STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315434	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

(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 000	INITIAL COMMENTS Survey Date: 03/02/23 Census: 88 Sample: 18 + 3 closed records + 15 = 36 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 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for one (1) of 18 residents, (Resident #39) for a total of eight (8) quarters reviewed for [redacted] and was evidenced by the following: According to the Centers for Medicare & Medicaid Services (CMS) Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual dated October 2019, page L-1 (423), Item Rationale, Health-related Quality of Life, included that poor oral health has a negative impact on quality of life, overall health, and nutritional status. Assessment can identify periodontal disease that	F 641	Resident #39's MDS was modified to accurately reflect the [redacted] of the patient's [redacted] on the OBRA MDS Assessments. Resident #39's Care plan was modified to accurately reflect the [redacted] and plan of care for the patient. All residents have the potential to be affected by this deficient practice. Therefore, this applies to residents (current and future). Interdisciplinary Team was re in serviced regarding the accuracy on assessment, documentation and MDS coding. MDS Coordinator was re in serviced on OBRA MDS Assessments to accurately	4/5/23

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

Electronically Signed | 03/17/2023

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F 641	Continued From page 1 can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes. Planning for Care: assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes. On 02/16/2022 at 10:10 AM, the surveyor observed Resident #39 in bed in their room watching television. During the conversation of the surveyor with the resident, the surveyor observed that the resident's teeth were [NJ Exec. Order 2] [redacted] d and some [NJ Exec. Order 26:4.b.1]. The surveyor asked the resident if he/she had soreness in their mouth and discomfort when eating. The resident stated that he/she NJ Exec. Order 26:4.b.1. The surveyor reviewed the medical records of Resident #39 and revealed the following: The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with a diagnosis that included but was not limited to [NJ Exec. Order 26:4.b.1] [redacted] The Admission Nutritional Assessment dated [NJ Exec. Order 26:4.b] [redacted] under dentition section #8 revealed the resident had [NJ Exec. Order 26:4.b.1] [redacted].	F 641	reflect the resident□s status. MDS Director or designee will review and audit 5 charts per week for 90 days for MDS accuracy of coded items, and monthly thereafter. Regional MDS Director or designee will audit 5 charts per week for 90 days on MDS accuracy of assessment, and monthly thereafter. Results of this audit and observation will be discussed in morning clinical meeting for immediate resolution. In addition, this will be discussed in the monthly QAPI quarterly QA program.	

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F 641	Continued From page 2	F 641		

The Quarterly MDS (QMDS), dated [redacted], showed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that the resident's [redacted]. The QMDS Section L Oral/Dental of Resident #39 did not reflect dental descriptions of the resident's current dental status.

Further review of the resident's quarterly MDS for the following dates showed that Section L was not accurately coded to reflect the dental condition of the resident:

[redacted] Quarterly
[redacted] Quarterly
[redacted] Annual
[redacted] Quarterly
[redacted] Quarterly
[redacted] Quarterly
[redacted] Annual
[redacted] Quarterly

There was no documentation that the resident's oral/dental assessment was done from [redacted] through [redacted], to be reflected in the quarterly MDS.

A review of the patient centered care plan showed no information that reflected the resident's dental status.

On 02/23/23 at 10:14 AM, the Director of Nursing (DON) stated, "when a resident is admitted they have a head-to-toe assessment, and the nurse documents any abnormalities found. Including, their teeth, hearing, and vision status. The DON further stated that "then it is reported to the attending. He (the doctor) will give orders according to what the resident's issues are."

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F 641	Continued From page 3	F 641		

On 02/21/23 at 10:58 AM, the Registered Nurse (RN) stated that it was the nurse's responsibility to call the physician to report "any" oral issues such as missing, brown discolored, chipped teeth, and noticeable issues upon admission or throughout their stay at the facility. The RN further stated, "if a resident or their POA (power of attorney) refuses dental care it is documented in the nursing notes or on the admission assessment."

On 02/23/23 at 10:56 AM, the surveyor asked the MDS Director what was the facility process in assessing the resident's dental status and whether should it be reflected in the resident's MDS. The MDS Director acknowledged that Section L in the MDS should reflect the resident's dental status. She further stated, "we interview the resident, we physically look at the resident, but during this time the resident may have been wearing a mask because of Covid regulations."

On that same date and time, the MDS Director acknowledged that when the Dietician documented on [NJ Exec. Order 26] 's Admission Nutritional Assessment that the resident had [NJ Exec. Order 26:4.b.1], the MDS should have been coded appropriately to reflect the current dental status of the resident. The MDS Director stated that the succeeding MDS assessment should reflect the current dental status of the resident.

On 02/27/23 at 11:37 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Regional DON (RDON), and Administrator In Training (AIT) and were made aware of the above findings.

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F 641	Continued From page 4 On 02/28/23 at 01:06 PM, the survey team met with the Chief Operating Officer (COO), DON, LNHA, AIT, and the RDON. The RDON acknowledged that there was no care plan initiated for the resident's dental/oral care. On that same date and time, the LNHA stated that there was an insurance concern about resident's dental consultations. The surveyor notified the facility management that the surveyor's findings were about the accuracy of the assessment wherein the dental assessments for the past eight quarters did not have supporting documentation that the dental/oral assessments were done and MDS was not coded accurately from [redacted] through NJ Exec. Order 26:4.b.1, and that the personalized care plan of the resident did not reflect oral/dental care, not until the surveyor's inquiry. On 3/02/23 at 12:01 PM, the survey team met with the LNHA, RDON, COO, AIT, DON, and the Medical Director. The facility management did not provide additional information.	F 641		
F 661 SS=D	NJAC 8:39-33.2 (d) Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		4/5/23

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F 661	Continued From page 5 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on the interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to obtain an order for discharge and document a discharge summary which included a recapitulation of the resident's stay and a final summary of the resident's status for one (1) of three (3) closed records reviewed for discharge (Resident #76). This deficient practice was evidenced by the following: On 02/24/23 at 11:29 AM, the surveyor reviewed the closed medical record for Resident #76 and revealed the following: The Admission Record (or face sheet; admission summary) indicated that the resident was	F 661	A review of the Progress Notes dated NJ Ex Order 26.4b1 showed a Social Services Note (SSN) that indicated that Resident #76 will be transferred to another facility on NJ Ex Order 26.4b1, secured a bed and will be picked up at NJ Ex Order 2. The NJ Ex Order 26.4b1 SSN revealed that the transfer was a resident initiated planned discharge. Social worker indicated that resident #76 was discharged to another skilled facility and no longer a resident at Ridgewood. A discharge summary was created for Resident #76 which included a final summary of the resident□s status. A physician□s order was obtained for discharge of Resident #76. Licensed nurses were re in service regarding obtaining orders the completion	

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F 661	Continued From page 6 admitted to the facility with medical diagnoses that included but were not limited to [NJ Exec. Order 26:4.b.1] [redacted] requiring the resident [NJ Exec. Order 26:4.b.1]), acquired [NJ Exec. Order 26:4.b.1] [redacted]. The Nursing Home Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of [NJ Exec. Order 26:4] showed that the resident was discharged to another nursing home. A review of the Progress Notes dated [NJ Exec. Order 26:4] showed a Social Services Note (SSN) that indicated that Resident #76 will be transferred to another facility on [NJ Exec. Order 26:4], secured a bed and will be picked up at 11 AM. The [NJ Exec. Order 26:4] SSN revealed that the transfer was a resident-initiated planned discharge. The medical record revealed that there was no documented physician order, Universal Transfer Form (UTF; must be used by all licensed healthcare facilities and programs when a patient is transferred from one care setting to another to ensure that accurate communication of pertinent clinical patient care information is conveyed at the time of a transfer), and discharge summary. In addition, there was no documentation on the day of discharge a nurse's note about what time the resident left the facility, assessment of the resident's condition upon discharge, and notification of family representative nor the	F 661	of discharge summary including a recapitulation of the resident's stay and a final summary. Licensed nurses were rein service were on documentation on the day of discharge, assessment of resident condition, notification of family representative or a receiving facility. Interdisciplinary team was re in service regarding completion of discharge summary including a recapitulation of the resident's stay and a final summary. All residents have the potential to be affected by this deficient practice. All licensed nurses were reinserviced on documentation, and completion of resident□s Discharge Summary and Universal Transfer Form when going home or transferring to another facility. Interdisciplinary team was re in service regarding completion of discharge summary including a recapitulation of the resident's stay and a final summary. Licensed nurses were reinserviced were on documentation on the day of discharge, assessment of resident condition, notification of family representative or a receiving facility. Unit manager or designee will review 5 discharge charts in the morning meeting weekly for 4 weeks, and monthly thereafter. This review will include a completed discharge summary for each resident and a physician's order for discharge. Results of these findings will be discussed	

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F 661	Continued From page 7 receiving facility. On 02/24/23 at 11:50 AM, the surveyor notified the Regional Director of Director of Nursing (RDDON) of the above findings, and the RDDON stated that she will get back to the surveyor. On that same date at 12:01 PM, the Infection Preventionist Nurse (IPN) showed to the surveyor the discharge (d/c) order to the hospital of the resident for [NJ Exec. Order 26:4.b] dated [NJ Exec. Order 26:4] in the Order Summary Report of the resident's electronic medical record. The surveyor notified the IPN that the most recent d/c was a transfer to another facility on [NJ Exec. Order 26:4], the IPN stated "oh I am sorry, I will get back to you." Furthermore, during an interview of the surveyor with the IPN, the IPN stated that all d/c orders should be in electronic medical records. She further stated that the nurse must obtain an order from the physician of an order to d/c the resident and document it in the electronic medical records. On 02/24/23 at 12:18 PM, the surveyor interviewed the Director of Social Services (DSS) who documented the [NJ Exec. Order 26:4.b] SSN the planned discharge to another facility. The DSS informed the surveyor of the facility d/c process when a resident initiated discharge to another facility. The DSS stated that the d/c will be discussed in the morning meeting with the IDT (interdisciplinary team), the social worker will talk to the resident, set up the transportation, the nurse will get an order for the d/c, and there should be an order for d/c. On that same date and time, the DSS stated that the d/c summary will be an IDT (nursing, social	F 661	with the administrator in the morning clinical meeting for immediate resolution and will be discussed in monthly QAPI and will be a part of the quarterly QA.	

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F 661	Continued From page 8	F 661		

services, rehab, activity, and dietician) summary of each discipline together with d/c instructions provided for d/c to home. She further stated that the d/c to another facility does not require a d/c summary and that the facility "just" provide a UTF to the receiving facility. In addition, the DSS indicated that the nurse should have obtained a physician order for d/c.

On 02/24/23 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON). The DON informed the surveyor that the facility practice and policy for d/c to another facility included an order from the physician for d/c. The DON stated that "we do not need a d/c summary" if a resident will be transferred to another facility. She further stated that it was an expectation that the nurse document in the electronic medical record the resident's information of pick time and the assessment of the resident upon discharge.

At that same time, the surveyor notified the DON of the above findings. The DON checked the paper medical record and was not able to locate an order for d/c and the UTF. The DON stated that she will get back to the surveyor with regard to the UTF.

On 02/24/23 at 01:09 PM, the DON provided a copy of the UTF dated [redacted] that included the information of the resident's name, name of transferring and receiving facilities, date and time of transfer, language, date of birth, gender, physician's name, vital signs (blood pressure, respiratory rate, pulse, and temperature), allergies, and incomplete immunizations/screening. The [redacted] UTF information for code status, contact person, the reason for transfer, pain rating/assessment,

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primary diagnosis and secondary diagnosis, isolation precaution, sensory assessment, skin condition, diet, personal items sent to with patient, attached documents (current medication information, face sheet, MAR or medication administration record, TAR or treatment administration record, diagnostic studies, code status, discharge summary, therapy notes, and history and physical), at risk alerts, mental status, function, bowel and bladder assessment, sending facility contact and receiving facility contact (that included names, titles, units, and phone numbers) were left blank and unanswered. The one piece paper UTF that was provided by the DON was incomplete.

On 02/27/23 at 10:39 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) that was assigned to the resident on the day of the d/c. The LPN informed the surveyor that it was the facility's practice and protocol that the nurse obtain an order for d/c, complete a nurse's notes on the day of the d/c, complete the Skilled Note for d/c in the electronic medical record, complete the Discharge Instructions where all IDT can write their d/c notes, and fill out the UTF. The LPN showed the Assessment tab in the electronic medical record where to complete the Skilled Note for d/c.

On that same date and time, the LPN acknowledged that she was the assigned nurse when the resident was d/c on [redacted] and stated "I do not recall what had happened," why there was no d/c order from the physician and no d/c summary. She further stated that "it was always very busy here," and that she was by herself in the unit as a nurse for 16 residents in the 7-3 PM shift when "most" of d/c of residents happened.

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F 661	Continued From page 10 On 02/27/23 at 11:37 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Regional DON (RDON), and Administrator in Training (AIT) and were notified of the above findings. A review of the facility's Discharge Summary and Plan of Care that was provided by the RDON with an effective date of [redacted] included that there should be a d/c order, recapitulation of the resident's stay that includes, but is not limited to: diagnoses, course of illness/treatment therapy, and any pertinent lab, radiology, and consultation results, and the discharge summary should include: completion of a discharge form by the charge nurse or designee, for anticipated discharge home or to another facility. On 3/02/23 at 12:01 PM, the survey team met with the LNHA, RDON, Chief Operating Officer, AIT, DON, and the Medical Director. The facility management did not provide additional information and did not dispute the findings.	F 661		
F 695 SS=D	NJAC 8:39-35.2(d)(16) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		4/5/23

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F 695	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to maintain the necessary NJ Exec. Order 26:4.b.1 and services for residents who were receiving NJ Exec. Order 26 and NJ Exec. Order 26:4.b.1 according to standards of practice. This deficient practice was identified for two (2) of five (5) residents (Resident #8 and #32) reviewed for NJ Exec. Order 26:4.b.1. This deficient practice was evidenced by the following: 1. On 02/16/23 at 11:27 AM, the surveyor observed Resident #8 lying in bed with NJ Exec. Order 2 ongoing at NJ Exec. Order 26:4.b.1 that was attached to an NJ Exec. Order 26:4.b.1). The NJ Exec. Order 26:4.b.1 was not dated. The surveyor asked Resident #8 if the NJ Exec had been changed weekly. Resident #8 did not know if the NJ Exec was being changed weekly. The surveyor reviewed the medical records of Resident #8. The resident's Admission Record (AR; or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec. Order 26:4.b.1 and NJ Exec. Order	F 695	The NJ Ex Order 26.4b1 for Resident #8 and resident #32 was discarded and replaced. NJ Ex Order 26.4b1 was dated and NJ Ex Order 26.4 appropriately. NJ Ex Order 26.4b1 was discarded and replaced for Resident #32. All residents with Respiratory care who were receiving oxygen and nebulizer (neb) treatments were checked to ensure they were dated and bagged and store accordingly. All residents have the potential to be affected by this deficient practice. Therefore this applied to both current and future residents. Nursing staff in-serviced to date, label, and store respiratory equipment properly. Nursing staff in-serviced on policy and procedure to administer oxygen, including storage of biologicals. Unit managers or designee will audit five (5) residents on oxygen weekly for 4 weeks to ensure it is dated, labelled, and stored respiratory equipment properly. Nursing staff in-serviced on Infection Control, change oxygen tubings, cannula/mask weekly and as needed. Infection Preventionist (IP) or designee will audit 5 residents monthly receiving Nebulizer treatment and Oxygen for 90 days to ensure they are dated, bagged, and stored properly. Results of this audit and observation will be discuss in morning clinical meeting for immediate resolution and this will be	

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F 695	Continued From page 12 NJ Exec. Order 26:4.b.1). A review of the NJ Exec. Order 26:4 Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, revealed a Brief Interview for Mental Status (BIMS) score was [redacted], which indicated that the resident's cognition [redacted]. The CMDS reflected that the resident was [redacted] The NJ Exec. Order 26:4.b.1 Order Summary Report (OSR) revealed an order date of [redacted] for change NJ Exec. Order 26:4.b.1 weekly. Label with date, time, and nurse's initials every night shift every Thu (Thursday) for NJ Exec. Order 26:4.b.1 care. In addition, the medical records showed that the above order was transferred to the NJ Exec. Order 26:4.b.1 electronic Medication Administration Record (eMAR) and signed by nurses as administered on [redacted]. 2. On 02/17/23 at 8:25 AM, the surveyor observed Resident #32 laying on the bed with a call bell on their right hand. The surveyor observed on the left side of the bed a nightstand table drawer was open, there was a NJ Exec. Order 26:4.b.1 [redacted], and directly touched the personal belonging of the resident that including a shirt. The NJ Exec. Order 26:4.b.1 had a date on it [redacted]. On 02/17/23 at 10:15 AM, the surveyor observed the resident laying on the bed. The nightstand drawer was open with a [redacted] inside the nightstand drawer not stored properly [redacted] dated [redacted].	F 695	discussed in monthly QAPI and this will be a part of quarterly QA.	

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F 695	Continued From page 13 On that same date at 10:17 AM, the surveyor asked the Licensed Practical Nurse (LPN) to go with the surveyor inside the resident's room because the assigned nurse was busy administering medications to another resident at that time. Inside the resident's room, both the surveyor and the LPN observed the NJ Exec. Order 26:4.b.1 and dated NJ Exec. Order 26:4.b At that time, after exiting the resident's room, the surveyor interviewed the LPN. The LPN informed the surveyor that the NJ Exec. Order 26:4.b.1 should have been changed weekly by the 11-7 shift every Thursday. The LPN acknowledged that the date on the NJ Exec. Order 26:4.b.1 and he stated that the NJ Exec. Order 26:4.b should have been NJ Exec. Order 26:4.b.1 when not in use for infection control. The surveyor reviewed the medical records of Resident #32. The resident's AR reflected that the resident was admitted to the facility with diagnoses that include NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 and The NJ Exec. Order 26:4 CMDS revealed a BIMS score of NJ Exe	F 695		

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out of 15, which indicated that the resident's cognition was NJ Exec. Order 26:4.b.1. The CMDS reflected that the resident was on NJ Exec. Order 26:4.b.1 [redacted]

The NJ Exec. Order 26:4.b.1 OSR revealed an order date of NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 [redacted]). An order dated NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 [redacted]

In addition, the medical records showed that the above orders were transferred to the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 eMAR and signed by nurses as administered.

Further review of the NJ Exec. Order 26:4.b.1 OSR showed that the order for NJ Exec. Order 26:4.b.1 was ordered after the surveyor's inquiry. The order was dated NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1 weekly every night shift every Wednesday for NJ Exec. Order 26:4.b.1 [redacted]

The personalized care plan for NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 was reflected after the surveyor's inquiry. The interventions to NJ Exec. Order 26:4.b.1 as ordered and to NJ Exec. Order 26:4.b.1 [redacted] weekly every Wednesday were documented and initiated on NJ Exec. Order 26:4.b.1

On 02/22/23 at 11:55 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN). The IPN informed the surveyor that it was an expectation that the nurse follows the facility policy with regard to NJ Exec. Order 26:4.b.1

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changes that included NJ Exec. Order 26:4.b.1 and dated weekly on the 11-7 shift, and NJ Exec. Order 26:4.b.1 when not in use for infection control.

