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	315349	A. BUILDING _____ B. WING _____	01/26/2023

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COMPLETE CARE AT INGLEMOOR, LLC	**333 GRAND AVE ENGLEWOOD, NJ 07631**

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F 000	INITIAL COMMENTS Survey Date: 1/26/23 Census: 54 Sample: 17 + 3 closed records +10=30 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 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		3/15/23

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

Electronically Signed | 02/19/2023

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

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to develop a person-centered comprehensive care plan to address: a) the use of antipsychotic medication for one of five residents (Resident #27) from Ex Order 26. 4B1 [redacted] reviewed for unnecessary medications, for a total of five months and b) activities of daily living (ADL) of one of seventeen residents (Resident#44), reviewed for comprehensive care plan. This deficient practice was evidenced by the following: 1. On 01/22/23 at 11:20 AM, Surveyor#1	F 656	1. Resident # 27 and Resident #44 had the potential to be affected by this deficient practice. Care plans for the two identified resident were immediately updated to ensure a person-centered approach. 2. All residents have the potential to be effected by this deficient practice. 3. An audit was completed to ensure all residents in the facility had patient-centered care plans addressing Ex Order 26. 4B1 [redacted] and the use of Ex Order 26. 4B1 medications, if applicable. Licensed nurses educated on person-centered care plan requirement. 4. The Director of Nursing or Designee	

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F 656	Continued From page 2 observed Resident #27 laying on the bed with their eyes closed. Surveyor#1 reviewed Resident #27's medical records. The Admission Record (AR or face sheet; an admission summary) showed that the resident was admitted to the facility with diagnoses that included *Ex Order 26. 4B1* [redacted] The 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* showed cognitive skills for daily decision-making score of [redacted] which indicated that the resident's decisions regarding tasks of daily life was *Ex Order 26. 4B1* [redacted]. The QMDS included that the resident received *Ex Order 26. 4B1* medications. The August 2022 electronic Medication Administration Record (eMAR) revealed a physician order (PO) dated *Ex Order 26. 4B1* for *Ex Order 26. 4B1* [redacted] and	F 656	will and audit of five resident care plans weekly for four weeks, then monthly for an additional two months, to ensure person-centered approach to psychoactive medication monitoring and activities of daily living Audit results will be reported during monthly QAPI meeting.	

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F 656	Continued From page 3	F 656		

Ex Order 26. 4B1

Ex Order 26. 4B1 a day for increased Ex Order 26. 4B1.

The above PO for Ex Order 26. 4B1 was signed by nurses as administered as shown on eMAR from Ex Order 26. 4B1.

The personalized care plan did not include the use of the Ex Order 26. 4B1 medication Ex Order 26. 4B1.

On 01/24/23 at 12:31 PM, Surveyor#1 interviewed Licensed Practical Nurse#1 (LPN#1). LPN#1 informed the surveyor that she was the assigned nurse of the resident. LPN#1 stated that Resident #27 was Ex Order 26. 4B1, required total assistance with Ex Order 26, and had no unusual behavior. She further stated that she was unsure who will be responsible for initiating a care plan.

On 01/24/23 at 12:34 PM, Surveyor#1 interviewed the Registered Desk Nurse (RDN) regarding the care plan. The RDN stated that it was the responsibility of the nurse for initiating a care plan that included the use of Ex Order 26. 4B1 medications like Ex Order 26. 4B1 an Ex Order 26. 4B1 medication. She further stated that updating and revising the care plan will be the responsibility of the MDS Coordinator.

On that same date and time, the surveyor asked the RDN if the resident had a care plan for Ex Order 26. 4B1 use, and the RDN responded that there should be a care plan. Afterward, the RDN checked the electronic medical record and stated that she did not find a care plan. The surveyor asked the RDN why there was no care plan for Ex Order 26. 4B1 use, and the RDN did not respond.

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F 656	Continued From page 4 On 01/25/23 at 11:16 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Infection Preventionist Nurse (IPN), Regional Director of Clinical Services (RDCS) and Regional Clinical Specialist (RCS) and were made aware of the above findings. On 01/26/23 at 12:50 PM, the survey team met with the LNHA, DON, and IPN. The DON stated that Resident #27's care plan was not done and it should have been done. The DON acknowledged that the care plan for use of Ex Order 26. 4B1 should have been initiated when it was first ordered on Ex Order 26. 4B1. 2. On 01/22/23 at 10:33 AM, Surveyor #2 observed Resident #44 sleeping in bed. On 1/24/23 at 1:54 PM, Surveyor #2 reviewed Resident #44's care plan which included the following: Focus-Resident/Patient requires assistance/is dependent for ADL care in _____(specify: bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Recent _____(illness, fall, hospitalization, etc.) resulting in _____ (fatigue, activity intolerance, confusion, etc) Date initiated: 12/25/2022 Goal-Resident/Patient will improve current level of function in: _____(specify: bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) by next review as evidenced by improved ADL scores. Date initiated: 12/25/2022 Revision on: 1/02/2023	F 656		

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F 656	Continued From page 5 Target Date: 03/09/2023 Interventions-Monitor conditions that may contribute to ADL decline, including: metabolic causes (e.g., delirium, diabetes, thyroid disorder, liver disease, renal failure, electrolyte imbalance) respiratory problems, CVA, delusions, hallucinations, psychiatric disorder(s), poor nutrition, hearing or vision impairment, new/acute health problem, exacerbation of a chronic condition, constipation, infection, head injury, pain, fever, dehydration or alcohol withdrawal. Date initiated: 12/25/2022 .... Resident #44's care plan was not person-centered to meet his/her preferences and goals, and did not address the resident's [redacted], [redacted] and Ex Order 26. 4B1 needs. On 01/24/23 at 01:57 PM, Surveyor #2 asked LPN #2 if Resident #44's care plan was individualize and specific to the resident. LPN #2 stated she was not sure and would have to ask the MDS Coordinator (MDSC). On 01/24/23 at 02:11 PM, Surveyor #2 interviewed the MDSC regarding Resident #44's care plan. The MDSC stated that she had started the resident's care plan but did not go back to personalize the care plan. She added that there is a template and that you have to go back and personalize it to the resident. She then stated that she did not get a chance to go back. On 01/25/23 at 11:16 AM, in the presence of the survey team, Surveyor #2 notified the facility's administration team, which included the LNHA, DON, IPN, RCS, and RDCS, of the above findings that Resident #44's care plan was not	F 656		

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F 656	Continued From page 6 individualized and specific to the resident. On 01/26/23 at 12:54 PM, in the presence of the survey team, the DON confirmed that Resident #44's care plan was not individualized and specific to the resident. She added that it should have been done at first. A review of the facility provided policy titled, "Care Plans, Comprehensive Person-Centered" with a reviewed date of 01/2023 included the following: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .... 7. The care planning process will: a. Facilitate resident and/or representative involvement; b. Include an assessment of the resident's strengths and needs; and c. Incorporate the resident's personal and cultural preferences in developing the goals of care. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial	F 656		

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F 656	Continued From page 7 well-being; ... e. Include the resident's stated goals upon admission and desired outcomes. .. g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; ... 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process ... 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).	F 656		
F 726 SS=D	NJAC 8:39-11.2 (e)(1)(2) Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		3/15/23

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F 726	Continued From page 8 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to ensure that a nurse aide had the skills and techniques necessary prior to providing care to residents. This deficient practice occurred for one (1) of four (4) newly hired employees and was evidenced by the following: On 01/22/23 at 9:59 AM, the surveyor interviewed Registered Nurse#1 (RN#1) and a Licensed Practical Nurse (LPN) who stated that they were the two nurses assigned to the [redacted] floor for that day. RN#1 and LPN stated that they had a resident census of [redacted] residents and that there were four Certified Nurses Aides (CNA) working on the [redacted] floor. At that time, RN#1 provided the surveyor with a CNA assignment sheet for the [redacted] floor. In addition, RN#1 and LPN were able to point out, from a distance, each of the employees corresponding to the four CNA names listed on the assignment sheet that were working on the [redacted] floor.	F 726	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. The identified staff member was removed from the schedule until appropriate license verification and education/ competencies were completed. 3. Nurse Educator/ designee conducted an audit to ensure license verification and competencies have been completed for all current and newly hired licensed/certified staff. Staffing Coordinator, Human Resources, and Director of Nursing educated on license verification for current and newly hired staff. Any employee identified as not meeting the regulation was educated/ competencies or removed from the schedule if the license verification was unable to be obtained. 4. Nurse educator/ designee will conduct an audit of five licensed/Certified staff weekly for four weeks, then monthly for two months to ensure education/ competencies have been completed and license verification obtained. Results of	

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F 726	Continued From page 9 On 01/23/23 at 12:00 PM, the surveyor interviewed the employee that corresponded to one of the four CNA names listed on the assignment sheet from 01/22/23. The employee stated that she had been hired recently in *Ex Order 26. 4B1* but was able to discuss Resident #20 because she was assigned to the resident and was familiar with the resident. At that time, the employee showed the surveyor her badge which had Staffing Coordinator (SC) on it. The employee stated that she was currently attending CNA school. The employee stated that she had a CNA license that had lapsed more than two years. The SC added that she had an assignment of other residents on the floor but was helped by the other CNA's and the nurses. The SC further explained that she had started CNA school on *Ex Order 26. 4B1* and had a CNA license from *Ex Order 26. 4B1* but had let her certification lapse for personal reasons. The SC added that she had found out that because the lapse was greater than two years, she had to retake the CNA course. The SC also stated that the facility was willing to pay for the CNA school and she had recently started classes and felt that she had remembered a lot. The SC then stated that she was going to care for Resident #20 and had obtained linens before entering the resident's room. On 01/23/23 at 12:10 PM, the surveyor was provided by RN#2 the CNA assignment sheet for the [redacted] floor that she had completed for that day. A review of the assignment sheet for 01/23/23 revealed that the SC was listed as a CNA and had eight residents listed under her name.	F 726	the audits will be reported monthly during QAPI.	

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F 726	Continued From page 10 Further review of the CNA assignment sheet from 01/22/23 also had the SC listed as a CNA with her name above eight different resident names that she had been assigned to on that day. On 01/23/23 at 12:27 PM, the surveyor interviewed two CNA's listed on the [redacted] floor assignment sheet for 01/23/23, CNA#1 and CNA#2 who both stated that they help the SC with her assignment because she was new and was not supposed to do everything on her own. Both CNAs acknowledged that the assignment sheet had their names listed with the residents listed below that they were assigned to provide care. Both CNAs repeated that they help the SC who had an assignment listed under her name as well. Both CNAs could not speak to whether the SC was a CNA but thought the SC was in school. On 01/23/23 at 01:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that she was aware that the SC was attending school to be a CNA but was unsure of any skills assessment. On 01/23/23 01:39 PM, the surveyor was provided by the DON a Human Resources (HR) file for the SC. The DON added that the Infection Preventionist/ Registered Nurse (IP/RN) would provide the orientation and any skills and inservices completed. A review of the file revealed the following documents: - A date of hire of [redacted] for the nursing department in the position of CNA. -An Employee Immunization Statement & Health	F 726		

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F 726	Continued From page 11 Examination with the job title of CNA. -A background check completed Ex Order 26. 4B1. -An Employment Application dated Ex Order 26. 4B1 with the position applying for as a CNA. -A Professional Licenses/Certifications form with CNA completed as the type and New Jersey (NJ) as the state issued and signed by the SC on Ex Order 26. 4B1. The date issued, expiration date and number were blank, in addition to the "witnessed" signature line. - A Nurse Aide Certification Repayment Agreement dated Ex Order 26. 4B1 and signed by the SC and Licensed Nursing Home Administrator (LNHA). -An invoice dated 12/20/22 from the school offering a CNA course that revealed the payment was for SC's training, license fee and uniform fee for the class that would be starting on 01/17/23. -A check dated 01/06/23 from the facility to the CNA school for the invoice amount. On 01/23/23 at 01:43 PM, the surveyor was provided by the IP/RN the In-Person Orientation dated 12/20/22 for SC. The IP/RN stated that SC was provided an orientation with the topics covered on the form. The IP/RN added that the completed forms by the SC were the inservices completed on 12/20/22 from 8:30 AM to 12:45 PM. The RN/IP stated that this was a general orientation packet for new employees. The RN/IP could not speak to education or skills completed by the SC. On 01/24/23 at 01:52 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was familiar with the SC and could speak to her being hired. The LNHA stated that he knew she had a CNA license awhile ago but had hired her to work	F 726		

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F 726	Continued From page 12	F 726		

as the receptionist and assist the staffing coordinator while both had taken time off. The LNHA stated that the SC worked as the receptionist for 10 days after being hired, then assisted the staffing coordinator for approximately two and a half (2 ½) weeks until 01/16/23 and was not on the units providing care.

Furthermore, the LNHA stated that the SC started CNA school recently and should not have been working as a CNA. The LNHA added that any time a nursing aide (NA) was in school, the nurses on the floors knew that they should not be on the unit providing care or they can be paired up after having the recommended amount of hours. The LNHA stated that he had no knowledge of the SC being on floor providing care on 01/22/23 or 01/23/23.

On 01/24/23 at 02:01 PM, the surveyor interviewed RN#1 who stated that she was the nurse on 01/22/23 and had completed the assignment sheet with the LPN. RN#1 stated that SC was on the schedule as a CNA doing care with help. RN#1 added that the SC worked on 01/22/23 and 01/23/23 but could not speak to any other days prior. In addition, RN#1 could not speak to whether the SC was a CNA.

On 01/24/23 at 02:04 PM, the surveyor interviewed the DON who stated that the LNHA was in charge of staffing. The DON added that she had been employed by the facility for approximately three months and was not familiar with hiring NAs and had experience with only hiring CNAs. The DON added that the LNHA had told her that a non-certified NA could work with another CNA. The DON stated that the NA, referring to the SC, was on the floor providing

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care on 01/22/23 and 01/23/23 and had told SC that she was to work with another CNA and the nurses and could not work independently.

At that same time, the DON stated that she was aware that the SC was not a CNA because the LNHA had informed her but SC was put on the schedule by the LNHA. The DON also stated that she was aware that the badge of the noncertified NA had SC typed on it. The DON stated that prior to the SC starting CNA school, she had worked as a receptionist and helped the staffing coordinator.

On 01/25/23 at 11:16 AM, the survey team met with the administrative team. The LNHA stated that the SC should not have been providing care and assisting the staff for personal care. The LNHA stated that the nurses on the unit make the assignments and it had been explained to them that any NA would only shadow and not provide any care or have an assignment. The IP/RN stated that a NA enrolled in a CNA school would have to finish the care module first and should not be providing care on the floor. The IP/RN added that after completing the coursework an NA would have a skills competency completed.

On 01/25/23 at 12:15 PM, the surveyor interviewed RN#2 who stated that she receives a schedule of who is working for the day and makes the assignments. RN#2 added that she thought the schedule came from the staffing coordinator. RN#2 explained that on 01/23/23 she had made the assignments based on the list of staff assigned to the floor. RN#2 added that she was unaware that the SC was not supposed to have an assignment.

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F 726	Continued From page 14 A review of the Daily Nursing Sheets from 01/16/23 to 01/23/23 provided by the LNHA revealed that SC was listed on the schedule on the second floor as "shadowing" on 01/19/23 and 01/20/23. Further review revealed that on 01/22/23 the SC was listed on the schedule in a CNA slot with NA after her name and on 01/23/23 was listed on the schedule with no indication of CNA or NA. On 01/25/23 at 12:23 the surveyor reviewed the CNA assignment sheets kept in the binder on the second floor. The CNA assignment sheet completed on 01/19/23 had as a CNA with an assignment of nine residents for CNA#1 with SC designated by "CNA#1/SC." On 01/26/23 at 12:50 PM, the survey team met with the administrative team. The LNHA stated that he had been calling the CNA school but was unable to get information regarding completed coursework for the SC. The LNHA added that he was unable to find a license verification from six years ago. The LNHA stated that he should have checked the license verification. The LNHA stated that the protocol for a NA applying included a background check prior to orientation being needed before starting employment. The LNHA added that SC was hired as an unlicensed staff so a license verification check was not performed. The LNHA stated that the SC was assigned to help in the dayroom as an activities assistant for 01/22/23 and should not have been assigned to any residents. In addition, the DON stated that she was unaware that a license could be checked from six years ago. The DON acknowledged that the license should have been checked for verification for SC.	F 726		

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F 726	Continued From page 15 On 01/26/23 at 02:59 PM, the survey team met with the administrative team. The surveyor was provided by the LNHA a copy of a NA registration card for the SC from the NJ Department of Health. The NA registration card revealed that the original issue date was 8/26/2005 and had expired 3/12/2016. The LNHA stated that he had contacted the school and was told that the NA received 12 hours of CNA coursework in classroom education from 01/17/23 to 01/19/23. There was no additional documentation of the coursework provided. The LNHA stated that the license had not been checked when the SC was hired because it had expired. N.J.A.C. 8:39-9.3(a)(2),(3); 43.1(a)(1)(2)(3); 43.15(a)(b)(c)	F 726		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		3/15/23

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F 732	Continued From page 16 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documents, it was determined that the facility failed to routinely and accurately post the nurse staffing information on four of six days during the survey period in a place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 01/22/23 at 9:14 AM, upon entry into the facility, the surveyor observed that the Nursing Home Resident Care Staffing Report (NHRCSR) that was posted in the reception area of the lobby showed a staffing report dated 01/20/23 with the census (total number of residents) of [redacted] for Day Shift, shift hours of 7 AM - 3 PM.	F 732	1. No residents were affected by this deficient practice. Immediately upon notification the posted nurse staffing was updated 2. All residents have the potential to be affected by this deficient practice 3. Licensed Nursing Home Administrator/ designee educated the staffing manager and receptionists on the daily posting of accurate staffing data requirement. 4. Licensed Nursing Home Administrator / designee will conduct an audit 3x weekly for 4 weeks then monthly x2 months to ensure the daily posted nurse staffing is accurate. Any discrepancies will be immediately corrected. Results of the audits will be reviewed monthly during	

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F 732	Continued From page 17 On 01/22/23 at 10:28 AM, during the Entrance Conference of the surveyor with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Infection Preventionist Nurse (IPN), the LNHA stated that the facility census was [redacted] with one bed hold. On 01/22/23 at 01:04 PM, during the team meeting of the surveyors, there were discrepancies on what was provided on Entrance Conference and facility tour as follows: [redacted] unit census=[redacted] residents with plus two-bed hold [redacted] unit census=[redacted] residents On 01/23/23 at 8:12 AM, upon entry into the facility, the surveyor observed that the NHRCSR that was posted in the reception area of the lobby showed a staffing report dated 01/20/23 with the census of [redacted] for Day Shift. At the same time, the surveyor asked the Receptionist in the presence of a federal surveyor who was responsible for posting the NHRCSR, and the Receptionist stated it was the Staffing Coordinator (SC). On 01/25/23 at 8:09 AM, upon entry into the facility, the surveyor observed that the NHRCSR that was posted in the reception area showed a staffing report dated 01/24/23 with the census of [redacted] for the Day Shift. On 01/25/23 at 10:22 AM, the Regional Director of Clinical Services (RDCS) provided a copy of the 01/24/23 and 01/25/22 Daily Staffing Sheet (DSS) to the surveyor in the presence of the	F 732	QAPI.	

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F 732	Continued From page 18 Regional Clinical Specialist (RCS). The DSS revealed a census of [redacted] residents for both dates. On that same date and time, the surveyor then asked the RDCS why the posted on 01/22/23 (when the survey team entered the facility) NHRCSR was dated 01/20/23 with a census of 57 when the facility provided a copy of the two weeks Nurse Staffing Report, the period 01/15/23 to 01/21/23 showed that on 01/20/23 the census was [redacted] In addition, the surveyor asked the RDCS and the RCS why today (01/25/23) the posted NHRCSR was dated 01/24/23 with a census of [redacted] when the provided paper for DSS for dates 01/24/23 and 01/25/23 both had a census of [redacted] residents. Both the RDCS and RCS stated "I don't know," it was the SC who posted it and the Admission person who provided them with the census that was entered in the printed DSS. At that time, the surveyor notified both the RDCS and the RCS of the above findings that there were discrepancies on the posted NHRCSR with regard to census and timeliness of posting the NHRCSR. On 01/25/23 at 11:16 AM, the survey team met with the LNHA, DON, IPN, RDCS, and RCS, and were made aware of the above findings. On 01/26/23 at 8:36 AM, the surveyor interviewed the SC. The SC informed the surveyor that it was her responsibility to make sure to fill out and post the staffing master schedule and DSS. She stated that the NHRCSR should be posted daily with accurate information including the census and the DSS to the nursing units. She further stated that she was able to gather the census information from verbal communication with the	F 732		

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F 732	Continued From page 19 Admission Director or the DON. At that same time, the SC informed the surveyor that she works from Monday through Friday, from 7 AM - 3 PM. She stated that she pre-printed the NHRCSR for weekends, and if there will be changes in the census, no one can change the NHRCSR, and it will be done on Monday because "I do not know if anyone else knows how to do it." The SC acknowledged that the NHRCSR should be posted routinely, updated as needed to reflect the actual census on that date, and this was not done on some days. A review of the facility's Posting Direct Care Staffing Numbers Policy with a review date of 12/2022 that was provided by the LNHA showed that it was the facility's policy to post the nurse staffing information daily, at the start of each business day, posted in a prominent location (accessible to residents and visitors) and a clear and readable format. The information recorded on the form shall include the date for which the information is posted, and the resident census at the beginning of the shift for which the information is posted. On 01/26/23 at 5:04 PM, the survey team met with the LNHA, DON, IPN, RDCS, RCS, and Administrator In Training. The facility management acknowledged the above findings and there was no further documentation was provided to the survey team to refute these findings.	F 732		
F 755 SS=D	NJAC 8:39-41.2 (a)(b)(c)(1) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		3/15/23

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F 755	Continued From page 20 §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 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 interview, record review, and other pertinent facility documentation, it was determined that the facility failed to ensure a medication used for moderate to severe pain ([redacted]) was available and administered as	F 755	1. Resident #458 had the potential to be affected by this deficient practice. The medication was ordered to be delivered. Pain assessments completed with no pain noted.	

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F 755	Continued From page 21 ordered for a resident with a history of [redacted] (Resident #458). This deficient practice was identified during the Medication Storage Task for one of one resident reviewed for pain management. The evidence was as follows: On 01/ 26/23 at 10:42 AM, while performing the Medication Storage Task the surveyor interviewed the Director of Nursing (DON). The surveyor asked if the facility had any unresolved narcotic discrepancies with their automated medication dispensing machine and the DON responded no, but they did have an incident last month with a nurse. The DON stated a nurse who had worked night shift had received the pharmacy delivery, one of the medications delivered was for Resident #458, *Ex Order 26. 4B1* [redacted]. The pharmacy had dispensed the tablets using two blister pack cards, one containing thirty tablets and one containing twenty-six tablets. The nurse took the cards and fabricated a declining inventory sheet (a record used for accountability of controlled drugs) for thirty tablets and handed off the blister pack containing the thirty tablets to Resident #458's nurse and did not account for the second blister pack containing twenty-six tablets. The DON stated the discrepancy was not discovered until the resident ran out of their supply of *Ex Order 26. 4B1* and a refill was requested from the pharmacy. The surveyor reviewed the medical record for Resident #458. The Admission Record (or face sheet, an admission summary) reflected the resident was newly admitted to the facility with diagnoses	F 755	2. All resident receiving a controlled substance has the potential to be affected by the deficient practice. 3. Licensed nurses educated on the process of obtaining and maintaining controlled substances as required. 4. Director of Nursing/ designee will conduct an audit of five residents receiving controlled substances weekly for four weeks then monthly for two months to ensure the appropriate stock of medication is on hand. All identified concerns will be immediately reconciled. Results of the audits will be reviewed in monthly QAPI.	

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included *Ex Order 26. 4B1* [redacted]

The Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated *Ex Order 26. 4B1*, reflected a Brief Interview for Mental Status (BIMS) score [redacted] which reflected that the resident was *Ex Order 26. 4B1*.

A review of the resident's individualized comprehensive Care Plan reflected a focus area initiated 12/07/22 that the resident exhibits or is at risk for alterations in comfort related to *Ex Order 26. 4B1* [redacted]. The goal to medicate resident as ordered for pain and monitor for effectiveness.

The resident's most recent physician Order Summary Report reflected the following physician's order (PO) related to pain management:

1. *Ex Order 26. 4B1* [redacted]; give one tablet by mouth [redacted] a day for [redacted]. Date ordered [redacted]
2. *Ex Order 26. 4B1* [redacted]; give *Ex Order 26. 4B1* by mouth [redacted] a day for *Ex Order 26. 4B1*. Date ordered *Ex Order 26. 4B1*
3. *Ex Order 26. 4B1* [redacted]; give *Ex Order 26. 4B1* by mouth every [redacted] hours as needed for *Ex Order 26. 4B1*. Date ordered *Ex Order 26. 4B1*
4. Pain assessment every shift. Date ordered

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Ex Order 26. 4B1

A review of the electronic Medication Administration Record (eMAR) for Ex Order 26. 4B1 reflected the following order for Ex Order 26. 4B1: A PO dated [redacted] for Ex Order 26. 4B1 [redacted]; give Ex Order 26. 4B1 by mouth [redacted] times a day for Ex Order 26. 4B1 .

The nurse signed that the resident received the [redacted] through [redacted].

Then from Ex Order 26. 4B1 9:00 AM, through Ex Order 26. 4B1 01:00 PM, the nurses signed either a code "3" which indicated the medication was not given and "hold/see nurse notes", or a code "7", which indicated the medication was not given and "other/see Nurse Notes."

The same eMAR reflected that the resident allegedly received the Ex Order 26. 4B1 on [redacted]

Then on Ex Order 26. 4B1 [redacted] scheduled consistent administration resumed.

A review of the facility provided corresponding electronic Progress Notes (PN) for the above dates reflected the following Nurse Notes (NN): On Ex Order 26. 4B1, untimed Progress note text: Ex Order 26. 4B1 [redacted] give Ex Order 26. 4B1 by mouth [redacted] times a day for [redacted]: Pending Delivery. A second [redacted], untimed Progress note text: Ex Order 26. 4B1 [redacted] give Ex Order 26. 4B1 by mouth [redacted] times a day for Ex Order 26. 4B1 : Pending Delivery. A third [redacted] Ex Order 26. 4B1, untimed Progress note text:

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F 755	Continued From page 24 Ex Order 26. 4B1 give Ex Order 26. 4B1 by mouth times a day for Ex Order 26. 4B1 : awaiting pharmacy delivery. A fourth Ex Order 26. 4B1 , untimed Progress note text: Ex Order 26. 4B1 give Ex Order 26. 4B1 by mouth times a day for : awaiting pharmacy delivery. The facility did not provide any further NN documentation for any other dates. Further review of the eMAR for Ex Order 26. 4B1 reflected the following order for Ex Order 26. 4B1 : A PO dated Ex Order 26. 4B1 , Ex Order 26. 4B1 ; give Ex Order 26. 4B1 by mouth times a day for Ex Order 26. 4B1 . The nurse signed that the resident received the Ex Order 26. 4B1 , through Ex Order 26. 4B1 , as prescribed. A review of the eMAR for Ex Order 26. 4B1 reflected the following order for assessment: A PO dated Ex Order 26. 4B1 , assessment every shift. The nurses documented the resident's was Ex Order 26. 4B1 for the dates in question Ex Order 26. 4B1 through Ex Order 26. 4B1 on all shifts, day, evening and night. A review of the facility provided declining inventory sheet for the resident's Ex Order 26. 4B1 revealed resident had received #30 Ex Order 26. 4B1 from Ex Order 26. 4B1 , until Ex Order 26. 4B1 . On 01/26/23 at 01:48 PM, the surveyor interviewed the DON in the presence of the survey team and the facility management and together reviewed the resident's eMAR. The	F 755		

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	315349	A. BUILDING _____ B. WING _____	01/26/2023

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COMPLETE CARE AT INGLEMOOR, LLC	**333 GRAND AVE ENGLEWOOD, NJ 07631**

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F 755	Continued From page 25 DON stated the indication "7" she believed was resident refusal. The DON further stated the date they discovered the medication was missing was 12/16/22, because on 12/15/22 the pharmacy was called, and they said the medication was not eligible for refill because it was too early. They had delivered [redacted] On 01/26/23 at 01:54 PM, the Infection Preventionist (IP) stated there was no [redacted] in the backup medication stock to give the resident during that time period. On 01/26/22 at 3:10 PM, the facility's Regional Clinical Specialist (RCS) clarified that on the eMAR, a "7" with initials - means "other see nurses notes", a "3" indicated "Hold- see nurses notes", they should all then correspond to a Nurses Note in the nursing notes. If there was no nursing note, then "If it's not documented then it is not done". The process should be if a medication was missing then the DON would need to follow-up with an investigation. On 01/26/22 at 3:12 PM, the DON stated after the medications were missing, she called the resident's physician and got a new prescription. The DON acknowledged the nurses who received the medication should have verified the quantity of the medication sent with the pharmacy packing slip. The process should be that the nurse counts the medication, signs the packing slip that she received the correct amount. Then that nurse would take the medication to the nurse on the medication cart together they verify the packing slip quantity and then they both sign the packing slip. On 01/26/23 at 3:23 PM, the RCS stated there	F 755		

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F 755	Continued From page 26 should be oversight of the two nurses signing for the received medication from the pharmacy to ensure accuracy and that person should be the DON. The RCS stated and acknowledged there should never be a handwritten declining inventory sheet. On 01/26/23 at 3:29 PM, the surveyor in the presence of the survey team interviewed one of the resident's Registered Nurse (RN) who still worked at the facility. The RN stated she remembered the resident. The RN stated she remembered the resident was on Ex Order 26. 4B1 and other medications used for Ex Order 2 and the Ex Order 26. 4B1 was used routinely for his/ her Ex Order 26. 4B1 . When asked what she would do if a resident were out of their medications and the RN stated you were not supposed to borrow from other residents. That if a med was not available you have to document that in the eMAR and call the pharmacy. The surveyor reviewed the resident's eMAR with the RN, who confirmed the check mark meant the medication had been administered. The RN stated the resident was alert and oriented and that the RN would ask the resident every day what Ex Order pain level was. A review of the facility's "Controlled Substances Policy" updated 3/2021 included that... controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record. A review of the facility's "Administering Medications Policy" reviewed 01/23 included that ...Medications are administered in accordance	F 755		

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F 755	Continued From page 27 with prescriber orders ... NJAC 8:39-29.2(d)	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756		3/15/23

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F 756	Continued From page 28 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility provided documents, it was determined that the facility failed to follow up on the Consultant Pharmacist's (CP) recommendations of a medication irregularity for one of five residents (Resident #27) reviewed for unnecessary medications for a total of five months from August 2022 through January 2023. This deficient practice was evidenced by the following: On 01/22/23 at 11:20 AM, the surveyor observed Resident #27 laying on the bed with their eyes closed. The surveyor reviewed Resident #27's medical records. The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with diagnoses that included *Ex Order 26. 4B1* [redacted]	F 756	1. Resident #27 has the potential to be affected by the deficient practice. Pharmacy consultant recommendations were carried out for resident #27. 2. All residents have the potential to be affected by the deficient practice. 3. Licensed nurses educated on the requirement of carrying out the recommendations of the consultant pharmacist. An audit was completed for the previous 3 months to ensure pharmacy consultant recommendations have been carried out. 4. Director of Nursing/ designee will complete an audit of 5 residents weekly x4 weeks then monthlyx2 months to ensure pharmacy recommendations have been implemented. Any discrepancies will be immediately resolved. The results of the audits will be reported during monthly QAPI	

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F 756	Continued From page 29	F 756		

Ex Order 26. 4B1 [redacted].

The 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 showed cognitive skills for daily decision-making score of two which indicated that the resident's decisions regarding tasks of daily life was Ex Order 26. 4B1 [redacted]. The QMDS included that the resident received [redacted] medications.

The Ex Order 26. 4B1 electronic Medication Administration Record (eMAR) revealed a physician order (PO) dated Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted] Ex Order 26. 4B1 a day for increased Ex Order 26. 4B1.

The above PO for Ex Order 26. 4B1 was signed by nurses as administered as shown on eMAR from Ex Order 26. 4B1 [redacted].

Further review of the Ex Order 26. 4B1 and eMAR from Ex Order 26. 4B1 revealed that there were no targeted behavior and monitoring for the use of Ex Order 26. 4B1 medication.

According to the Summary Report of Pharmacy Consultant Review (SRPCR or Monthly Medication Record Review) that was provided by the Licensed Nursing Home Administrator (LNHA) showed that on Ex Order 26. 4B1,

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F 756	Continued From page 30 *Ex Order 26. 4B1* the CP documented about *Ex Order 26. 4B1* should have an appropriate diagnosis, *Ex Order 26. 4B1* . The facility did not act upon and followed up on the CP's recommendations according to the monthly SRPCR. On 01/24/23 at 02:36 PM, the surveyor interviewed the Registered Desk Nurse (RDN) regarding the resident's *Ex Order 26. 4B1* order and the CPs recommendations. The RDN stated that it was the nurse's responsibility to follow up and act upon the CP recommendations and the completed paper will be filed in the Director of Nursing's (DON) office in a binder. On that same date and time, the surveyor asked the RDN why the CPs recommendations were not followed for the resident's *Ex Order 26. 4B1*, and the RDN did not respond. On 01/25/23 at 11:16 AM, the survey team met with the LNHA, DON, Infection Preventionist Nurse (IPN), Regional Director of Clinical Services (RDCS), and Regional Clinical Specialist (RCS) and were made aware of the above findings. On 01/25/23 at 03:02 PM, the surveyor interviewed the CP regarding SRPCR and pharmacy reports. He stated that he review the binder that includes the CP's review and recommendations and let the facility know that there were follow up that needed to be done. He further stated that recommendations were made regarding the resident's *Ex Order 26. 4B1*. A review of the facility's Consultant Pharmacist Services Policy that was provided by the RCS	F 756		

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F 756	Continued From page 31 with a review date of 01/2023 included that the CP will provide specific activities related to the medication regimen of each resident at least including: a. A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. b. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. On 01/26/23 at 12:50 PM, the survey team met with the LNHA, DON, and IPN. The DON stated that Resident #27's [redacted] order and recommendations of CP were overlooked, "I cannot justify more than that." The DON acknowledged that the CP recommendations should have been followed up and acted upon since August 2022. She indicated that there was no negative effect on the resident. NJAC 8:39-29.3 (a)(1)	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		3/15/23

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F 758	Continued From page 32 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 33 Based on observation, interview, record review, and review of the facility provided documents, it was determined that the facility failed to consistently monitor, document, and evaluate the ongoing benefit use of Ex Order 26. 4B1, an Ex Order 26. 4B1 [redacted] This deficient practice was identified for one of three residents (Resident #27) reviewed for Ex Order 26. 4B1 use for a total of five months from Ex Order 26. 4B1 [redacted]. This deficient practice was evidenced by the following: On 01/22/23 at 11:20 AM, the surveyor observed Resident #27 laying on the bed with their eyes closed. The surveyor reviewed Resident #27's medical records. The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with diagnoses that included Ex Order 26. 4B1 [redacted].	F 758	1. Resident #27 has the potential to be affected by the deficient practice. The Ex Order 26. 4B1 medication was discontinued for resident #27. 2. All residents receiving Ex Order 26. 4B1 medication have the potential to be affected by this alleged deficient practice. 3. An audit was completed for residents receiving Ex Order 26. 4B1 medication to ensure medication reviews, GDRs, care plans, and target behaviors are documented as required. Licensed nurses and CNAs educated on the process of documenting and monitoring Ex Order 26. 4B1 medications per regulations 4. Director of Nursing/ designee to audit 5 residents receiving Ex Order 26. 4B1 medications weekly x4 weeks then monthly x2 months to ensure psychotropic medication documentation is completed per regulation. Any discrepancies identified during the audit will be corrected immediately. Results of the audits will be reported during monthly QAPI	

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F 758	Continued From page 34 The 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 showed cognitive skills for daily decision-making score of two which indicated that the resident's decisions regarding tasks of daily life was Ex Order 26. 4B1 . The QMDS included that the resident received Ex Order 26. 4B1 medication. The Ex Order 26. 4B1 electronic Medication Administration Record (eMAR) revealed a physician order (PO) dated Ex Order 26. 4B1 for Ex Order 26. 4B1 Ex Order 26. 4B1 (tab) time a day for increased Ex Order 26. 4B1 . The above PO for Ex Order 26. 4B1 was signed by nurses as administered as shown on eMAR from Ex Order 26. 4B1 . Further review of the eMAR and electronic Treatment Record (eTAR) from Ex Order 26. 4B1 revealed that there were no targeted behavior and monitoring for the use of the Ex Order 26. 4B1 medication Ex Order 26. 4B1 . The Ex Order 26. 4B1 Medication Use Evaluation (P/tMUE; is the monthly review of the nurse in the electronic medical record) showed the following: September 2022 through October 2022=no review record November 13, 2022=section status was In Progress (was not completed) December 31, 2022=section status was Error (was not completed) January 17, 2023=section status Signed (was completed)	F 758		

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F 758	Continued From page 35 On 01/24/23 at 12:30 PM, the surveyor interviewed the Certified Nursing Aide (CNA) assigned to the resident. The CNA informed the surveyor that Resident #27 was Ex Order 26. 4B1 [redacted], required total assistance with activities of daily living (ADL), and had no unusual behavior. On 01/24/23 at 12:31 PM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN informed the surveyor that she was the assigned nurse of the resident. The LPN stated that Resident #27 was Ex Order 26. 4B1 [redacted], required total assistance with ADL, and had no unusual behavior. She further stated that she was unsure if the resident was on Ex Order 26. 4B1 medications. Later on, after checking the electronic medical records, the LPN stated that the resident was on Ex Order 26. 4B1 during the 3 PM-11 PM shift. At that same time, the surveyor asked the LPN regarding behavior monitoring and targeted behavior if the resident was on Ex Order 26. 4B1 medications. The LPN stated that there should be targeted behavior and monitoring of the resident's eTAR. The surveyor then asked the LPN why there was no behavior monitoring and targeted behavior for the resident's use of Ex Order 26. 4B1, the LPN stated "I don't know." On 01/24/23 at 02:36 PM, the surveyor interviewed the Registered Desk Nurse (RDN) regarding the resident's Ex Order 26. 4B1 order. The RDN stated that the resident's Ex Order 26. 4B1 was ordered by Ex Order 26. 4B1 which was why the resident was not seen by the Ex Order 26. 4B1 for follow-up.	F 758		

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On that same date and time, the RDN informed the surveyor that the monthly review of the resident's use of Ex Order 26. 4B1 should be done in the electronic medical records P/tMUE by nurses according to the schedule. The RDN then showed the paper schedule of Ex Order 26. 4B1 Charting dated for Ex Order 26. 4B1 with no year indicated. The Ex Order 26. 4B1 Charting paper included typewritten information that it will be done during the first two weeks of the month reviewing the previous month and that Resident #27 was included for 11-7 shift documentation. The Ex Order 26. 4B1 Charting paper had handwritten information of "done 01/17/23" for the paper provided by the RDN.

At that time, the surveyor asked the RDN why the Ex Order 26. 4B1 Charting for Ex Order 26. 4B1 had no year included and where were the other Ex Order 26. 4B1 Charting paper schedules. The RDN stated that it was "probably" with the Director of Nursing's (DON's) office. Immediately, the RDN went to DON's office. The surveyor observed inside the office of the DON and the Infection Preventionist Nurse (IPN). The RDN asked for the Ex Order 26. 4B1 Charting schedules, and both the DON and IPN responded that they did not know.

On 01/25/23 at 11:16 AM, the survey team met with the LNHA, DON, IPN, Regional Director of Clinical Services (RDCS), and Regional Clinical Specialist (RCS) and were made aware of the above findings.

A review of the facility's Ex Order 26. 4B1 Medication Use Policy provided by the RCS with a reviewed date of Ex Order 26. 4B1 included that Ex Order 26. 4B1 medications may be considered for residents with

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F 758	Continued From page 37 dementia but only after medical, physical, functional, Ex Order 26. 4B1, emotional Ex Order 26. 4B1, social, and environmental causes of behavioral symptoms have been identified. Ex Order 26. 4B1 medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction and re-review. Diagnosis of a specific condition for which Ex Order 26. 4B1 medications are necessary to treat will be based on a comprehensive assessment of the resident. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of Ex Order 26. 4B1 medications to the attending physician. On 01/26/23 at 12:50 PM, the survey team met with the LNHA, DON, and IPN. The DON stated that the resident's order for Ex Order 26. 4B1 was now discontinued and that the resident did not need the medication because the resident was calm. She further stated that "I cannot justify more than that." She indicated that there was no negative effect on the resident.	F 758		
F 759 SS=D	NJAC 8:39-11.2(b), 33.2(a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility provided documentation, it was determined that the facility failed to ensure that all	F 759	1. Resident #31 and resident #42 had the potential to be affected by this deficient practice. Resident #31 and	3/15/23

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	315349	A. BUILDING _____ B. WING _____	01/26/2023

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F 759	Continued From page 38 medications were administered without error of 5% or more. During the medication observation performed on 01/24/23, the surveyor observed two (2) nurses administered medications to five (5) residents. There were 27 opportunities, and two (2) errors were observed, which calculated to a medication administration error rate of 7.41 %. This deficient practice was identified for two (2) of five (5) residents, (Resident #31 and #42), that were administered medications by one (1) of two (2) nurses. The deficient practice was evidenced by the following: 1. On 01/24/22 at 8:34 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN) in the room of Resident #31. The surveyor observed the LPN obtained vital signs using an electronic *Ex Order 26. 4B1* [redacted]. The surveyor also observed the LPN discussed with the resident the medications that were going to be prepared for administration. On 01/24/23 at 8:37 AM, the surveyor observed the LPN preparing to administer eight (8) medications to Resident #31 which included one (1) *Ex Order 26. 4B1* [redacted]). The LPN stated that she spoke with the resident, and that the resident refused to take three (3) of the eight (8) medications. The LPN then stated that she would also not be administering the *Ex Order 26. 4B1* [redacted] because she knew that she had none in her medication cart or in the facility because she had already checked and had told the supervisor that she could not find any *Ex Order 26. 4B1* [redacted]. The LPN added that the *Ex Order 26. 4B1* [redacted] were an	F 759	resident #42 received the *Ex Order 26. 4B1* [redacted]. 2. All residents that receive *Ex Order 26. 4B1* [redacted] have the potential to be effected by deficient practice. 3. Licensed nurses educated on completing a medication pass including the required response of an unavailable medication. 4. Director of Nursing/ designee will conduct 3 medication pass competencies on licensed medication nurses weeklyx4 then monthly x 2 months. Identified concerns will be immediately corrected. Results of the nurse competencies will be reviewed during monthly QAPI	

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F 759	Continued From page 39	F 759		

Ex Order 26. 4B1 (OTC) medication and that was considered facility house stock. The LPN further stated that she was told that the *Ex Order 26. 4B1* were ordered and should be coming in.

On 01/24/23 at 8:56 AM, the surveyor observed the LPN administer four (4) of the eight (8) medications to Resident #31. The *Ex Order 26. 4B1* was not administered.
Upon returning to the medication cart, the surveyor observed the LPN document in the electronic medication administration record (eMAR) that three (3) of the eight (8) medications were refused by the resident. In addition, the LPN documented in the eMAR a code number seven (7) and was awaiting delivery for the administration of the *Ex Order 26. 4B1*. The LPN explained that the number seven meant that the medication was not administered and documented the reason. ERROR #1

The surveyor reviewed the medical record for Resident #31.

The Admission Record (AR or face sheet, an admission summary) revealed diagnoses which included *Ex Order 26. 4B1*

The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care dated *Ex Order 26. 4B1*, reflected the resident had a Brief Interview for Mental Status (BIMS) score of *Ex Order 26. 4B1*, indicating that the resident had an *Ex Order 26. 4B1*.

The *Ex Order 26. 4B1* Order Summary Report (OSR) reflected a physician's order (PO) with a start

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F 759	Continued From page 40 date of Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted] A review of the Ex Order 26. 4B1 eMAR revealed a PO with an order date of Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted] The eMAR indicated that the Ex Order 26. 4B1 was to be applied at 9:00 AM and removed at 9:00 PM. On 01/24/23 at 9:40 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the OTC medications were stored in her office. The surveyor observed the OTC medications in the DON's office and there was no observation of Ex Order 26. 4B1 . The DON stated that she was unsure if there was a list of the OTC medications that the facility provided and would check with the Licensed Nursing Home Administrator (LNHA) since the central supply staff was not working. At that same time, the DON stated that she and the MDS Coordinator (MDSC) would give out the OTC medications to the nurses when requested and the supervisor on the weekends. The DON added that if a nurse needed an OTC medication and the facility did not have any left then the facility would have to send someone out to get it or the physician would have to be called and made aware that they could not get the OTC medication and follow up with any new orders. On 01/24/23 at 11:24 AM, the LNHA provided the surveyor with the "OTC/DNS" list. The LNHA stated that this was the list of the facility OTC medications. The surveyor reviewed the list and	F 759		

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F 759	Continued From page 41 [redacted] was not listed. On 01/24/23 at 12:08 PM , the surveyor, in the presence of a Certified Nursing Assistant (CNA), interviewed Resident #31. The resident stated that he/she was not in any pain and thought he got the '[redacted]." The resident was unable to express when the [redacted] was applied. At that time the CNA checked the resident's [redacted] area and stated that there was no [redacted] on the resident. On 01/24/23 at 12:17 PM, the surveyor interviewed the MDSC who stated that she had been helping out with getting the nurses any OTC medications because the staff member in charge of the central supply had been out as of Monday. The MDSC was unable to speak to the ordering process of the OTC medications and referred to the Administrator in Training (AIT). On 01/24/23 at 12:26 PM, the surveyor interviewed the AIT who stated that he had placed an order for OTC medications yesterday. The AIT acknowledged that *Ex Order 26. 4B1* were needed and added that the *Ex Order 26. 4B1* would be coming in within an hour. The AIT added that if the facility was completely out of an OTC medication, then he would go pick up the medication from a sister facility or go to a local pharmacy. The AIT stated that he was not positive if the facility was completely out of *Ex Order 26. 4B1* . 2. On 01/24/23 at 8:49 AM, during the medication administration observation, the surveyor observed the LPN preparing to administer seven (7) medications to Resident #42	F 759		

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F 759	Continued From page 42 which included one (1) Ex Order 26. 4B1 [redacted]. The LPN stated that she would not be administering the Ex Order 26. 4B1 because she did not have any as was the case for Resident #31. On 01/24/23 at 8:56 AM, the surveyor observed the LPN administer six (6) of the seven (7) medications to Resident #42. The Ex Order 26. 4B1 [redacted] was not administered. Upon returning to the medication cart, the surveyor observed the LPN document in the eMAR a code number 7 (seven) and was awaiting delivery. The LPN explained that the number 7 (seven) meant that the medication was not administered and documented the reason, which was the same for Resident #31. ERROR #2 The surveyor reviewed the medical record for Resident #42. The AR revealed diagnoses which included Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1. The QMDS dated Ex Order 26. 4B1, reflected the resident had a BIMS score of [redacted], indicating that the resident was unable to complete the interview. Further review of the MDS, reflected that the staff performed a cognitive assessment which reflected that the resident had a Ex Order 26. 4B1 [redacted] problem with a Ex Order 26. 4B1 [redacted].	F 759		

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F 759	Continued From page 43 The Ex Order 26. 4B1 OSR reflected a PO with a start date of Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted] The Ex Order 26. 4B1 eMAR revealed a PO with an order date of Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted] The eMAR indicated that the Ex Order 26. 4B1 was to be applied at 9:00 AM and removed at 8:59 PM. On 01/24/23 at 9:40 AM, the surveyor interviewed the DON who stated that the OTC medications were stored in her office. The surveyor observed the OTC medications in the DON's office and there was no observation of Ex Order 26. 4B1 . The DON stated that she was unsure if there was a list of the OTC medications that the facility provided and would check with the LNHA since the central supply staff was not working. The DON stated that she and the MDS Coordinator would give out the OTC medications to the nurses when requested and the supervisor on the weekends. The DON added that if a nurse needed an OTC medication and the facility did not have any left then the facility would have to send someone out to get it or the physician would have to be called and made aware that they could not get the OTC medication and follow up with any new orders. On 01/24/23 at 11:24 AM, the LNHA provided the surveyor with the "OTC/DNS" list. The LNHA stated that this was the list of the facility OTC medications. The surveyor reviewed the list and Ex Order 26. 4B1 was not listed.	F 759		

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F 759	Continued From page 44 On 01/24/23 at 11:45 AM, the surveyor interviewed Resident #42 who shook their head "No" when asked if he/she had any pain. The resident also pointed to their Ex Order 26. 4B1 when asked if the resident received a Ex Order 26. 4B1. The resident also shook their head "no" when asked if the Ex Order 26. 4B1 had been applied today. The surveyor observed the resident's shoulder which had no Ex Order 26. 4B1 applied. On 01/24/23 at 12:17 PM, the surveyor interviewed the MDSC who stated that she had been helping out with getting the nurses any OTC medications because the staff member in charge of the central supply had been out as of Monday. The MDSC was unable to speak to the ordering process of the OTC medications and referred to the AIT. On 01/24/23 at 12:26 PM, the surveyor interviewed the AIT who stated that he had placed an order for OTC medications yesterday. The AIT acknowledged that Ex Order 26. 4B1 were needed and added that the Ex Order 26. 4B1 would be coming in within an hour. The AIT added that if the facility was completely out of an OTC medication, then he would go pick up the medication from a sister facility or go to a local pharmacy. The AIT stated that he was not positive if the facility was completely out of Ex Order 26. 4B1. On 01/25/23 at 10:12 AM, the surveyor interviewed the LPN who stated that Resident #42 can understand and be understood and speaks another language but could understand English. The LPN stated that the resident's voice was not strong, but he/she can use gestures and	F 759		

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F 759	Continued From page 45 be understood. On 01/25/23 at 11:16 AM, the survey team met with the facility administrative team. The DON acknowledged that the [redacted] should have been administered. On 01/25/22 at 3:02 PM, the surveyor interviewed the CP via telephone who stated that he has done medication observations and in-services for the nurses. The CP added that he had instructed the nurses that when a medication, whether prescription or OTC, was not available and there was no back up supply to call the physician to make them aware and ask if another medication that was available could be used or receive follow up orders. The CP added that if the medication was an OTC medication, then he would think the facility could get the medication within the time frame for administration. A review of a Medication Pass Observation for the LPN dated [redacted] and completed by the CP indicated a [redacted] for "Knows proper procedure for missing medication." The Medication Pass Observation had not indicated a medication error rate or passed/failed. A review of the CP inservice handout on Med Pass Overview provided by the LNHA revealed that the medication cart should be fully prepared prior to the medication pass. In addition, "Meds must be passed within the 1 hour window to remain compliant." A review of the facility policy dated as revised January 2023 for "Administering Medications" provided by the LNHA revealed "Medications are administered in in a safe and timely manner, and	F 759		

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F 759	Continued From page 46 as prescribed." Further review of the policy revealed "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)."	F 759		
F 812 SS=D	NJAC 8:39-11.2(b), 29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation, it was determined that the facility failed to store foods and maintain kitchen sanitation in a manner intended to prevent the spread of food borne illness as evidenced by the following:	F 812	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. The frozen hamburger patties, frozen tilapia filets, and container of sweet potatoes identified were immediately discarded.	3/15/23

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F 812	Continued From page 47 On 01/22/23 at 12:31 PM, the surveyor toured the kitchen with the Food Service Manager (FSM), in the presence of the Region Food Service Director (RFSD) and the Account Manager (AM) and observed the following: 1. In the freezer the surveyor found; one opened box of hamburgers without an open and use by date. The interior bag holding 12 hamburgers was opened and unlabeled. The FSM stated that the exterior of the box should be labeled with the open and used by date. He also stated, the interior bag once opened should be label and dated. 2. In the freezer the surveyor found; one opened box of tilapia fish fillets. The exterior of the box was labeled with 01/18/2023. The morning (AM) cook or the FSM could not explain if 01/18/2023 was a used by or open date. The interior bag holding nine tilapia fish fillets was open and unlabeled. The FSM stated that the exterior of the box should be labeled with the open and used by date. He also stated, the interior bag once opened should be label and dated. 3. In the refrigerator surveyor found; one container labeled 01/15/23 with a use by date of 01/21/23 containing sweet potatoes in liquid. The FSD stated, that should have been discarded by the AM Cook on 01/21/23. He also stated that he was the AM cook that day. 4. The dry food storage room was unkept. The floors were discolored with food debris under the food shelving units and walking areas. An accountability schedule for cleaning the area could not be provided. The FSD stated it was the responsibility of the utility aid to be done nightly	F 812	The food storage room was cleaned and organized including but not limited to the floors under the shelving. 3. Food Service Director and Dietary staff educated on proper storage, dating, and labeling of food items. Dietary staff were also educated on cleaning and maintaining a sanitary environment in the dry food storage area. Weekly cleaning Schedule checklist implemented to correct accountability and prevent the issue from recurring. Regional support will oversee food service department cleanliness and accountability to ensure compliance. Identified issues will be immediately corrected. Accountability will be achieved through progressive disciplinary action as deemed appropriate. 4. Food Service Director/ designee will conduct an audit five times per week for four weeks, then weekly for two months to ensure there are no expired items and proper labeling and dating is maintained. The Food Service Director or Designee will conduct an audit five times per week for four weeks, then weekly for two months to ensure cleaning and accountability of the dry storage area is completed per protocol. Identified concerns will be immediately addressed. Results of the audits will be reviewed during monthly QAPI meeting.	

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F 812	Continued From page 48 and throughout the day if it was soiled. The surveyor inquired if the FSD thought it was being done as assigned, the FSD state, "no, clearly it is not being done." A review of "Receiving and Storage" provided by the FSD, labeled Inservice manual DHCC 2010 page 162 and 163, indicated. -section labeled "General guidelines;" Monitor that all products received have been labeled and dated by vendor or established guidelines to label and date on arrival. - section labeled "Care of storeroom;" #4) Keep floors, walls, shelves, and equipment clean. #5) Floors must be swept clean at all times and mopped at least weekly. -section labeled "Refrigerated Storage;" #2) date refrigerated and frozen foods upon delivery. Note: for perishable foods without expiration dates, obtain printed material from supplier and make available for all staff. This information should be included as the "used by date" on labeling. A review of a job description and nightly duties for a utility / aid position provided by the FSD, indicated a responsibility of but limited to; sweep and mop storeroom floors, straighten and keep storerooms clean during their 7.5-hour shift.	F 812		
F 814 SS=D	NJAC 8:39-17.2(g) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 814	1. No residents were affected by this	3/15/23

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F 814	Continued From page 49 the facility provided documentation, it was determined that the facility failed to properly dispose and maintain waste in garbage dumpster areas. This deficient practice was identified for three of three garbage dumpsters in garbage disposal area. This deficient practice was evidenced by the following: On 01/22/2023 at 9:15 AM, the surveyor observed trash and food waste behind and surrounding three dumpsters in the parking lot. The dumpster lids and surrounding gate were not closed. On 01/23/2023 at 11:15 AM, the surveyor observed trash and food waste behind and surrounding three dumpsters in the parking lot. The dumpster lids and the surrounding gates were not closed. On 01/23/23 at 11:40 AM the Regional Maintenance Director (RMD), explained that it is every departments responsibility to maintain the dumpster area. The RMD stated that the Housekeeping was supposed to keep the grounds picked up, the lids closed, and the gates shut. He further stated that it can cause an issue if not done because of pests and vagrants. During an interview on 01/23/23 at 11:49 AM, the Housekeeping Director (HD) explained that the dumpster area should be clutter free, lids down and boxes broken down for the recycling dumpster. The HD stated, anytime you go to the dumpster, one (1) in the morning, 7 AM, 2:30 PM, 2:45 PM, and 6:30 PM, gates should be "always" shut. She further stated that each department is	F 814	deficient practice. The garbage area was immediately cleaned and secured per regulation. 2. All residents have the potential to be affected by this deficient practice. 3. Housekeeping and Dietary staff educated on proper disposal of garbage and refuse. In addition, Housekeeping and Dietary staff will be educated on maintaining a debris-free area surrounding dumpsters, while ensuring surrounding gate remains closed when not in use. 4. Housekeeping Director/ designee will audit the dumpster area five times weekly for four weeks, then 3 times per week for two months. Identified concerns will be immediately corrected. Audit results will be communicated at Monthly QAPI meeting.	

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F 814	Continued From page 50 responsible to maintain the area when trash is brought out. The dumpster lids should be shut, and the trash area gate should be always closed. A review of the facility Policy titled, "Food Garbage and Refuse Disposal," with a reviewed date of 01/2023, included that, 1) Waste shall be kept in containers and 2) All garbage and refuse containers are provided with covers and must be kept covered when stored or not in continuous use. 5) Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. 7) Outside dumpsters provided by garbage pick up services will be kept closed and free of standing liter. NJAC 8:39-19.3(a); 19.7(a)(b)	F 814		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		3/15/23

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F 880	Continued From page 51 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. §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.	F 880		

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F 880	Continued From page 52 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility provided documentation, it was determined that the facility failed to: a) establish, assess, and maintain record measures to minimize the risk of Ex Order 26.4B1 and other opportunistic pathogens in building water systems, this deficient practice had the potential to affect all 54 residents; b) properly doffed (remove) and discard the PPE (personal protective equipment) for one of three staff observed; c) perform handwashing appropriately for one (Certified Nursing Aide) of six staff observed for hand hygiene; d) disinfect and sanitize the equipment used for checking blood pressure for one of two nurses during medication administration), and e) adhere to accepted standards of infection control practices for the proper storage of respiratory tubing, and nasal cannula after use for one of two residents, Resident #47 reviewed for oxygen use in accordance with the facility policy and the Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice was evidenced by the following: According to the U.S. CDC Water Management in Healthcare Facilities, Page last reviewed: March 25, 2021, CDC encourages healthcare facilities	F 880	1. No residents were affected by this deficient practice 2. All residents have the potential to be affected by this deficient practice. A) Contracted laboratory performed a comprehensive water test, confirming no presence of Ex Order 26. 4B1 B) CNA # Was Inservice on Proper donning/ doffing and disposal of Ex Order 26. 4B1 (PPE). C) CNA #2 was inserviced on proper hand hygiene. D) LPN # was inserviced on disinfecting multi use medical equipment. E) Ex Order 26. 4B1 was immediately discarded and replaced. 3. A) Maintenance Director/ Maintenance assistant was educated on Water Management Plan with respect to Ex Order 26. 4B1 . B) CNA was educated on proper donning/doffing and disposal of Ex Order 26. 4B1 . C) Licensed nurses and CNAs were educated on proper handwashing technique and proper hand hygiene procedures. D) Licensed Nurses were educated on proper cleaning and disinfection of environmental surfaces according to current CDC guidelines and the OSHA Ex Order 26. 4B1	

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F 880	Continued From page 53 included in the scope of ASHRAE Standard 188 (Section 5.2) to develop and implement comprehensive water management programs. Water management programs can help reduce the risk for EX Order 26.4B1 growth and transmission. Water management programs should therefore be monitored for their efficacy in reducing risk for a variety of pathogens. According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, 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, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. According to the U.S. CDC Disinfection and Sterilization, Cleaning of Patient-Care Devices, Page last reviewed on May 24, 2019, included, Clean medical devices as soon as practical after use (e.g., at the point of use) because soiled materials become dried onto the instruments. Dried or baked materials on the instrument make the removal process more difficult and the disinfection or sterilization process less effective or ineffective.	F 880	Standards. E) Nursing staff were educated on Oxygen Administration Policy, proper labeling and dating of *Ex Order 26. 4B1* , and care of *Ex Order 26. 4B1* when not in use. 4. An audit will be completed by the Maintenance Director/ designee once a week for four weeks to ensure documentation related to Water Management Plan are up to date. *Ex Order 26. 4B1* / designee will audit five employees weekly for four weeks, then monthly for two months on donning and doffing PPE and hand hygiene. Director of Nursing/Designee will perform an audit weekly for four weeks, then bi-weekly for two months to ensure Oxygen Administration / Respiratory Supplies are labeled and stored properly. Any concerns identified during the audit process will be immediately corrected. All findings will be reported and reviewed by the QAPI committee monthly. A DPOC was imposed upon the facility and an RCA was completed. In-service videos and modules were viewed by staff as follows: Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350 All topline staff completed this training. CDC COVID-19 - Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw All frontline staff completed this training. CDC COVID-19 Sparkling Surfaces https://youtu.be/t7OH8ORr5IG All frontline staff completed this training.	

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F 880	Continued From page 54 1. On 01/25/23 at 12:00 PM, the surveyor interviewed the Director of Maintenance who stated that he was not sure how often the facility tested the water for EX Order 26.4B1 and further stated that the Licensed Nursing Home Administrator (LNHA) was responsible for the testing. On 01/25/23 at 12:55 PM, the surveyor interviewed the LNHA who stated that the facility tested the water for EX Order 26.4B1 annually. The surveyor asked for the name of the contracted company that performed the last test and requested a copy of the most recent report. On 01/25/23 at 01:32 PM, the LNHA stated that he did not know where the previous Maintenance Director had kept the reports and was unable to provide the surveyor with a copy. Review of the Facility's undated Water Management Plan, reflected the areas subject to EX Order 26.4B1 are the following: Ice Machines Less frequently used areas Water Coolers Respiratory therapy equipment HVAC-PTAC units Juice Machines Eyewash Systems Hot water holding tanks Faucets Aerator/Shower heads On 01/26/23 at 9:00 AM, the facility was unable to provide the survey team with any documentation confirming that the facility had tested the water system for EX Order 26.4B1	F 880	CDC COVID-19 Clean Hands https://youtu.be/xmYMUly7qiE All frontline staff completed this training. Module 5 Outbreaks https://www.train.org/cdctrain/course/1081803/ All topline staff completed this training. Module 11B Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ All staff completed this training. Module 7 Hand Hygiene https://www.train.org/main/course/1081806/ All staff completed this training. Module 6A Principles of Standard Precautions https://www.train.org/main/course/1081804/ All staff completed this training. Module 6B Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ All staff completed this training. Module 11A Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814/ All topline staff completed this training. Root Cause Analysis: Why(A): Current Maintenance Director misunderstood facility's Water Management Plan and was out when the new EX Order 26.4B1 testing kit arrived. Why(B): CNA made an honest mistake of not discarding PPE in the resident's room.	

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F 880	Continued From page 55 On 01/26/23 at 12:50 PM, the survey team met with the LNHA, DON, and the Infection Preventionist Nurse (IPN) and were made aware of the above findings. The surveyor asked the IPN about her responsibility with regard to the EX Order 26.4B1 and the facility's water management. The IPN stated that it was the LNHA who takes care of it. At that same time, the LNHA stated that it was required annually to test the water, "I planned to educate the Maintenance department on the process." He further stated that the last time the water was tested was on May 2022, "I cannot find the report," and it was an internal test that the facility does. The LNHA confirmed that the facility was not able to provide documentation that it was done on May 2022. No further information was provided by the facility. On 01/30/23 at 7:23 AM, the LNHA provided in an email a copy of the EX Order 26.4B1 Water Test result dated 01/28/23 for the collection date sampled date on 01/26/23 indicating that water was not brown, and the interpretation of the result was no presence of EX Order 26.4B1 The result was provided after the surveyor's inquiry on 01/26/23. 2. On 01/22/23 at 12:10 PM, the surveyor observed Certified Nurses Aide#1 (CNA#1) exit Resident #33's room wearing a blue disposable gown, gloves, N95 mask and face shield. Resident #33's room had a sign that indicated the resident was on Transmission Based Precautions (TBP) which required staff to don (put on) a gown, mask or respirator, goggles or face shield and gloves prior to entering the room. The surveyor observed CNA#1 removed the blue	F 880	Why(C): CNA was previously educated on proper handwashing technique, but became Ex Order 26. 4B1 during surveyor observation causing the alleged deficiency. Why(D): Alleged deficient practice was caused by a lack of understanding of protocol. LPN stated she through she only had to disinfect equipment that came in contact with the resident. Why(E): Alleged deficient practice was caused by labeling and dating being missed during routine weekly Ex Order 26. 4B1 supply change.	

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disposable gown and gown at the doorway. CNA#1 then proceeded to roll up the gown and gloves as she walked down the hallway to where there was a covered garbage can. CNA#1 then placed the rolled-up gown and gloves in the garbage can and performed hand hygiene with alcohol based hand rub (ABHR).

On that same date and time, the surveyor asked CNA#1 the reason she did not doff (take off) the gown and gloves in Resident #33's room. CNA#1 stated that there was only a small garbage can in the room so she had been putting the gown and gloves in the garbage can in the hallway. She added that she had noticed that other staff had been using the garbage can in the hallway and that she "followed suit." The surveyor then asked CNA#1 if the doffing should be done in the resident's room. CNA#1 stated that everywhere she had worked the gown and gloves were doffed inside the room. She added that other places had bigger garbage cans in the room.

On 01/22/23 at 12:56 PM, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) regarding the process for doffing the gown and gloves for a resident that was on TBP. LPN#1 stated that the gown and gloves should be doffed inside the resident's room. She then stated that she was not sure why the garbage can was outside the room. She added that she was told to doff it inside the room.

On 01/25/23 at 9:48 AM, the surveyor asked the IPN what the process was for doffing the gown and gloves for a resident that was on TBP. The IPN stated that the gown and gloves should be removed in the room and thrown out in room.

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A review of the facility provided policy titled, "Use of Personal Protective Equipment Utilized by Cohort" with a reviewed date of 01/2023, did not include information regarding doffing the gown and glove.

A review of the sign that was posted outside Resident #33's room titled "How to Safely Remove Personal Protective Equipment (PPE)" included the following:
Remove all PPE before exiting the patient room except a respirator, if worn.

3. On 01/22/23 at 9:50 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S). The RN/S informed the surveyor that as of 01/22/23, there was a total of 12 residents and four staff who tested positive for COVID-19.

On 01/22/23 at 11:41 AM, the surveyor observed CNA#2 with gloves on, had direct contact with Resident #27, exited the resident's room, and removed used gloves without performing hand hygiene. The surveyor asked the aide about hand hygiene, the use of PPE, and her education about it. CNA#2 stated that the IPN provided education about hand hygiene and PPE use. She further stated that hand hygiene should be performed after removing PPE which included gloves and after direct contact with the resident. She indicated that handwashing and scrubbing of hands were at least 25 seconds.

On that same date and time, the surveyor asked CNA#2 if she performed hand hygiene after direct contact with Resident #27's *Ex Order 26. 4B1* [redacted], and after removing her gloves, CNA#2 did not respond.

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Afterward, CNA#2 performed handwashing with soap and water inside the resident's bathroom after the surveyor's inquiry. The surveyor observed CNA#2 scrubbed both hands for five seconds and then immediately washed off soap under the stream of running water. During an interview of the surveyor with CNA#2, the aide stated that handwashing should be at least 25 seconds, scrubbing both hands outside the water and not under the stream of running water. The surveyor then asked CNA#2 if she followed the proper handwashing procedure as she stated earlier, the CNA did not reply.

On 01/24/23 at 03:22 PM, the survey team met with the LNHA, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), and Regional Clinical Specialist (RCS) and were made aware of the above findings.

A review of the facility's Handwashing/Hand Hygiene Policy that was provided by the IPN with an updated date of 1/2022 included that the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene to follow in situations that included but were not limited to before and after direct contact with residents, before donning gloves, and after removing gloves. Washing hands vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds.

On 01/26/23 at 12:50 PM, the survey team met with the LNHA, DON, and IPN. The LNHA stated that he observed CNA#2 did perform proper

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F 880	Continued From page 59 handwashing (ineffective ladder) during individualized re-education after the surveyor's inquiry and findings and was asked to cut her nails because it was too long. 4. On 01/24/22 at 8:34 AM, during the medication administration observation, the surveyor observed LPN#2 in the room of Resident #31. The surveyor observed the LPN obtaining vital signs using an Ex Order 26. 4B1 (BP) machine that included a Ex Order 26. 4B1 and a thermometer on a monitor stand at the resident's bedside. The LPN obtained results for the Ex Order 26. 4B1 of the resident. Upon returning to the medication cart, LPN#2 obtained a bleach wipe from the medication cart, disconnected the Ex Order 26. 4B1 that was used on Resident #31 from the wire of the monitor stand and cleaned the Ex Order 26. 4B1. After cleaning the Ex Order 26. 4B1, the LPN connected the Ex Order back onto the wire of the stand. On 01/24/23 at 8:47 AM, during the medication administration observation, the surveyor observed LPN#2 in the room of Resident #42 obtaining Ex Order 26. 4B1 using the same Ex Order 26. 4B1. The surveyor observed the wires of the Ex Order 26. 4B1 touching the bed that the resident was sitting on and the resident's Ex Order. The LPN obtained results for the Ex Order 26. 4B1 for the resident.	F 880		

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F 880	Continued From page 60 Upon returning to the medication cart, LPN#2 obtained a bleach wipe from the medication cart, disconnected the *Ex Order 26. 4B1* that was used on Resident #42 from the wire on the monitor stand and cleaned the *Ex Order 26. 4B1*. After cleaning the *Ex Order 26. 4B1*, the LPN connected the *Ex Order* back onto the wire of the stand. On 01/24/23 at 9:00 AM, during the medication administration observation, the surveyor observed LPN#2 in the room of an unsampled resident obtaining vital signs using the same *Ex Order 26. 4B1*. The surveyor observed the LPN having to retake the temperature of the unsampled resident because an inaccurate reading was obtained and during the process the surveyor observed wires from the *Ex Order 26. 4B1* touching the bed and body of the unsampled resident. LPN#2 obtained results for the *Ex Order* and temperature for the resident. Upon returning to the medication cart, LPN#2 obtained a bleach wipe from the medication cart, disconnected the *Ex Order 26. 4B1* that was used on the unsampled resident from the wire on the monitor stand and cleaned the *Ex Order 26. 4B1*. After cleaning the *Ex Order 26. 4B1*, the LPN connected the *Ex Order* back onto the wire of the stand. The surveyor had not observed LPN#2 use any cleaner or wipes on any other part of the *Ex Order 26. 4B1* including any of the wires or *Ex Order 26. 4B1* in between the three (3) residents during the medication administration observation. On 01/24/23 at 9:46 AM, the surveyor interviewed the Registered Nurse (RN) who was responsible for medication administration. The RN stated that	F 880		

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F 880	Continued From page 61 the Ex Order 26. 4B1 that was used to take vital signs of a resident had to be cleaned with bleach wipes after each use so that the machine was ready for the next use. The RN explained that the body of the machine, the Ex Order 26. 4B1, probes and wires or cables were all cleaned with a bleach wipe in between residents because when taking vitals on a resident the wires can touch the resident or other things in the room. On 01/24/23 at 9:59 AM, the surveyor interviewed the IPN who stated that she would expect the nurses to use a bleach wipe on the Ex Order 26. 4B1, machine, wires, and Ex Order 26. 4B1 in between residents. The IPN added that she had performed in-services for the nurses regarding the proper technique for cleaning equipment such as the Ex Orde that was used on the residents. A review of an In-Person Orientation attended by LPN#2 was provided by the IPN revealed that on 12/13/22 in-service topics of "Hand Hygiene Competency, Infection Control Procedures/Bloodborne Pathogens, Donning & Doffing PPE/COVID 19" were presented by the IPN. On 01/24/23 at 10:09 AM, the surveyor interviewed LPN#2 who stated that she cleaned the Ex Order 26. 4B1 with a bleach wipe because that is what touches the resident. The LPN also stated that she cleans the entire machine before her shift and at the end of her shift. The LPN added that she thought cleaning the Ex Order 26. 4B1 in between residents was what the process should be. A review of the facility policy for Cleaning and Disinfection of Environmental Surfaces dated November 2018 provided by the IPN included that	F 880		

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F 880	Continued From page 62 "Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard." In addition, the policy reflected that "Non-critical items are those that come in contact with intact skin but not mucous membranes." And "Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location)." 5. On 01/24/23 at 12:16 PM, the surveyor observed Resident #47 out of bed in a chair and a bedside table in reach. The supplemental *Ex Order 26. 4B1* was present on the right side of the bed. Attached to the *Ex Order 26. 4B1* was *Ex Order 26. 4B1* and a bottle of water for humidification use. The *Ex Order 26. 4B1* end had a *Ex Order 26. 4B1* . The *Ex Order 26. 4B1* was not in use or attached to the resident. The surveyor observed the *Ex Order 26. 4B1* loose, uncovered and tied around the *Ex Order 26. 4B1* of the resident's bed. The *Ex Order 26. 4B1* or the humidified bottle were not labeled or dated. On 01/25/23 at 10:46 AM, the surveyor observed the bare *Ex Order 26. 4B1* and *Ex Order 26. 4B1* directly touching and wrapped around the *Ex Order* . The humidification bottle was attached to the compressor, and neither compressor had a label or date.	F 880		

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F 880	Continued From page 63 The surveyor reviewed the medical records of Resident #47 as follows: The Admission Record (or face sheet, an admission summary) reflected Resident #47 was admitted to the facility with medical diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. The Vital Sign sheets, provided by the LNHA on Ex Order 26. 4B1 at 01:30 PM, revealed that resident #47 Ex Order 26. 4B1 was taken while the resident was wearing Ex Orde on three instances. ~Ex Order 26. 4B1 at 4:15 PM, Ex Order 26. 4B1 [redacted] ~Ex Order 26. 4B1 at 12:59 PM, Ex Order 26. 4B1 [redacted] ~Ex Order 26. 4B1 at 4:57 PM, Ex Order 26. 4B1 [redacted] The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care dated Ex Order 26. 4B1, reflected that Brief Interview for Mental Status (BIMS) could not be obtained. The staff performed a cognitive assessment which reflected the resident had a Ex Order 26. 4B1 [redacted]. The electronic Treatment Administration Record (eTAR) did not indicate the resident was on Ex Orde or an order for Ex Order 26. 4B1. The electronic Medication Administration Record (eMAR) did not indicate the resident was on Ex Orde or an order for Ex Order 26. 4B1.	F 880		

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F 880	Continued From page 64 A review of the Order Summary Report (OSR) for [redacted] revealed there was no order for supplemental [redacted] for Resident #47. During an interview on 01/24/23 at 12:16 PM, Resident #47, who stated, [redacted] " The surveyor asked about the [redacted], the resident stated, [redacted] On 01/25/23 at 11:06 AM, the MDS Coordinator (MDSC) stated, "the nurse will process the order for [redacted] and every week the humidification bottles and tubing get changed by the night shift on Sundays. If the [redacted] is applied under emergent conditions, it would be the crash cart and portable [redacted] that is applied to the resident. If the order is written [redacted]" the night shift still does the change out on Sundays, but when not in use the mask or nasal cannula and tubing should be in a labeled and dated bag attached to the concentrator. A review of the facility policy titled, "Oxygen Administration Policy," updated 10/2019, evidenced under preparation; 1) verify that there is a physician's order for this procedure. Evidenced under Steps in the procedure; 12) discard used supplies into designated containers. It did not indicate care of oxygen tubing or nasal cannula when not in use. On 01/26/23 at 5:04 PM, the survey team met for exit conference with the facility LNHA, DON, AIT, RDCS, RCS, and IPN. There was no additional information provided by the facility management to refute the findings above.	F 880		

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F 880	Continued From page 65 NJAC 8:39-19.1, 19.4(a)(1, 2)	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		3/15/23

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F 886	Continued From page 66 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on the observation, interview, record review, and other pertinent facility documentation it was determined that the facility failed to: a) conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests and b) perform COVID-19 testing for three of six residents (Resident #6, #17, and #32) reviewed for PUI (person under investigation) and one of three staff members reviewed for COVID-19 testing in accordance with the facility policy and Centers for Disease	F 886	1. Residents #6, 17, and 32 were covid tested with Ex Order 26. 4B1. residents # 6, 17, and 32 remained on the testing schedule per cdc and doh guidance. 2. All residents have the potential to be effected by this deficient practice. Employee was immediately educated on proper [redacted] testing procedure. Nursing staff were educated on testing requirement based on current standards of practice.	

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F 886	Continued From page 67 Control and Prevention guidelines (CDC) for infection control and to mitigate the spread of COVID-19 (A highly contagious respiratory disease caused by the SARS-CoV-2 virus). This deficient practice was evidenced by the following: According to the U.S. CDC Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings, Specimen Collection & Handling of Rapid Tests in Point-of-Care Settings, updated 4/04/22, included that Each point-of-care test has been authorized for use with certain specimen types and should only be used with those specimen types. Proper specimen collection and handling are critical for all COVID-19 testing, including those tests performed in point-of-care settings. A specimen that is not collected or handled correctly can lead to an inaccurate or unreliable test result. Store reagents, specimens, kit contents, and test devices according to the manufacturer's instructions found in the package insert. Do not open reagents, test devices, and cassettes until the test process is about to occur. Refer to the manufacturer's instructions to see how long a reagent, test device, or cassette can be used after opening. After the test, read and record results only within the amount of time specified in the manufacturer's instructions. Do not record results from tests that have not been read within the manufacturer's specified timeframe. According to the CDC guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic with an updated date of	F 886	3. Facility staff were educated on the proper Ex Order 26. 4B1 testing procedure for residents and staff. 4. Director of Nursing or designee will conduct an audit of 5 staff covid tests and 5 resident covid tests weekly to ensure proper procedures are maintained. Identified issues will be corrected immediately. Results of these audits will be reviewed in QAPI monthly.	

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F 886	Continued From page 68 Sept. 23, 2022, included the following: Perform SARS-CoV-2 Viral Testing Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ... Nursing Homes ... Responding to a newly identified SARS-CoV-2-infected HCP or resident When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not	F 886		

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F 886	Continued From page 69 earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5... 1. On 01/22/23 at 9:50 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/S). The RN/S informed the surveyor that as of 01/22/23, there was a total of 12 residents and four staff who tested EX Order 26.4B1 On 01/22/23 at 10:28 AM, the surveyor meet with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Infection Preventionist Nurse (IPN), and the Administrator in Training (AIT) during Entrance Conference. The DON stated that staff testing was filed on a separate log book and the residents' COVID test results were on the electronic Medication Administration Record (eMAR). The IPN stated that the facility was at a moderate level of community transmission "right now." On 01/23/23 at 10:08 AM, the surveyors observed the 1st-floor testing location in the enclosed partition in the dining area with three used COVID-19 testing kits and two unused opened testing kits for COVID on top of the table near a clipboard with paper. The paper on the clipboard revealed an Employee Covid Testing Log that included the corresponding names of three employees with used COVID testing kits on top of the table as follows: Rehab Aide (RA)=date 01/23/23, time 9:01, tester self, result (blank), lot# (blank), expiration date (blank)	F 886		

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F 886	Continued From page 70 Director of Activities (DoA)=date 01/23/23, time 9:00, tester DoA, result (blank), lot#187320, expiration date 5/25/23 Regional Maintenance Director (RMD)=date 01/23/23, 9:10, tester AIT, lot#205010, expiration date 9/8/23 The above testing rapid test results of RA, DoA, and RMD both had one red line which indicated that the results were negative for COVID. On that same date and time, the surveyor in the presence of another surveyor, at the testing area, interviewed and asked the IPN about the used and unused opened COVID testing kits on top of the table, and what happened why they were on top of the table. The IPN informed the surveyors that it was the AIT who was responsible for the testing kits and testing of staff today. She further stated that the used testing kits should have been read for results within 15 minutes, discarded after reading results to the red covered bin nearby, and the testing kits should be opened "only" when about to use and that the testing kits on top of the table should have not happened and not in accordance to facility protocol with regard to infection control. At that same time, the IPN acknowledged that the time 9 AM, 9:01 AM, and 9:10 AM in the Employee COVID Testing Log should have been read within 15 minutes, and it was now 10:08 AM and the results were not logged accordingly. The IPN further stated, "I don't know what happened." On 01/24/23 at 10:02 AM, the surveyor met with the LNHA and the DON and was made aware of the above findings. The surveyor asked the facility management about employee testing and	F 886		

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F 886	Continued From page 71	F 886		

their process. The LNHA informed the surveyor that there was no specific person in charge of testing staff, it was a day-to-day assignment, and on 01/23/23, it was the AIT's responsibility to do staff testing, and that the AIT was educated about staff testing. He further stated that the AIT "probably" step out at that time which was why the surveyors observed the three testing kits of the DoA, RA, and the RMD together with the unused opened testing kits on top of the table in the 1st-floor testing area.

On 01/24/23 at 10:34 AM, the surveyor interviewed the DoA. The DoA informed the surveyor that she swabbed her nose with the supervision of the assigned person in testing, wait for 15 minutes for the result, and if the result was negative, then she can go to work. The DoA stated that it was the responsibility of the person in charge of the testing area to dispose of the used testing kits and log the results. She further stated that all staff was required to test for COVID-19 even the vaccinated. She indicated that she was up to date with her COVID vaccination.

On that same day and time, the DoA stated that it was the AIT who was in charge of testing on 01/23/23, "I swabbed myself, waited for 15 minutes, I don't do the card (putting drops on the testing kit), I gave it to the AIT," the AIT was pulled away before the 15 minutes. She further stated that the result was negative, "I did not put the results when I left, the AIT was not there and the card (used testing kit) was still there." The DoA indicated that she did not put the result of the COVID test in the Employee COVID Testing Log.

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F 886	Continued From page 72 On 01/24/23 at 11:32 AM, the surveyor called and interviewed the RMD in the presence of the survey team. The RMD stated that the AIT did his COVID test on 01/23/23, the AIT swabbed his nose and logged all his information in the Employee COVID Testing Log. The RMD further stated that the AIT left after 15 minutes, "I saw it was negative (the test result) and I left the room and I never see him (AIT) again." The RMD stated, "there's no timer, I approximate it was 15 minutes, it was only one line so it was negative, I told the LNHA that I'm going downstairs to the office, I told the LNHA I was negative." He indicated that it was the AIT's responsibility to discard the used COVID test kit. He indicated that he was up to date with his COVID vaccination. On 01/24/23 at 11:41 AM, the surveyor interviewed the RA. The RA informed the surveyor that as per facility practice and protocol, upon entering the facility lobby, to use the kiosk in answering the COVID screening questions that included checking the temperature, time in, and then to do a COVID test "across the dining hall." The RA stated that there was an assigned person in the COVID testing area and on 01/23/23, it was the AIT who was in charge at that time. The RA indicated that he was up to date with his COVID vaccination. On that same date and time, the RA informed the surveyor that the AIT was the one who filled out the Employee COVID Testing Log for the RA's information and swabbed his nose. The RA stated that "wait for 15 minutes either using my watch or the AIT's watch and then the AIT decides if it was negative or positive." He further stated that "I think it was over 15 minutes at that time, the AIT was not there and I decided it was negative	F 886		

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because it was one line, then I just left when I know I am negative." He indicated that the AIT should be the one to dispose of the use COVID test kit. The RA confirmed that it was he who had some blank information in the Employee COVID Testing Log on 01/23/23.

On 01/24/23 at 11:54 AM, the surveyor interviewed the AIT in the presence of the survey team. The AIT informed the surveyor that part of his training as an AIT was the responsibility of staff COVID testing and that he was educated on the proper way of COVID testing according to the manufacturer's instructions and facility protocol. The AIT stated that "the staff will enter the testing area, usually the staff will fill out the form (Employee COVID Testing Log), I prepare the cards (testing kit) to put the drops, purell (hand sanitizer), gloves, swabbed their nostrils, put it in the card, seal it and set the timer, an old fashioned timer on top of the table, set at 15 minutes." He further stated that it was hard to be exact with the timer and had to set it between 15-17 minutes, then the AIT will tell the staff of the results, and then he logged in to the Employee COVID Testing Log. He indicated that if the result was negative, he will dispose of it in the covered bin "right away," if it was positive, I leave it on top of the table for the LNHA, DON, or IPN to deal with it.

In addition, the AIT stated that it was important to dispose of used kits immediately due to infection control prevention and to disinfect the table. He further stated that he did not pre-open testing kits because it can affect the result of the test, did not put the used testing kits near the clean testing kits, and "in general keep clean and neat." The AIT stated "honestly I do not know," why there

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F 886	Continued From page 74 were opened unused testing kits near the used testing kits on top of the table. At that same time, the AIT stated that he did remember that he did the COVID test of the RA, RMD, and DoA on 01/23/23, got pulled away, and "obviously forgot to log and discard" the used test kits. The AIT further stated that "it was not okay to be there (the used kits) for over an hour and not read the results, for infection control." He indicated that the testing area should not be left unattended with used testing kits and supplies for safety and infection control purposes. A review of the [name redacted] type of testing kit that was used by the facility that was provided by the IPN included important information about the product insert including the complete instructions, warnings, precautions, and limitations of the testing kit that false negative results may occur if specimens are tested past one-hour collection; specimens should be tested as quickly as possible after specimen collection; and read the result in the window 15 minutes after closing the card, and to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before. Results should not be read after 30 minutes. On 01/26/23 at 5:04 PM, the survey team met with the LNHA, DON, AIT, IPN, Regional Director of Clinical Services (RDCS), and Regional Clinical Specialist (RCS) and there was no additional information provided by the facility management.	F 886		

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2. On 01/22/23 at 11:23 AM, during initial tour of the [redacted] unit in the presence of a federal surveyor, the surveyor entered Resident #6's room. There were no signs on Resident #6's room to indicate that the resident was on Transmission Based Precautions (TBP) or to indicate the resident was a [redacted]. Resident #6 told the surveyors that he/she was not doing well and that someone had told him/her that he/she had [redacted] The surveyors then left Resident #6's room and went to the nurse's station.

On 01/22/23 at 11:32 AM, in the presence of the federal surveyor, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) regarding Resident #6. The LPN stated that Resident #6 was EX Order 26.4B1 and that the resident was not on TBP. LPN#1 further stated that on 01/19/23, Resident #6 was last tested for EX Order 26.4B1 because the resident EX Order 26.4B1 of a EX Order 26.4B1, but that Resident #6 had EX Order 26.4B1 routinely. The LPN added that Resident #6's test was EX Order 26.4B1. The LPN then stated that Resident #6 was also tested on Ex Order 26. 4B1 when all the residents on the unit were tested when one of the resident on the unit tested Ex Order 26. 4B1. The surveyor then asked for Resident #6's Ex Order 26. 4B1 test results.

On 01/22/23 at 11:43 AM, the RN/S provided the surveyors with Resident #6's Ex Order 26. 4B1 test, which was performed on Ex Order 26. 4B1 which included the following: [redacted] done as part of screening and Ex Order 26. 4B1. The RN/S did not provide any additional Ex Order 26. 4B1 tests for Resident #6.

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F 886	Continued From page 76 On 01/23/23 at 11:50 AM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) regarding Resident #6. The MDSC stated that Resident #6 had a roommate that had a [redacted] on [redacted] and that the roommate was tested for [redacted] that day and tested [redacted]. The roommate of Resident #6 was then moved to another room. The MDSC further stated that Resident #6 was tested for [redacted] at that time and the result was [redacted]. At that time, the surveyor asked the MDSC if Resident #6 was considered a [redacted] and she confirmed that Resident #6 was a [redacted]. The surveyor then asked what the process for testing was. The MDSC stated that she believed that the testing was two times a week. She added that testing was done on admission and that it was more frequent after a resident became [redacted] for [redacted]. On 01/23/23 at 11:59 AM, the surveyor interviewed the IPN regarding testing of PUI residents. The IPN stated that testing was done the prior evening because the [redacted] were on day three [of their exposure]. The surveyor asked the IPN where the facility documented the COVID-19 tests for residents. The IPN stated that the tests were placed into each resident's electronic medical record and that she did not have a log of the test results. On that same date and time, the surveyor then asked the IPN which residents were PUI due to exposure to [redacted] from residents that tested [redacted]. The IPN stated that Resident #6, Resident #17, Resident #32 and three other residents were PUIs. The surveyor asked the IPN	F 886		

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what the process was for [redacted] testing of residents that were PUI. The IPN stated that the protocol for PUIs was to test the resident on day one, day three and day five [after they were exposed to a resident that tested COVID-19 positive].

On 01/23/23 at 12:48 PM, the surveyor asked the IPN to provide all the [redacted] tests performed since [redacted] for Resident #6, Resident #17 and Resident #32.

On 01/23/23 at 01:20 PM, in the presence of the survey team, the IPN provided the surveyor the [redacted] test results that were requested which included the following:

Resident #6: [redacted] test dated [redacted] which was [redacted]. (The facility had previously provided a test dated [redacted] which was [redacted])
Resident #17 [redacted] test dated [redacted] and [redacted] which were both [redacted].
Resident #32: [redacted] test dated [redacted] and [redacted] which were both [redacted].

At that same time, the surveyor then asked the IPN what the reason was that the PUI residents were not tested on day three after exposure to COVID-19. The IPN stated that the CDC guidance was to wait 24 hours after exposure and then wait three to seven days to retest. The surveyor then asked the IPN to read the facility policy. The IPN confirmed that the facility policy stated that testing was to be done on day one, day three and day five. The IPN added that she thought the CDC guidance said three to seven days.

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F 886	Continued From page 78 On 01/23/23 at 01:35 PM, the surveyor reviewed the electronic medical record (eMR) for Resident #6, Resident #17 and Resident #32. The test dates that were in the eMR were the same tests that the facility provided to surveyor. There were no additional test dates documented in the eMR from *Ex Order 26. 4B1* . On 01/25/23 at 11:16 AM, in the presence of the survey team, the surveyor notified the facility's administration team, which included the LNHA, DON, IPN, RCS, and RDCS, of the findings that residents who were close contacts (exposed to COVID-19) were not tested for *Ex Order 26. 4B1* according to CDC guidance. On 01/26/23 at 8:05 AM, the LNHA provided to the survey team an undated policy titled "Testing in Response to newly Identified Covid Positive Resident/HCP. The facility had the following section highlighted: Broad-based approach for residents/HCP: Perform SARS-CoV-2 testing for all patients/residents and staff on the affected unit(s), regardless of vaccination status, who have not been previously positive within the past 30 days**, immediately and, again 3-7 days later. The surveyor then reviewed the rest of that policy which included the following: When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in any HCP (health care provider) or resident should be evaluated to determine if others in the facility could have been exposed ...	F 886		

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Perform testing for all residents and HCP identified as close contacts
Testing is recommended immediately (but not earlier that 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day one (where day of exposure is day 0), day 3, and day 5.

On 01/26/23 at 01:00 PM, the surveyor asked the IPN the reason the PUI residents were not tested on day 3. The IPN stated that the RCS had told her they could do broad based testing every three to seven days, so they did the testing on day 4. The facility did not provide testing for day four (4) for the three residents. The testing provided was day one and day five. The surveyor then asked the IPN if PUI residents were considered close contacts. The IPN stated that a resident is a PUI because they are a close contact since their roommate had tested COVID-19 positive.

On 01/26/23 at 4:01 PM, in the presence of the survey team, the LNHA, DON, IPN, AIT, RCS, and RDCS, the surveyor asked if the facility could provide any additional information to indicate that a resident who was a PUI because their roommate had tested COVID-19 positive, should not be tested on day one, day three and day five as per CDC guidance.

At that same time, the RCS stated that after the initial round of testing, any additional testing would move to a broad based approach which would be on all affected units. He added that they would then test the residents every three to seven days. The surveyor then asked the facility to provide the CDC guidance which stated that a

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F 886	Continued From page 80 PUI could be tested every three to seven days. On 01/26/23 at 9:05 PM, the facility emailed the survey team a document titled "Outbreak Management Checklist for COVID-19 in Nursing Homes and other Post-acute Care Settings" which was dated December 13, 2022 and the facility had the following highlighted: Note: A broad-based approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. The surveyor reviewed the rest of the document which also included the following under the section the facility highlighted: 5. Broad-based approach: Perform SARS-CoV-2 testing for all patients/residents and staff on the affected unit(s), regardless of vaccination status, who have not been previously positive within the past 30 days**, immediately and, if negative, again 48 hours after first negative test, and if negative, again 48 hours after second negative test. The document also included the following above the section the facility highlighted: 1. Facilities should perform contact tracing to identify all high-risk staff exposures and close contact encounters with patients/residents ... 2. Contact tracing approach: Perform SARS-CoV-2 viral testing for all patients/residents identified as close contacts and all staff who have higher-risk exposures, regardless of vaccination status, who have not been previously positive within the past 30 days**. *Ex Order 26. 4B1*	F 886		

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F 886	Continued From page 81 patients/residents and staff with close contact or higher-risk exposures should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately but not earlier than 24 hours after exposure and, if negative, 48 hours after the first negative test. If negative, again 48 hours after the second negative test. This will typically be on days 1 (one), 3 (three), and 5 (five) (where the day of exposure is day 0). 3. Continue performing contact tracing if testing reveals additional cases ... A review of the facility provided policy titled, "Policy for Emergent Infectious Diseases (COVID-19) (Outbreak Plan V10)", with an updated date of 10/24/22, included the following: Goal To protect our residents, families, representatives, and staff from harm resulting from exposure to an emergent infectious disease while they are in our care center. 3. Suspected case in the care facility ...f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC ... h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC ... 6. Response to Newly Identified Case Testing of Residents When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public	F 886		

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F 886	Continued From page 82 health authority. A single new case of SARS-CoV-2 infection in any HCP (health care provider) or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier that 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ... PUI-Individuals consisting of all symptomatic and asymptomatic patients/residents who test negative for SARS-CoV-2 with an identified exposure (i.e., close contact) to someone SARS CoV-2 positive ... 3. On 01/22/23, during the entrance conference, the surveyor requested documentation related to COVID-19 testing. On 01/23/23 at 12:48 PM, the surveyor asked the IPN to view the COVID-19 testing log for the facility's staff for the last four weeks. On 01/24/23 at 10:16 AM, the surveyor	F 886		

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interviewed the DON regarding the process for COVID-19 testing of staff. The DON stated that the facility used a log for the staff COVID-19 testing and that when staff came in they would go to get tested every three to seven days. She added that some staff were per-diem (someone whose work hours may vary from week to week depending on need) and that they had to track them and test them every time they worked. The DON added that they had a list of staff who was working and that it was a small facility and it was easy to track.

On that same date and time, the surveyor asked who was responsible for the tracking. The DON stated that Human Resources was responsible but that the person was out due to COVID-19 and that the LNHA and AIT were responsible for tracking. The surveyor asked the DON if any staff were unvaccinated for COVID-19. The DON stated that there were two nursing staff (a Certified Nurse Aid (CNA) and LPN#2 and that they were getting tested two times per week.

On 01/24/23 at 11:01 AM, the surveyor requested from the LNHA, the time cards for the CNA and LPN#2.

On 01/24/23 at 2:09 PM, the surveyor reviewed the facility provided time card and the COVID-19 testing log for staff which included the LPN#2 which included the following:

Worked 01/01/23, 01/02/23, 01/05/23, 01/12/23, 01/13/23, 01/14/23, 01/20/23 and 01/21/23. Sick on 01/19/23 and 01/22/23. Tested on 01/01/23 and 01/02/23. There were no other COVID-19 tests documented in the facility provided staff testing logs from 01/03/23 to 01/24/23.

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F 886	Continued From page 84 On 01/25/23 at 11:16 AM, in the presence of the survey team, the surveyor notified the facility's administration team, which included the LNHA, DON, IPN, RCS, and RDCS, of the above findings that LPN#2 was not COVID-19 tested according to CDC guidance and the facility policy. The facility did not provide any additional information prior to survey exit on 01/26/23 at 5:04 PM. A review of the facility provided policy titled, "Policy for Emergent Infectious Diseases (COVID-19) (Outbreak Plan V10)", with an updated date of 10/24/22, included the following: Testing of nursing home HCP 1. If testing capacity allows, PPS of all HCP should be considered in ...facilities with a suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well. 2. Testing will be completed in a cyclic approach as designated by NJDOH/CDC guidance ... 5. All unvaccinated staff will complete weekly/biweekly testing according to the NJDOH guidance and Cali score or CDC transmission rates (whichever is higher) ... 3. Routine testing: All staff testing must be completed prior to entering the facility and Units to decrease exposure to the residents and staff ... Staff:All staff who have not yet submitted proof of full vaccination must be tested, at a minimum, on a once or twice weekly basis in accordance with E.O. 252 and NJDOH E.D. 21-011. If additional cases are identified, testing should	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315349	A. BUILDING _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	**333 GRAND AVE ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 85 continue on the affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care as indicated, until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 (three) days), should be considered. N.J.A.C. 8:39-5.1(a), 19.4 (a)(k)	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060210	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	333 GRAND AVE ENGLEWOOD, NJ 07631

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for 4 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. No residents were affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The identified staff member was removed from the schedule. Additional per diem, part time and full time staff were scheduled to meet minimum staff-to-resident ratios. These staff were recruited. We also hired new employees, and converting existing staff from part time to full time to address the immediate need. Licenses/ certifications were verified by the staffing manager/ Human Resources for current licensed/ certified staff. Clearing House Coordinator was notified regarding the identified staff member. LNHA and Nursing Administration	3/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060210	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	333 GRAND AVE ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 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 01/08/23 to 01/14/23 and 01/15/23 to 01/21/23, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -01/08/23 had 5 CNAs for 53 residents on the day shift, required 7 CNAs. -01/10/23 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. -01/15/23 had 5 CNAs for 56 residents on the day shift, required 7 CNAs. -01/17/23 had 6 CNAs for 56 residents on the day shift, required 7 CNAs. On 01/26/23 at 8:36 AM, the surveyor interviewed Staffing Coordinator#1 (SC#1) who stated that she was responsible for the schedules for the nursing department. The SC added that she was aware of the requirement for the ratios of a CNA to resident for the 7 AM to 3 PM day shift was eight (8) CNAs, and unsure about the ratio for 3 PM to 11 PM and 11 PM to 7 AM shifts. SC#1	S 560	educated on New Jersey Administrative code 13.34E-3.1 requirement to notify of the clearing house coordination. 2. DON / Designee to in-service Staffing Coordinator on appropriate staffing levels. Facility has advertised open jobs through online recruitment platforms as well as traditional recruitment firms. The facility has conducted job fairs and has contracts with nursing staffing agencies. The staffing coordinator and human resource manager were educated on the protocol for verifying licensure/certification prior to employment. Management Staff educated on the requirement of reporting to clearinghouse 3. The facility utilized online recruiting platforms and also attends in-person career fairs. LNHA or Designee will audit licensure verification weekly x4 weeks then monthly x 2 months. LNHA or Designee will audit facility healthcare professionals who are terminated, suspended, or have privileges revoked to ensure that the Clearing House Coordinator is notified of the termination weekly x4 weeks then monthly x2months, and the scheduling manager or designee will audit weekly x4 weeks and monthly x2 months to ensure staffing levels are with the mandated ratios. All identified concerns will be corrected immediately. The results of the audits will be reviewed in QAPI monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060210	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 added that the facility was not meeting the required ratios every day and "honestly, it was not perfectly fine every day." The SC further stated that if the ratio was not being met then she would inform the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) to help the SC to split the assignments to make it equal for CNAs and nurses. On that same date and time, SC#1 informed the surveyor that when she first started, the facility was "using a lot of agency," then the LNHA was able to hire "some people," and now the facility does not utilize an agency for staffing needs. The SC stated that "in some cases, I mentioned about trying to have an agency again if the facility does need it again, and the LNHA said no." A review of the facility policy reviewed 01/2023 titled, "Staffing" provided by the LNHA included the following policy statement that the facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans, the facility assessment, and/or applicable state laws. On 01/26/23 at 3:53 PM, the survey team met with the LNHA, DON, Infection Preventionist Nurse (IPN), Administrator In Training (AIT), Regional Director of Clinical Services (RDCS), and the Regional Clinical Specialist (RCS) and made aware of the above findings.	S 560		

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S 560	Continued From page 3 Part B: Based on observation, interview and review of the facility provided documentation, the facility failed to check a license of a new employee through a multi-state licensure verification prior to the new employee providing care in the facility. The deficient practice occurred for one (1) of four (4) newly hired employees. The evidence was as follows: On 01/22/23 at 9:59 AM, the surveyor interviewed Registered Nurse (RN) and Licensed Practical Nurse#1 (LPN#1) who stated that they were the two (2) nurses assigned to the second floor for that day. The RN and LPN#1 stated that they had a resident census of 30 residents and that there were four (4) CNAs working on the second floor. At that time, the RN provided the surveyor with a CNA assignment sheet for the second floor. In addition, the RN and LPN#1 were able to point out, from a distance, each of the employees corresponding to the four (4) CNA names listed on the assignment sheet that were working on the second floor. On 01/23/23 at 12:00 PM, the surveyor interviewed the employee that corresponded to one (1) of the four (4) CNA names listed on the assignment sheet from 01/22/23. The employee stated that she had been hired recently in December but was able to discuss Resident #20 because she was assigned to the resident and was familiar with the resident. At that time, the employee showed the surveyor her badge which had SC#2 on it. The employee stated that she was currently attending CNA	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 school. The employee stated that she had a CNA license that had lapsed more than two (2) years. The SC added that she had an assignment of other residents on the floor but was helped by the other CNA's and the nurses. The SC further explained that she had started CNA school on 01/17/23 and had a CNA license from 2004 until 2016 but had let her certification lapse for personal reasons. SC#2 added that she had found out that because the lapse was greater than two (2) years, she had to retake the CNA course. SC#2 further stated that the facility was willing to pay for the CNA school and she had recently started classes and felt that she had remembered a lot. The SC then stated that she was going to care for Resident #20 and had obtained linens before entering the resident's room. On 01/23/23 01:39 PM, the surveyor was provided by the DON a Human Resources (HR) file for SC#2. The DON added that the IPN would provide the orientation and any skills and inservices completed. A review of the file of SC#2 revealed the following documents: - A date of hire of [redacted] for the nursing department in the position of CNA. -An Employee Immunization Statement & Health Examination with the job title of CNA. -A background check completed [redacted]. -An Employment Application dated [redacted] with the position applying for as a CNA. -A Professional Licenses/Certifications form with CNA completed as the type and New Jersey (NJ) as the state issued and signed by the SC on [redacted] The date issued, expiration date and number were blank, in addition to the "witnessed"	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 5 signature line. - A Nurse Aide Certification Repayment Agreement dated 01/06/23 and signed by the SC and LNHA. -An invoice dated 12/20/22 from the school offering a CNA course that revealed the payment was for SC's training, license fee and uniform fee for the class that would be starting on 01/17/23. -A check dated 01/06/23 from the facility to the CNA school for the invoice amount. There was no CNA or Nursing Aide license on file and no verification of a license check. On 01/26/23 at 12:50 PM, the survey team met with the administrative team. The LNHA stated that he had been calling the CNA school but was unable to get information regarding completed coursework for SC#2. The LNHA added that he was unable to find a license verification from six (6) years ago. The LNHA stated that he should have checked the license verification. On that same date and time, the LNHA stated that the protocol for a NA applying included prior to orientation a background check was needed before starting. The LNHA added that SC#2 was an unlicensed staff and hired as an unlicensed staff so a license verification check was not performed. The LNHA stated that SC#2 was assigned to help in the dayroom as an activities assistant for 01/22/23 and should not have been assigned to any residents. At that time, the DON stated that she was unaware that a license could be checked from six years ago. The DON acknowledged that the license should have been checked for verification for SC#2.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 6 On 01/26/23 at 02:59 PM, the survey team met with the administrative team. The surveyor was provided by the LNHA a copy of a NA registration card for the SC from the NJ Department of Health. The NA registration revealed that the original issue date was 8/26/2005 and had expired 3/12/2016. The LNHA stated that he had contacted the school and was told that SC#2 had received 12 hours of CNA coursework in classroom education from 01/17/23 to 01/19/23. There was no additional documentation of the coursework provided. The LNHA stated that the license had not been checked when SC#2 was hired because it had expired. Part C: Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the Clearing House Coordinator of a Licensed Practical Nurse (LPN#2) who was terminated of their services after the nurse's failure to follow standard medication count procedures; failure to inform supervisor of medication delivery discrepancy; failure to track and safeguard controlled substances as mandated by the State of New Jersey. This deficient practice was identified for one of one investigation reviewed and the findings were as follows: Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 7 Care Professional Reporting Responsibility. Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House Coordinator concerning a health care professional who is employed by, under contract to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity; i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services: On 01/26/23 at 10:42 AM, the surveyor interviewed the DON who stated the facility had	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 8 an incident in December of 2022 where a resident's controlled medication went missing. The DON stated the facility had reported the incident to the state board, and NJDOH. The DON stated she would provide the surveyor the reports. On 01/26/23 at 11:43 AM, the surveyor again asked for the facility investigation, including all interviews as well as witness statements. On 01/26/23 at 12:50 PM, the LNHA provided a file regarding the investigation which Included an email from the LNHA to New Jersey Division of Consumer Affairs titled "NJ Professional and Occupational Board Complaint Form" the email did not have a date of submission or information regarding whom the complaint was being filed against. On 01/26/23 at 3:53 PM, the survey team met with the facility Administration team, the LNHA stated he could not provide evidence the nurse had been reported to the Clearing House as required.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315349 Y1	A. Building B. Wing Y2	3/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	333 GRAND AVE ENGLEWOOD, NJ 07631

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 F0656	Correction	ID Prefix F0726	Correction	ID Prefix F0732	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.35(a)(3)(4)(c)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	03/15/2023	LSC	03/15/2023	LSC	03/15/2023
ID Prefix F0755	Correction	ID Prefix F0756	Correction	ID Prefix F0758	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	03/15/2023	LSC	03/15/2023	LSC	03/15/2023
ID Prefix F0759	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	03/15/2023	LSC	03/15/2023	LSC	03/15/2023
ID Prefix F0880	Correction	ID Prefix F0886	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80 (h)(1)-(6)	Completed	Reg. #	Completed
LSC	03/15/2023	LSC	03/15/2023	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	
1/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060210		3/24/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	333 GRAND AVE ENGLEWOOD, NJ 07631

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 03/15/2023	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	
1/26/2023	☐ 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
	315349	A. BUILDING **01** B. WING _____	**01/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	**333 GRAND AVE** **ENGLEWOOD, NJ 07631**

(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 01/24/23. 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 the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/24/23 and was found not 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. Complete Care of Inglemoor is a two-story building with a basement that was built in 1965. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 54 of 62. .	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to	K 211		3/15/23

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

Electronically Signed | 02/18/2023

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
	315349	A. BUILDING **01** B. WING _____	**01/26/2023**

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K 211	Continued From page 1 full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: . Based on document review, observation and interview, the facility failed to ensure 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 54 residents. Findings include: A document review of the facility's inspection binder for 2022 provided by the Administrator revealed there was no evidence the fire door inspections were conducted. An observation from 12:25 PM to 1:30 PM on 01/24/23 revealed inspections were not conducted on any of the facility's fire doors and the doors lacked the required inspection tags. The Administrator was present at the time of observation and confirmed the fire doors were not inspected. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 211	1. No residents were effected by this deficient practice. 2. All residents have the potential to be effected by this deficient practice. 3. An outside vendor will inspect all fire doors for compliance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. 4. An audit will be completed by the Maintenance Director or designee once a week for four weeks to ensure documentation related to recurring life safety audits are completed. All findings will be reported and reviewed by the QAPI committee monthly.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation	K 311		3/15/23

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K 311	Continued From page 2 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews the facility failed to ensure fire doors were free of holes due to changes or removal of hardware and repaired by one of the following methods: (1) Install steel fasteners that completely fill the holes (2) Fill the screw or bolt holes with the same material as the door frame in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010 Edition) Section 5.2.15.4(1)(2). In addition, the facility failed to ensure the fire door latched into the frame in accordance with NFPA 101 Life Safety Code (2010 Edition) 8.6.5. This deficient practice had the potential to affect all 54 residents. Findings include: An observation at 12:45 PM on 01/24/23 revealed the basement fire door to the North stairway adjacent to the mechanical room had five unsealed penetrations, three above the doorknob and two below the doorknob and the fire door did not latch into the frame. An observation at 12:51 PM on 01/24/23 revealed the basement fire door to the South stairway adjacent to the kitchen had three unsealed	K 311	1. No residents were effected by this deficient practice. 2. All residents have the potential to be effected by this deficient practice. 3. Contracted vendor came out to the facility and properly sealed the penetrations to the North Basement stairwell and South Basement stairwell doors. Contracted vendor came out to the facility to correct latch mechanism, and ensure North Basement Stairwell door latches properly. 4. Maintenance Director or Designee will audit five random fire doors weekly for four weeks, then monthly for two months. Results of the audits will be discussed during Monthly QAPI meeting.	

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K 311	Continued From page 3 penetrations, two above the doorknob and one below the doorknob. The Administrator and Maintenance Director were present at the time of the observations and verified the penetrations in both fire doors and the North fire door did not latch into the frame. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 311		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure an electrical outlet box and conduit were securely fastened in place and conduit was secured within three feet of an electrical box in accordance with NFPA 70 National Electrical Code (2011 Edition) section 300.11. This deficient practice had the potential to affect all 54 residents.	K 511	1. No residents were effected by this deficient practice. 2. All residents have the potential to be effected by this deficient practice. 3. Maintenance Director securely fastened electrical box and conduit. 4. Maintenance Director or Designee will perform electrical safety audit weekly for four weeks, then monthly for two months. Results of the audits will be discussed	3/15/23

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K 511	Continued From page 4 Findings include: An observation on 01/24/23 at 12:50 PM revealed conduit coming from the ceiling was bent towards an electrical outlet box attached to the preparation table in the kitchen and the conduit was pulled out of the box. The Administrator and Maintenance Director were present at the time of observation and verified the conduit was bent and pulled out from the outlet box. NJAC 8:39-31.2(e) NFPA 70 .	K 511	during Monthly QAPI meeting.	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: . Based on observations and interview, the facility failed to ensure portable space heaters were not being used for supplemental heat in accordance with NFPA 101 Life Safety Code (2012 Edition) 19.7.8. This deficient practice had the potential to affect all 54 residents. Findings include:	K 781	1. No residents were effected by this deficient practice. 2. All residents have the potential to be effected by this deficient practice. 3. Contracted service to come out to center to install new heating/cooling units. Portable heating/cooling units removed. Time limit waiver has been submitted with an estimated completion date of 12/15/2023.	3/15/23

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K 781	Continued From page 5 An observation on 01/24/23 from 12:25 PM to 1:08 PM revealed portable heat pump type space heating devices were being used as supplemental heat in patient rooms Ex Order 26. 4B1 [redacted], Ex Order 26. 4B1 dining room, Ex Order 26. 4B1 dining room, Ex Orde [redacted] lobby and rehabilitation. The Administrator was present at the time of the observations and verified the portable space heaters were present and used as supplemental heat. The Administrator stated that in November of 2022 there were concerns with the heating system not keeping some areas at 71 degrees so, they purchased portable heaters to supplement the heat until they got approval to install a new heating system. They purchased PTAC (Packaged Terminal Air Conditioner) units to replace the old heating system. They have sent all required documentation to the city for approval. The Administrator informed the city stated the nursing home would have to hire a structural engineer to determine if they could install the PTAC units because they would have to cut through the outside walls in each room to install the units. NJAC 8:39-31.2(e) .	K 781	4. Director of Maintenance/ designee will conduct a facility wide audit to ensure portable air condition/ heating units are not in use weekly x4 weeks then monthly x2 months. Identified concerns will be immediately corrected. Results of the audits will be reviewed monthly in the QAPI meeting	

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
315349 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/30/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT INGLEMOOR, LLC	333 GRAND AVE ENGLEWOOD, NJ 07631

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	03/15/2023	LSC K0311	03/15/2023	LSC K0511	03/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0781	03/15/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
1/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO