STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE PARAMUS, NJ 07652**

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F 000	INITIAL COMMENTS Complaint #s: NJ00147735, NJ00152035, NJ00153877, NJ00154277, NJ00154455 and NJ00156573 Survey Date: 7/18/23 Census: 84 Sample: 19 + 3 closed records + 16 = 38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 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	F 610		8/26/23

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

Electronically Signed | 08/04/2023

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F 610	Continued From page 1 by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to thoroughly investigate a [redacted] of unknown origin on 3/02/23 of Resident#10. This deficient practice was identified for one (1) of three (3) residents reviewed for incident/accident and was evidenced by the following: On 7/06/23 at 10:59 AM, the surveyor observed Resident #10 seated in a wheelchair inside their room, with one [redacted] to the [redacted] side of the bed. The resident stated to the surveyor that he/she had a [redacted] incident last night while in the [redacted] At the same time, Certified Nursing Aide#1 (CNA#1) who was also inside the room informed the surveyor that she was the aide of the resident. The CNA stated that the [redacted] incident happened not on her shift. On 7/11/23 at 9:09 AM, the surveyor observed the resident was not in their room, there was one [redacted] on the floor to the [redacted] side of the bed. On 7/11/23 at 9:10 AM, Licensed Practical Nurse#1 (LPN#1) informed the surveyor that Resident #10 was in the [redacted], transferred to [redacted]) on [redacted] (status post) [redacted] due to the [redacted] was done and resulted in [redacted]. The LPN stated that the resident [redacted] the night before. She further stated that the resident had [redacted] from the community, resident was non-compliant at times with safety precautions, and feels that the resident thinks that the resident	F 610	1) How the corrective action will be accomplished for those residdents found to have been affected by the deficient practice For Resident #10 staff statements were collected for a 72 hour look back period of the alleged event. It was reviewed to include for resident #10 event summary and concluded that the [redacted] was unsubstantiated. Resident #10 was reassessed upon return from the hospital. The Facility Risk Management log was reviewed for proper investigation, and the gathering of statements to conclude if the event is either of unknown origin or unwitnessed. 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 and if the alleged violation is verified appropriate corrective action must betaken 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents	

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F 610	Continued From page 2 can still do things on their own despite the education provided to the resident. On that same date and time, LPN#1 informed the surveyor that the resident requires Ex.Order 26.4(b)(1) [redacted] assists with adls (activities of daily living) except eating. She further stated that the resident was able to make needs known to staff with EX Order 26.4B1. The surveyor reviewed Resident #10's medical record. The resident's Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility and had a diagnosis of EX Order 26.4B1 [redacted] The resident's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with an Assessment Reference Date (ARD) of EX Order 26.4B1 reflected that the Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1) which indicated that the resident's EX Order 26.4B1 was EX Order 26.4B1	F 610	(current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur All staff were re-inserviced regarding the policy and procedure of Abuse, Neglect and exploitation. Staff will 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, and if the alleged violation is verified appropriate corrective action must be taken. All licensed nurses were re-inserviced on proper procedure of reporting, gathering statements of any unwitnessed events, Ex.Order 26.4(b)(1) origin, or any events that warrant investigation following policy and procedure of abuse, neglect and exploitation. Staff was re in serviced on the importance of gathering statements with a look back period of 72 hours to complete the investigation. Unit Manager or designee will gather all statements of any event that needs a thorough investigation and submit to the administrator for review. Director of Nursing or designee will	

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F 610	Continued From page 3 The Reportable Event Record/Report (RER/R) indicated that the significant event was called in on 3/03/23 at 11:47 AM for an unknown date and time of the event on Resident #10's complaint of EX Order 26.4B1 was completed, and showed a EX Order 26.4B1. Attached to RER/R was a document with typewritten information that included that the incident date was EX Order 26.4B1 included that the resident was asked about the incident and that there were two RNs (registered nurses; who were not identified) who did the head-to-toe assessment. The typewritten document included a conclusion that based on staff and resident statements there was EX Order 26.4B or EX Order 26.4B1 that transpired and there was Ex.Order 26.4(b)(1) of trauma therefore abuse and neglect were unsubstantiated. There were no statements from the staff regarding the provided RER/R and attachments that were provided to the surveyor on 7/11/23 at 11:07 AM by the Licensed Nursing Home Administration (LNHA). The provided Risk Management (investigation) dated 3/02/23 by the LNHA included that Assistant Director of Nursing#1 (ADON#1) prepared the incident report that showed that the resident EX Order 26.4B1 EX Order 26.4B1 and EX Order 26.4B1 and that the resident was unable to give a description. The investigation included that no witness was found. A review of the above investigation that was provided to the surveyor and a review of the electronic medical records (EMR) did not reflect that staff statements from different shifts were obtained for an injury of unknown origin. On 7/13/23 at 12:33 PM, the survey team met	F 610	review 5 charts weekly x 90 days and thereafter for any accidents and incidents that occurred to determine if correct process was followed. Audits will be monitored for completion by the Administrator or designee and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended as indicated. Adverse findings will be immediately addressed 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Any incidents will be discussed in morning clinical meeting for immediate resolution. The results of the audits will be reported in monthly QAPI and this will be a part of quarterly QA to track trends and identify further action needed.	

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F 610	Continued From page 4	F 610		

with the LNHA, Director of Nursing (DON), ADON#1 and #2, Regional DON (RDON), Regional Interim DON (RIDON), and Assistant Administrator (AA). The surveyor asked if the documents previously provided to the surveyor for the requested investigation were provided including statements of staff. ADON#1 stated that everything including statements was provided to the surveyor. The surveyor then asked the facility management what was their facility's policy and protocol with regard to obtaining staff statements for Ex.Order 26.4(b)(1) .

At this time, RDON informed the survey team that for unwitnessed incidents, "we ask to write in a piece of paper, or blank paper, or pre-printed statement form" the staff statements and that the lookback period will be 48 hours. The surveyor then asked if that will be the facility's practice or policy. The RDON stated that "I do not know if it is in our policy, but it is a standard of practice." The LNHA stated that they will get back to the surveyor. The surveyor notified the facility management of the above findings that there were no staff statements for an injury of unknown origin reported.

On 7/13/23 at 01:30 PM, ADON#1 provided copies in addition to investigation papers that were provided by the LNHA on 7/11/23. The provided documents now included the following:

a. Statement from LPN#2 dated 3/06/23 indicated that the statement typewritten and signed by LPN#2 was in reference to the condition and events on 02/26/23 and 02/27/23 at the 3-11 shift.
b. Statement from LPN#3 dated and signed on

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F 610	Continued From page 5 3/06/23 indicated on the typewritten statement that LPN#3 was a regular nurse worked on 3/01/23 and that the resident did not [redacted]. A review of the above 7/13/23 provided documents of ADON#1 revealed that there were no statements from other shifts and other staff that also had direct care to the resident which included CNAs. On 7/14/23 at 12:10 PM, the survey team met with the DON, ADON#1 and #2, RIDON, RDON, LNHA, and AA, and made aware of the above findings. On 7/17/23 at 9:59 AM, the LNHA provided additional documents with regard to the above investigation that included statements from: CNA#2 on the 3-11 shift of 02/27/23-3/01/23 CNA#3 on the 7-3 shift of 02/27/23-3/01/23 CNA#4 on the 11-7 shift of 02/27/23-02/28/23-3/01/23 LPN#4 on the 11-7 shift of 02/28/23-3/01/23 LPN#5 on the 11-7 shift of 02/27/23 At the same time, the surveyor asked the LNHA why the above statements from CNA#2, #3, and #4 including LPN#4 and #5's statement were not included in the previously provided investigation to the surveyor. The surveyor asked also when the statements were obtained, and the LNHA stated that he will get back to the surveyor. On 7/17/23 at 10:38 AM, ADON#1 informed the surveyor in the presence of another surveyor that the statements that were provided by the LNHA on 7/17/23 at 9:59 AM were interviews of ADON	F 610		

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F 610	Continued From page 6 from the assigned staff based on the schedule on 02/27/23, 02/28/23, and 3/01/23 for the investigation on 3/02/23. She further stated that the above statements from CNA#2, #3, and #4, including statements from LPN#4 and #5 were obtained after the surveyor's inquiry. On 7/17/23 at 11:36 AM, the survey team met with the RIDON, RDON, DON, ADON#1, LNHA, and AA. The RIDON acknowledged that there should be statements from staff at least 48 to 72 hours of lookback for Ex.Order 26.4(b)(1) that make a complete investigation. A review of the facility's Accidents and Incidents-Investigating and Reporting with a reviewed/Revised date of 3/2023 revealed there was no information included with regard to Ex.Order 26.4(b)(1) on gathering staff statements. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with facility LNHA, AA, DON, RIDON, RDON, ADON#1, and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and facility management both stated that there was no additional information.	F 610		
F 637 SS=D	NJAC-8.39-27.1(a) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		8/26/23

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F 637	Continued From page 7 purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a Significant Change in Status Assessment (SCSA) was completed for Resident #10. This deficient practice was identified for one (1) of 19 residents reviewed, and was evidenced by the following: According to the MDS (minimum data set) 3.0 RAI (Resident Assessment Instrument) Manual October 2019 page 2-22 (pages 44-49) included that the SCSA is a comprehensive assessment for a resident must be completed when the IDT (interdisciplinary team) has determined that a resident meets the significant change guidelines for either major improvement or decline. A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.	F 637	1) How the corective action will be accomplished for those residents found to have been affected by the deficient practice Resident #10 MDS was modified to accurately reflect the significant change status of the patient. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur MDS Director or designee will review and audit every MDS completed to ensure accuracy of coded items.	

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F 637	Continued From page 8 On 7/06/23 at 10:59 AM, the surveyor observed Resident #10 seated in a wheelchair inside their room with a [redacted] to the [redacted] side. On 7/11/23 at 9:10 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #10 was in the [redacted] The LPN stated that the resident required Ex.Order 26.4(b)(1) [redacted] with adls (activities of daily living) except eating. She further stated that the resident was able to make needs known to staff with Ex.Order 26.4(b)(1). She further stated that the resident had periods of Ex.Order 26.4(b)(1) [redacted]. The surveyor reviewed Resident #10's medical record. The resident's Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility and had a diagnosis of EX Order 26.4B1 [redacted] The resident's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with an	F 637	MDS Director or designee will review with the IDT to assess whether a Significant Change in Assessment MDS should be opened during the OBRA MDS review schedule. Regional MDS Directors and designee will audit MDS Assessments completed in the center for accuracy of assessment. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Upcoming MDS assessments will be discussed in morning clinical meeting. The results of the audits will be reported in monthly QAPI and this will be a part of quarterly QA to track trends and identify further action needed.	

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Assessment Reference Date (ARD) of [redacted] reflected that the Brief Interview for Mental Status (BIMS) score of [redacted]) which indicated that the resident's cognition was [redacted]. The qMDS Section [redacted] was coded [redacted] reflected that [redacted]. Section [redacted] Status for walk in room and corridor was coded as [redacted] which indicated that activity [redacted]. Section [redacted] was coded as [redacted] which indicated frequently [redacted]

A review of the annual MDS (aMDS) with an ARD of [redacted] for Section [redacted] revealed a BIMS score of [redacted] which indicated that the resident's cognition was [redacted]. The aMDS Section [redacted] was coded with [redacted]. Section [redacted] walk in room and corridor was coded as [redacted] which reflected that the resident was [redacted] Section [redacted] was coded as [redacted] which reflected that the resident was [redacted] of both [redacted]

Further review of the above MDS revealed that the resident was noted with a [redacted] status, [redacted] noted, [redacted] and an SCSA not done on ARD of [redacted]

The personalized care plan of the resident showed a focus on the resident's [redacted] and [redacted] to (r/t) the diagnosis of [redacted]

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EX Order 26.4B1 [redacted]

On 7/14/23 at 10:51 AM, the surveyor in the presence of another surveyor interviewed the MDS Coordinator/Licensed Practical Nurse (MDSC/LPN). The MDSC/LPN informed the surveyors that the facility had no specific policy regarding MDS, the facility follows the RAI Manual. The MDSC/LPN stated that the MDS Coordinators were responsible for answering MDS Sections C, G, H, and J. She further stated that information in the MDS was gathered from the resident's medical records from nurses and other interdisciplinary team assessments and documentation.

On that same date and time, the MDSC/LPN informed the surveyors that if there will be two or more changes either improvement or decline in the resident's status, that will be the criteria that the MDS assessment for SCSA will be done. The surveyor then asked the MDSC/LPN why the resident's qMDS on ARD 4/21/23 was not an SCSA considering the above change and decline in resident's status in comparison to aMDS on 7/19/22, and the MDSC/LPN stated that she will get back to the surveyor.

On 7/17/23 at 12:05 PM, the survey team met with the Regional MDS/Registered Nurse (RMDS/RN) and MDSC/LPN. The MDSC/LPN informed the surveyor that the SCSA for the resident was not done because the resident was picked up for Ex.Order 26.4(b)(1) back in

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F 637	Continued From page 11 3/2023 and when the resident was discharged from Ex.Order 26.4(b)(1), the resident went back to baseline afterward. The surveyor then asked the facility management if the resident had declined in EX Order 26.4B1 , noted with Ex.Order 26.4(b)(1), and Ex.Order 26.4(b)(1) why the mentioned criteria still did not meet the SCSA. The RMDS/RN responded that the April 2023 qMDS of Resident#10 should have been a SCSA. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with the facility's Licensed Nursing Home Administrator, Assistant Administrator, Director Of Nursing (DON), Regional Interim DON, Regional DON, and Assistant Director Of Nursing#1 and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and the facility management stated that there was no additional information. NJAC 8:39-11.1	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 3 (three) of 19	F 641	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #10, #11, and #54 MDS were	8/26/23

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F 641	Continued From page 12 residents, (Residents #10, #11 and #54) reviewed, and was evidenced by the following: 1. On 7/06/23 at 10:59 AM, the surveyor observed Resident #10 seated in a wheelchair inside their room with the Certified Nursing Aide (CNA) with one [redacted] to the [redacted] side of the bed and informed the surveyor that she was the aide of the resident. The resident stated to the surveyor that he/she had a [redacted] incident last night while in the bathroom. The CNA stated that the [redacted] incident happened not on her shift. On 7/11/23 at 9:09 AM, the surveyor observed the resident was not in their room, there was one [redacted] on the floor to the [redacted] of the bed. On 7/11/23 at 9:10 AM, the Licensed Practical Nurse (LPN) came and informed the surveyor that Resident #10 was in the [redacted], transferred to [redacted]) on [redacted] due to the [redacted] was done and resulted in [redacted]. The LPN stated that the resident [redacted] the night before. She further stated that the resident had [redacted] from the community, resident was non-compliant at times with safety precautions, and the "resident thinks" that the resident can still do things on their own despite the education provided that the resident required [redacted] with ADLs (activities of daily living). On that same date and time, the LPN informed the surveyor that the resident requires [redacted] with ADLs except eating. She further stated that the resident was able to make needs known to staff with periods of [redacted]	F 641	modified to accurately reflect the status of the patient. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur MDS Director or designee will review and audit MDSs completed to ensure accuracy of coded items. Regional Team will construct a new UDA Assessment to incorporate all required Quarterly and Annual Assessments needed for MDS Completion. Regional MDS Directors or designee will audit MDS Assessments completed in the center for accuracy of assessment. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of the audits will be reported	

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F 641	Continued From page 13 The surveyor reviewed Resident #10's medical record. The resident's Admission Record (AR or face sheet; admission summary) reflected that the resident was admitted to the facility and had a diagnosis but not limited to EX Order 26.4B1 [redacted] The resident's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with an Assessment Reference Date (ARD) of EX Order 26.4B1 reflected that the Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1 which indicated that the resident's cognition was EX Order 26.4B1. Section EX O Health Conditions showed that the resident had Ex.Order 26.4(b)(1) since admission or reentry or prior assessment. Further review of the MDS showed a PPS (Prospective Payment System) assessment ARD EX Order 26.4B1 BIMS score of EX Order 26.4B1) which indicated also that the resident's FEX Order 26.4B1 was EX Order 26.4B1 [redacted] Section EX O indicated that the resident	F 641	in monthly QAPI and this will be a part of quarterly QA to track trends and identify further action needed.	

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F 641	Continued From page 14 had [redacted] incident with [redacted]. A review of the unwitnessed report dated [redacted] showed that the resident had a [redacted] with a [redacted]. According to the RAI (Resident Assessment Instrument) Manual for answering Section [redacted], the MDS with an ARD of [redacted] should have been coded as [redacted] (except major) for any [redacted] that causes the resident to complain of [redacted] because the resident had a [redacted] incident on [redacted] that the resident had [redacted]. On 7/14/23 at 10:51 AM, the surveyor in the presence of another surveyor interviewed the MDS Coordinator/LPN (MDSC/LPN). The MDSC/LPN informed the surveyors that it was her responsibility and that other MDSCs to answer Sections C, G, H, and J in the MDS. The surveyor asked for the facility's policy with regard to MDS and the MDSC/LPN stated that there was no specific policy for MDS and that the facility followed the RAI Manual. At that same time, the surveyor then asked the MDSC/LPN what documents and information that she looks at to answer Section [redacted] of MDS about [redacted]. The MDSC/LPN stated that "I look at Risk management (investigation report) to check if there's a [redacted] incident." The surveyor asked the MDSC/LPN why section [redacted] was coded as [redacted] with [redacted] if there was a [redacted] with a [redacted] on the [redacted] unwitnessed investigation. The MDSC/LPN stated that she will get back to the surveyor.	F 641		

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F 641	Continued From page 15 On 7/17/23 at 12:05 PM, the survey team met with the Regional MDS/Registered Nurse (RMDS/RN) and MDSC/LPN. Both the RMDS/RN and the MDSC/LPN acknowledged that Section [EX O] should have been coded as [EX Order] [EX Orde] with EX Order 26.4B1) because the resident had a EX Order 26.4B1 on the [EX Order 26.4B1] [EX Order 26.4B1] investigation. 2. On 7/11/23 at 9:00 AM, the surveyor observed Resident#54 laying on a specialized mattress covered with a blanket and there was no foul odor. The resident stated that breakfast was done and no complaints with care. The surveyor reviewed Resident #54's medical record. The resident's AR reflected that the resident was admitted to the facility and had a diagnosis of but not limited to EX Order 26.4B1 [redacted] The resident's most recent qMDS with an ARD of [EX Order 26.4B1] reflected a BIMS score of [EX Orde] indicated that the resident's cognition was [EX Order 26.4B1] [EX Order 26.4B1]. Section [EX Order 26.4B1] Conditions, M0100 B. Formal Assessment Instrument/tool (e.g., [EX Order 26.4B1]) was checked off which means that the facility utilized a formal assessment instrument or tool in answering this section. A review of the assessment in the electronic medical record (EMR) revealed that [EX Order 26.4B1] Scale for Predicting EX Order 26.4B1 Risk [Ex.Order 26.4(b)(1)]) was done on [EX Order 26.4B1] with a score of	F 641		

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Further review of the assessment in the EMR revealed that there was no BSPPSR done for June 2023 to reflect in the 6/20/23 qMDS. The assessment in the EMR for BSPPSR was also in red which means that the assessment was not done for June 2023 for BSPPSR.

On 7/14/23 at 9:59 AM, the survey team met with Assistant Director of Nursing#1 (ADON#1) and ADON#2 and discussed about skin impairment and skin assessments in accordance with the facility's practice and policy. According to ADON#1, the Braden scale is utilized for admission, "I believe when there's a quarterly" for MDS, and when a resident had a skin breakdown "they (nurses)" suppose to use that also. ADON#1 stated that "anyone can utilize Braden but honestly some agency nurses don't know what the Braden is."

On that same date and time, DON#1 stated that "if there's an admission we open Braden," mostly the admission is in the 3-11 shift, and that the 3-11 supervisor "knows how to open that."

At that same time, ADON#2 stated that it was the responsibility of the Unit Manager (UM) to check that the Braden assessment was done.

On 7/14/23 at 10:51 AM, the surveyor in the presence of another surveyor met with MDSC/LPN. The MDSC/LPN stated that she was responsible for coding Section M in the MDS and that the information was gathered from her review of admission and readmission nursing assessment and skin assessment. She further

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stated that part of the skin assessment was the BSPPSR which should be done on admission and readmission, after 4 weeks, and then quarterly assessment.

On that same date and time, the MDSC/LPN informed the surveyors that the UDA (user define assessment) in the EMR was being scheduled by the UM that included the BSPPSR schedules for quarterly which corresponds to the schedule of MDS that the MDSC/LPN provided to the UM. She further stated that because it was given to the manager, the MDSC/LPN was on the assumption that the BSPPSR was completed.

In addition, the MDSC/LPN stated that there were missing assessments even before and that the facility discussed this in QAPI (Quality Assurance Performance Improvement) for a while (but unable to remember when) and that she encountered doing MDS. The surveyor asked if this include the findings of the surveyor for no BSPPSR for June 2023 that correspond to the qMDS on 6/20/23, and the MDSC/LPN responded "Not on this particular, I have done previous residents." The surveyor asked the MDSC/LPN if the MDS was coded accurately when the MDS was checked off for formal method of skin assessment but no Braden assessment was done, and the LPN stated that "since you brought to us the concern" that no Braden assessment correspond the MDS, "yes base from the findings from today the MDS for section M0100 was coded inaccurately."

On 7/14/23 at 12:10 PM, the survey team met with the Director of Nursing (DON), ADON#1 and #2, Regional Interim DON (RIDON), Regional

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F 641	Continued From page 18	F 641		

DON (RDON), Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA). The surveyor notified the facility management of the above findings regarding the MDS accuracy.

On 7/17/23 at 11:36 AM, the survey team met with the RIDON, RDON, DON, ADON#1, LNHA, and AA. The RDON informed the survey team that the Braden scale assessment should be done for admission and quarterly assessments.

3. On 7/10/23 at 10:59 AM, the surveyor observed Resident #11 seated in a wheelchair inside their room with one [redacted] to the [redacted] side of the bed.

On 7/12/23 at 9:45 AM, the surveyor observed the resident was not in their room, there was one [redacted] on the floor to the [redacted] side of the bed.

The surveyor reviewed Resident #11's medical record.

The resident's AR reflected that the resident was admitted to the facility and had a diagnosis but not limited to EX Order 26.4B1 [redacted]

The resident's most recent qMDS with an ARD of [redacted] reflected that the resident's [redacted] was EX Order 26.4B1 and [redacted] complete the interview.

The resident's qMDS with an ARD of [redacted] and [redacted] revealed Section [redacted] Conditions,

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F 641	Continued From page 19 M0100 B. Formal Assessment Instrument/tool, (e.g., EX Order 26.4B1 was checked off which means that the facility utilized a formal assessment instrument or tool in answering this section. A review of the assessment in the EMR revealed that BSPPSR was done on EX Order 26.4B1. The next EX Order 26.4B1 scale completion done on EX Order 26.4B1 after surveyor inquiry. Further review of the assessment in the EMR revealed that there was no BSPPSR done for March 2023 to reflect in the 3/10/23 qMDS. The assessment in the EMR for BSPPSR was also in red which means that the assessment was not done for March 2023 for BSPPSR Further review of the assessment in the EMR revealed that there was no BSPPSR done for June 2023 to reflect in the 6/08/23 qMDS. The assessment in the EMR for BSPPSR was also in red which means that the assessment was not done for June 2023 for BSPPSR. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with the LNHA, AA, DON, RIDON, RDON, ADON#1, and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and the facility management both stated that there was no additional information. NJAC 8:39-33.2(d)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		8/26/23

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F 658	Continued From page 20 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 facility provided documents, it was determined that the facility failed to follow and revised the diet slip of one (1) of 19 residents, Resident #32 observed during breakfast observation according to the standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family	F 658	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Registered Dietician assessed the resident #32 and diet slip was updated. Scrambled eggs was added as per resident□s preference. Dieced peaches was added to the meal tray. Dietary staff was re in-serviced regarding following the diet slip and to provide resident meal preferences. Registered Dietician updated the food preferences and communicated to Food Service Director to update the tray card. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future).	

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F 658	Continued From page 21 teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 7/12/23 at 8:12 AM, the surveyor observed the Certified Nursing Aide (CNA) standing at the bedside of the resident while Resident#32 was seated on the bed. The resident Ex.Order 26.4(b)(1) [redacted] The surveyor observed the breakfast tray with the following: 4 (four) oz (ounces) orange juice mechanical soft/chopped scrambled egg yellow in color cinnamon oatmeal (plastic cover showed printed sticker super) mechanical soft/chopped blueberry muffin margarine 4 oz milk cup of coffee On that same date and time, the surveyor asked the CNA if the surveyor could check the diet slip that was under the resident's plate and the CNA stated "yes," and provided the diet slip. The diet slip showed the resident's name and room number and the following information: Ex.Order 26.4(b)(1) [redacted], dated Wednesday breakfast 7/12/23, and that included everything on the tray except that the diced peaches were missing, and the diet slip indicated that the resident should get soft/chopped hard-boiled eggs instead of scrambled eggs. At that time, the surveyor asked the CNA where	F 658	3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur All dietary staff was re- inserviced regarding following the diet slip when preparing meal trays. Food Service Director was re-inserviced to update resident diet slip based on the resident□s preferences following the diet order. Licensed nurses will be checking the diet slip before the meal trays are distributed to all residents. Registered Dietician or designee will check tray lines for accuracy of meals daily for 4 weeks, then weekly for 90 days and thereafter. Corporate Food Service Director will review tray cards for accuracy of meals served monthly for 90days and thereafter. Audits will be monitored for completion by the Administrator or designee and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended as indicated. Adverse findings will be immediately	

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F 658	Continued From page 22 the diced peaches and the CNA did not respond. The surveyor asked why there were no soft/chopped hard-boiled eggs and the CNA stated that the resident likes scrambled eggs "anyway" instead of hard-boiled eggs. During an interview outside the resident's room, the CNA informed the surveyor that Resident#32 was EX Order 26.4B1. The CNA confirmed that there were no diced peaches on the tray and no mechanical soft/chopped hardboiled egg instead it was a scrambled egg. The CNA stated that the resident did not like peaches. On 7/12/23 at 8:29 AM, the surveyor interviewed Assistant Director of Nursing#1 (ADON#1). The surveyor and ADON#1 went inside the resident's room. ADON#1 confirmed that the resident did not receive diced peaches and received scrambled eggs instead of hard-boiled eggs that were written in the diet slip. The ADON stated that she will get back to the surveyor about the concerns. On 7/12/23 at 8:40 AM, the surveyor interviewed the Food Service Director (FSD). The surveyor asked the FSD who was responsible for the tray line to make sure that the diet slip matches the actual tray and she responded that it was her responsibility and she was the one assigned today. The surveyor then asked why the resident did not receive Ex.Order 26.4(b)(1) [redacted], instead the resident got scrambled eggs. The surveyor asked the FSD also why there were no diced peaches in Resident #32's breakfast tray. On that same date and time, the FSD informed	F 658	addressed 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Results of this audit and observation will be discuss in morning clinical meeting for immediate resolution and this will be discussed in monthly QAPI and this will be a part of quarterly QA.	

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F 658	Continued From page 23 the surveyor that she spoke to the responsible party (RP) of the resident yesterday and the RP notified her that the resident preferred scrambled eggs instead of hard-boiled eggs. The FSD stated that she did not know why there were no diced peaches in the resident's tray, and that the facility had available peaches. At that time, the surveyor asked the FSD who was responsible for changing the diet slip according to the resident's preference. The FSD stated that she can change the diet preference in the diet slip and also the Dietician. The surveyor asked the FSD if she knew that the resident preferred the scrambled eggs, and why she did not change the diet slip. The FSD stated that she should have changed it. On 7/12/23 at 11:56 AM, the survey team met with the Regional Director Interim Director of Nursing (RIDON), Regional DON (RDON) Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), DON, Assistant DON#1 (ADON#1) and #2, and were notified of the above findings. The RIDON informed the survey team that the dietary staff and CNAs have to double-check the diet slip. She further stated that "Today I talked to the Dietician she had to review the diet slip and assess the resident." The surveyor reviewed the medical records of Resident#32. The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with a diagnosis that included but not limited to EX Order 26.4B1 [redacted],	F 658		

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F 658	Continued From page 24 EX Order 26.4B1 [redacted] The most recent quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of EX Order 26.4B1 revealed a Brief Interview for Mental Status (BIMS) score of EX Ord, which indicated that the resident's EX Order 26.4B1 status was EX Order 26.4B1. A review of the facility's Therapeutic Diets Policy with a revised date of December 2008 that was provided by the LNHA included that mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered "therapeutic diets." The Food Service Manager will establish and use a tray identification system to ensure that each resident receives his/her diet as ordered. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with the facility's LNHA, AA, DON, RIDON, RDON, and ADON#1 and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and the facility management stated that there was no additional information.	F 658		
F 684 SS=E	NJAC 8:39-11.2(b) Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		8/26/23

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F 684	Continued From page 25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint #NJ00154277 Based on the interview, review of the facility closed record, and the review of facility provided documents, it was determined that the facility failed to: a) document the Ex.Order 26.4(b)(1) of the resident, b) provide scheduled showers, c) administer medications according to the order of the physician, and d) notify the physician of late administration of prescribed medications in accordance with the resident's preferences, goals for care and professional standards of clinical practice for one (1) of 19 residents, (Resident#127) reviewed for quality of care 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 and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 684	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #127 was discharged and is no longer in the facility All residents will be re assessed for Ex.Order 2 [redacted] shower forms will be completed. 7-3 LPN #6 and RN#1 were re educated to inform physicians when the patients refuse medications, to document refusals and update care plans and residentts preferences. All licensed nurses were re-inserviced on Ex.Order 2 [redacted] assessments and providing showers as scheduled not unless it was refused. This will be documented in residentts clinical records. Licensed nurses were re- inserviced on medication administration. Licensed nurses were re in-serviced	

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F 684	Continued From page 26 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." According to the Admission Record (or face sheet; an admission summary), Resident #127 was admitted to the facility with a diagnosis that was not limited to EX Order 26.4B1 [redacted] The most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with an ARD (assessment reference date) of EX Order 26.4B1 showed that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order which reflected that the resident's EX Order 26.4B1 was EX Order 26.4B. Section EX Order 26.4B1 Conditions indicated that the resident had EX Order 26.4B1). The Report of Consultation dated EX Order 26.4B1	F 684	regarding on providing shower, documentation, refusals, and providing shouwers as scheduled. No other residents were affected by this deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put in place or systematic changes made to ensure that the deficient practice would not recur All licensed nurses were re-inserviced regarding documentation on treatment and procedure refusals. All licensed nurses were re-inserviced on Medication administrations. All licensed nurses were re-inserviced on updating care plans on residents preferences/refusals for showers, and other treatments and procedures. Unit managers and designee will audit 5 charts weekly x90 days and thereafter. DON and designee will audit 5 charts	

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F 684	Continued From page 27 showed that the resident was seen by a EX Order 26.4B1 and the findings were EX Order 26.4B1 [redacted] with a diagnosis (dx) of EX Order 26.4B1 [redacted] A review of the resident's medical records revealed that there was no EX Order 26 assessment done by the facility nurse on EX Order 26.4B1 when the resident came back from the EX Order 26.4B1 consult. The Medication Review Report for EX Order 26.4B1 showed a physician order for the following: 1. Order date EX Order 26.4B1 for Ex.Order 26.4(b)(1) weekly: (I) intact or (NI) not intact with a progress note every night shift every Tue (Tuesday) for routine Ex.Order 26 monitoring. 2. Order date EX Order 26.4B1 for EX Order 26.4B1 EX Order 26.4B1 [redacted] every day and evening shift for EX Order 26.4B1 The above physician orders were transcribed into the electronic Treatment Administration Record (eTAR) for EX Order 26.4B1 and revealed that on 4/19/22 a nurse documented "I" and on 4/26/22 another nurse documented "I" for the night. The order for EX Order 26.4B [redacted] lotion was also signed every day and evening shift as administered in the EX Order 26 [redacted] EX Order 26 [redacted] eTAR.	F 684	monthly x 90 days and thereafter. Audits will be monitored for completion by the Administrator or designee and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended as indicated. Adverse findings will be immediately addressed 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of the audits will be reported in monthly QAPI and this will be a part of quarterly QA to track trends and identify further action needed.	

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The Skilled Note in the Progress Note (PN) dated EX Order 26.4B1 signed by Registered Nurse#1 (RN#1) included that the resident was provided EX Order 26.4B lotion secondary to EX Order 26.4B1 On EX Order 26.4B1 PN at 6:49 PM signed by RN#2 showed that EX Order 26.4B lotion was provided secondary to EX Order 26.4B1.

On 7/13/23 at 10:21 AM, the surveyor interviewed the Regional Director of Nursing (RDON). The surveyor asked the RDON about the resident's consultation dated EX Order 26.4B1 with dx of EX Order 26.4B1 and what will be the expectation for the facility with regard to assessment. The RDON stated that Ex.Order 26.4(b)(1) should be done in the assessment part of the electronic medical record (EMR) and body assessment notes at least in the PN by the nurse. She further stated that "usually" in nurse's notes Ex.Order 26.4(b)(1) should include what the EX Order 26.4 look like, and check the room for signs of EX Order 26.4B1, and that was the protocol that "we follow."

On that same date and time, the surveyor asked the RDON to provide a copy of the facility's protocol for EX Order 26.4B1, skin/body assessment notes, nursing and aides assignments including the shower schedule for April 15-30, 2022, and the orders and electronic Medication Administration Record (eMAR) and eTAR for EX Order 26.4B1 and she stated she will get back to the surveyor.

On 7/13/23 at 01:26 PM, the surveyor reviewed the provided documents of the RDON and showed the following:

1. On 4/21/22 at 01:00 PM. Ex.Order 26 checks were

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F 684	Continued From page 29 done on [EX Order] side residents, no new onset of [EX Order 26.4B1] in other residents except Resident # 127. 2. Conclusion: after investigation, it was determined that there was no further incident of [EX Order 26.4B1] in the building. 3. Body Check Sheet dated 4/21/22 of Resident#127. Comments: EX Order 26.4B1 [redacted], all over the body signed by LPN#1. 4. The Documentation Survey Report (tasks of CNAs) provided did not include information that a shower was provided to the resident on [EX Order 26] [EX Order 26.4] On 7/14/23 at 8:46 AM, the surveyor asked the Licensed Nursing Home Administration (LNHA) for a copy of the showers that were done to the resident for the whole month of [EX Order 26.4B1] and he stated that he will get back to the surveyor. On 7/14/23 at 9:59 AM, the survey team met with Assistant Director of Nursing#1 (ADON#1) and #2 and discussed about Ex.Order 26.4(b)(1) [redacted] in accordance with the facility's practice and policy. According to ADON#2 skin assessment is "usually" done by an RN, "I believe in the morning we document in the progress notes." At that same time, ADON#1 informed the surveyors that if there will be a [Ex.Order 26.4(b)(1)] like Ex.Order 26.4(b)(1), "we document" in PN and Risk Management. ADON further stated, for the [Ex.Order 26.4] s "I have to clarify," if noted fungal rash from the diaper, "we" call the doctor and get the treatment order. In addition, ADON#2 informed the surveyors that	F 684		

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she was aware of the resident's EX Order 26.4B1 incident. The surveyor notified the two ADON about the above EX Order 26.4B1 eTAR EX Order 26.4B1 for two nurses who coded I (intact) for weekly Ex.Order 26. even though on EX Order 26.4B1 EX Order 26.4B1 Consult showed multiple areas of Ex.Order 26.4(b)(1) The surveyor also asked why there was no actual Ex.Order 26 assessment done on EX Order 26.4B1. ADON#2 stated I don't know what happened or why the Ex.Order 2 assessment was done late. She further stated that "maybe the nurse waiting for the doctor." The surveyor then asked the ADON what will be the expectation for the nurse to do if the resident came back with the doctor's note about EX Order 26.4B1. ADON#2 stated that there should be a kind of note that describes the resident's Ex.Order 26.4 color, and measurement when the resident came back from the EX Order 26.4B1 consult.

Furthermore, the surveyor asked for the full names and titles of the 4/19/22 and 4/26/22 nurses who signed the eTAR and if they still work at the facility for the surveyor to interview them, and both ADON#1 and #2 stated that they will get back to the surveyor.

On 7/14/23 at 12:10 PM, the survey team met with the Director of Nursing (DON), ADON#1 and #2, Regional Interim DON (RIDON), RDON, LNHA, and, Assistant Administrator (AA), and made aware of the above findings. The surveyor asked the facility management when the scheduled shower of the resident and the facility stated that they will get back to the surveyor.

On 7/14/23 at 01:20 PM, the surveyor reviewed the provided documents by the LNHA that was handwritten on a white bond paper that included the following information for shower and with

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F 684	Continued From page 31 attached notes: 5/23/22 page EX Ord 5/19/23 page EX Ord 5/18/23 page EX Ord 4/22/22 page EX Order 4/21/22 page EX Order 4/21/22 page EX Order 4/20/22 page EX Order, EX Order 4/9/22 page EX Order Attached were PN: Page EX Order showed that the effective date was EX Order 26.4B1 "..showered this shift."-electronically signed by LPN#2 Page EX Order showed that the effective date was EX Order 26.4B1 " ...for 1 day to entire body from EX Order 26.4B1 leave on overnight for 8 hrs then shower repeat in 5 day."-electronically signed by LPN#3 Page EX Order showed that the effective date was EX Order 26.4B1 "Resident came back from EX Order 26.4B1 consult ...Endorsed to the nurse about the treatment plan for the resident."-electronically signed by RN#4 Page EX Order showed that the effective date was EX Order 26.4B1 "..showered as ordered."-electronically signed by RN#5 Page EX Order showed that the effective date was EX Order 26.4B1 "..Patient was given the EX Order 26.4B1 during am care and was told he/she will shower at 7-8 PM ..."-electronically signed by LPN#4 Page EX Order showed that the effective date was EX Order 26.4B1 " ...Resident showered and put on the EX Order 26.4B1 for EX Order 26.4B1 on all Ex.Order 26.4(b)(1) on 7 PM, 4/21/22."-electronically signed by LPN#1	F 684		

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F 684	Continued From page 32 Page [EX Ord] showed that the effective date was EX Order 26.4B1 PM "..had shower."-electronically signed by RN#3 Page [EX Ord] showed that the effective date was EX Order 26.4B1 "..had shower."-electronically signed by RN#2 Page [EX Order] showed that the effective date was 5/23/22 at 10:32 PM "..had [EX Order 26.4B1] "-electronically signed by RN#3 There were no other showers provided for [EX Order 26.4B1] On 7/17/23 at 8:24 AM, the RDON in the presence of ADON#2 and the survey team informed the surveyor that according to LPN#4, who "usually" works 11-7 and who worked on that date on 4/19/22 at 3-11 shift and signed skin intact "thought" that if the resident had already previous documentation of [EX Order 26.4B1] does not need to document that the Ex.Order 26.4(b)(1) because it was not something new to the resident and that eTAR only pertains to EX Order 26.4B1. The RDON further stated that education was provided to the nurse regarding the appropriate documentation and that it should have been documented as [Ex.Ord]) on 4/19/22. In addition, the RDON stated that LPN#5 who coded Ex.Order 26.4(b)(1) on 4/26/22 of the 3-11 shift [EX Ords] and last work day was on 12/24/22. On that same date and time, the RDON also provided a copy of the signed attestation of RN/Supervisor (RN/S) stating that he was the nursing supervisor for the 3-11 shift on 4/21/22, the signed attestation was dated 7/14/23. The RDON indicated that according to the attestation, the RN/S remembered that date on 4/21/22 that the RN/S was told by the previous DON to	F 684		

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F 684	Continued From page 33 conduct body checks on all the residents on the [redacted] side using the body check sheet because one of the residents in the [redacted] side was found to have [redacted], so they needed to proactively check the rest of the residents on the same side. The RDON further stated that the RN/S instructed the evening nurses on the [redacted] side to complete the body checks and alert him if there are any new [redacted] or evidence of [redacted] so the RN/S can perform a [redacted] assessment, and the RN/S recalled that there was "no any reports of new [redacted] or signs of [redacted]." The surveyor then notified the facility management that based on the explanation of the RDON from the RN/S signed statements, still no RN assessment on that same date of 4/20/22 that will show that body assessment was done that will include a description of Ex.Order 26.4(b)(1), location, and size according to the facility practice and protocol that was mentioned by the facility management, not until 4/21/22. At that same time, the surveyor followed up again with the RDON and ADON#2 on the shower days of the resident and how often in a week the resident gets a shower. The RDON informed the surveyor that the resident gets a shower 2 x/a week and will provide the surveyor with a copy of the shower list "but just right now it's being updated," and will get back to the surveyor about the actual dates of the shower "the resident gets to shower every 3-11 shift." The surveyor asked the facility management what is the acceptable shower time in the 3-11 shift the resident gets a shower and if should it be documented when the shower provided at a later time in the 3-11 shift. The RDON stated that the acceptable time is at least before 10 PM not even after 8:30 PM	F 684		

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because the resident is prepping for bedtime "already." The RDON further stated that she will get back to the surveyor for the shower policy of the facility.

In addition, the surveyor asked the RDON and ADON#2 why the shower was given only on 4/09/22, 4/20/22, and 4/21/22 according to the provided documentation if the resident was supposed to get showered 2 x/a week and documented time for 4/09/22 for showered given was at 10:42 PM, and the RDON stated that she will get back to the surveyor. The RDON stated that showers should be given 2 x/a week and there should be documentation for refusal, a care plan, and notes if showers were not provided.

The surveyor also asked for a copy of the EX Order 26 EX Order 26 eMAR of the resident that included the time meds were administered and both stated that they will get back to the surveyor.

On 7/17/23 at 11:25 AM, the surveyor reviewed the provided printout of the resident's April 2022 Medication Admin Audit Report that was provided by the RDON showed that there were multiple 8 AM and 9 AM meds that were administered beyond an hour or more and not according to the physician's ordered time to administer medications as follows:

1. EX Order 26.4B1 topically one time a day for Ex.Order 26.4(b)(1). Scheduled Administration (SA) time 8:59 AM =administered: 4/01/22 at 02:04 PM, 4/04/22 at 12:53 PM, 4/06/22 at 12:19 PM, 4/11/22 at 02:23 PM, 4/12/22 at 12:23 PM, 4/13/22 at 11:58 AM, 4/14/22 at 5:07 PM, 4/19/22 at 02/51 PM, 4/22/22

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DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE PARAMUS, NJ 07652**

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F 684	Continued From page 35 at 11:36 AM, 4/23/22 at 11:40 AM, 4/25/22 at 11:36 AM, 4/26/22 at 11:15 AM 2. EX Order 26.4B1 give Ex.Order 26.4(b)(1) one time a day for EX Order 26.4B1. SA time 9:00 AM=administered 4/01/22 at 02:04 PM, 4/09/22 at 12:00 PM, 4/13/22 at 11:58 AM, 4/14/22 at 5:08 PM, 4/22/22 at 11:36 AM, 4/23/22 at 11:41 AM, 4/25/22 at 11:37 AM, 4/26/22 at 11:15 AM 3. EX Order 26.4B1 Ex.Order 26.4(b)(1) x/a day for EX Order 26.4B1 SA time 9:00 AM=administered 4/01/22 at 02:04 PM, 4/25/22 at 11:37 AM, 4/26/22 at 11:15 AM 4. EX Order 26.4B1 apply to Ex.Order 26 topically one time a day for EX Order 26.4B1. SA time 9:00 AM=administered 4/01/22 at 02:05 PM, 4/04/22 at 12:53 PM, 4/06/22 at 12:19 PM, 4/11/22 at 02:23 PM, 4/12/22 at 12:23 PM, 4/19/22 at 02:52 PM, 4/23/22 at 11:40 AM, 4/25/22 at 11:37 AM, 4/26/22 at 11:15 AM 5. Ex.Order 26.4(b)(1) g give one tab by mouth every 12 hours (hrs) for Ex.Order 26.4(b)(1) time 9:00 AM=administered 4/01/22 at 4:50 PM, 6. EX Order 26.4B1 capsule (cap) by Ex.Order 26.4(b)(1) x/a day EX Order 26.4B1. SA 8:00 AM=administered 4/05/22 at 9:52 AM, 4/09/22 at 11:59 AM, 4/12/22 at 10:15 AM, 4/13/22 at 10:14 AM, 4/17/22 at 9:43 AM, 4/19/22 at 9:51 AM, 4/21/22 at 9:56 AM, 4/22/22 at 9:59 AM, 4/25/22 at 11:36 AM, 4/28/22 at 9:53 AM 7. EX Order 26.4B1 Ex.Order 26.4(b)(1) one time a day for EX Order 26.4 EX Order prevention. SA time 8:00 AM=administered 4/08/22 at 9:39 AM, 4/12/22 at 10:16 AM, 4/13/23 at 10:14 AM, 4/17/22 at 9:43 AM, 4/21/22 at 9:56 AM, 4/22/22 at 9:59 AM, 4/25/22 at 11:36 AM, 4/28/22 at 9:51 AM 8. EX Order 26.4B1 one cap by mouth one time a day for EX Order 26.4B1 SA	F 684		

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F 684	Continued From page 36 time 9:00 AM=administered 4/09/22 at 11:07 AM, 4/25/22 at 11:37 AM 9. Ex.Order 26.4(b)(1) [redacted]. SA time 9:00 AM=administered 4/25/22 at 11:37 AM, 4/26/22 at 11:15 AM 10. Ex.Order 26.4(b)(1) [redacted] maintenance. SA time 9:00 AM=administered 4/25/22 at 11:37 AM, 4/26/22 11:15 AM 11. Ex.Order 26.4(b)(1) [redacted]. SA time 9:00 AM=administered 4/25/22 at 11:37 AM, 4/26/22 at 11:15 AM 12. Ex.Order 26.4(b)(1) [redacted]. SA time 9:00 AM=administered 11:17 AM 13. Ex.Order 26.4(b)(1) [redacted] SA time 9:00 AM=administered 4/26/22 at 11:15 AM At that same time, the surveyor notified ADON#2 of the above concern and asked the ADON why the medications were administered beyond the physician's order and she stated that she will get back to the surveyor. On 7/17/23 at 11:36 AM, the survey team met with the RIDON, RDON, DON, ADON#1, LNHA, and AA. The RDON stated that after the investigation, "I think" what happened was the resident was given a shower at 6 or 7 PM and the nurses documented late. The RDON further stated that "But I don't have proof that this happened, I'm just talking about my experience that no CNA gave a shower late." The RDON stated that "I know the UM (unit manager)	F 684		

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F 684	Continued From page 37 reminding to give a shower but not documented." On that same date and time, the RDON informed the surveyors that the facility documentation about showers was "not tight," and the problem was "I can't prove to you that shower was provided." On 7/17/23 at 12:34 PM, The RDON provided a Census list for the resident that showed that Resident#127 was in room [redacted], attached documents indicated that the resident's shower schedule for the 3-11 shift was highlighted every Wednesday and Saturday. On 7/18/23 at 10:07 AM, the survey team met with the LNHA, AA, DON, RIDON, RDON, ADON#1, and #2. The RDON informed the surveyors that she interviewed the assigned nurses of the resident who administered late medications to the resident on April 2022 for one hour, two hours, and thirty minutes. The RDON stated that RN#1 works with LPN#5, the resident preferred RN#1 over LPN#5 and that was the reason why medications were administered some days late because RN#1 had to finish his assigned residents first before going to Resident #127. She further stated that at times when RN#1 was about to administer medications to Resident #127, the resident will decline and will come back to administer medications. On that same date and time, the surveyor asked the facility management what was their policy and protocol with regard to late administration of medications, was this specific behavior for late administration of medications and staff preference for nurse administering medications	F 684		

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F 684	Continued From page 38	F 684		

were included in the resident's care plan, and if the physician was notified about late administration of medications and documented. The facility management acknowledged that the care plan did not include specific focus problems and interventions regarding the late administration of medication and that the doctor was notified of the late administration because there was no documentation in the resident's medical records about it.

At that time, the RIDON stated "I agree with that 100%," and agreed that the care plan should include the preference of the resident and intervention appropriate to a specific problem to target the interventions and prevent further problems. The RDON also acknowledged that there was no documentation that the above problem for late administration of medications was discussed and put into the care plan. The facility management acknowledged that this should have been done since it was repeatedly administered late.

On 7/18/23 at 01:09 PM, the surveyor reviewed the provided documents by the LNHA on 7/18/23 at 10:07 AM included the following:

1. Patient and Family Concerns dated 10/29/21 reported by the resident showed that the resident had a concern that the resident did not receive a scheduled shower on Thursday. Action: 3-11 supervisor was notified and the resident received a shower on Friday and ongoing education with staff to follow the resident's shower schedule. Follow-up: the facility has developed QAPI to follow resident's shower schedules and this is ongoing. This was reviewed and signed by the

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F 684	Continued From page 39 LNHA. 2. The documented interview of the nurses who administered late medications to the resident on [redacted] showed that: a. 7-3 LPN#6 stated that the resident sometimes will ask the nurse to come back when medications were to be administered. b. 7-3 RN#1 stated that the resident "likes him to administer resident's medications" and when the nurse is ready to administer medication, the resident will refuse and ask the nurse to come back at a later time. According to the provided Medication Administration Documentation investigation summary that was provided by the LNHA on showed that based on record review and staff interview, the resident was [redacted], no significant changes documented and the [redacted] were Ex.Order 26.4(b)(1) despite medications being administered beyond the prescribed time of the physician. This investigation summary was provided after the surveyor's inquiry. A review of the facility's Nursing Skin Assessment Policy with the last reviewed date of 10/2022 that was provided by the LNHA included that it is the facility's policy to perform a full body skin assessment as part of the facility's systematic approach for pressure ulcer prevention and the promotion of healing of various skin conditions. Documentation of skin assessment: include date and time of assessment, name, and title of doing the assessment, document observations (i.e. skin conditions, how the resident tolerated the procedure, etc.), document type of wound (measurements, color, type of tissue in wound bed, drainage, odor, pain), document if resident	F 684		

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F 684	Continued From page 40 refused assessment and why. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with the facility LNHA, AA, DON, RIDON, RDON, and ADON#1 and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and the facility management stated that there was no additional information. NJAC 8:39-27.1(a)	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to assess for risk for EX Order 26.4B1 quarterly and accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for one (1) of three (3)	F 686	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #40 was immediately assessed by an RN and a significant change was	8/26/23

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F 686	Continued From page 41 residents reviewed for EX Order 26.4B1 (Resident #40). The deficient practice was evidenced by the following: On 7/06/23 at 10:48 AM, the surveyor observed Resident #40 lying in bed with an EX Order 26.4B1. The surveyor reviewed the medical records of Resident #40 which revealed the following: The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with medical diagnoses that included but were not limited to EX Order 26.4B1 The most recent quarterly MDS (qMDS), with an Assessment Reference Date (ARD) of EX Order 26.4B1 showed that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1 which reflected that the resident's cognition was EX Order 26.4B1. Review of Section EX Order 26.4B1 EX Order 26.4B1 indicated the following: M0100. Determination of EX Order 26.4B1 Risk. The following were checked to indicate they applied to Resident #40. Resident has a EX Order 26.4B1 EX Order 26.4B1, a EX Order 26.4B1, or a Ex.Order 26.4(b)(1); Formal assessment instrument/tool (e.g. EX Order 26.4B1,	F 686	done. Minimum Data Set (MDS) was completed and submitted. Resident #10 EX Order 26.4B1 Scale assessment was performed by Unit manager. All current residents were assessed for Ex.Order 26.4(b)(1) and EX Order 26.4B1 Scale form was completed electronically. No other residents were affected of this deficient practice. 2) How the facility will identify other residents having the potential to be effected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put in place or systematic changes made to ensure that the deficient practice would not recur All Licensed nurses were re-inserviced on Ex.Order 26.4(b)(1) assessment and completion of [redacted] Scale form electronically. All findings must be reported immediately for proper treatment and management. Unit Mangers or designee will complete all assessments including EX Order 26.4B1 Scale before the ARD date (Comprehensive assessment) on	

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F 686	Continued From page 42 or other); Clinical Assessment. M0150. Risk of EX Order 26.4B1 indicated that Resident #40 was Ex.Order 26.4(b)(1) developing EX Order 26.4B1 M0210. EX Order 26.4B1 indicated that Resident #40 had one or more EX Order 26.4B1 . M0300 Current Number of EX Order 26.4B1 at Each Stage indicated Resident #40 had Ex.Order 26.4(b)(1) EX Order 26.4B1 that were not present upon admission/entry or reentry [into the facility]. The 5-day Medicare Part A Stay MDS, with an ARD of EX Order 26.4B1, showed that the resident had a BIMS score of EX Order 26.4B1 which reflected that the resident's cognition was EX Order 26.4B1. Review of Section EX Order 26.4B1 indicated the following: M0100. Determination of EX Order 26.4B1 Risk. The following were checked to indicate they applied to Resident #40. Resident has a EX Order 26.4B1 EX Order 26.4B1 , or a Ex.Order 26.4(b)(1) ; Formal assessment instrument/tool (e.g. EX Order 26.4B1, or other); Clinical Assessment. M0150. Risk of EX Order 26.4B1 indicated that Resident #40 was Ex.Order 26.4(b)(1) developing EX Order 26.4B1 . M0210. EX Order 26.4B1 indicated that Resident #40 had one or more EX Order 26.4B1 . M0300 Current Number of EX Order 26.4B1 EX Order 26.4B1 at Each Stage indicated Resident #40 had Ex.Order 26.4(b)(1) EX Order 26.4B1 EX Order 26.4B1 and one (1) EX Order 26.4B1 that was not present upon admission/entry or reentry [into the facility].	F 686	admission, Quarterly, Annually and Significant changes. Director of Nursing and designee will review 5 charts weekly X 90 days for 3 months and thereafter. MDS Coordinator was re-inserviced to ensure that all assessments including EX Order 26.4B1 Scale assessment are completed during their ARD date and completion of (RAI), MDS. Regional MDS or designee will review 5 charts monthly for 90 days and thereafter for accuracy of RAI (MDS)coding and assessments. Audits will be monitored for completion by the Administrator or designee and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended as indicated. Adverse findings will be immediately addressed 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of the audits will be reported in monthly QAPI and this will be a part of quarterly QA to track trends and identify	

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F 686	Continued From page 43 The qMDS, with an ARD of EX Order 26.4B1, showed that the resident had a BIMS score of EX Order 26.4B1 EX Ord which reflected that the resident's cognition was EX Order 26.4B1. Review of EX Order 26.4B1 Conditions indicated the following: M0100. Determination of EX Order 26.4B1 Risk. The following were checked to indicate they applied to Resident #40. Resident has a EX Order 26.4B1 EX Order 26.4B1, or a Ex.Order 26.4(b)(1); Formal assessment instrument/tool (e.g. EX Order 26.4B1, or other); Clinical Assessment. M0150. Risk of EX Order 26.4B1 indicated that Resident #40 was Ex.Order 26.4(b)(1) EX Order 26.4B1. M0210. EX Order 26.4B1 indicated that Resident #40 had one or more EX Order 26.4B1. M0300 Current Number of EX Order 26.4B1 at Each Stage indicated Resident #40 had Ex.Order 26.4(b)(1) The Significant Change MDS, with an ARD of EX Order 26.4B1 showed that the resident had a BIMS score of EX Ord out of EX Ord which reflected that the resident's cognition was EX Order 26.4B1. Review of Section EX Order 26.4B1 Conditions indicated the following: M0100. Determination of EX Order 26.4B1 Risk. The following was checked to indicate it applied to Resident #40. Clinical Assessment. M0150. Risk of EX Order 26.4B1 indicated that Resident #40 was Ex.Order 26.4(b)(1) EX Order 26.4B1. M0210. EX Order 26.4B1 indicated that Resident #40 Ex.Order 26.4(b)(1) or more EX Order 26.4B1.	F 686	further action needed.	

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F 686	Continued From page 44	F 686		

The annual MDS, with an ARD of EX Order 26.4B1, showed that the resident had a BIMS score of [redacted] out of [redacted] which reflected that the resident's cognition was EX Order 26.4B1. Review of Section EX Order 26.4B1 Conditions indicated the following:
M0100. Determination of EX Order 26.4B1 Risk. The following were checked to indicate they applied to Resident #40. Resident has a EX Order 26.4B1 or a Ex.Order 26.4(b)(1); Formal assessment instrument/tool (e.g. EX Order 26.4B1, or other); Clinical Assessment.
M0150. Risk of EX Order 26.4B1 Ex.Order 26.4(b)(1) /Injuries indicated that Resident #40 was developing EX Order 26.4B1.
M0210. EX Order 26.4B1 indicated that Resident #40 had one or more EX Order 26.4B1.
M0300 Current Number of EX Order 26.4B1 EX Order 26.4B1 at Each Stage indicated Resident #40 had Ex.Order 26.4(b)(1).

A review of the assessments tab in the electronic medical record indicated that the last EX Order 26.4B1 Scale For Predicting EX Order 26.4B1 Ex.Order 26.4(b)(1) assessment EX Order 26.4B1, a formal assessment tool used by health professionals, especially nurses, to assess a patient's risk of developing a EX Order 26.4B1) was done on EX Order 26.4B1. Under next assessment due was (in red lettering) EX Order 26.4B1 For Predicting EX Order 26.4B1 Risk 808 days overdue-4/24/21. A review of the EX Order 26.4B1 For Predicting EX Order 26.4B1 Risk dated 01/24/21 indicated the score was [redacted] and the resident had a EX Order 26.4B1

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F 686	Continued From page 45 The facility did not perform quarterly EX Order 26.4B1 EX Order 26.4 assessments. The facility coded four of the last five MDS' incorrectly which indicated the facility used a formal assessment tool when the facility did not. On 7/12/23 at 10:52 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) regarding the EX Order 26.4B1 Scale assessments. The UM/RN stated that the assessments would be in the electronic medical record under the assessment tab and that the assessments were done according to the MDS. On 7/13/23 at 11:39 AM, the surveyor asked the UM/RN to view Resident #40's electronic medical record. The UM/RN confirmed that Resident #40's last EX Order 26.4B1 assessment was done on 01/21/21. She also confirmed that there was an indication in red that the next EX Order 26.4B1 assessment was due EX Order 26.4B1 which was 810 days overdue. The surveyor then asked the UM/RN what the purpose of the EX Order 26.4B1 assessment was. She stated that the purpose for the EX Order 26.4B1 was to determine if a person was Ex.Order 26.4(b)(1) . She added that it helps to indicate if they need interventions to prevent a EX Order 26.4B1 . The surveyor asked the UM/RN if Resident #40 should have had quarterly EX Order 26.4B1 Scale assessments. The UM/RN stated that Resident #40 should have had EX Order 26.4B1 Scale assessments. She added that even though the assessments were not done, the resident had interventions in place including an Ex.Order 26.4(b)(1) physician visited the resident weekly. On 7/14/23 at 10:00 AM, in the presence of	F 686		

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another surveyor, the surveyor interviewed Assistant Director of Nursing (ADON) #1 and ADON #2 regarding the protocol for assessing risk for EX Order 26.4B1. ADON #2 stated that the facility used the EX Order 26.4B1 Scale assessment and that it was done on admission and that she believed quarterly with the MDS. The surveyor then asked where the assessment would be located. ADON #2 stated that it was in the electronic medical record under the assessment tab. She added that the facility mostly had agency nurses (nurse employed by an outside agency, not the facility) and that some of them did not know what a EX Order 26.4B1 Scale was.

On 7/14/23 at 10:25 AM, in the presence of another surveyor and ADON #1, the surveyor interviewed ADON #2 regarding Resident #40. ADON #2 stated that Resident #40 should have had quarterly EX Order 26.4B1 Scale assessments and that she was not aware that there were missing EX Order 26.4B1 Scale assessments. The surveyor then asked ADON #2 who was responsible for checking that the assessments were done. ADON #2 stated that the Unit Manager should have checked that the EX Order 26.4B1 Scale was done.

On 7/14/23 at 10:51 AM, in the presence of another surveyor, the surveyor interviewed the MDS Coordinator/Licensed Practical Nurse (MDSC/LPN) regarding Resident #40's MDS and how the assessment was done for Section EX Order 26.4B conditions. The MDSC/LPN stated that on admission she would review the orders and check the assessment that was done by the nurse that admitted the resident. She stated that it populates a quarterly assessment and that she provided a calendar to the unit managers which

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F 686	Continued From page 47 indicated when the assessment was due. She stated that the assessment is then scheduled by the unit manager according to the schedule that she provided them. The MDSC/LPN stated that it was an assumption that the assessment would be completed. She added that if an assessment was missing she would have populated a QAPI (Quality Assurance and Performance Improvement is a data driven and proactive approach to quality improvement). The surveyor then asked the MDSC/LPN how she coded Resident #40's MDS accurately when she indicated that a formal assessment tool was used when the last EX Order 26.4B1 Scale that was done was 1/24/21. The MDSC/LPN stated that the MDS would be inaccurate based on the findings for today. She added that she had done a QAPI on EX Order 26.4B1 Scale assessment on EX Order 26.4B1. The surveyor then asked the MDSC/LPN should Resident #40's missing EX Order 26.4B1 Scale assessments been picked up at that time. She confirmed that the missing assessments should have been noticed during the EX Order 26.4B1 QAPI. On 7/14/23 at 12:39 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administration (LNHA), Assistant Administrator (AA), Director of Nursing (DON), Assistant Director of Nursing (ADON) #1, ADON #2, Regional Interim DON (RIDON) and Regional DON (RDON) the concern that facility had not done quarterly EX Order 26.4B1 Scale assessments and that the MDS' were coded incorrectly for Resident #40. On 7/17/23 at 11:48 AM, in the presence of the survey team, LNHA, AA, DON, ADON #1 and RDON, the RIDON stated that Resident #40	F 686		

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F 686	Continued From page 48 should have had [EX Order 26.4B1] Scale assessments done quarterly. She added that the [EX Order 26.4B1] Scale assessments should be done on admission and quarterly. A review of the facility provided policy titled, "Pressure Ulcer Risk Assessment" with a reviewed/revised date of 10/22/2022, included the following: Purpose: The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk for developing pressure ulcers .... Assessment: 1. Risk Assessment. A pressure ulcer risk assessment will be completed upon admission, with each additional assessment; quarterly , annually and with significant changes ... 4. Because a resident at risk can develop a pressure injury within 2 to 6 hours of the onset of pressure, the at at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure injuries. The admission evaluation helps define those initial care approaches ... 8. The comprehensive assessment, which includes the Resident Assessment Instrument (RAI)/MDS, evaluates the resident's intrinsic risks, the resident's skin condition, other factors (including causal factors) which place the resident at risk for developing pressure ulcers and/or experiencing delayed healing, and the nature of the pressure to which the resident may be subjected. The assessment should identify which risk factors can be removed or modified ... Equipment and Supplies: The following equipment and supplies will be necessary when providing a pressure ulcer risk assessment:	F 686		

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F 686	Continued From page 49 1. Resident's medical record, including admission data; 2. MDS assessment form; 3. Assessment tools such as the EX Order 26.4B1 Scale or EX Order 26.4B1 r Scale; and 4. Personal protective equipment ... N.J.A.C. 8:39-27.1(a)	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		8/26/23

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F 755	Continued From page 50 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility provided documents, it was determined that the facility failed to ensure a) proper storage of medication (med) for one (1) of 19 residents, Resident #32 observed during the first day of tour; b) med was available for one (1) of four (4) residents, Resident#45 during med administration observation; c) proper disposal of med for one (1) of three (3) nurses observed during med administration; d) med was administered according to the order of the physician for one (1) of 19 residents, Resident#129 observed during med cart inspection according to the standards of clinical practice and facility policies. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 755	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #19, #32; and #45 were assessed by an RN with Ex.Order 26.4(b)(1) [redacted] noted. Affected Licensed Nurses were counselled for not following proper storage of biologicals and medication administration. Physician was immediately notified, orders of said Vitamins was added to the resident orders for facility to administer. Daughter was educated on facility medication administrration policies and not to bring in any type of medications without notifying the nurses or the physician. LPN # 1 was counselled on calling the pharmacy and to notify the supervisor for any missing medications. For Resident #45 the primary physician was called regarding the EX Order 26.4B1 [redacted] that was not available during medication pass.	

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F 755	Continued From page 51 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 7/06/23 at 10:50 AM, the surveyor observed Resident #32 seated in a wheelchair with the Certified Nursing Aide (CNA) at the bedside. The surveyor observed a closed bottle of [name redacted] vitamins with the resident's last name and room number. The surveyor asked the CNA what was the bottle and who was for, and the CNA stated that it was for the resident and the family "probably" brought it. On 7/06/23 at 11:24 AM, the surveyor went back to the resident's room with the Director of Nursing (DON) and observed the same bottle of vitamins at the same location on top of the nightstand. The surveyor asked the DON should the med be at the bedside and the DON stated that she will get back to the surveyor. On 7/06/23 at 12:27 PM, the surveyor interviewed the DON. The surveyor asked the DON should the bottle of vitamins be at the resident's bedside, and the DON stated "The answer is no, I took it out and gave it to the	F 755	Pharmacy provider was immediately notified to deliver the medication. LPN #2 was immediately reported to agency supervisor regarding her work performance. Agency nurse will not return to facility anymore and requested agency to provide re-education to nurse. LPN #3 was immediately counselled and re in serviced regarding proper medication administration and pre-pouring of medications is not accepted. Attending physician was notified and all seven medications were properly disposed to drug buster witnessed by 2 nurses and was provided at a later time per physcian instruction. No other residents were affected of this deficient practice 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put in place or systematic changes made to ensure that the deficient practice would not recur	

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F 755	Continued From page 52 nurse, and the unit clerk now calling the doctor if the doctor wanted to order the med since the resident had no order for it." The DON further stated that the MD (medical doctor) was called to notify of the concern. The surveyor notified the DON that at the time the surveyor observed the med was when the CNA was at the bedside. At that time, Licensed Practical Nurse#1 (LPN#1) came and informed the surveyor in the presence of the DON that the CNA should have told her that she saw the med at the bedside and that the med should not be left at the bedside. LPN#1 confirmed that the resident had no order for the vitamin that was found at the bedside. The surveyor reviewed the medical records of Resident#32. The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with a diagnosis that included but not limited to EX Order 26.4B1 [redacted]. The most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] revealed a brief interview for mental status (BIMS) score of [redacted] which indicated that the resident's status was EX Order 26.4B1.	F 755	All nurses were re educated on medication administration policy and procedure and storage of biological and proper disposal of medications and COVID -19 swab. DON or designee will review 5 nurses monthly for 90 days and thereafter for medication administration and storage of biologicals. Unit manager or designee will inspect medication carts 3x a week x 90 days, then monthly and thereafter for pre -poured medications, disposals and storage of medications. Pharmacy consultant will review 2 nurses monthly x 6 months and thereafter for medication pass monthly. DON or designee will review medication delivery daily for 4 weeks X 90 days and thereafter. Audits will be monitored for completion by the Administrator or designee and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met. This plan can be amended as indicated. Adverse findings will be immediately addressed	

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F 755	Continued From page 53 A review of the July 2023 Order Summary Report (physician's orders) revealed that there was no order for the above vitamins. On 7/10/23 at 9:47 AM the Licensed Nursing Home Administrator (LNHA) provided a copy of the summary in regards to the bottle of vitamins that were found at the resident's bedside which showed that when the surveyor observed during the round on 7/06/23 a bottle of multivitamins (MVI) at the resident bedside, immediately the physician was notified. The summary also included that it was the responsible party who brought the MVI and that the resident was assessed and there were no significant changes noted to the resident. On 7/12/23 at 11:56 AM, the survey team met with the Regional Interim Director of Nursing (RIDON), Regional Director of Nursing (RDON), LNHA, Assistant Administrator (AA), DON, Assistant DON#1 (ADON#1) and ADON#2, and were made aware of the above findings. The RIDON stated that meds should not be left at the bedside. The ADON acknowledged that the CNA should have notified the nurse immediately of the MVI at the bedside and it should have been properly stored, and not left at the bedside. On 7/13/23 at 8:49 AM, the RDON in the presence of the LNHA stated that the facility's protocol should have been followed when med was found at the bedside, the staff should notify the nurse, not leave at the table, and call the doctor. 2. On 7/10/23 at 7:50 AM, during med administration, the surveyor observed LPN#1	F 755	4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of the audits will be reported in monthly QAPI and this will be a part of quarterly QA to track trends and identify further action needed.	

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prepared and administered med to Resident #45. The med [redacted] tablet (tab) order to be given was not available.

On that same date and time, both LPN#1 and Registered Nurse/Supervisor (RN/S) confirmed that the [redacted] med was not available. LPN#1 stated that the med will be held and will call the doctor and pharmacy because it's not an in-house stock.

A review of Resident#45's electronic Medication Administration Record (eMAR) for July 2023 showed that [redacted] oral give [redacted] for [redacted] was ordered on [redacted] and remained as an active order.

Further review of the [redacted] eMAR order for [redacted] showed that on 7/02/23, 7/04/23, and 7/10/23 at 9 AM and 7/01/23 and 7/09/23 at 5 PM, the eMAR was coded as 9 which indicated "other/see progress notes."

A review of the packing slip from the pharmacy dated [redacted] showed med [redacted] tab and quantity delivered was [redacted] tabs. The packing slip from the pharmacy dated [redacted] for [redacted] and quantity delivered was [redacted] tabs.

On 7/10/23 at 9:41 AM, The surveyor observed LPN#1 in the nursing station, and LPN#1 informed the surveyor that the med [redacted] of Resident#45 was held by the doctor, and the pharmacist was called to deliver the med. The LPN showed the July 2023 eMAR from 7/01/23-7/10/23. The surveyor asked the LPN

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what was code 9 (nine) in the eMAR meant for, and the LPN stated that the med was not available and waiting for delivery.

On 7/12/23 at 11:56 AM, the survey team met with the RIDON, RDON, LNHA, AA, DON, ADON#1 and #2, and ADON and were notified of the above findings. The RDON stated that "about Resident#45's med, the facility had a process that we follow in the facility," which was to call the pharmacy and follow up med, to notify the supervisor if not available, call the doctor, and document. The surveyor then asked the RDON if the process was followed and the RDON stated "I did not see, that was why we QAPI (Quality Assurance Performance Improvement) it."

3. On 7/10/23 at 8:54 AM, during med administration observation, the surveyor observed LPN#2's open med cart garbage with one white marquise-shaped (an elongated elliptical shape with pointed ends) tablet, inside the garbage receptacle mixed with a wrapper of COVID kit and used gloves. The surveyor asked LPN#2 what was inside her med cart garbage receptacle and she responded that it was a EX Order 26.4B1 med and it was not her, that it was "probably" the 11-7 shift nurse who throw the med in the garbage. She further stated that the med should have been thrown in the drug buster (the medication disposal system quickly turns most non-hazardous medications into a non-toxic slurry that can be safely put in the trash) not in the garbage. The LPN then took the EX Order 26.4B1 med and disposed of it into the drug buster that was inside her med cart.

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F 755	Continued From page 56 On that same date and time, the surveyor asked LPN#2 how did she know that it was a EX Order 26.4B1 EX Order 26.4B. The LPN stated that "I just knew," because she encountered the medication previously and had been giving meds. The surveyor then asked the LPN if she knew who was the resident that have an order for EX Order 26.4B1 in her assignment, and the LPN responded "I do not know." On 7/17/23 at 11:16 AM, the DON provided documents and informed the surveyor that after investigation, it was Resident #39 who had the EX Order 26.4B1 pill found in the garbage on EX Order 26.4B1 med administration observation of the surveyor. She further stated that Resident #39 was one of the residents that was on LPN#2's assignment. On 7/17/23 at 11:36 AM, the survey team met with the RIDON, RDON, DON, ADON#1, LNHA, and AA. The RDON stated that there were two residents on EX Order 26.4B1. The DON stated that she looked at all Ex.Orde residents that LPN#2 had on 7/10/23 and it was concluded that the EX Order 26.4B1 in the garbage was from Resident #39, based on the date meds were ordered, the timing of med, how many were delivered, and how many were administered to the resident. 4. On 7/14/23 at 11:56 AM, the surveyor observed LPN#3 in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM) opened the Ex.Orde med cart during med cart inspection. The surveyor observed a cup of medicine filled with Ex.O different meds. The surveyor asked LPN#3 what medications, and to whom the meds belong.	F 755		

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F 755	Continued From page 57 LPN#3 stated that the meds were for Resident #129 and that she did not know that the resident was not in the room at the time when she poured the medications. LPN#3 further stated that the [redacted] meds were for 11 AM. On that same date and time, the surveyor asked LPN#3 if the facility allowed the nurse to pre-pour meds and what she should have done with the meds when she found out that the resident was not in the room. LPN#3 did not respond. The LPN/UM then responded that it was not allowed to pre-pour the meds and that the nurse should have discarded it in the drug buster if she realized that the resident was not in the room and not left it in the med cart. ADON#1 provided a handwritten list of Resident#129's pre-poured [redacted] meds and showed that the meds were not for 11 AM as follows: EX Order 26.4B1 [redacted] On 7/17/23 at 11:36 AM, the survey team met with the RIDON, RDON, DON, ADON#1, LNHA, and AA, and were made aware of the above findings. The RDON stated that an investigation was done with regard to Resident#129's meds	F 755		

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F 755	Continued From page 58	F 755		

that were pre-poured by an agency nurse, LPN#3. The RDON further stated that the [redacted] meds were discarded to the drug buster and that according to the LPN/UM, the doctor was notified and ordered to administer the new batch of meds around 12:30 PM for 8 AM and 9 AM meds. The facility management acknowledged that the doctor was notified of 8 AM and 9 AM meds were not administered on time after the surveyor's inquiry.

A review of the facility's Storage Medications Policy that was provided by the LNHA with a reviewed/revised date of 10/20/22 included that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining med storage and preparation areas in a clean, safe, and sanitary manner.

A review of the undated Medication Re-Ordering Process that was provided by the LNHA included that if any medication is not available or not delivered in your shift: 1. call the pharmacy to check availability/delivery times 2. notify your supervisor/DON 3. if medication not available, inform MD and get orders 4. document.

A review of the Ordering and Receiving Non-Controlled Medications Policy with a revision date of 08-2020 that included that reorder medications based on the estimated refill date (ERD) on the pharmacy Rx label, or at least three days in advance, to ensure an adequate supply is on hand; and that the refill order is called in, faxed, sent electronically, or otherwise transmitted to the pharmacy. Delivery records are retained in accordance with facility policy.

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	315129	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE PARAMUS, NJ 07652**

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F 755	Continued From page 59 A review of the facility's Physician Medication Orders Policy with a reviewed/revised date of 10/2022 that was provided by the LNHA included that drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with the facility LNHA, AA, DON, RIDON, RDON, and ADON#1 and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and the facility management stated that there was no additional information. NJAC 8:39-11.2(b), 29.2(d)	F 755		
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,	F 880		8/30/23

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F 880	Continued From page 60 identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (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.	F 880		

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F 880	Continued From page 61 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to: a) label and properly store the EX Order 26.4B1 for one (1) of two (2) residents, (Resident#126) reviewed for EX Order 26.4B1 and b) perform hand hygiene appropriately for one (1) (Licensed Practical Nurse) of three (3) staff observed during medication (med) administration in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and facility policy. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 01/08/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's	F 880	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #126 was assessed by an RN and the Ex.Order 26.4(b)(1) was discarded, was replaced with a new [redacted] were properly labelled, and dated and stored accordingly Affected LPN was in-serviced regarding proper hand hygiene and completed the hand hygiene competency. This deficient practice did not result in any harm. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be	

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F 880	Continued From page 62 immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. In addition, wear gloves, according to Standard Precautions, when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur; gloves are not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment, and after removing gloves. When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry them. Use a towel to turn off the faucet. 1. On 7/06/23 at 11:13 AM, the surveyor observed Resident #126 laying on a specialized mattress with a responsible party (RP) at the bedside. The RP informed the surveyor that the resident was newly diagnosed with [redacted]. The RP further stated that the resident was not [redacted] at home and was not sure how often the resident use [redacted] at the facility. On that same date and time, the surveyor observed the [redacted] on top of the nightstand was not properly stored, directly in contact with	F 880	affected by this deficient practice. Therefore, this applies to all residents (current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practices would not recur Nursing Staff Education regarding proper care of [redacted] treatment, labeling and storage, entering [redacted] orders on eMAR, and Proper Hand Hygiene was completed. When all staff training has been completed, Infection Preventionist (IP) or designee will check 5 employees weekly X 90 days for proper hand hygiene procedure. DON or designee will perform hand Hygiene competency to 5 employees weekly x 4 weeks and thereafter. Regional IP nurse will conduct weekly rounds to ensure compliance with Centers for Disease Control and Prevention (CDC) guidelines and facility policy. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of the audits will be reported	

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F 880	Continued From page 63 the paper, and not dated. On 7/06/23 at 12:51 PM, the Assistant Administrator (AA) informed the survey team that the facility was 15th day of the COVID-19 outbreak. On 7/11/23 at 9:01 AM, the surveyor and Assistant Director of Nursing#1 (ADON#1) went inside the resident's room. The resident was laying on the bed and awake. Both the surveyor and ADON#1 observed the Ex.Order 26.4(b)(1) on top of the nightstand table and a Ex.Order 26.4(b)(connector was inside the nightstand drawer, and the surveyor asked the ADON to check the resident's Ex.Order [redacted] inside the drawer. The ADON opened the drawer and showed the surveyor the Ex.Order 26.4(b)(1) inside a plastic bag and the surveyor asked the ADON to check if there was a label or date in the Ex.Order 26.4(b)(1) and the ADON did not respond. Later on, the ADON stated that she will discard the Ex.Order [redacted] and replace a new one because there was no date. Furthermore, the ADON stated that it should be dated. The surveyor reviewed Resident#126's medical record. The resident's Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to muscle weakness, essential hypertension (abnormal blood pressure), chronic kidney disease, COPD, and type two diabetes mellitus with unspecified complications (a chronic disease affecting blood glucose regulation).	F 880	in monthly QAPI and this will be a part of quarterly QA to track trends and identify further action needed.	

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F 880	Continued From page 64 The most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with a brief interview for mental status (BIMS) score of [redacted] which reflected that the resident's [redacted] status was [redacted] On 7/12/23 at 11:56 AM, the survey team met with the Regional Interim Director of Nursing (RIDON), Regional DON (RDON), Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), DON, Assistant Director of Nursing#1 (ADON#1), and ADON#2 and were made aware of the above findings. At that time, ADON#1 stated that according to the Registered Nurse Supervisor (RNS) that there was a clear plastic tape with the 7/09/23 date wrapped around the [redacted] when both the surveyor and ADON saw the resident on 7/11/23. ADON#1 further stated that she did not see the tape, and that clear tape should not be used because it was not according to the facility's protocol to use clear tape. On that same date and time, ADON#1 informed the surveyor that the [redacted] should not be on top of the nightstand table and not properly stored when not in use. She further stated that it should be stored inside a plastic bag when not in use according to the facility's protocol and practice. On 7/13/23 at 12:33 PM, the survey team met with the LNHA, DON, ADON#1 and #2, RDON, RIDON, and AA. The RDON informed the survey team that Ex.Order 26.4(b)(1) were the responsibility of the 11-7 shift nurse to change once a week every Wednesday. The RDON	F 880		

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F 880	Continued From page 65 further stated that the accountability for changing the Ex.Order 26.4(b)(1) should be documented in the resident's electronic Treatment Administration Record (eTAR) and that there should be an order for it. The surveyor then notified the facility management that there was no order and there was no documented evidence in the eTAR that the [redacted] change once a week was being done. The RIDON stated that she will get back to the surveyor why there was no order and no documentation in the eTAR. A review of the facility's Ex.Order 26.4(b)(1) r Care Policy that was provided by the LNHA updated on 4/18/23 included care of the Ex.Order 26.4(b)(1) Ex.Order 26.4(b)(1) in a plastic bag when dry; change Ex.Order 26.4(b)(1) weekly. The policy did include accountability documentation for weekly change. 2. On 7/10/23 at 8:54 AM The surveyor observed the Licensed Practical Nurse (LPN) enter and exit room [redacted] after administration of meds without performing hand hygiene. During an interview, the surveyor asked the LPN what was in her med cart garbage, immediately the LPN donned (applied) new pair of gloves without performing hand hygiene, and grabbed a white marquise size tablet from the garbage. The LPN stated that the med should have been disposed of in the drug buster (which provides immediate disposal of unused medications and drugs). Afterward, the LPN doffed off (removed) the used gloves and did not perform hand hygiene. On 7/10/23 at 8:59 AM, the surveyor observed the LPN prepared meds for Resident#21. The LPN entered Resident#21's room and performed	F 880		

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F 880	Continued From page 66 handwashing and scrubbed both hands for 13 seconds under the stream of running water. Then, the LPN administered all meds by mouth, immediately donned a new pair of gloves without performing hand hygiene, and handed the resident the EX Order 26.4B1 [redacted] On that same date and time, the LPN while inside the resident's room performed handwashing, and scrubbed both hands under the stream of running water for 33 seconds. On 7/10/23 at 9:33 AM, the surveyor interviewed the LPN. The LPN informed the surveyor that she was from an agency, and it was her third time working in the facility. The surveyor asked the LPN if she had an education and competency about hand hygiene at the facility, and the LPN stated that she was not sure. The LPN further stated that "I know that handwashing should be at least 20 seconds." On that same date and time, the surveyor asked the LPN to state the process of handwashing and the LPN stated that handwashing or scrubbing of hands should be under the stream of water. The surveyor then asked the LPN if she washed her hands for 20 seconds and she did not respond. On 7/11/23 at 8:15 AM, the surveyor met with the LNHA and the AA and was made aware of the above findings. On 7/12/23 at 11:56 AM, the survey team met with the RIDON, RDON, LNHA, AA, DON, ADON#1, and ADON#2 and were made aware of	F 880		

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F 880	Continued From page 67 the above findings. A review of the facility's Handwashing/Hand Hygiene Policy with a revised date of 4/2010 that was provided by the LNHA included that the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Employees must perform hand hygiene but not limited to after removing gloves; hand hygiene is the final step after removing and disposing of personal protective equipment; before and after direct resident contact; after contact with the resident's intact skin. The use of gloves does not replace hand washing/hand hygiene. The washing of hands procedure included vigorously lathering hands with soap and rubbing them together, creating friction to all surfaces, for at least 20 seconds. On 7/18/23 at 02:42 PM, the survey team met for an exit conference with the facility LNHA, AA, DON, RIDON, RDON, and ADON#1 and #2. The surveyor asked the facility management if there will be additional information for the findings that were notified to the facility, and the facility management stated that there was no additional information. NJAC 8:39-19.4 (a)(1)(n)	F 880		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 6 out of 14 Day Shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1) How the corrective action will be accomplished for those residents found to have been afected by the deficient practice All efforts to hire facility Certified Nursing Aide(s) C.N.A will continue until there is adequate staff to serve all residents. Until the time, facility will utilize staffing agencies to fill any open spots in the schedule .Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs,	8/26/23

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

Electronically Signed | 08/04/23

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 06/18/2023 to 6/24/2023 and 06/25/2023 to 7/01/2023, the staffing to resident ratios that did not meet the minimum requirement of one (1) CNA to eight (8) residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: 06/18/23 had 9 CNAs for 83 residents on the day shift, required 10 CNAs. 06/19/23 had 9 CNAs for 79 residents on the day shift, required 10 CNAs. 06/21/23 had 9 CNAs for 79 residents on the day shift, required 10 CNAs. 06/23/23 had 8 CNAs for 79 residents on the day shift, required 10 CNAs. 06/27/23 had 9 CNAs for 79 residents on the day shift, required 10 CNAs.	S 560	shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. No resident was affected with this deficient practice. 2) How the facility will identify other residents having the potential to be affected by the same practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents(current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials, sign on bonuses and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. The Administrator or designee will review staffing schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts.	

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S 560	Continued From page 2 06/30/23 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. On 7/18/2023 at 10:55 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing. The SC acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs.	S 560	4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

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
315129 Y1	A. Building B. Wing Y2	9/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	532 FARVIEW AVE PARAMUS, NJ 07652

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0610	Correction	ID Prefix F0637	Correction	ID Prefix F0641	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g)	Completed
LSC	08/26/2023	LSC	08/26/2023	LSC	08/26/2023
ID Prefix F0658	Correction	ID Prefix F0684	Correction	ID Prefix F0686	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	08/26/2023	LSC	08/26/2023	LSC	08/26/2023
ID Prefix F0755	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	08/26/2023	LSC	08/30/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/18/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
060207 Y1	Y2	9/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	532 FARVIEW AVE PARAMUS, NJ 07652

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/26/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**07/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE** **PARAMUS, NJ 07652**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 07/12/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/12/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Dellridge Health and Rehabilitation Center is a one-story building with partial basement that was built in the 1970's. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator does approximately 100 % of the building per the Maintenance Director. The current occupied beds are 85 of 88.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour.	K 311		7/26/23

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

Electronically Signed | 08/04/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**07/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE** **PARAMUS, NJ 07652**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 1 An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.2.1.7.2. This deficient practice had the potential to affect 85 residents. Findings include: An observation on 07/12/23 at 2:24 PM revealed the stairway exit doors in the basement were equipped with panic hardware which violated the listing of the rated fire door assembly. At the time of observation, the Maintenance Director was present and verified the panic hardware on the stairway doors. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 311	1) How the corrective action will be accomplished for those residents found to have been effected by the deficient practice Fire rated panic bars that are appropriate for the two stairway exit doors in the basement were ordered on Wednesday July 19th, 2023 and installed Wednesday July 26th, 2023 and applied to the doors Current 185 residents in house was assessed and were not affected with this deficient practice 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**07/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	**532 FARVIEW AVE** **PARAMUS, NJ 07652**

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K 311	Continued From page 2	K 311	All fire exit doors in the facility were evaluated to ensure the appropriate fire rated panic hardware was in place Administrator or designee will conduct daily rounds x 90days and thereafter ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance within 101 Life Safety Code. Audits will be conducted monthly for three months and then quarterly by the facility Maintenance Director or Designee 4) How the faclity will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of these audits will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review by the facility Administrator or designee Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K 761		8/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**07/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 3 Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 85 residents. Findings include: A review of the facility's binder, provided by the Maintenance Director, revealed fire door inspections were not conducted. An observation on 07/12/23 from 1:30 PM to 2:24 PM confirmed no inspections had been conducted on any of the facility's fire doors in that the doors lacked the required inspection tags that would be placed on the door after the inspection. At the time of the observation, the Maintenance Director was present and confirmed the doors were not inspected. NJAC 8:39-31.2(e) NFPA 80	K 761	1) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice The facility Maintenance Director obtained on Wednesday July 19th, 2023 the NFPA 101 inspection and testing of fire and smoke door assembly audit tool to be used on each door. This tool was used to complete inspection and testing on each fire and smoke door and assemblies in the facility. The Regional Maintenance Director will be certified in NFPA 101 for annual fire and smoke door inspections by August 30th, 2023. Current 185 residents in house was assessed and were not affected with this deficient practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**07/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 4	K 761	2) How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). 3) What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur An audit of the facility maintenance book will be completed by the facility Maintenance Director of designee monthly for three months and then quarterly to ensure there is a completed inspection tool for each fire and smoke door in the facility. Regional Director of Environmental Services will review maintenance book monthly x 6 months x 12 months and thereafter to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition)7.2.1.15. 4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur The results of these audits will be submitted to the (Quarterly Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING **01** B. WING _____	**07/18/2023**

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K 761	Continued From page 5	K 761	Performance Improvement (QAPI) committee for review by the facility Administrator or designee. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

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
315129 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLRIDGE HEALTH & REHABILITATION CENTER	532 FARVIEW AVE PARAMUS, NJ 07652

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 07/26/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 08/30/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 7/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**