On that same date and time, the surveyor notified the IPN of the above findings. The IPN stated that the resident's NJ Exec. Order 26:4.b should have been NJ Exec. Order 26:4.b.1 weekly according to facility practice and policy.

On 02/23/23 at 12:11 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Administrator In Training (AIT), and Regional DON (RDON), and were made aware of the above findings.

On 02/27/23 at 8:58 AM, both the surveyor and the Minimum Data Set Coordinator (MDSC) went inside the resident's room. The MDSC opened the resident's nightstand drawer, and both the surveyor and MDSC observed the NJ Exec. Order 26:4.b inside the drawer covered by the resident's personal belongings which included clothing and single-serve syrups. The NJ Exec. Order 26:4.b.1 and directly touching the surrounding of the drawer. The MDSC stated that she will discard the NJ Exec. Order 26:4.b "now." At that time, the assigned Registered Nurse#1 (RN#1) was inside the resident's room.

On that same date and time, both the surveyor and the two nurses came out of the resident's room. RN#1 informed the surveyor that when she came in today at 7 AM, she was not able to check the resident's NJ Exec. Order 26:4.b and she did not "yet" administer NJ Exec. Order 26:4.b.1. RN#1 acknowledged that the NJ Exec. Order 26:4.b should have been NJ Exec. Order 26:4.b.1 when not in use.

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F 695	Continued From page 16 On 02/27/23 at 9:12 AM, the surveyor called and left a message for RN#2 who was the assigned nurse for the 11-7 shift last night. RN#2's information including phone number was provided by the MDSC. A review of the facility's Oxygen/Nebulizer Care Policy that was provided by the RDON with a last reviewed date of 6/2022 included that cannulas, masks, nebulizer tubing, and incentive spirometers should be changed weekly or as necessary, label with date and initials; and all tubing and masks shall be placed in a plastic bag for storage when not in use. On 02/27/23 at 11:37 AM, the survey team met with the LNHA, DON, RDON, and AIT. The RDON stated that the MDSC informed her of the concern with the resident's NJ Ex Order 26.4b1 not properly NJ Ex Order 26.4b1 when not in use. The RDON further stated that RN#2 was on vacation starting today after the RNs duty last night and that the facility will do a one-to-one education when RN#2 comes back. The RDON acknowledged that there was no care plan for the use and care of the NJ Ex Order 26.4b1 not until the surveyor's inquiry. NJAC 8:39-11.2 (e)(1)(2)	F 695		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4	F 728		3/31/23

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F 728	Continued From page 17 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the pertinent facility provided documents, it was determined that the facility failed to ensure that the staff complied with nursing aide requirements with federal and state guidance prior to providing direct care to the resident. This deficient practice	F 728	Hospitality Aide (HA) performing resident care on Resident #27 was reinserviced regarding her job responsibilities as Hospitality Aide. Staffing Coordinator was reinserviced to monitor staff that were hired as hospitality	

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F 728	Continued From page 18 was identified for one (1) of two (2) none Certified Nursing Aides observed during an initial tour as evidenced by the following: On 02/16/23 at 10:16 AM the surveyor observed a Hospitality Aide (HA) performing resident care on Resident #27. The HA [NJ Ex Order 26.] the resident and provided direct care to the resident. A review of the 02/16/23 staffing that was provided by the Staffing Coordinator (SC) revealed that the HA was on the schedule and listed as a Certified Nursing Assistant (CNA) for South Ground. A review of the HA's employee file revealed that on [NJ Exec. Order 26:4.b.] the employee applied for a CNA position. In addition, on [NJ Exec. Order 26:4.b.] the facility offered her a position as a full-time HA in training as N-CNA (non-CNA) as evidenced by her orientation checklist for dates [NJ Exec. Order 26:4.b.1] that was completed and had signatures by the employee, the preceptor, and the staff development officer. A review of a document from [name redacted], a school where the HA attended the CNA program, showed that the HA was enrolled with a start date of [NJ Exec. Order 2] and an ending date of [NJ Exec. Order 26:4] A review of the facility provided a timeline of the HA and showed that the HA had failed the 1st ([NJ Exec. Order 26:4]) and 2nd ([NJ Exec. Order 26:4]) written tests for CNA. On 02/21/23 at 12:39 PM, the Regional Director of Nursing (RDON) stated, "There is nothing in the job description of Hospitality Aide that they should be helping a resident to the restroom. She	F 728	aides to ensure they were not on the schedule with an assignment. All residents have the potential to be affected by this deficient practice. Nursing staff were reinserviced on the Hospitality Aide Job description and reminded that Hospitality Aides can□t provide direct care. Hospitality Aide was reinserviced on her allowable job duties based on her job description. Staffing schedule was revised to include a separate section for Hospitality Aides separated from the assignment of Certified Nursing Assistant. Administrator or designee will check and review staffing schedule daily for 90 days for accuracy, and monthly thereafter. Results of these findings will be discussed in the monthly QAPI and will also be a part of the quarterly QA program.	

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(HA) should have gotten somebody to assist the resident once she answered the call bell for the resident's safety. It is not in the HA job description."

During an interview on 02/21/23 at 12:39 PM, the SC stated, "She (HA) should not have been on the schedule with an assignment, the nurse on the floor gives the room assignment for the staff." The surveyor asked the SC who was responsible for filling out the Daily Staffing Sheet (DSS) on [redacted], and the SC responded that he was the one who did the DSS on that day.

On 02/23/23 at 12:11 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Administrator In Training (AIT), and RDON and were notified of the above findings.

On 3/01/23 at 10:58 AM, the Human Resources Director (HRD) stated that the HA was hired as a hospitality aide and CNA in training. The HRD further stated, "meaning if you attended a class for CNA and passed your skills test that is when we hire you." The HRD indicated that then they have 120 days to work as HA in training for CNA until they take their written test, "We HR does not hire them unless they have completed their 6-week course and their skills test but before their written exam."

On that same date and time, the surveyor asked the HRD who was responsible to follow up on their testing results to ensure it was done and advance their work assignment. The HRD stated, "our SC is responsible to watch if they pass or fail and then he alerts HR of the upgrade in position. HR hired her as an HA. She has never

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F 728	Continued From page 20 transitioned to CNA status or received a raise to reflect it in our system. The surveyor inquired when the HA was hired. The HRD responded, "On [NJ Exec. Order 26] she has been an employee for approximately [NJ Exec. Order 26:4.b.1]." A review of a document titled Position Title - Hospitality Aid Summary, implemented on 4/19 included #4) Answer call bell promptly and notify CNA or nurse of patient's needs. NJAC 8:39-43.1(a)(2)	F 728		
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. (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	F 732		3/31/23

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F 732	Continued From page 21 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 pertinent facility documents, it was determined that the facility failed to accurately post the nurse staffing information on two (2) of nine (9) 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 02/16/23 at 10:00 AM, the surveyor observed the facility Resident Care Staffing Report (RCSR) dated 02/16/23 posted in a plastic cover attached to the front reception desk. The RCSR revealed that there was a current resident census (total number of residents) of 88 and there were 11 certified nursing aides (CNA) with 7.5 actual hours worked in the facility for the 7 AM to 3 PM shift which calculated to one (1) CNA to eight (8) residents for the staff to resident ratio. On 02/16/23 at 10:16 AM, the surveyor interviewed the Director of Nursing (DON) who	F 732	The Posted Staffing Information with the (2) of the (3) names listed as Certified Nursing Assistants was inaccurate. This was immediately corrected. NA#1 and HA#2 are unlicensed staff and should not have been counted as CNAs. Staffing Coordinator immediately updated the Daily Staffing Schedule to indicate their job responsibilities as NA and HA. Staff actual hours worked will match for staff to resident ratio. All residents have the potential to be affected by this deficient practice. Staffing Coordinator was reinserviced on Posted Nurse Staffing Information. This includes ensuring accuracy with the facility total number and the actual hours worked by the categories of licensed and unlicensed nursing staff. Administrator or designee will review daily Posted Staffing Information for 90 days for accuracy of total number of hours for	

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F 732	Continued From page 22 was the acting Unit Manager for the South Ground (SG) unit. The DON stated that there was a census of 24 residents and there were two (2) CNAs and one (1) Nursing Aide (NA). The DON added that she was unsure of the NA certification date. On 02/16/23 at 10:38 AM, the Team Coordinator surveyor conducted an Entrance Conference with the Licensed Nursing Home Administrator (LNHA), Regional Director of Nursing (DON) and the Administrator in Training (AIT). The LNHA stated that the facility had no nursing assistants and provided the name of one (1) Hospitality Aide (HA). This contradicted the statement by the DON that a NA was working on the SG unit. On 02/16/23 at 10:53 AM, the surveyor was provided a facility Daily Staffing Sheet (DSS) dated 02/16/23 by the Minimum Data Set (MDS) Coordinator. The DSS revealed that there were three (3) names listed as CNA assigned to the SG unit which included the name of the NA and HA. On 02/17/23 at 10:00 AM, the surveyor observed the facility RCSR dated 02/17/23 posted in a plastic cover attached to the front reception desk. The RCSR revealed that there was a current resident census of 87 and there were 11 CNAs with 7.5 actual hours worked in the facility for the 7 AM to 3 PM shift which calculated to a one (1) CNA to 7.9 residents for the staff to resident ratio. On 02/17/23 at 10:02 AM, the surveyor interviewed the front desk receptionist (FDR) who stated that she was responsible for completing the RCSR that was posted at the front desk each day. The FDR added that she was given the	F 732	Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides and Resident Census, and monthly thereafter. Results of findings will be discussed in the monthly QAPI and will also be reviewed in the quarterly QA program.	

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responsibility of completing the RCSR a couple of months ago because the sheet was posted right at her desk. The FDR added that she bases the numbers listed on the RCSR from the DSS that she was given every day by the AIT. The FDR could not speak to the scheduling of the CNA names listed on the DSS. The FDR stated that the AIT was responsible for the DSS.

On 02/17/23 at 10:26 AM, the surveyor was provided the facility CNA assignment sheets for all four (4) units by the DON which revealed that there was a total of 11 CNA names listed which included the name of the HA. The DSS was not provided for the date of 02/17/23.

On 02/21/23 at 8:46 AM, the surveyor was provided employee folders for the HA and NA by the RDON. The RDON verified that the HA that had been identified during the Entrance Conference was actually a NA#1 and that the NA that had been identified by the DON on the SG unit was actually a HA#2.

Further review of the DSS dated 02/16/23 revealed that in addition to two (2) of the three (3) CNA names listed inaccurately as a CNA, also had their job titles transposed during surveyor inquiry.

On 02/23/23 at 10:47 AM, the surveyor interviewed the AIT who stated that he was responsible for the DSS and was the Staffing Coordinator (SC). The AIT/SC stated that he completed the DSS by using an electronic program. The AIT/SC added that he kept track of the CNAs from the list of licenses and that in the electronic program there was a different section for a NA. The AIT/SC stated he thought he was

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able to list NAs and HAs on the DSS.

On that same date and time, the AIT stated that he was just told today that the unlicensed staff were not allowed to be counted as CNAs. The AIT/SC acknowledged that the RCSR for 02/16/23 and 02/17/23 were inaccurate. The AIT/SC further stated that he had changed the DSS.

On 02/23/23 at 10:57 AM, the surveyor was provided by the AIT/SC a DSS dated 02/23/23. The AIT/SC stated that this was an example of how the DSS had been changed to reflect that a NA was assigned to the unit. The surveyor with the AIT/SC reviewed the DSS dated 02/23/23 which revealed that for the SG unit there were two (2) names listed as CNAs and there was one name listed as a NA#1.

On 02/27/23 at 11:37 AM, the survey team met with the LNHA, RDON, DON and AIT/SC. The RDON stated that the DSS was updated to indicate NAs and HAs. The RDON also stated that the FDR was in serviced regarding the accuracy of completing the RCSR so that the posting would reflect accurate numbers.

At that same time, the RDON acknowledged that the posting for 02/16/23 and 02/17/23 were inaccurate for the total number of CNAs. In addition, the RDON stated that the staff was educated as to what NA means and if the NA can have an assignment, as well as, that a HA would not have an assignment.

On 3/01/23 at 12:55 PM, the survey team met with the facility administrative team. The RDON stated she was unsure if there was policy for

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F 732	Continued From page 25 posting the staffing report. The LNHA stated that the facility posted the staffing report to the public based on the regulation for posting the nurse staffing and following the ratio. On 3/02/23 at 11:01 AM, the survey team met with the facility administrative team. The LNHA stated that there was no facility policy for Posting and the protocol was as stated that the AIT/SC was responsible for completing the DSS and the FDR was responsible for completing the RCSR.	F 732		
F 755 SS=D	NJAC 8:39-41.2 (a)(b)(c)(2) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		3/31/23

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F 755	Continued From page 26 §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 observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to assure that a medication ([redacted]) was administered according to a physician's order for one (1) of five (5) residents (Resident #69) reviewed for medication management. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 755	Resident #69 was assessed by an RN with vital signs within [redacted]. Resident was discharged home on [redacted]. All residents with orders to check parameters when administering medications were reviewed. All residents have the potential to be affected by this deficient practice. Licensed nurses were reinserviced regarding Policy and Procedure on Medication administration. Licensed nurses were reinserviced regarding administration of medications with parameters/ cautionary following physician□s order Pharmacy Consultant will review all new and re-admissions for Midodrine parameters. Findings will be reported to Director of Nursing DON or designee will audit 5 charts weekly for 90 days for medication parameters/ cautionaries, and monthly thereafter. Results of this audit will be discussed in	

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F 755	Continued From page 27 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the following: On 02/16/23 at 11:14 AM, the surveyor interviewed Resident #69 who stated that he/she was at the facility for rehab because he/she had NJ Ex Order 26.4b1 and was going to be discharged NJ Ex Order 26.4b1. The surveyor reviewed the medical record for Resident #69. The resident's Admission Record (or face sheet, an admission summary) revealed that the resident had diagnoses which included NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, reflected the resident had a brief interview for mental status (BIMS) score of NJ Ex out of 15, indicating that the resident had NJ Ex Order 26.4b1. The Order Summary Report with an order date range of NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 revealed a physician's order (PO) dated NJ Ex Order 26.4b1 for "NJ Ex Order 26.4b1	F 755	the morning clinical meeting for immediate resolution. This will also be discussed in the monthly QAPI and quarterly QA.	

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NJ Ex Order 26.4b1, give one tablet by mouth two times a day for NJ Ex Order 26.4b1 for three days, hold for NJ Ex Order 26.4b1."

A review of the NJ Ex Order 26.4b1 electronic medication administration record (eMAR) revealed that on NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 the resident had been administered the NJ Ex Order 26.4b1. There were no NJ Ex Order 26.4b1 results on the eMAR that corresponded with the administration of the NJ Ex Order 26.4b1.

On 02/17/23 at 11:34 AM, the surveyor interviewed Resident #69 who stated that he/she was NJ Ex Order 26.4b1. The resident stated that during their stay at the facility, a NJ Ex Order 26.4b1 was taken by the nurses many times but was unaware if the NJ Ex O was taken before being administered his/her medications. The resident further stated that he/she had been administered NJ Ex Order 26.4b1 for a short period of time because he/she had NJ Ex Order 26.4b1 and was NJ Ex Order 26.4b1

On 02/17/23 at 11:47 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she was familiar with Resident #69 and had administered medications to the resident. The RN also stated that she had taken the resident's NJ Ex frequently and documented electronically the results. The RN stated that she was aware that the resident had received NJ Ex Order 26.4b1 for a short time.

At that time, the surveyor, with the RN, reviewed

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the eMAR which revealed the PO for [NJ Ex Order 26.4b1] dated [NJ Ex Order 26.4b1]. The RN acknowledged that she had administered the [NJ Ex Order 26.4b1] at 9 AM on [NJ Ex Order 26.4b1] and on [NJ Ex Order 26.4b1] according to the eMAR and that the eMAR had no [NJ Ex] results. The RN stated that usually when a PO had parameters to be obtained the eMAR would have the parameters documented with the medication.

In addition, the surveyor, with the RN, reviewed the electronic vital signs that had been documented for Resident #69. The RN stated that she had entered a [NJ Ex] of [NJ Ex Order 26] on [NJ Ex Order 26.4b1] at 11:44 AM and a [NJ Ex] of [NJ Ex Order 26] at 11:51 AM. The RN acknowledged that both days the [NJ Ex Ord] was greater than [NJ Ex O]. The RN added that the [NJ Ex] results were not obtained prior to the administration of the [NJ Ex Order 26.4b1]. The RN also stated that any medication that had a PO with parameters required that the parameters such as the [NJ Ex] were to be taken prior to administering the medication. The RN added that she should have obtained a [NJ Ex] result prior to the administration of the [NJ Ex Order 26.4b1]. The RN also reviewed the [NJ Ex] of [NJ Ex Order 26] documented on [NJ Ex Order 26.4b1] at 22:35 (10:35 PM) and stated that she was not the nurse that administered the [NJ Ex Order 26.4b1] on [NJ Ex Order 26.4b1] for the administration time of 5 PM and was unsure if the [NJ Ex] was taken prior to the 5 PM dose because usually medications were administered within the hour of the administration time.

On 02/23/23 at 12:11 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Regional Director Of Nursing (RDON), DON and Administrator In Training (AIT). The RDON and DON acknowledged that when a medication had parameters the nurses were to obtain the the results and should document the

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results prior to the medication being administered. In addition, the RDON and DON acknowledged that the parameters should be documented in the eMAR and should correlate with the times of administration for the medication according to the PO.

On 3/01/23 at 9:54 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated that she had completed a drug regimen review for Resident #69 in NJ Ex Order 26.4b but that the resident had not had a PO for NJ Ex Order 26.4b1 at that time. The CP added that when the next drug regimen review was due in NJ Ex Order 26.4b1 the resident had been NJ Ex Order 26.4b1. The CP stated that any PO for a medication that included following parameters required that the nurses obtain and record the parameters prior to the administration of the medication. The CP added that the parameter that was obtained was used to determine whether the medication was held or administered. The CP stated that she thought the NJ Ex would be taken every shift but was unsure if that would coincide with the time prior to the administration of the medication.

A review of the current facility policy dated as revised April 2010 for "Administering Medications Using Electronic System" provided by the RDON revealed that "Medications shall be administered in a safe and timely manner, and as prescribed." In addition, the policy reflected that the individual administering the medication must check the label three (3) times to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication. In addition, the policy instructed that the following information must be checked/verified for each resident prior to administering medications: vital

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F 755	Continued From page 31 signs, if necessary. NJAC 8:39-11.2(b), 29.2(d)	F 755		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to notify the physician or nurse practitioner of the results that fall outside the clinical reference ranges (abnormal results) in accordance with facility policies and procedures for notification of a practitioner for one (1) of 18 residents reviewed, (Resident #46). This deficient practice was evidenced by the following: On 02/17/23 at 08:29 AM, the surveyor observed Resident #46 laying on the bed with their eyes closed. There was a NJ Ex Order 26.4b1 on top of the nightstand table.	F 777	The medical record of resident #46 was reviewed. Results of the NJ Ex Order dated on NJ Ex Order 26.4 were not reported to the physician or other practitioners. All laboratory and radiology reports that were not reviewed were called in to the physicians. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). Licensed nurses were reinserviced on facility policy and procedure on diagnostic services to promptly notify the ordering physician, nurse practitioner, or other covering practitioners as soon as the	4/5/23

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F 777	Continued From page 32 On 02/21/23 at 9:54 AM, the surveyor observed the resident seated on the bed. There was no NJ Ex O [redacted] on top of the nightstand table. On 02/21/23 at 10:08 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the resident's NJ Ex Order 26.4b1. The LPN informed the surveyor that the resident was noted last week with NJ Ex Order 26.4b1 that included a NJ Ex Order 2[redacted], and the doctor ordered a NJ Ex Order 26.4b1[redacted]. The LPN stated that in anticipation of a "possible" order for NJ Ex O[redacted] treatment, the nurse last week prepared a NJ Ex Order 26.4b1 and left it in the resident's room. She indicated that she did not know who was the nurse who left the NJ Ex O [redacted] in the resident's room. She further stated that when she realized that there was no order for NJ Ex O[redacted] treatment, the LPN removed the NJ Ex Order 26.4b1 after the surveyor's inquiry on NJ Ex Order 2[redacted] (NJ Ex Order 26.4b1[redacted]). The surveyor reviewed Resident #46's medical records and showed the following: The Admission Record (or face sheet; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 [redacted], NJ Ex Order 26.4b1 [redacted], NJ Ex Order 26.4b1 [redacted], NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 [redacted]. The Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the	F 777	result is received. Unit Manager or designee will audit Electronic Health Records daily for any un-reviewed radiology results for 90 days, and monthly thereafter. DON or designee will audit 5 charts weekly for 90 days to ensure Radiology Reports were reported timely, and monthly thereafter. Results of these reviews will be discussed in morning clinical meeting for immediate resolution and will be discussed in monthly QAPI and this will be a part of Quarterly QA.	

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management of care, with an Assessment Reference Date (ARD) of NJ Ex Order 26.4b1 revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4b1 out of 15, which reflected that the resident's cognitive status was NJ Ex Order 26.4b1.

The February 2023 Order Summary Report showed a physician order dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1.

The Radiology results in the electronic medical record showed that there was an examination for NJ Ex Order 26.4b1 dated NJ Ex Order 26.4b1 with a review status: "to be reviewed." The NJ Ex Order 26.4b1 included NJ Ex Order 26.4b1 and the findings are new compared to NJ Ex Order 26.4b1.

The printed Preventive Diagnostics patient report in the paper medical record (chart) showed that the date of service of NJ Ex Order 26.4b1 was on NJ Ex Order 26.4b1 with a referring physician name. The NJ Ex Order 26.4b1 report included the same NJ Ex Order 26.4b1 that were written on the electronic radiology results above. The printed NJ Ex Order 26.4b1 report did not have information that the results were relayed to the referring physician or other practitioners.

A review of the Progress Notes (PN) revealed that there was no documentation that the results of the NJ Ex Order 26.4b1 were relayed and notified to the referring physician or other practitioners.

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The 24-hour Report/Change Condition North Ground showed that on NJ Ex Order 26.4b1 remarks on the 11AM-7 PM shift revealed that the NJ Ex Order 26.4b1 for diagnosis NJ Ex Order 26.4b1 was ordered. The 24-hour Report for 7 AM-3 PM and 3 PM-11 PM shifts remarks did not include documentation that the physician was notified of the NJ Ex Order 26.4b1 results on NJ Ex Order 26.4b1.

On 02/22/23 at 9:44 AM, the surveyor interviewed the LPN. The LPN informed the surveyor that residents with laboratory NJ Ex Order 26.4b1 results should be relayed to the physician, document the information including the doctor's new order, or if the doctor did not have a new order in the PN and radiology results tabs in the electronic medical records. The LPN showed the radiology result tab which she explained that if the results were relayed to the physician, the review status will be "reviewed." She further stated that the review status "to be reviewed" meant that the results were not relayed to the physician. She indicated that the paper printed NJ Ex Orde report should have handwritten documentation of the date when the results were called to the physician and nurse information who called the results.

On that same date and time, the surveyor asked the LPN why the NJ Ex Order 26.4b1 results review status was "to be reviewed," the printed NJ Ex Orde results in the paper medical record did not include the above handwritten information, and there was no documentation in the PN that the results were relayed to the physician. The LPN stated, "I do not know."

On 02/22/23 at 11:02 AM, the surveyor interviewed the Director of Nursing (DON) and was notified of the above findings. The DON

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claimed that she used to be the Unit Manager in the North Ground unit where the resident currently stayed. The DON informed the surveyor that it was the facility practice that PN from a nurse will be seen in the electronic medical records when NJ Ex Orde results were relayed to the physician. The DON stated that the NJ Ex Orde results should be relayed as soon as possible to the physician or within the day the result was received.

On 02/22/23 at 12:14 PM, the surveyor interviewed the physician who was also the Medical Director (MD) via a phone conference. The MD informed the surveyor that Resident #46 had a diagnosis of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 which the responsible party (RP) was aware of and did not want a medical intervention or any NJ Ex Order 26.4b1 treatment. The MD stated that the RP prefers NJ Ex Order 26.4b1 measures "only" and "possible" NJ Ex Order 26.4b1 .

On that same date and time, the MD claimed that he was aware of the resident's NJ Ex Order 2 and that was why the NJ Ex Order 26.4b1 was ordered. The MD further stated that he was not called or notified of the NJ Ex Order 26.4b1 results and was not sure if Nurse Practitioner#1 (NP#1) was. The MD stated that he will get back to the surveyor about the above findings and that he will have to talk to NP#1 first and verify what happened.

On 02/23/23 at 8:23 AM, the surveyor interviewed the DON. The DON stated that "probably" the nurse called NP#1 at that time when the results came out and the NP did not respond to the call. The DON acknowledged that no documentation and interview will show who called and when the nurse called to notify NP#1 of the NJ Ex Order 26.4b1

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NJ Ex Order 26.4b1 results.

At that same time, the DON informed the surveyor that there was a new NP, NP#1 (the DON was unable to recall the name) covering for the MD, and "probably" the reason why the incident happened. She further stated that NP#2, the in-house NP of the facility who covers all physicians was responsible for all NJ Ex Orde reports and results of the residents in the facility was away. The DON acknowledged that the NJ Ex Orde results should have been relayed to the physician because the resident did not have a diagnosis of NJ Ex Order 26.4b1 and that the findings were new compared to the NJ Ex Order 26.4b1 report.

A review of the facility's Acute Condition Changes-Clinical Protocol with a revised date of October 2010 that was provided by the Regional DON (RDON) showed that as part of the initial assessment, the Physician will help identify individuals with a significant risk for having acute changes condition during their stay, in addition, the Nurse shall assess and document/report the following baseline information which included vital signs, level of consciousness, recent labs, and/or radiology, all active diagnoses, and all current medications.

On 02/27/23 at 11:37 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Administrator In Training (AIT), and Regional DON and were made aware of the above findings. The facility management provided an updated care plan to include the focus diagnosis of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 initiated on NJ Ex Order 26.4b1. The facility management did not refute the findings.

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/31/23

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F 880	Continued From page 38 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 facility provided documents, it was determined that the facility failed to: a) perform hand hygiene appropriately for two (Recreation Assistant and Licensed Practical Nurse) of eleven staff and b) properly use PPE (personal protective equipment) for one (Recreation Assistant) of eight staff observed in accordance	F 880	Recreation assistant (RA) did not perform proper hand hygiene after touching an object and putting on a new pair of gloves. RA□s gown was also observed touching the floor when RA attempted to open the Zipper on the bottom of the door. RA was immediately reinserviced regarding Infection Control and Proper hand	

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F 880	Continued From page 39 with the Centers for Disease Control and Prevention (CDC) guidelines and facility policy. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 01/08/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. In addition, wear gloves, according to Standard Precautions, when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur; gloves are not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. According to the U.S. CDC guidelines titled Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 6/03/20 included, "Donning (putting on the gear): ... 1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct... 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by another HCP ...."	F 880	hygiene. LPN who performed treatment pass did not follow proper procedure in hand hygiene after holding an object, holding call lights, and drawing the curtain. LPN touched the resident□s body with ungloved hands and applied a new pair of gloves without performing hand hygiene. LPN was reinserviced regarding infection control and Proper hand hygiene. This deficient practice did not result in any harm. All residents have the potential to be affected by this deficient practice. Recreation assistant (RA) was reinserviced on Infection Control □ Proper Hand Hygiene and Donning/Doffing of Isolation Gown LPN was reinserviced on Infection Control □ Proper Hand Hygiene. LPN completed the hand hygiene competency. Recreation Assistant (RA) completed the hand hygiene and donning/doffing of isolation gown competency. All staff were reinserviced regarding Proper Hand Hygiene and Donning/Doffing of Isolation Gown. Infection Preventionist (IP) or designee will observe 5 employees weekly for 90 days for proper hand hygiene and donning and doffing of Isolation Gown, and monthly thereafter. DON or designee will perform Hand Hygiene and Donning and Doffing of Isolation Gown competency on 5 employees weekly for 4 weeks.	

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F 880	Continued From page 40 1. On 02/16/23 at 9:28 AM, the survey team entered the facility. The Administrator In Training (AIT) and Director of Nursing (DON) welcomed and accompanied the surveyors to the 1st-floor dining area. The AIT informed the surveyor that the census (total number of residents) was 88, there were [NJ Ex O] in-house NJ Ex Order 26.4b1 residents in the NJ Ex Order 26.4b1 unit, and the most recent [NJ Ex Order 26.4b1] outbreak was on [NJ Ex Order 26.4b1]. The AIT further stated that staff must wear full PPE, that is, eye protection, N95 mask, gown, and gloves before entering the [NJ Ex Order 26.] room, and to perform hand hygiene before entering and after exiting the room. On 02/22/23 at 9:40 AM, the surveyor observed the Recreation Assistant (RA) with eye protection, and an N95 mask while holding papers in front of room [NJ Ex O] in the [NJ Ex O] unit. The surveyor observed room [NJ Ex O] with a closed plastic zipper door, a PPE box outside the door, and three posted papers that included information about Contact (involves contact of a susceptible person with a contaminated intermediate object such as needles, dressings, gloves or contaminated (unwashed) hands) and Droplet Precautions (are steps that healthcare facility visitors and staff need to follow before going into or leaving a patient's room), to perform hand hygiene before and after exiting the room, and what PPE to use. Then, the RA placed the papers on top of the recreation cart, immediately applied a new pair of gloves without performing hand hygiene, did not tie all the ties on the gown, bend down to reach the zipper on the bottom of the door, and attempted to open the zipper door. The surveyor observed that the RA's gown touched the floor. Afterward, the surveyor asked the RA for an	F 880	Results of this review will be discussed in the morning clinical meeting for immediate resolution. Results will also be reviewed in the monthly QAPI and quarterly QA program.	

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interview. The surveyor asked about hand hygiene and PPE use. The RA informed the surveyor that room [NJ Ex C] was in isolation due to NJ Ex Order 26.4b1. The RA stated that she should have performed hand hygiene before applying a new pair of gloves and properly tied her isolation gown before entering the room for infection control and according to the education she received from the Nurse educator. The RA acknowledged that the isolation gown had touched the floor and should have been discarded because it was contaminated.

On 02/22/23 at 11:55 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) and was notified of the above findings. The IPN informed the surveyor that the staff must perform hand hygiene before applying and removing gloves, before and after PPE use. The IPN stated that staff should properly tie the gown before going inside the isolation room because it will determine how to remove the gown, prevent contamination, and protect themselves.

On that same date and time, the IPN stated that the RA should have performed hand hygiene before donning gloves and gown, and considered the gown contaminated because it touched the floor.

On 02/23/23 at 12:11 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, AIT, and Regional DON (RDON) and were made aware of the above findings.

A review of the Droplet Precautions Stop sign that was provided by the IPN on 02/16/23 at 01:05 PM, which was posted outside the resident's room showed that Everyone Must: Clean their

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hands, including before entering and when leaving the room.

2. On 02/16/23 at 01:59 PM, the RDON informed the surveyor that Resident #32 was the "only" resident with facility acquired NJ Ex Order 26. The RDON provided a copy of the facility-acquired NJ Ex Order 26 that showed the resident had a NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1.

On 02/17/23 at 10:15 AM, the surveyor observed the resident laying on the bed.

The surveyor reviewed the medical records of Resident #32.

The resident's Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

The NJ Ex Order 26.4b1 Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, revealed a Brief Interview for Mental Status (BIMS) score was NJ Ex, which indicated that the resident's cognition was NJ Ex Order 26.4b1. The CMDS showed that the resident did not have an NJ Ex Order 26.4b1.

The NJ Ex Order 26.4b1 Order Summary Report

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revealed an order date on NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 every day shift.

A review of the provided NJ Ex Order 26 Timeline by the RDON showed that the resident upon admission had no NJ Ex Order 26.4b1 with preventative interventions of assisting with NJ Ex Order 26.4b1 every two (2) hours and as needed, keep NJ Ex Order 26.4b1, use o NJ Ex Order 26.4b1, and encourage good nutrition and hydration to promote NJ Ex Order 26.4b1. On NJ Ex Order 26.4b1, NJ Ex Order 26.4b was noted and measured NJ Ex Order 26.4b1 with interventions of NJ Ex Order 26.4b1, prompt care with each NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and was referred to a NJ Ex Order 26 doctor.

On 02/23/23 at 9:30 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform NJ Ex Order 26 treatment to Resident #32's NJ Ex Order 26.4b1. The LPN placed the treatment supplies on top of the disinfected table inside the resident's room. The LPN after performing hand hygiene, draw the curtain of the resident for privacy, checked the resident's name band, verified the resident's identity, and transferred the call bell from the resident's chest to the side of the resident's pillow cover. The LPN with bare hands directly touched the resident's body and resident's environment, repositioned the resident, and applied a new pair of gloves without performing hand hygiene. The new pair of gloves were taken from the clean field (area) of treatment supplies. Then, the LPN pulled the table with treatment supplies towards the right side of the bed while the resident was positioned towards the left side, facing the wall, and the LPN removed the NJ Ex Order 26.4b1.

At that same time, the LPN stated that the

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F 880	Continued From page 44 resident preferred to NJ Ex Order 26.4b1 due to NJ Ex Order 26.4b1. The LPN further stated upon removing of NJ Ex Order 26.4b1 that she had to measure the NJ Ex Order 26.4b1 because it "now" progressed from NJ Ex Order 26.4b1 because of the NJ Ex Order 26.4b1. She indicated that the measurement yesterday NJ Ex Order 26.4b1 was NJ Ex Order 26.4b1. In addition, the LPN stated that the NJ Ex Order 26.4b1 was unavoidable due to the resident's comorbidities (associated with worse health outcomes; or occurs when a person has more than one disease or condition at the same time). Then, after the LPN removed her gloves and performed hand hygiene, applied a new pair of gloves. The LPN measured the NJ Ex Order 26.4b1 and stated it was NJ Ex Order 26.4b1. She further stated that she will call the physician and responsible party to notify the status of the midback wound. At that time, the LPN with the same pair of gloves, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, applied the NJ Ex Order 26.4b1 on top of the NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 with pre handwritten signed date and signature of the LPN. The LPN did not change gloves and perform hand hygiene in between NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. Then, the LPN repositioned back the resident to NJ Ex Order 26.4b1, discarded the unused and used supplies for NJ Ex Order 26.4b1, removed her used gloves,	F 880		

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disinfected the table, proceeded to perform handwashing, and left the resident's room.

During an interview, the LPN stated that it was the facility's practice that she should have washed her hands after direct contact with the resident and the resident's surroundings for infection control. She further stated that she should have changed her gloves after direct contact with a soiled or contaminated object, and when transferring from a dirty to a clean area, and immediately perform hand hygiene. The surveyor then asked the LPN if she followed the facility's practice during the [NJ Ex Order 26] treatment of Resident #32. The LPN stated that the [NJ Ex Order 26] care was considered a clean technique not sterile "but I should have changed my gloves," after NJ Ex Order 26.4b1, wash my hands, and apply a new pair of gloves before putting on a [NJ Ex Order 26] . The LPN further stated that she should have washed her hands after direct contact with the resident's curtain, linen, and pillow when she repositioned the resident and the resident's call bell.

On 02/23/23 at 11:25 AM, the IPN informed the surveyor in the presence of the survey team that she heard about what had happened during the [NJ Ex Order 26] treatment. The IPN further stated that the LPN acknowledged that she did not follow the facility's practice with the use of gloves and appropriate hand hygiene.

A review of the facility's Wound Care Policy with a revised date of October 2010 that was provided by the DON, included the steps in the procedure indicated to put on the exam glove, remove the dressing then pull the glove over the dressing and discard into the appropriate receptacle, wash,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 and dry hands thoroughly before putting a new pair of gloves. The Policy also included that be certain all clean items are on the clean field. A review of the Handwashing/Hand Hygiene Policy with a revised date of January 2022 that was provided by the IPN included that employees must wash their hands for at least twenty seconds under the following conditions: before and after direct resident contact, before and after changing a dressing, after contact with a resident's mucous membranes and body fluids or excretions, after handling soiled or used linens, dressings, after holding soiled equipment, before and after entering isolation precaution settings, and after removing gloves. On 02/27/23 at 11:37 AM, the survey team met with the LNHA, DON, RDON, and AIT. The RDON stated that the resident's NJ Ex Order 26.4b1 was re-assessed by the Registered Nurse (RN). The RDON further stated that the LPN acknowledged that she should have done "the right hand hygiene protocol." NJAC 8:39-19.4 (a)(1)(n)	F 880		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		4/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315434	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

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F 882	Continued From page 47 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the designated Infection Preventionist (IP) a) completed the required training in infection prevention and control prior to assuming the position of an IP for one (1) of three (3) staff, b) met the required at least part-time position for one (1) of three (3) staff, and c) qualified for primary professional training requirement for one (1) of three (3) staff in accordance with the facility policy and Centers for Medicare and Medicaid Services (CMS) and New Jersey (NJ) guidelines. This deficient practice was evidenced by the following: According to the NJ Executive Directive 21-012 (revised 12/22/22) included "ii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's Infection Prevention and Control (IPC) program by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo	F 882	Facility hired a Part-Time Infection Preventionist (IP) who completed specialized training in infection prevention and control. The IP will primarily work in this facility for a minimum of 20 hours per week. Current IP is a Licensed Professional Nurse. The IP is physically working onsite mitigating infectious diseases through an effective infection prevention and control program. All residents have the potential to be affected by this deficient practice. Facility Administrator was reinserviced regarding the Infection Preventionist (IP) requirements. This is to ensure the designated Infection Preventionist (IP) has completed the required training in infection prevention and control prior to assuming the position in accordance with the facility policy and Centers for Medicare and Medicaid Services (CMS) and New Jersey (NJ) guidelines. Senior Regional Director of Nursing or designee will review facility Infection Preventionist monthly for 6 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315434	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

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F 882	Continued From page 48 dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. According to the CMS Infection Prevention, Control & Immunizations pathway dated 10/2022 included that in reviewing the facility records for the designated IP, the facility must provide documentation of the IP's primary professional training, which must be one of the following: Certificate/diploma or degree in nursing; or Bachelor's degree (or higher) in microbiology or epidemiology; or Associate degree or higher in medical technology or clinical laboratory science; or Completion in training in another related field such as that for physicians, pharmacists, and physician's assistants. Specialized training in infection prevention and control was completed prior to assuming the role of the IP, and evidence of completion is available (example certificate). On 3/02/23 at 9:22 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Nursing (RDON). The RDON informed the surveyor that the Infection Preventionist Nurse (IPN) was hired in late NJ Exec. Order 26:4.b.1 (unable to remember the date) and started in	F 882	annually thereafter to ensure Facility Infection Preventionist (IP) holds a current Certificate required by CMS. Results of this review will be discussed with the Administrator for immediate resolution. This will be discussed in a monthly QAPI and this will be a part of quarterly QA.	

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F 882	Continued From page 49	F 882		

NJ Exec. Order 26:4.b.1 (unable to remember the date). The RDON stated that between NJ Exec. Order 26:4.b.1 through NJ Exec. Order 26:4.b.1 the IP then was now the Regional IPN (R/IPN) and was transitioned to the Administrator In Training (AIT) from NJ Exec. Order 26:4.b.1 through NJ Exec. Order 26:4.b.1 before the IPN started. The RDON was unable to remember the exact date of coverage for the IP of the R/IPN. The surveyor then asked the facility management for the R/IPN and the AIT's resume, infection control certification of completion, and time card records from NJ Exec. Order 26:4.b.1 .

A review of the facility provided Quality Assurance (QA) sign-in sheet by the RDON showed that the designated IP that attended the quarterly meeting on NJ Exec. Order 2 and NJ Exec. Order 26:4 was the AIT (IP designation next to AIT's name). The provided NJ Exec. Order 26:4 QA sign-in sheet did not have a designated IP even though the AIT (IP designation was not attached to AIT's name) attended the meeting.

Further review of the facility provided documents showed the following:

AIT=did not comply with the requirements of an IP because he completed the Centers for Disease Control and Prevention (CDC) 19.3 hours Nursing Home Infection Preventionist Training on 10/09/22 (was completed after assuming the role of the IP), and did not meet the criteria for professional training because according to his resume, he graduated with a Bachelor of Science in Healthcare Administration with a focus on Leadership.

R/IPN=did not comply with the requirement of an IP because the IP must physically work onsite

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F 882	Continued From page 50	F 882		

and cannot be an off-site consultant or work at a separate location, and work at least part-time. The Chief Operating Officer (COO) provided the time cards record of the R/IPN from [redacted] through [redacted] for four hours and [redacted] for 5.50 hours) for a total of 9.50 hours and from [redacted] through [redacted] for seven hours and on [redacted] for 8.50 hours) for a total of 15.50 hours. The time cards did not reflect that the R/IPN attended the QA meeting on [redacted] and [redacted].

A review of the facility's Infection Preventionist Policy that was provided by the RDON with the last reviewed date of 06/2022 did not include the updated guidance and regulation requirements for an IP.

According to the facility's Infection Preventionist Job Description that was provided by the RDON included the Position Qualifications and Credentials as follows:
1. Professional licensure, epidemiology, microbiology, medical technology, public health, or other healthcare science is preferred but not required.
2. Specialty training in Infection Prevention and Control through accredited continuing education.
3. Must complete the CDC Infection Control training program and obtain certification within six months of employment.

On 3/02/23 at 10:58 AM, the COO informed the surveyor that the R/IPN assumed the regional position on [redacted].

On 3/02/23 at 11:01 AM, the survey team met with the RDON, LNHA, AIT, DON, and COO. The COO stated that the facility had been recruiting

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F 882	Continued From page 51 for a while for the IP position and that not every nurse has the qualifications. The COO acknowledged that the designated IP must attend the QA meeting as a requirement of an IP. On that same date and time, the RDON informed the surveyors that the AIT was not a nurse. The RDON acknowledged that she did not know that the AIT did not meet the required professional training because she thought that the AIT's Bachelor's degree and CNA (Certified Nursing Aide) certification were enough. The RDON stated that it was difficult to recruit an IP. NJAC 8:39-19.1(b)	F 882		

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	060227	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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 six (6) of 14 day shifts. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	All efforts to hire facility Certified Nursing Aides (CNAs) will continue until there is adequate staff to serve all residents. Until that time, facility will utilize staffing agencies to fill any open spots in the schedule. All residents have the potential to be affected by this deficient practice. Contracts with 3 staffing agencies will be finalized to supplement facility staff. Contracts with additional staffing agencies will be secured. Hiring and recruitment efforts including wage adjustments, online job listings, job fairs, shift differentials and referral	3/31/23

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

Electronically Signed | 03/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. This deficient practice was evidenced by the following: As per the "Nurse Staffing Report" completed by the facility for the weeks of 01/29/23 and 02/05/23, the facility was deficient in CNA staffing for residents on six (6) of 14 day shifts as follows: -01/29/23 had 8 CNAs for 85 residents on the day shift, required 11 CNAs. -02/01/23 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. -02/02/23 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. -02/04/23 had 9 CNAs for 84 residents on the day shift, required 10 CNAs. -02/05/23 had 8 CNAs for 84 residents on the day shift, required 10 CNAs. -02/11/23 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. On 02/23/23 at 10:47 AM, the surveyor interviewed the Administrator in Training (AIT) who stated that he was responsible for the Daily Staffing Sheet (DSS) and was the Staffing	S 560	bonuses will be increased to become more competitive. Facility will conduct free Nurse Aide Certification classes to recruit more CNAs. Sponsorship of foreign nurse professionals through a recruitment agency will be secured to supplement nurse staffing. Administrator or designee will review staffing schedules weekly for 90 days and monthly thereafter to ensure adequate staffing for all shifts. The results of this review will be discussed in monthly QAPI and quarterly QA program.	

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S 560	Continued From page 2 Coordinator (SC). The AIT/SC stated that the DSS was completed electronically and based the staffing on the facility census. The AIT/SC explained that the number of CNAs needed was according to the required ratios which were one (1) to eight (8) for the day shift, one (1) to 10 for the evening shift and one (1) to 14 for the evening shift. The AIT/SC added that sometimes he had trouble with the numbers, meaning having enough CNAs required, and would provide incentives to fulfill the ratios. The AIT/SC added that if the ratios were unable to be met than he would verbally alert the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and that it was a group effort to recruit staff to fulfill the ratios. On 02/28/23 at 01:06 PM, the survey team met with the LNHA, Regional Director of Nursing (RDON), Chief Operating Officer (COO), DON and AIT/SC. The RDON stated that the facility has been short staffed and that it was a challenge. The COO stated that the facility has done a lot to maintain staffing and that staffing was a challenge and the facility was doing as much as possible. On 03/06/23 at 4:16 PM, the surveyor received an electronic mail from the LNHA which revealed that the facility had no formal Facility Staffing Policy.	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
315434 Y1	A. Building B. Wing Y2	5/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

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 F0641	Correction	ID Prefix F0661	Correction	ID Prefix F0695	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25(i)	Completed
LSC	04/05/2023	LSC	04/05/2023	LSC	04/05/2023
ID Prefix F0728	Correction	ID Prefix F0732	Correction	ID Prefix F0755	Correction
Reg. # 483.35(d)(1)-(3)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0777	Correction	ID Prefix F0880	Correction	ID Prefix F0882	Correction
Reg. # 483.50(b)(2)(i)(ii)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed
LSC	04/05/2023	LSC	03/31/2023	LSC	04/05/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/2/2023	☐ 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 (Y2)	DATE OF REVISIT (Y3)
060227	A. Building B. Wing	5/1/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

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 03/31/2023	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
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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 3/2/2023	☐ 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
	315434	A. BUILDING **02** B. WING _____	**03/02/2023**

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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 02/16/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/16/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Family of Caring Healthcare at Ridgewood is a one-story building which was built in 1960. It is composed of Type II protected construction. The facility is divided into four smoke zones. The current occupied beds are 88 of 96.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		3/3/23

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

Electronically Signed | 03/17/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	**304 S. VAN DIEN AVE** **RIDGEWOOD, NJ 07450**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315434	A. BUILDING **02** B. WING _____	**03/02/2023**

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FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	**304 S. VAN DIEN AVE** **RIDGEWOOD, NJ 07450**

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K 222	Continued From page 2 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an irreversible process released a delayed-egress locking arrangement in the direction of egress within 15 seconds, or 30 seconds, upon application of a force to the release device in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice could affect 22 residents. Findings include: An observation on 02/16/23 at 1:29 PM revealed when force was applied by the Maintenance Director to the 15 second delayed-egress locking arrangement for the exit door, located adjacent to Room 230, an audible signal was activated, but the locking arrangement did not release. During an interview at the time of the observation, the Maintenance Director confirmed the locking arrangement did not release; however, the door does release upon activation of the fire alarm system. He stated he regularly checks the doors but was not aware the locking arrangement was not working. NJAC 8:39-31.1(c), 31.2(e)	K 222	The locking arrangement identified in the statement of deficiencies which did not release after 15 seconds was immediately addressed and corrected so that the locking arrangement would release the door lock after 15 seconds, allowing for egress. After such adjustment, it was confirmed that when force is applied to the door, the audible signal is activated, and, after 15 seconds, the locking arrangement releases and the door opens. All residents in the facility have the potential to be affected by this deficient practice. All maintenance staff were re-educated on the regulation of egress doors and the importance of the locking arrangement releasing after 15 seconds for all delayed-egress locking exit doors. The Maintenance Director, or designee, will audit all delayed-egress locking exit doors to ensure all audible signals initiate after force is applied to the exit door and that the locking arrangements release after 15 seconds.	

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K 222	Continued From page 3	K 222	The Maintenance Director, or designee, will audit all exit doors weekly for 3 months, and monthly thereafter, for compliance with the delayed-egress locking arrangements releasing after 15 seconds. Results will be discussed in the facility□s monthly QAPI and will be a part of the facility□s quarterly Quality Assurance Program.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure exits that were obviously and clearly identifiable as exits, were marked by an approved sign that was readily visible from any direction of exit access and horizontal components of the egress pass were marked by an approved exit or directional exit sign where the continuation of the egress path was not obvious in accordance with NFPA 101 (2012 Edition) Section 7.10.1.2. This deficient practice had the potential to affect 45 residents. Findings include:	K 293	The areas identified in the statement of deficiencies which did not have illuminated exit or directional exit signs were immediately addressed and illuminated exit or directional exit signs were installed to alert the occupants of these areas where the path of egress is. All residents in the facility have the potential to be affected by the deficient practice. Illuminated exit or directional exit signs were installed to alert the occupants of the	3/3/23

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K 293	Continued From page 4 An observation on 02/16/23 at 1:41 PM revealed the smoke barrier doors, located adjacent to Room 214, were not marked by an exit sign to indicate the path of egress. An observation on 02/16/23 at 1:52 PM revealed there was not a directional exit sign, adjacent to Room 212, to indicate the path of egress. An observation on 02/16/23 at 1:55 PM revealed the smoke barrier doors, located adjacent to the nurses' station, were not marked by an exit sign to indicate the path of egress. During an interview at the time of the observations, the Maintenance Director confirmed that exit signs were missing to indicate the path of egress. He stated the signs were removed when the facility was having renovations completed and the exit signs were not put back up. NJAC 8:39-31.1(c), 31.2(e)	K 293	identified areas where the location of egress is. Maintenance staff were re-educated on the regulation of continuously illuminated exit or directional exit signs to clearly and obviously identify all paths of egress. The Maintenance Director, or designee, will audit all egress locations to ensure all paths of egress are clearly and obviously identified with the use of approved exit or directional exit signs with continuous illumination. The Maintenance Director, or designee, will audit all paths of egress weekly for 3 months, and monthly thereafter, for compliance with the clearly and obviously identified paths of egress via approved exit and directional exit signs with continuous illumination. Results will be discussed in the facility□s monthly QAPI and will be a part of the facility□s quarterly Quality Assurance Program.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		5/1/23

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K 372	Continued From page 5 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to smoke barriers were continuous from an outside wall to an outside wall or from a floor to a floor in accordance with NFPA 101 Life Safety Code (2012 edition) Section 8.5.2.1. This deficient practice had the potential to affect 39 residents. Findings include: An observation on 02/16/23 at 12:54 PM revealed the smoke barrier, located above the ceiling tiles adjacent to the First Floor nurses' station, did not extend from floor to floor. The Maintenance Director measured an opening one foot in height which extended an unknown distance in width. During an interview at the time of the observation, the Maintenance Director confirmed the opening in the smoke barrier. He stated, when he was hired, he noticed the smoke barrier did not extend to the floor above, but he did not contact the owner about it. NJAC 8:39-31.1(c), 31.2(e)	K 372	The area identified in the statement of deficiencies was immediately addressed to ensure the smoke barriers extended from a floor to a floor in accordance with NFPA 101 Life Safety Code (2012 Edition Section 8.5.2.1. All residents in the facility have the potential to be affected by the deficient practice. A plan is being drafted with the construction company to extend the smoke barriers in the identified area to extend from a floor to a floor. All maintenance staff were re-educated on the regulation of smoke barrier construction as it applies to subdivision of building spaces and the importance of smoke barriers extending from an outside wall to an outside wall or from a floor to a floor. The Maintenance Director, or designee, will immediately audit all smoke barriers in the facility to ensure all barriers extend from an outside wall to an outside wall or from a floor to a floor. The Maintenance Director, or designee, will audit all smoke barriers weekly for 3 months, and monthly thereafter, for compliance with the smoke barrier construction regulation. Results will be discussed in the facility's monthly QAPI and will be a part of the facility's quarterly	

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K 372	Continued From page 6	K 372	Quality Assurance Program. Project Completion Date set for 05/01/2023.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		3/17/23

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K 918	Continued From page 7 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the diesel-powered Emergency Power Supply System (EPSS) was exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours in accordance with NFPA 110 Emergency and Standby Power Systems (2010 Edition) Section 8.4.2.3. This deficient practice had the potential to affect all 88 residents. Findings include: A record review of the generator inspection and maintenance reports located in the "State Log" binder for the dates January 2022 - February 16, 2023 provided by the Maintenance Director, revealed the generator was inspected on 12/08/22 and 03/15/22. There was no record the diesel-powered EPSS was exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. During an interview on 02/16/23 at 2:06 PM, the Maintenance Director stated he did not know the test was a requirement. He contacted the contracted generator company and the company	K 918	The area identified in the statement of deficiencies which did not confirm the diesel-powered Emergency Power Supply System (EPSS) was exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours was immediately addressed. A supplemental contract was signed with Electrical Power Systems, Inc. to provide an annual test of the EPSS to comply with this regulation. The first annual test is scheduled to be performed on March 17, 2023. All residents in the facility have the potential to be affected by the deficient practice. All maintenance staff were re-educated on the regulation of testing the diesel-powered Emergency Power Supply System (EPSS) annually in accordance with the NFPA regulation. The facility will sign a contract with Electrical Power Systems, Inc. to perform an annual load test to comply with this regulation. The Maintenance Director, or designee, will audit the diesel-powered Emergency	

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K 918	Continued From page 8 stated a load bank test was not part of the facility's contract. The Maintenance Director informed he would schedule a load bank test. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	Power Supply System (EPSS) weekly for 3 months, and monthly thereafter, for compliance with the annual exercising of not less than a total of 1.5 continuous hours as per NFPA 110 Section 8.4.2.3 (2010 Edition). Testing logs will be maintained by the Maintenance Director. Results will be discussed in the facility□s monthly QAPI and will be a part of the facility□s quarterly Quality Assurance Program.	
K 929 SS=E	Gas Equipment - Precautions for Handling Oxyg CFR(s): NFPA 101 Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure freestanding compressed Oxygen cylinders were properly chained or supported in a proper cylinder stand or cart in accordance with NFPA 99 Health Care Facilities Code (2012 Edition) Section 11.6.2.3(11). This deficient practice had the potential to affect 16 residents. Findings include:	K 929	The area identified in the statement of deficiencies where two oxygen cylinders were not properly chained or supported in a stand or cart was immediately addressed. The identified cylinders were secured and/or removed from the facility. All residents in the facility have the potential to be affected by the deficient practice.	3/3/23

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K 929	Continued From page 9 An observation on 02/16/23 at 1:21 PM revealed the Utility Room, located adjacent to Room 102, had two oxygen cylinders that were not properly chained or supported in a stand or a cart. During an interview at the time of the observation, the Maintenance Director confirmed the oxygen cylinders were not secured. He stated the staff know the oxygen cylinders need to be secure. When surveyor questioned the Maintenance Director regarding documented training of the staff regarding oxygen safety, he stated he was unaware of any documentation of the training. During an interview on 02/16/23 at 3:00 PM the Regional Director of Nursing (RDON) stated in-service was provided to new staff verbally by staff members by telling them how to handle the cylinders, but there was no official training and documentation. The RDON informed that during the survey "Using Oxygen Safely" training was provided to the staff currently working and would be provided to the additional staff. The RDON provided documentation of the training to the surveyor. NJAC 8:39-31.2(e) NFPA 99	K 929	All facility staff were re-educated on the regulation of proper use and storage of oxygen cylinders, including oxygen safety. The Maintenance Director, or designee, will audit all oxygen cylinder storage areas weekly for 3 months, and monthly thereafter, for compliance with proper storage of oxygen cylinders. Results will be discussed in the facility□s monthly QAPI and will be a part of the facility□s quarterly Quality Assurance Program. The Director of Nursing, Assistant Director of Nursing, or designee will provide education regarding proper use and storage of oxygen cylinders as well as oxygen safety to all newly hired staff, and annually thereafter.	

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
315434 Y1	A. Building 02 - BUILDING B. Wing Y2	5/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0222	03/03/2023	LSC	K0293	03/03/2023	LSC	K0372	05/01/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0918	03/17/2023	LSC	K0929	03/03/2023	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
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LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO