what type of TBP was in place. A review of Resident #206's medical records revealed the following: An Admission Record revealed Resident #206 had been admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted] An Admission Minimum Data Set (MDS - an assessment tool), dated 2/28/22, revealed a Brief Interview for Mental Status (BIMS) of EX Order 15 which indicated the resident was EX Order 26 § 4b1	F 880	F880 Element One Corrective Actions - Signage to stop and see the nurse and droplet and contact precautions which included personal protective equipment (PPE) to wear was immediately placed on the door of Resident #206. - The housekeeper who cleaned the room occupied by Resident #206 was re-educated on need to remove PPE when leaving a room on precautions. - The CNA who delivered the breakfast tray to Resident #206 on 3/1/22 was re-educated on droplet and contact precautions including proper PPE to wear. - The CNA who delivered the lunch tray to Resident #209 on 2/28/22 was re-educated on droplet and contact precautions including proper PPE to wear. - The nursing supervisor who administered insulin on 3/1/22 was re-educated and completed a hand hygiene competency. Element Two Identification of at Risk Residents - All residents have the potential to be	

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F 880	Continued From page 141 EX Order 26 § 4b1; and an active diagnoses of EX Order 26 § 4b1 The Physician's Order Sheet (POS) revealed an undated order for EX Order 26 § 4b1 On 02/28/22 at 9:43 AM, Surveyor #1 observed a housekeeper in Resident #206's room. The housekeeper was wearing a washable PPE gown, gloves, two surgical masks and a face shield. The housekeeper had been dusting, sweeping and mopping the room. When the housekeeper finished cleaning, she exited the room and began to walk across the hall still wearing the same PPE gown, gloves, face shield and two surgical masks when the surveyor interviewed the housekeeper at that time. During an interview at that time, the housekeeper stated she had worked at the facility for 15 years. She stated the resident was on isolation for COVID-19 and that she should wear her gown, gloves, face shield and masks in the room. The housekeeper stated she had been educated on and had in-services regarding PPE. She further stated she knew she should not have left the room in her PPE because of 'infection control'. On 02/28/22 at 9:52 AM, Resident #206's Licensed Practical Nurse (LPN) was observed wearing her surgical mask and face shield. The LPN stated Resident #206 was on contact precaution for EX Order 26 §. The LPN stated staff should not leave the isolation room wearing their PPE because they could spread infection. The LPN stated the resident had been in the room for about one week and acknowledged that there was no "stop" sign see to nurse prior to entering,	F 880	affected by these practices. Element Three Systemic Changes The facility conducted root cause analysis to determine why the facility was deficient in Infection control. - Root cause of lack of informative signage for use of correct PPE was addressed by procuring signage for contact and droplet precautions. - Root cause of lack of knowledge on how and when to don and doff PPE was addressed by reeducation of affected staff. - Root cause of lack of knowledge of the correct process for washing hands and use of ABHR was addressed by reeducation of affected staff. - PPE rounds are made weekly by the Infection Preventionist. Staff who are observed not to wear PPE appropriately receive re-education. - 5 observations of staff performing hand hygiene are conducted by the facility IC preventionist on a weekly basis. - Directed in-service training was provided to the appropriate staff as required by NJDOH: - Nursing Home Infection Preventionist	

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F 880	Continued From page 142 or type of TBP sign on the door. On 02/28/22 at 10:00 AM, the Director of Nursing (DON) was on the first floor unit and accompanied Surveyor #1 to Resident #206's room. The DON stated that there should be a "see nurse" sign and the type of TBP sign on the room so anyone going in there would know the proper PPE to wear and that "it's very important for the staff to know". The DON further stated that the housekeeper should have doffed (removed) the PPE prior to leaving the resident's room. On 03/01/22 at 8:39 AM, Surveyor #1 observed Resident #206 lying in bed on air mattress with a breakfast tray in front of him/her on the over bed table. On 03/01/22 at 8:41 AM, Surveyor #1 observed a Certified Nursing Assistant (CNA) #1 wearing an N95 mask and face shield, enter the room. The CNA delivered a cup of ice and handed it directly to the resident. The CNA next used two brown paper towels to pick up the resident's breakfast tray off the over bed table and exited the room. On 03/01/22 at 8:43 AM, CNA #1 stated that the process was that "some paper towels could be used in place of gloves to just remove the breakfast tray" and that the over bed table was not part of the resident's environment in the isolation room. CNA #1 further stated that the resident moved and touched his/her over bed table but that unless she was washing the resident, she did not have to wear any other PPE such as the gown or gloves. On 03/01/22 at 8:52 AM, The Registered Nurse Infection Preventionist RN/IP stated staff should	F 880	Training Course Module 1 □ Infection Prevention and Control Program - training provided to Topline staff and infection preventionist - Nursing Home Infection Preventionist Training Course Module 4 □ Infection Surveillance training provided to Topline staff and infection preventionist - Nursing Home Infection Preventionist Training Course Module 5 □ Outbreaks - training provided to the Topline staff and infection preventionist - Nursing Home Infection Preventionist Training Course Module 6A □ Principles of Standard Precautions training provided to all staff including topline staff and infection preventionist - Nursing Home Infection Preventionist Training Course Module 6B □ Principles of Transmission Based Precautions - training provided to all staff including topline staff and infection preventionist - Nursing Home Infection Preventionist Training Course Module 7 □ Hand Hygiene □ training provided to all staff including topline staff and infection preventionist - CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff □ Keep COVID-19 Out! - training provided to Frontline staff - CDC COVID-19 Prevention Messages	

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be wearing gloves and a PPE gown along with their N95 masks and eye protection into the two isolation rooms on the first floor. She stated that the over the bed table was part of the environment and that the staff should wear gloves when touching or removing trays from the over bed table in order to prevent the spread of infection.

b.) On 02/28/22 at 9:55 AM, Surveyor #1 observed Resident #209's room with a plastic barrier taped to the front of the open doorway. Across from the doorway was a plastic bin with PPE in the drawers and a red plastic bin for "dirty PPE". The resident was visible through the plastic barrier and spoke to the surveyor. The resident stated there was nothing wrong but that he/she had been in the room because he/she was new to the facility.

A review of Resident #209's medical records revealed the following:

An Admission Record revealed the resident had been recently admitted to the facility with diagnoses which included but were not limited to NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1.
An Admission MDS, dated 2/24/22, revealed a BIMS of EX Ord /15 which indicated the resident was EX Order 26 § 4b1.

On 02/28/22 at 9:58 AM, the DON stated that Resident #209 had been placed on droplet precautions for being a new admission and not being vaccinated against COVID-19.

On 02/28/22 at 12:23 PM, Surveyor #1 observed

for Front Line Long-Term Care Staff □
Use PPE Correctly for COVID-19 - training provided to Frontline staff

Element Four

Quality Assurance

A QAPI performance improvement project based on the root cause analysis was formed to address the concern. The results of PPE rounds and hand hygiene observations shall be reported to the DON and QAPI committee on a quarterly basis for review and further direction as appropriate.

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CNA #2 deliver a lunch tray into the isolation room of Resident #209 wearing only her N95 mask and eye goggles. CNA #2 stated she did not have to wear PPE to put the tray on the bedside table and that the bedside table was not part of the resident's environment. CNA #2 further stated she did not have to wear PPE if she was going to be in the room for less than 5 minutes.

On 02/28/22 at 12:30 PM, the DON stated the staff should wear full PPE into Resident #209's room to stop the spread of infection.

A review of the facility provided in-services and competency revealed the following:

"Infection Control-Handwashing, Standard & Transmission Precautions Isolation, PPE", dated 01/13/21, revealed that the housekeeper and CNA #1 attended. The in-service information included but was not limited to: Procedure: transmission-based precautions are used whenever measures more stringent than standard precautions are needed to prevent or control the spread of infection. Contact Precautions are implemented for residents with known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Gloves- gloves are worn when entering the room and gloves are removed before leaving the room and hands are washed immediately; Gown- gown is worn for interactions that may involve contact with the resident or items in the resident's environment and the gown is removed before leaving the resident's environment.

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"Handwashing, PPE, Standard Precaution, Transmission Based Precaution, Isolation Precaution", dated 12/20/21, revealed that the housekeeper and CNA #1 attended. The in-service information included but was not limited to: transmission-based precautions are used whenever measures more stringent than standard precautions are needed to prevent or control the spread of infection. Contact Precautions are implemented for residents with known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Gloves- gloves are worn when entering the room and gloves are removed before leaving the room and hands are washed immediately; Gown- gown is worn for interactions that may involve contact with the resident or items in the resident's environment and the gown is removed before leaving the resident's environment.

"Donning (put on) & Doffing (remove) PPE Contact Isolation Precautions Skills Competency Checklist", dated 12/31/21, revealed that the housekeeper had been deemed competent in donning and doffing PPE.

The facility documentation also revealed that CNA #1 had also attended in-services on Infection Control, Standard & Transmission Based Precautions, Isolation, PPE, and Donning/Doffing on 02/10/21, 03/04/21, 05/03/21, 06/07/21, 07/19/21, 09/14/21, and 11/08/21.

2. On 03/01/2022 at 08:38 AM, The Registered Nurse Supervisor of Nursing (RN/SON) used alcohol Based Hand Rub (ABHR) to sanitize her

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hands. The RN/SON then donned gloves and entered a resident room and administered Insulin (an anti-diabetic medication to an unsampled resident. After she completed the procedure, she removed the gloves and proceeded to the sink to wash her hands with soap and water. The RN/SON turned on the faucet, applied soap and lathered her hands for 3.34 seconds under running water.

The RN/SON then dried her hands and returned to the medication cart. The surveyor showed the RN/SON the stopwatch time on the device. The RN/SON stated,"Since I used ABHR prior to don gloves I just wash my hands."

During an interview with the RN/SON at 11:00 AM, she confirmed that she did not washed her hands properly. The surveyor asked the RN/SON to elaborate on the process for hand hygiene. The RN/SON stated that she was not aware of the facility's allotted time for hand hygiene.

During a second interview with the RN/SON on 03/01/2022 at 12:09 PM, she went on to state that she should have washed her hands for 60 seconds. The surveyor told the RN/SON to consult with the Director of Nursing (DON) for the facility's policy on hand hygiene.

On 03/08/2022 at 12:53 PM, the DON provided a policy titled, "Hand washing" last revised 03/2021. The following were documented:

Policy:
All employees must thoroughly wash their hands:
Before each shift
Before and after venipuncture
Before handling food/ medications

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F 880	Continued From page 147 Before and after invasive procedure.... Procedure: 1.) Wet hands with warm water and apply disinfectant soap, lathering up to mid arm. 2.) Work lather into hands for 20-30 seconds. 3.) Keep hands away from side of sink. 4.) Rinse thoroughly under running warm water, allowing water to flow from the arms down to the fingertips. 5.) Use a paper towel to turn off the faucet to avoid contact with faucet germs. 6.) Dry hand with a single use, disposal towel. 7.) Take another paper towel and turn off the faucet. The procedure was not being followed. On 03/01/22 at 12:30 PM, the facility provided their, "Resident Isolation-Categories of Transmission-Based Precautions", reviewed 1/26/22, included but was not limited to: transmission-based precautions are used whenever measures more stringent than standard precautions are needed to prevent or control the spread of infection. Contact Precautions are implemented for residents with known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Gloves- gloves are worn when entering the room and gloves are removed before leaving the room and hands are washed immediately; Gown- gown is worn for interactions that may involve contact with the resident or items in the resident's environment and the gown is removed before leaving the resident's environment. Droplet	F 880		

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F 880	Continued From page 148 Precautions are implemented for a resident who is documented or is suspected of being infected with microorganisms transmitted by droplets. A mask is worn when working within 3 feet of the resident. On 03/10/22 at 12:30 PM, during a pre- exit conference, the facility was made aware of the above issues. On 03/11/22 the DON told the survey team that in-services for hand hygiene were completed.	F 880		
F 881 SS=F	NJAC 8:39-19.4(a)(c)(n) Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to monitor and track resident antibiotic use for 3 of 3 months (January 2022, February 2022, and March 2022) reviewed for Antibiotic Stewardship. This deficient practice was evidenced by the following: The survey team entered the facility on 02/28/22. The facility was asked to provide information for	F 881	F881 Element One □ Corrective Actions " The Infection Preventionist was re-educated on the use of the 24-hour report, labs and pharmacy reports to track antibiotic use and facility infections. " The Infection Preventionist was re-educated on the policy to monitor antibiotic therapy on monthly basis.	4/30/22

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F 881	Continued From page 149 review which included the Antibiotic Stewardship tracking. The survey team was provided daily with an Antibiotic Stewardship log book dated 2021. On 02/28/22 at 10:15 AM, Surveyor #2 observed Resident #206 lying in bed and a yellow container of Personal Protective Equipment (PPE) hanging on the door. A review of the Admission Record revealed Resident #206 had been admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]. A review of the Admission Minimum Data Set (MDS - an assessment tool), dated 2/28/22, revealed a Brief Interview for Mental Status (BIMS) of [redacted]/15 which indicated the resident was severely EX Order 26 § 4b1 ; and an active diagnoses of Multidrug-Resistant Organism (MDRO). A review of the Physician's Order sheet revealed an undated order for contact isolation EX Order 26 § 4b1 [redacted] On 02/28/22 at 9:41 AM, Surveyor #2 observed Resident #208 lying awake in bed. Resident #208 did not speak English but motioned for the surveyor to come into the room. Resident #208 pulled up the sheet and pointed at his/her feet. Surveyor #2 observed Resident #208's both feet were swollen and reddish in color. A review of the Admission Record revealed Resident #208 had been admitted to the facility with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]. A review of the Admission MDS, dated 01/25/22, revealed a BIMS of [redacted]/15 which indicated the resident was	F 881	Element Two □ Identification of at Risk Residents " All residents have the potential to be affected by these practices. Element Three □ Systemic Changes " Staff were re-educated to enter new antibiotic orders on the 24-hour report. " New antibiotic orders are discussed at morning clinical meetings. " The IP will prepare and submit antibiotic therapy reports on a monthly basis to the DON, Medical Director and Administrator. Element Four □ Quality Assurance " The IP will report infection and antibiotic therapy audit statistics in aggregate at the quarterly QAPI committee meeting for action and further guidance as appropriate	

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EX Order 26 § 4b1 . A review of the Physician's Order sheet revealed an order dated 2/11/22 for EX Order 26 § 4b1 [redacted]

On 03/08/22 at 10:44 AM, the Registered Nurse Infection Preventionist (RN/IP), in the presence of two surveyors, stated the purpose of the facility Antibiotic Stewardship was to track trends in antibiotic use and facility infections. The RN/IP stated the information would be used to determine such things as if the antibiotic needed to be discontinued or if a culture or repeat laboratory test needed to be done. The RN/IP further stated that if a resident was on an antibiotic longer than needed or the wrong antibiotic, it could lead to being resistant to the antibiotic. She stated that the facility also had a monthly meeting for infection control. The RN/IP stated that as of this date, there were no residents on antibiotics in the facility. The RN/IP stated stated she checked the 24 hour reports daily to see who was on antibiotics and that she would discuss the antibiotic stewardship information with the medical director quarterly. She stated the information was also reviewed with the facility in the Quality Assurance meetings. The RN/IP reviewed the Antibiotic Stewardship log book, acknowledged antibiotics were not being monitored or tracked since the beginning of 2022, and stated she had no reason to provide why the residents on antibiotics were not being tracked or monitored. The RN/IP stated she had spoken to the physician regarding Resident #206 having EX Order 26 § [redacted] of the EX Order 26 § 4b1 [redacted] and what was being done about it, but had

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not documented that information anywhere. The RN/IP further stated she was not aware that Resident #208 had been ordered an EX Order 26 § 4b1 on 2/11/22.

On 03/09/22 at 9:06 AM, the MDS RN stated if an EX Order 26 § 4b1 were started on a resident, it would be discussed during morning meeting with the team. She stated it was important for the antibiotics to be monitored for effectiveness and side effects.

On 03/10/22 at 11:50 AM, the Medical Director stated she was not too involved with Infection Control because the facility used to have an Infectious Disease doctor. She further stated she was not aware that the facility's EX Order 26 § 4b1 Stewardship was not being tracked for 2022 and that it was definitely important so the facility could be aware and keep track that antibiotics were given timely.

A review of the facility provided, "Infection Surveillance Form", revised 11/19, included but was not limited to: if 'criteria' was met or not met or hosp [hospital]/community; the date the infection was first noted or date or admission is less than 14 days; evidence of infection present at time of admission or re-admission; Diagnostic Workup; sections to include a type of infection and examples of symptoms and/or test results; antibiotic ordered, started and for how long; scheduled diagnostic follow up; and follow-up/comments.

A review of the facility provided, "Monthly Infection Control Rate" form, dated 8/19, revealed categories of tracking as infections, infections on each floor, if the criteria had been met, total number of nosocomial infections, current infection

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on admission, criteria not met antibiotics ordered, and antibiotic percentage rate utilization.

A review of the facility provided, "Comprehensive Antibiogram Toolkit: Phase 4 Sample Antibiotic Use Tracking Sheet", dated 5/14, included areas of tracking as onset date, signs and symptoms, site of infection, culture site, infection type, treatment start date, antibiotic name, broad or narrow spectrum, and UTI/pneumonia: adherent to antibiogram.

A review of the facility provided Infection Prevention and Control manual included the following policies:

"Criteria for Determining Infections", policy and process, reviewed 3/21, included but was not limited to: Policy- the following of a criteria (Infection Constitutional Criteria in Residents of Long-Term Care Facilities) to be used for establishing the presence of an infection may also prove useful in identifying community-acquired infections. Process- before a decision for the presence of infection is made, non-infectious causes of signs and symptoms should be considered.

"Infection Control Reporting", reviewed 3/21, included but was not limited to: Policy- to provide documentation on individual infections for surveillance activities. Process- all infections will be reported to the Infection Preventionist as soon as possible, the Infection Control Reporting form is to be completed, admission date and onset of disease date are important information, utilize one form for each infection regardless of how long the infection lasts.

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F 881	Continued From page 153 "Monthly Infection Control Report", reviewed 3/21, included but was not limited to: Policy- to collect, analyze and investigate infection data to reduce infection rates at this center. Process- all infections will be documented utilizing the form monthly, calculate the nosocomial rate, enter the total number of infections in the appropriate column, and enter the total number of hospitalizations due to the infection and all individuals receiving antibiotics. "Resident line listing", reviewed 3/21, included but was not limited to: Process- record all reported infections from the first day of the month to the last day, at the end of the month count the new nosocomial infection rate, the total becomes the numerator for calculation of rates, follow all infections in this manner until resolved, and analyze this data for potential outbreaks. On 03/10/22 at 1:00 PM, the concerns were discussed with the facility administrative staff. The facility had no additional information to provide.	F 881		
F 888 SS=D	NJAC 8:39-19.4(d)(g) COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The	F 888		4/30/22

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completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily

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delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further

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F 888	Continued From page 156 ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to ensure that the Mandatory COVID-19 Vaccine	F 888	F888 Element One □ Corrective Actions	

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F 888	Continued From page 157 Policy and Procedure was implemented to track and document the vaccination status for all facility staff. The deficient practice was evidenced by the following: On 03/01/22 at 9:40 AM, the Surveyor reviewed the National Healthcare Safety Network (NHSN) data regarding the facility reported percentage of fully vaccinated staff for the week ending 02/06/22. The facility reported the percentage of staff fully vaccinated was 94.2 %. On 03/01/22 at 12:30 PM, the Registered Nurse, Infection Preventionist (RNIP), confirmed she was responsible for the facility vaccination process. At that time the RNIP provided the surveyor with the COVID-19 Staff Vaccination Status for Providers. The documents revealed a total of 101 staff designated as "Direct Facility Hires" which the surveyor observed did not include the name of the facility medical director and other providers. At that time the RNIP stated she wanted to review the list. On 03/01/22 at 1:37 PM, the RNIP presented another COVID-19 Staff Vaccination Status for Providers list which included nine staff names. The list revealed four physicians, one physical therapist, one occupational therapist and four staff that had the title area left blank. The total number of staff listed at the top of the document was not updated to reflect the added staff. On 03/02/22 at 10:03 AM, the Surveyor conducted a telephone interview with the Pharmacy Consultant (PC). The PC stated he came to the facility monthly. The Surveyor inquired to the PC if he was ever requested to provide proof of vaccination to the facility. The PC	F 888	" The COVID-19 Staff Vaccination Status for Providers log was revised to include all fully vaccinated facility employees, practitioners, contractors and vendors who provide care, treatment, or other services to residents. Element Two □ Identification of at Risk Residents " All residents have the potential to be affected by these practices. Element Three □ Systemic Changes " The COVID-19 Staff Vaccination Status for Providers log will be maintained by the IP. " Full vaccination status will be verified for all new employees, practitioners, contractors and vendors who provide care, treatment, and other services to residents. . Element Four □ Quality Assurance " The IP will report on the number of fully vaccinated new employees, practitioners, contractors and vendors who provide care and treatment at the quarterly QAPI committee meeting for action and further guidance as appropriate.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	456 RAHWAY AVENUE ELIZABETH, NJ 07202

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F 888	Continued From page 158	F 888		

stated he could not recall if the facility requested the information.

On 03/01/22 at 10:21 AM, the Surveyor observed a staff member at the first floor nursing station, who upon Surveyor inquiry, identified herself as a Physician (MD). The MD was reviewing medical records and stated to the Surveyor that she was at the facility to see three residents.

On 03/02/22 at 11:03 AM, the Surveyor interviewed a Physical Therapist (PT) in the rehabilitation department. The Surveyor inquired to the PT regarding when the facility Speech Therapist (ST) treated residents at the facility. The PT stated the ST was at the the facility twice weekly to see residents.

On 03/03/22 at 10:56 AM, the Surveyor observed a staff member pulling a rolling cart, and she was interviewed by the Surveyor at that time. The staff identified herself as the dermatology consultant (DC) who stated she was going to see a patient. All four staff which included the PC, MD, ST and DC, were not listed on the original, or the subsequent staff vaccination list which was provided to the Surveyor by the RNIP. The NHSN number was not inclusive of all the staff.

On 03/02/22 at 1:42 PM, the RNIP in the presence of the Director of Nursing (DON), provided the Surveyor with an additional "COVID VACCINE LOG" and the RNIP stated all staff were included. The MD, CP, ST and DC were not documented on the list.

On 03/11/22 at 11:21 AM, the Surveyor interviewed the DON and the Licensed Nursing Home Administrator (LNHA), and inquired to the

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F 888	Continued From page 159	F 888		

LNHA regarding who was considered facility staff. The LNHA stated "someone that is on facility payroll" was the definition of facility staff related to the who should be including in the facility vaccination list. The LNHA stated the people that came into the facility to provide care were contractors. The DON stated that the ST should have been included on the vaccination list and she was not sure why she was not. The DON stated that she would have to ask the RNIP. The DON further stated "it is important" to know the vaccination status of the DC because she came to the facility monthly to see residents, and the DON acknowledged the staff vaccination list was incomplete.

A review of the facility provided Mandatory COVID-19 Vaccine Policy and Procedure, dated 2021 revealed the following:
Purpose: To ensure patient safety and protection from COVID-19 by requiring any and all facility employees, practitioners, contractors, vendors, students, trainees, volunteers, or any individuals who provide care, treatment, or other services (collectively "staff") for the "Facility" and/or its residents, to vaccinate against COVID-19.
Procedure:
...II. This policy applies to all Staff that physically enter the Facility or come in contact with staff who enter the Facility, whether or not such Staff provide resident care.
VI. Documentation.
A. The Facility shall track and securely document the vaccination status of all Staff, proof of vaccination and booster shots, as well as vaccine exemption requests and outcomes.

NJAC 8:39-19.1(b); 19.4(a)

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F 947	Continued From page 160	F 947		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined that the facility failed to provide the mandatory 12 hours of in-service education. This deficient practice was identified for 4 of 5 Certified Nursing Assistants (CNA #1, #2, #3, and #4) reviewed. This deficient practice was evidenced by the following: A review of the facility provided, "CNA Certification Log", dated 02/28/22, included a list of the employed CNAs and their hire dates. The log revealed the following hire dates:	F 947	F947 Element One □ Corrective Actions " The CNA certification log was revised to record instructor name and duration of program. " A spreadsheet was created to track staff progress in achieving the 12 hour mandatory requirement. Element Two □ Identification of at Risk Residents " All residents have the potential to be	4/30/22

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F 947	Continued From page 161 CNA #1 09/14/2018 CNA #2 08/27/1987 CNA #3 03/05/2001 CNA #4 09/01/2008 On 03/01/22 at 1:39 PM, the Registered Nurse (RN) Staff Educator provided the requested CNA in-services. The RN Staff Educator stated that the in-services she had provided were the yearly education for all the CNAs. The in-services provided did not include the in-service length of time or who presented the in-services. The in-services were as follows: 1/13/21: Infection control, handwashing, standard & transmission base precautions, isolation, PPE [personal protective equipment]. 2/10/21: pain management, HIPAA, Infection control-donning and doffing. 03/4/21: fire/electrical emergency preparedness, accident prevention, PPE, handwashing 05/3/21: infection control - PPE, donning / doffing 06/7/21: infection control - blood borne pathogens, drug resistance, disease, handwashing 7/19/21: donning/doffing, handwashing 7/12/21: resident's rights, cognitive impairment, meaningful activities, PPE, handwashing 08/9/21: falls, dysphagia, elopement, PPE, handwashing 9/15/21: body mechanics, employee safety, infection control 10/4/21: Abuse, neglect, infection control 11/8/21: infection control - tuberculosis, standard precaution 12/20/21: handwashing, PPE, standard precaution, transmission base precaution, isolation precaution	F 947	affected by these practices. Element Three □ Systemic Changes " In-service attendance sheets will be used to document instructor name and duration of program. " A master annual schedule for mandatory in-services will be maintained. " Attendance will be tracked on a spreadsheet that shows CNA progress in achieving the mandatory 12 hour requirement. . Element Four □ Quality Assurance " The staff educator will report on status of CNA attendance at 12 hour mandatory requirement in-services at quarterly QAPI committee meeting for action and further guidance as appropriate.	

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F 947	Continued From page 162	F 947		

On 03/02/22 at 10:11 AM, the RN Staff Educator and the Director of Nursing (DON) were present with the surveyor. The surveyor explained to the RN Staff Educator and the DON that we need to review the yearly educational information for the CNAs, date of hire to date of hire. The DON acknowledged she understood what was needed.

On 03/03/22 at 8:35 AM, the facility provided no additional information.

On 03/04/22 at 12:09 PM, the RN Staff Educator stated she had not been tracking the mandatory education and in-services for the CNAs, and did not track annually from the date of hire. The RN Staff Educator further stated she did not have the instructors names, or the amount of time of the education, or in-service education material provided for the documented sign in sheets.

A review of the facility provided, "Job Description-Certified Nursing Assistant', not dated, included but was not limited to attends conferences and in-services, including the 12 hours required for re-certification.

A review of the facility provided, "Policy and Procedure on Nurse Aide training and Performance review", revised 10/21, included but was not limited to the following: Procedure - Nurse staff educator will provide the annual in-services as required by DOH [Department of Health].

On 03/10/22 at 12:18 PM, the above concern was brought to the attention of the Licensed Nursing Home Administrator and the Director of Nursing. The facility had no additional information to

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F 947	Continued From page 163 provide. NJAC 8:39-43.17	F 947		

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	602030	A. BUILDING: _____ B. WING _____	03/17/2022

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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 for the day shift as mandated by the State of New Jersey. This was evident for 4 of 14-day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Element # 1 Immediate Corrective Actions Staffing coordinator was re in serviced on the requirement of CNA ratios for each shift . Element # 2 Identification of Other Residents All residents have the potential to be affected by this practice . Element # 3 Systemic Changes Staffing coordinator was inserviced to ensure there is sufficient staff per shift. Staffing coordinator will offer bonuses for staff to ensure proper coverage.	5/15/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/12/22

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S 560	Continued From page 1 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 02/06/22 and 02/13/22, the staffing to resident ratios that did not meet the minimum requirements as documented below: - 02/14/22 had 10 CNAs for 84 residents on the day shift, required 11 CNAs. - 02/15/22 had 10 CNAs for 84 residents on the day shift, required 11 CNAs. - 02/20/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. - 02/22/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. The facility was additionally deficient in CNA staffing for residents on 2 of 7 shifts as follows:	S 560	Element # 4 Monitoring of Corrective Actions DON/ designee will monitor ratios daily and report weekly to the administrator x 4 weeks . The results of these findings will be presented at the QAPI committee quarterly .	

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S 560	Continued From page 2 - 02/06/22 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. - 02/07/22 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. On 03/01/22 at 11:11 AM, a surveyor interviewed the Restorative Certified Nursing Assistant (RCNA) who stated that she performed range of motion (ROM) on residents. The RCNA showed the surveyor the restorative book. The RCNA stated that there were times when restorative nursing could not be performed because the restorative CNAs had to take a patient assignment or had to take residents out for appointments. On 03/01/22 at 12:08 PM, a surveyor interviewed the RCNA who stated that she or RCNA #2 worked with residents but that they sometimes would be pulled from their RNP functions to perform CNA functions. She added that they document the ROM exercises that they perform with a resident in a book but that it is hard to keep the book updated. The surveyor then asked RNCA#2 if he made anyone aware that the residents did not always receive RNP. He stated that he informed the Director of Nursing (DON) that it was not feasible to get to everyone daily On 03/10/22 at 10:26 AM, the Licensed Nursing Home Administrator provided the facility, "Staffing Guideline" policy and procedure, revised 3/20, which included but was not limited to the following: Policy - this center has established guidelines for each nursing unit to promote patient/resident safety resident care delivery. Staff Qualifications: 3. The minimum staffing needed for each skill level (RN, LPN, CNA, and Unit Clerk) is determined by the nurse-patient/resident ratio guidelines and the	S 560		

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S 560	Continued From page 3 patient/resident care needs. NJAC 8:39-5.1(a)	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. 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 provide residents two evening activity programs per week. This deficient practice was identified for 3 of 3 months reviewed, December 2021, January 2022 and February 2022, as evidenced by the following: On 2/28/22 at 10:16 AM, during initial tour of the first-floor unit, the surveyor observed a large activity calendar for February 2022 on the wall across from the nurse's station. Review of the calendar indicated the last activity scheduled was for 2:30 PM and snack time for 3:30 PM. At 10:18 AM, the surveyor asked Resident # 257 if the facility provided any activities in the evening. Resident #257 stated "no." On 3/1/22 at 10:14 AM, the surveyor interviewed the Recreation Director (RD). The RD stated that the last activity of the day ends at 4:20 PM, before dinner. She then stated that the facility did not have any activities in the evening at the	S 720	Immediate Corrective Action The Director of Recreation was inserviced to ensure that activities are scheduled for at least 2 evening programs per week . Identification of Other residents All residents have the potential to be affected by this practice. Systemic Changes Recreation Director was re-educated on the requirement of 2 evening activities per week . Monitoring of Corrective Action's The recreation director will conduct weekly checks to ensure evening programs are provided at least twice weekly .Results of these checks will be presented to the QAPI committee quarterly .	4/30/22

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S 720	Continued From page 4 moment. She confirmed that they had not provided any evening activities in the last three months. She added that in the past, the facility had an activity in the evening that was a happy hour that included games, cards and juice that occurred once a month. Review of the December 2021 activity calendar provided by the RD indicated the last activity scheduled was 2:30 PM and snacks scheduled was 3:00 PM during that month. Review of the January 2022 activity calendar provided by the RD indicated the last activity scheduled was 2:30 PM and snacks scheduled was 3:00 PM during that month. Review of the February 2022 activity calendar provided by the RD indicated the last activity scheduled was 3:30 PM and snacks scheduled was 3:30 PM during that month. On 3/11/22 at 11:08 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) confirmed that the facility did not have activities two evenings a week for the last three months. Review of the facility provided undated policy titled, "Employee Recreation Orientation" included the following: Policy Statement An ongoing program of activities is design to meet the needs of each resident ... Activities are offered seven days each week, and during at least two evenings per week. during hours convenient to the resident, including holidays and weekends.	S 720		

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S 720	Continued From page 5 N.J.A.C. 8:39-7.3(d)	S 720		

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
315483 Y1	A. Building B. Wing Y2	6/3/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	456 RAHWAY AVENUE ELIZABETH, NJ 07202

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0563	Correction	ID Prefix F0609	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(f)(4)(ii)-(v)	Completed	Reg. # 483.12(c)(1)(4)	Completed
LSC	04/30/2022	LSC	05/15/2022	LSC	05/15/2022
ID Prefix F0610	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	04/30/2022	LSC	04/30/2022	LSC	04/30/2022
ID Prefix F0678	Correction	ID Prefix F0688	Correction	ID Prefix F0689	Correction
Reg. # 483.24(a)(3)	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	05/15/2022	LSC	04/30/2022	LSC	05/15/2022
ID Prefix F0697	Correction	ID Prefix F0698	Correction	ID Prefix F0730	Correction
Reg. # 483.25(k)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(d)(7)	Completed
LSC	05/15/2022	LSC	05/15/2022	LSC	05/15/2022
ID Prefix F0742	Correction	ID Prefix F0761	Correction	ID Prefix F0770	Correction
Reg. # 483.40(b)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.50(a)(1)(i)	Completed
LSC	04/30/2022	LSC	05/15/2022	LSC	05/15/2022

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

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

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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	456 RAHWAY AVENUE ELIZABETH, NJ 07202

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0835	Correction	ID Prefix F0841	Correction	ID Prefix F0867	Correction
Reg. # 483.70	Completed	Reg. # 483.70(h)(1)(2)	Completed	Reg. # 483.75(g)(2)(ii)	Completed
LSC	05/15/2022	LSC	04/30/2022	LSC	04/30/2022
ID Prefix F0880	Correction	ID Prefix F0881	Correction	ID Prefix F0888	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. # 483.80(i)(1)-(3)(i)-(x)	Completed
LSC	05/19/2022	LSC	04/30/2022	LSC	04/30/2022
ID Prefix F0947	Correction				
Reg. # 483.95(g)(1)-(4)	Completed				
LSC	04/30/2022				

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/17/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
602030 Y1	A. Building B. Wing Y2	6/3/2022 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S0720	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-7.3(d)	Completed	Reg. #	Completed
LSC	05/15/2022	LSC	04/30/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/17/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315483	A. BUILDING **01** B. WING _____	**03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	**456 RAHWAY AVENUE** **ELIZABETH, NJ 07202**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/17/22, and was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The facility is a 3-story building that was built in the 1980's; It is composed of Type I fire resistant construction. The facility is divided into 11- smoke zones. The 80 KW generator does approximately 60% of the building. The building has a full basement that no residents are allowed to occupy. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/10/2022

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

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K 000	Continued From page 1 The facility has 128 certified beds. At the time of the survey the census was 83.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	K 222		4/30/22

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K 222	Continued From page 2 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was evidenced for 1 of 3 discharge egress/exits. At 12:38 PM, the Surveyor and Maintenance Director observed that the egress/exit door by the	K 222	K222 Immediate Corrective Actions The thumb turn lock on the basement door near the elevator in the basement was replaced with a doorknob without the thumb turn lock. Identification of other residents Residents and staff have the potential to be affected by this practice. No negative impact noted. Systemic Changes Other exit doors in the facility were	

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K 222	Continued From page 3 elevators in the basement required a thumb turn lock on the egress side. The thumb turn lock, 15-second delayed egress, and keypad activation fastening device on the door could restrict emergency use of the exit. The findings were verified by the Maintenance Director at the time of the observation. The Maintenance Director was informed of the finding at the Life Safety Code exit conference on 3/17/22. NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NJAC 8:39-31.2(e)	K 222	checked to ensure that thumb turn locks are not on the door knobs. Monitoring of Corrective Actions Facility Maintenance director will conduct quarterly rounds to ensure that exit doors do not have any thumb turn locks . Results of these rounds will be presented at the QA committee quarterly .	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/17/22, the facility failed to provide stair thread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3.	K 225	K225 Immediate Corrective Actions Yellow Marking stripes were placed on each step, handrail and landing in the stairwells of the facility. Identification of Other Residents Staff using the stairwell have the potential to be affected by this practice . No	4/30/22

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K 225	Continued From page 4 The deficient practice was observed in 3 of 3 stairwells in the facility by the following: While touring the facility from approximately 9:40 AM, to 3:30 PM, the Surveyor and Maintenance Director observed that the 3 egress stairwells revealed that marking stripes were not present on each step, floor landing, and handrails. The findings were verified by the Maintenance Director at the times of the observation. The Maintenance Director was informed of this finding during the Life Safety Code survey exit conference on 03/17/22. The Administrator was not present due to a religious holiday. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	Negative impact noted . Systemic changes Maintenance director received in-service regarding maintaining yellow stripes in the stairwells . Monitoring of Corrective Actions Maintenance Director or designee will do monthly rounds to ensure steps, landings and hand rails are marked with stripes. Results of these inspections will be reviewed quarterly at the QA committee	
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation in the presence of the facility's Maintenance Director on 3/17/22, it was	K 252	Immediate Corrective Actions Facility immediately held a FSES survey	5/20/22

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K 252	Continued From page 5 determined that the facility failed to provide at least two (2) acceptable exits, remote from each other, for each floor or fire section of the building. This deficient practice was evidenced by the following: The surveyor observed that the secondary exit from the 3rd floor was a stairwell that leads outside to a roof. Egress would be along the roof to the stairwell leading into another part of the building. At 10:10 AM, the third-floor dining room/recreation room was occupied by six (6) residents, along with two (2) facility staff members. The Physical Therapy room and Beauty shop were unoccupied at the 10:10 AM observation and are located on the third floor. The Maintenance Director was provided with a "Process for Past waivered citations" document at 9:45 AM. He stated it would be provided to the Administrator. The Maintenance Director was informed of the findings at the Life Safety Code exit conference. The Administrator was not present due to a religious holiday. NJAC 8:39-31.1(b)	K 252	to ensure there is no negative impact on residents or staff . Facility passed the FSES survey . Identification of Other Residents All residents have the potential to be affected by this practice . No negative impact noted . Systemic Changes The area is used a recreation/dining room and does not have any resident rooms . Area is supervised by staff when in use . All other areas in the facility contain 2 exits . Monitoring of Corrective Actions Maintenance Director will conduct quarterly rounds to ensure other corridors have 2 exits .Results of these rounds will be presented at the QAPI committee quarterly .	
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in	K 271		5/15/22

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K 271	Continued From page 6 elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/17/22, the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was evidenced for 2 of 6 exit discharge's by the following finding: 1. At 09:45 AM, the Surveyor and Maintenance Director observed that the floor-3 egress/exit ramp had an approximately 2" step at the top of the ramp which failing to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency. 2. At 09:55 AM, the Surveyor and Maintenance Director observed that the exterior top landing discharge at the exit near the generator measured approximately 4' x 4'. There was no railing on the street side edge approximately 4' the landing that was approximately 3' off the ground. An interview was conducted with the Maintenance Director, during the observations and confirmed the findings. NJAC 8:39-31.2(e)	K 271	K271 Element # 1 -Immediate Corrective Actions The door at the third floor exit area was replaced. the railing on the street side was installed . Please see attachments. Element # 2 -Identification of other residents Staff and residents have the potential to be affected by this practice . No negative impact noted Element # 3 -Systemic Changes Railing will be present on the street side of the loading dock area . Element # 4 -Monitoring of Corrective Actions Facility maintenance director will conduct monthly rounds to ensure exits are level free and not obstructed . Results of these inspections will be presented to the QA committee quarterly .	

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K 271	Continued From page 7 NFPA 101:2012 - 7.7, 19.2.7	K 271		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/17/22, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice was observed in 2 of 10 areas and evidenced by the following: 1. At 2:10 PM, the Surveyor and Maintenance Director observed the wall light switches at the main entrance where the receptionist desk was located. Observations revealed the switch controlling normal lighting supplied the normal and the emergency lighting for the means of egress but had no lighting when the switch was in the off position. 2. At 2:31 PM, the Surveyor and Maintenance Director observed the wall light switches in the 1st floor recreation/dining room, which revealed a switch controlling normal lighting supplied the normal and emergency lighting for the means of egress but had no lighting when the switch was in the off position.	K 281	K281 Element # 1 -Immediate Corrective Actions 1 light in the reception area , and in the first floor Dining Room was connected to a constant feed circuit . The 3 exterior light fixtures were replaced with fixtures that have 2 bulbs . The third floor egress area top deck light fixture was replaced and is working . The bulb malfunction on the first floor was repaired . Element # 2 -Identification of Other Residents Residents and staff have the potential to be affected by this practice . No negative impact noted . Element # 3- Systemic Changes Exterior light fixtures were checked to ensure that they are operational and they have 2 bulbs in each egress area . Element # 4 -Maintenance Director will check emergency illumination in egress areas and will check to ensure that illumination is in automatic operation on a monthly basis . Results of these audits will	5/15/22

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K 281	Continued From page 8 3. While touring the facility, the Surveyor and Maintenance Director observed 3 of 3 exterior light fixtures at the exit/egress discharge areas that had only a single bulb emergency lighting fixture. 4. At 9:30 AM, the Surveyor and Maintenance Director observed that the roof-deck exit into the building from the 3rd floor emergency egress area, did not have a top deck light fixture (broken) that illuminated the area and on the lower level (floor #1) there was no illumination due to a bulb malfunction. The findings were verified by Maintenance Director at the times of the observation. The Maintenance Director was informed of the findings at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. NJAC 8:39-31.2(e)	K 281	be presented to the QAPI committee quarterly .	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 293		5/15/22

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K 293	Continued From page 9 Based on observation and interview, the facility failed to provide signs with a directional indicator showing the direction of travel, in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was evidenced for 2 of 20 exit signs observed. On 03/17/22 at 2:10 PM, the Surveyor and Maintenance Director observed in the basement that when exiting the elevator, the 2-wall mounted exit signs would not provide a directional indicator as they were mounted flush onto the wall. The finding was verified by the Maintenance Director at the time of the observation. The Maintenance Director was informed of the finding at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293	K293 Element # 1 -Immediate Corrective Action The exit sign in the basement was replaced with a directional indicator. Element # 2 -Identification of Other Residents Residents and staff have the potential to be affected by this practice . No negative impact noted . Element # 3 -Systemic Changes Other exit signs closest to the exit door were checked to ensure that they maintain a directional indicator . Element # 4 -Monitoring of Corrective Actions Maintenance Director or designee will conduct quarterly rounds to ensure that exit signs closest to the exit maintain a directional indicator . Results of these rounds will be presented to the QA committee on a quarterly Basis .	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.	K 321		5/15/22

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K 321	Continued From page 10 Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/17/22, the facility failed to provide a fire barrier with two-hour fire resistance rating. Walls with transfer grilles shall not be used in corridor walls or doors, even though there is fusible link-operated damper in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 8.7.1. The deficient practice was evidenced for 3 of 4 floors observed by the following: 1. At 2:39 PM, the Surveyor and Maintenance Director, observed that floor 3, floor 1 and basement area, had an approximately 18" x 18" open wall air vent at the corridor upper wall. This air vent would allow smoke to be distributed to the floors above in the event of a smoke condition.	K 321	Element # 1 -Immediate Corrective Actions The 18X 18 vent area on floor 1 was closed with a cement board. Floor 2 and basement area corridor vents were closed up with a cement board. Maintenance director repaired the janitor closet by room 122 to ensure there are no holes. The open seam below the drop ceiling outside the elevator was sealed. Element # 2 -Identification of Other Residents All residents have the potential to be affected by this practice . No negative impact noted . Element # 3-Systemic Changes	

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K 321	Continued From page 11 2. At 2:50 PM, the Surveyor and Maintenance Director observed that the fire barrier outside the elevator in the basement was not complete at the upper wall. The wall stopped before the drop ceiling track was installed. The open seam around the room would allow smoke and fire to enter the area above. 3. At 3:10 PM, the surveyor and Maintenance Director, observed that the floor 1 janitors closet by room 122 had an open upper wall through the sheetrock approximately 5" x 5" and a large open wall below the janitors sink approximately 2' x 2'. The findings were verified by the Maintenance Director at the time of the observations. The Maintenance Director was informed of the findings at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NFPA 101, 2012 Edition, Section 19.3.2.1, 8.7.1. NJAC 8:39-31.2(e)	K 321	Maintenance director inserviced on importance of ensuring wall air vents are closed and that there are no open walls . Element # 4 Monitoring of Corrective Actions Maintenance Director will conduct quarterly rounds to ensure wall air vents are closed and that there are no holes in walls . Results of these rounds will be presented to the QAPI committee quarterly .	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced	K 345		5/15/22

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K 345	Continued From page 12 by: Based on observation and interview, the facility failed to provide and maintain supervised smoke detection in operating condition at all times in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.4.1, 9.6, 4.6.12.1. The deficient practice was observed for 31 of 60 resident rooms. While touring the facility, the Surveyor and Maintenance Director observed on floor #2 that new drop ceiling tiles were installed. The ceiling tiles were observed to have oversized cuts around the heat detectors creating approximately 1/4" to 3/4" gaps in the following resident rooms. The gaps would now delay the activation of the fire alarm system until the voids filled with heat and/or smoke. 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231 and 232. The findings were verified by the Maintenance Director at the times of the observation. The Maintenance Director was notified of the findings at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.4.1, 9.6, 4.6.12.1.	K 345	Immediate Corrective Actions Facility's alarm monitoring vendor came to the facility and adjusted the heat detectors in the following rooms :201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231 and 232 . Identification of Other Residents All residents have the potential to be affected by this practice. No negative impact noted . Systemic Changes Maintenance director was educated to notify the alarm company if cuts or gaps are noted so that it could be repaired immediately . Monitoring of corrective Actions Maintenance Director or designee will conduct monthly rounds to ensure there are no cuts or gaps around the heat detectors . Results of these rounds will be presented to the QA committee quarterly .	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101	K 347		5/15/22

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K 347	Continued From page 13 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on surveyor's observation, interview, and documentation review on 3/17/22 in the presence of the Maintenance Director, it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors as evidenced by the following: A tour of the facility, at 11:15 a.m., revealed that the facility resident rooms were provided with battery operated smoke detectors. It was observed that resident room 232 was not provided with a battery operated smoke detector. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance program for the testing of the detectors or for battery replacement. In an interview, at 10:55 a.m., the facility's Maintenance Director stated that there was no preventative maintenance program for testing the battery operated smoke detectors in resident rooms and could not provide any documentation on the year of installation. This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit	K 347	K347 Immediate Corrective Actions A smoke detector in room 232 was installed . A log was created for testing the detectors and for battery replacement . Identification of Other residents Residents and staff have the potential to be affected by this practice . No negative impact noted . Systemic Changes Logs will be created to ensure the operation of battery operated smoke detectors and that battery replacement is maintained on a quarterly basis . Monitoring of Corrective Actions Maintenance director or designee will conduct quarterly rounds to ensure all resident rooms have battery operated smoke detectors and battery is operational. Results of these findings will be presented to the QA committee on a quarterly basis	

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K 347	Continued From page 14 corridor where permanently wired smoke detectors were located. The Maintenance Director was informed of the findings at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/17/22, it was determined that the facility failed to maintain the sprinkler system, by ensuring that	K 353	Immediate Corrective Actions 1.Floor 2 dayroom was replaced with a new ceiling tile .2. Floor 2 shower rooms	5/22/22

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K 353	Continued From page 15 the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 09:30 AM to 03:25 PM, the Surveyor and Maintenance Director, observed drop ceiling tiles missing and/or holes in the drop ceiling tiles and/or (sheetrock) with oversized cuts around the fire sprinkler heads and missing escutcheon plates in the following areas of the facility: 1. floor-2 dayroom 1/2 opening in the ceiling tile. 2. floor-2 shower room hole in the drop ceiling. 3. floor-2 garbage room ceiling penetrations. 4. floor-2 corridor ceiling by resident room 20, holes in ceiling tiles. 5. washer/dryer room 1/2 opening into the ceiling from pipe installation. 6. floor-2 nurse station approximately 2" opening into the drop ceiling. 7. basement electrical room open ceiling (corner tile) approximately 2"x 4". 8. basement garbage room hole in ceiling approximately 8" round. 9. Oxygen storage room verticle ceiling opening by resident rooms 121 and 122. The Maintenance Director stated and confirmed the above findings during the building tour on 3/17/22. The Maintenance Director was informed of the findings at the Life Safety Code Exit Conference on 3/17/22. The Administrator was not present due to a religious holiday.	K 353	was applied with caulk. 3. Floor 2 garbage room was replaced with new tiles . 4.Corridor by room 223 was replaced with a new tile .5. Washer dryer room pipe installation was applied with caulk .6. Floor 2 Nurse station was replaced with a new tile . 7. Basement electrical room corner was repaired with compound .8.Basement garbage room was repaired with compound .9. Oxygen room was replaced with new ceiling tiles . Identification of Other Residents All resident shave the potential to be affected by this practice . No negative impact noted . Systemic Changes Maintenance director to check other areas of the facility to ensure no holes in ceiling tiles . Monitoring of corrective Actions Maintenance Director will conduct Monthly rounds on 10 rooms to ensure that there are no holes or penetrations .All findings will be rectified immediately .Results of these rounds will be presented to the QAPI committee quarterly .	

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K 353	Continued From page 16 NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/17/22, in the presence of the Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 5 of 10 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: The Surveyor and Maintenance Director observed that the ventilation in the following resident room bathrooms did not function: # 201, 212, 230, 231 and 232 The surveyor requested that the Maintenance Director confirm if the units were functioning by	K 521	Immediate Corrective Actions The facility's HVAC vendor was contacted to repair the exhaust vents in room 201, 212, 230, 231 and 232 in order to ensure proper ventilation in residents bathrooms . Identification of other residents All residents have the potential to be affected by this practice . No negative impact noted . Systemic changes Other bathrooms were checked to ensure HVAC is functioning properly . Monitoring of Corrective Actions Maintenance director will conduct monthly rounds of 5 rooms to ensure that exhaust fans are functioning properly . Results of these audits will be presented at the QAPI	4/30/22

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K 521	Continued From page 17 placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. The Maintenance Director was informed of this deficiency at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	committee quarterly .	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency	K 531		4/30/22

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K 531	Continued From page 18 personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that elevators were inspected and tested monthly for 2 of 2 elevators, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. The deficient practice could affect all residents and was evidenced by the following: At 12:50 PM, the Surveyor and Maintenance Director observed no evidence that the Fire Fighters Emergency Operations Inspection and Test was performed and a written record of Phase I recall by use of the key switch, and a minimum of one floor operation, including findings documented monthly. Maintenance Director only recorded elevator # 1 and elevator # 2 on a monthly checklist. The finding was verified by the Maintenance Director at the time of the observations. The Maintenance Director was informed of the finding at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531	Immediate Corrective Actions Elevator log book was revised to reflect the written record of phase 1 recall by use of the key switch and to reflect a minimum of one floor operation . Identification of other residents All residents have the potential to be impacted by this practice . no negative impact noted . Systemic changes Phase 1 recall test was conducted by the key and documented in the new log . Monitoring of corrective Actions Maintenance Director will conduct monthly checks of the phase 1 recall . These monthly checks will be presented to the QA committee quarterly .	

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K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on review of facility documents,	K 918	K918	5/10/22

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K 918	Continued From page 20 observations and interview on 03/17/22, in the presence of the Maintenance Director, it was determined that A. The facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. B. The facility did not ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. A. This deficient practice was evidenced for 1 of 1 generator logs provided by the Maintenance Director by the following: A review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds when the load test was conducted on the following dates: 2/28/22, 1/21/22, 12/29/21, 11/24/21, 10/26/21, 9/10/21, 8/20/21, 7/15/21, 6/20/21, 5/28/21,4/27/21 and 3/30/21. An interview was conducted with the Regional Plant Operations Director at the time of the record review, who confirmed there was no transfer time data on 12 of 12 monthly load tests documented on the facilities reports. B. On 03/17/22, the Surveyor and Maintenance Director observed that the facility generator was outside and encased. Further observation revealed that there was a remote manual stop station to prevent inadvertent or unintentional operation on the outside of the steel encased generator but was installed on the steel grill section of the casing.	K 918	Immediate Corrective Action The facility created a log to record that transfer time met the requirement of 10 seconds of the load test. The remote manual stop station was moved from steel grill casing and was placed in a remote area in order to ensure 10 second transfer and remote pull stop capability . Identification of Other Residents Residents and staff have the potential to be affected by this practice . No negative impact noted . Systemic Changes Emergency stop button to be in a remote area. Logs were revised to include the time of transfer of power to the generator . Monitoring of Corrective Actions Maintenance director or designee will present the results of the log of the 10 second transfer switch and the remote manual placement to the QA committee quarterly .	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315483	A. BUILDING **01** B. WING _____	**03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	**456 RAHWAY AVENUE** **ELIZABETH, NJ 07202**

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K 918	Continued From page 21 An interview was conducted during the observation with the Maintenance Director where he stated that he was unaware the installation of the remote manual stop station was in the wrong location and must be remote of the encased unit in the event of inadvertent or unintentional operation including a fire. The Maintenance Director was informed of the findings at the Life Safety Code exit conference on 3/17/22. The Administrator was not present due to a religious holiday. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		

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
315483 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/20/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA HEALTHCARE & REHABILITATION CENTER	456 RAHWAY AVENUE ELIZABETH, NJ 07202

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	04/30/2022	LSC K0225	04/30/2022	LSC K0252	05/20/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0271	05/15/2022	LSC K0281	05/15/2022	LSC K0293	05/15/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	05/15/2022	LSC K0345	05/15/2022	LSC K0347	05/15/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	05/22/2022	LSC K0521	04/30/2022	LSC K0531	04/30/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	05/10/2022	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	
3/17/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO