STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s: NJ160742, NJ163243, NJ163250, NJ163756, NJ165558, NJ167264, NJ169382, NJ170219, NJ174859 Survey Date: 06/25/24 through 07/15/24 Census: 103 Sample Size: 24 + 1 = 25 During a Recertification Survey conducted at Wynwood Rehabilitation and Healthcare Center from 06/25/24 through 07/15/24, to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities, it was determined that the Facility was found to be in Immediate Jeopardy (IJ) for F 600 and F 689. F 600- During the survey a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.12(a)(1) F 600 as the facility failed to ensure adequate supervision was provided for a NJ Exec Order 26.4b1 resident (Resident #84) who had a documented history of NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 into other resident rooms. On NJ Exec Order 26.4b1, Resident #84 NJ Exec Order 26.4b1 into Resident #152's room and was NJ Exec Order 26.4b1 which resulted in Resident #84 NJ Exec Order and	F 000		

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

Electronically Signed | 08/06/2024

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F 000	Continued From page 1	F 000		

NJ Exec Order 26.4b1 .
On NJ Exec Order 26.4b1 Resident #84 NJ Exec Order 26.4b1 into Resident #94's room, NJ Exec Order 26.4b1 Resident #94's NJ Exec Order .

Record review revealed that Resident #84 was admitted to the facility on NJ Exec Order 26.4b1

Record review revealed that Resident #84 was admitted to the facility with diagnoses which include but were not limited to: NJ Exec Order 26.4b1

The Quarterly Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 reflected that Resident #84 was NJ Exec Order 26.4b1. Resident #84 scored NJ Exec Ord on the Brief Interview for Mental Status (BIMS).

A Partial Extended Survey was initiated after the deficiency was identified at the IJ/SQC level.

The US FOIA (b) (6) was informed of the Immediate Jeopardy and was provided with the IJ template on 07/01/2024 at 3:44 PM.

An acceptable removal plan was received on 07/03/2024 at 10:01 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including:
1) Placing Resident #84 on a NJ Exec Order 26.4b1 ,
2) On NJ Exec Order 26.4b1 at approximately 5:00 PM, Resident #84 was transferred to another facility.

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F 000	Continued From page 2 The survey team verified the removal plan on-site on 07/03/24 at 12:43 PM. F 689- During the survey, a finding which constituted Immediate Jeopardy was identified under 42 CFR 483.25(d)(1)(2) F 689 as the facility failed to provide adequate and consistent supervision for residents who were assessed and identified as NJ Exec Order 26.4b1 including Resident #29 who was assessed as requiring NJ Exec Order 26.4b1 while NJ Exec Order 26.4b and was not assisted, rested a NJ [redacted] on a visibly NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and NJ Exec Order 2 Staff were observed disposing of NJ Exec Order on Resident #29's NJ Exec Order 26.4b [redacted] into the bushes below the NJ Exec Order 26.4b area. The US FOIA (b) (6) was informed of the IJ and was provided with the IJ template on 07/02/2024 at 2:46 PM. 1.) Record review revealed that Resident #29 was admitted to the facility in NJ Exec Order 26.4b1. Additionally, they had diagnoses including but not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #29's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 2 reflected that the resident had a BIMS score of NJ Exec Order 26.4b1, which indicated that Resident #29's NJ Exec Order 26.4b1. Additionally, the resident's functional range of motion for NJ Exec Order [redacted] was NJ Exec Order 26.4b1 [redacted].	F 000		

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F 000	Continued From page 3 2.) Record review revealed that Resident #39 was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses, including but not limited to; [redacted]. A review of Resident #39's most recent quarterly MDS, dated [redacted] reflected that the resident had a BIMS score of [redacted], which indicated that Resident #39's [redacted]. Additionally, the resident's activities for daily living required NJ Exec Order 26.4b1 where in the resident completed the activity and the NJ Exec Order [redacted] or NJ Exec Order 26.4b1 the activity. 3.) Record review revealed that Resident #72 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including, but not limited to; unspecified [redacted] A review of Resident #72's most recent quarterly MDS, dated [redacted], reflected that the resident had a BIMS score of [redacted], which indicated that Resident #72's [redacted]. The resident was NJ Exec Order 26.4b1 for activities for daily living and had NJ Exec Order 26.4b1 of a [redacted] An acceptable removal plan was received on 07/03/2024 at 10:00 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring: 1) Two staff members will be assigned to supervise each smoking time 2) Ensuring residents who require close supervision when smoking do not keep their own lighting materials, 3) Ensuring residents do not light other residents' cigarettes, 4) Ensure that cigarettes are not resting on anything including smoking aprons, 5) Disposing ashes in the smoking receptacle, 6) Ensuring cigarettes are only extinguished in the	F 000		

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F 000	Continued From page 4 smoking receptacle, 6) Ensuring residents do not keep their lighting materials on their person, 7) Ensuring ashes and cigarettes are not disposed of in the bushes, and 8) If burn holes are observed on resident clothing to immediately notify the nursing supervisor. The survey team verified the removal plan on-site on on 07/03/2024 at 1:16 PM.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, review of medical records (MRs), other facility documentation, and review of facility policy, it was determined that the facility failed to a.) protect residents from NJ Exec Order 26.4b1 as well as b.) ensure adequate supervision for a NJ Exec Order 26.4b1 resident (Resident #84) with a history of NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 into other resident rooms, leading to NJ Exec Order 26.4b1	F 600	1. Resident 84 was placed on a NJ Exec Order 26.4b1 Resident 84 had a NJ Exec Order 26.4b1 and it did not show any NJ Exec Order 26.4b1 Resident 84 remained on a NJ Exec Order 26.4b1 until discharged on NJ Exec Order 26.4b1 Resident 94 had a NJ Exec Order 26.4b1 check completed on NJ Exec Order 26.4b1 at 6:35am	8/14/24

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F 600	Continued From page 5 NJ Exec Order involving other residents. Due to the vulnerable nature of the nursing home population, there is a potential for NJ Exec Order 26.4b1 or NJ Exec Order 26 [redacted] or [redacted] from being NJ Exec Order 26.4b1 by Resident #152 and Resident #94 as well as Resident #84 [redacted] residents. This required immediate action to prevent further events of [redacted] by or to Resident #84 or other residents. This deficient practice was identified for 1 of 9 residents reviewed for [redacted] The Immediate Jeopardy (IJ) situation began on NJ Exec Order 26.4b, and was identified on 07/01/24. Resident #84 had a documented history of NJ Exec Order 26.4b1 into other resident rooms that began on NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 Resident #84 NJ Exec Order 26.4b1 into Resident #152's room. Resident #152 then NJ Exec Order 26 Resident #84 which caused Resident #84 to NJ Exec Order 26.4b1 [redacted]. On 06/28/24 at 7:30 AM, Resident #94, in the presence of the surveyor, told the US FOIA (b) (6) [redacted] that they were "NJ Exec Order" that Resident #84 NJ Exec Order 26.4b1 into their room, placed NJ Exec Order 26.4b1 [redacted] Resident # 94's NJ Exec Order 26.4b1. This failure to adequately supervise a NJ Exec Order 26.4b1 [redacted] resident with a known history of NJ Exec Order 26.4b1 into other resident rooms and NJ Exec Order 26.4b other residents in an NJ Exec Order 26.4b1 [redacted] placed all residents at an increase risk for the likelihood of NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 harm. This resulted in an Immediate Jeopardy (IJ) situation.	F 600	and it did not show any NJ Exec Order 26.4b1 Resident 94 had a NJ Exec Order 26.4b1 evaluation on NJ Exec Order 26.4b1 and the evaluation stated that he NJ Exec Order 26.4b1 and that NJ Exec Order 26.4b1 [redacted] changes were noted. Resident 94 was evaluated by NJ Exec Order 26.4b1 [redacted]. Resident 94 was visited by the NJ Exec Order 26.4b1 [redacted] on NJ Exec Order 26.4b1 2.The facility identified that all residents have the potential to be affected. All NJ Exec O [redacted] residents were interviewed by the Social Worker on 7/1/2024. The Social Worker interviewed them on whether residents have NJ Exec Order 26.4b1 into their rooms and if they have been NJ Exec Order 26 in any way by anyone. Every resident that the Social Worker interviewed denied being NJ Exec Order 26 while they have lived in the center. All remaining NJ Exec Order 26.4b1 residents had NJ Exec Order 26.4b1 completed on 7/1/2024 to rule out NJ Exec Order 2 including NJ Exec Order that could have occurred by a resident NJ Exec Order 26.4b1 into their rooms. The results of the NJ Exec O checks showed no signs of NJ Exec Order 2 3.Resident 84 was placed on a [redacted] and remained on a [redacted] until discharged on NJ Exec Order. On 7/1/2024 at 4pm, The Director of Nursing and designee began in-servicing all facility staff in every department on the Abuse-Neglect-Exploitation Policy, implementing effective interventions that work to prevent all residents from abuse and neglect, implementing effective interventions that work at preventing	

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F 600	Continued From page 6 The IJ template was provided to the US FOIA (b) (6) [redacted] on 07/01/24 at 3:44 PM. The facility submitted an acceptable Removal Plan (RP) on 07/03/24 at 12:43 PM, and was verified on-site on 07/03/24 at 12:43 PM, by the survey team. The removal plan indicated the facility took the following steps to prevent serious harm from occurring or recurring: The immediacy of the IJ was removed on 07/01/24. 1. Resident #84 was placed on a NJ Exec Order 26.4b1 [redacted]) on NJ Exec Order 26.4b1 at 1:45 PM and Resident #84 was Discharged from the facility on NJ Exec Order 26.4b1 at approximately 5:00 PM. 2. The facility identified that all residents have the potential to be affected. All alert and oriented residents were interviewed by the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 and all remaining NJ Exec Order 26.4b1 [redacted] residents had NJ Exec Order 26.4b1 completed on NJ Exec Order 26.4b1 to rule out abuse that could have occurred by a resident NJ Exec Order 26.4b1 into their rooms. 3. On 07/01/24 at 4:00 PM, the U.S. FOIA (b)(6) [redacted] and designee began in-servicing all facility staff in every department on the Abuse-Neglect-Exploitation Policy, implementing effective interventions to prevent all residents from abuse and neglect, implementing effective interventions to prevent residents who wander from entering other residents' rooms, protecting residents who wander from being abused, and implementing effective interventions after a	F 600	residents who wander from entering other residents rooms, protecting residents who wander from being abused, and implementing effective interventions that work after a resident abuse allegation to prevent it from happening again. This in-servicing will continue until all staff that work in the center are in-serviced. New hires and agency staff will receive the in-servicing in orientation. Effective interventions are placed on resident care plans. Residents with wandering behaviors have those behaviors placed on the care plan and that is how staff are aware of the interventions and who wanders. The Nursing Home Administrator or Director of Nursing will conduct audits on all residents with wandering behaviors by direct observation, resident interviews, and staff interviews to ensure that residents who have the potential to wander into other residents rooms have effective interventions in place to prevent them from wandering into other residents rooms and that abuse has not occurred. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. The Nursing Home Administrator or Director of Nursing will interview five alert and oriented residents regarding abuse. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. Findings of all audits will be reviewed by the Quality Assurance Committee at the monthly	

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F 600	Continued From page 7 resident abuse allegation. This in-servicing will continue until all staff that work in the center are in-serviced. Staff will be in-serviced prior to starting their assignment. 4. The[redacted] will conduct audits on all residents with wandering behaviors by direct observation, resident interviews, and staff interviews to ensure that residents who have the potential to wander into other residents' rooms have effective interventions in place to prevent them from wandering into other residents' rooms and that abuse has not occurred. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. The[redacted] will interview five alert and oriented residents regarding abuse. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. Findings of all audits will be reviewed by the Quality Assurance Committee at the monthly QAPI meetings x three months. The evidence was as follows: A review of the facility's abuse, neglect, and exploitation policy, Date Implemented (Left Blank), Date Reviewed/Revised 07/12/23 included, but was not limited to: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing policies and procedures that prohibits and prevent abuse, neglect, exploitation and misappropriation of resident property ... Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain and mental anguish. It includes verbal abuse, physical abuse, sexual abuse, and mental	F 600	QAPI meetings x three months. 4. The Nursing Home Administrator or Director of Nursing will conduct audits on all residents with wandering behaviors by direct observation, resident interviews, and staff interviews to ensure that residents who have the potential to wander into other residents□ rooms have effective interventions in place to prevent them from wandering into other residents□ rooms and that abuse has not occurred. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. The Nursing Home Administrator or Director of Nursing will interview five alert and oriented residents regarding abuse. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. Findings of all audits will be reviewed by the Quality Assurance Committee at the monthly QAPI meetings x three months.	

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F 600	Continued From page 8 abuse including abuse facilitated or enabled through use of technology ... The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse., neglect, and exploitation of residents and misappropriation of resident property b. Establish policies and procedures to investigate any such allegations: c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention ... 3. The facility will provide ongoing oversight and supervision of staff in order to assume that its policies are implemented as written ... 1. On 6/28/24 at 7:30 AM, in the presence of the surveyor, Resident #94 told the U.S. FOIA (6 that they were NJ Exec Orde that [Resident #84] came into their room and NJ Exec Order 26.4b1 . The surveyor then asked the U.S. FOIA if she heard what Resident #94 had said. The U.S. FOIA stated, "I heard it, management was already made aware." Resident #84 resided in the NJ Exec Order 26.4b1 from Resident #94. On 07/01/24 at 12:29 PM, the surveyor interviewed Resident #71 who was Resident #94's NJ Exec Order 26.4b1 Resident #71 stated, NJ Exec [Resident #84] NJ Exec and that the facility informed the resident that Resident #84 was NJ Exec Order 26.4b1 because the resident NJ Exec Order 26.4b1 . Resident #71 further stated, "NJ Exec Order 26.4b1 [Resident #84] is NJ Exec Order 26.4b1 " Resident #71 further stated that Resident #84 had been NJ Exec Order 26.4b1 into their rooms for	F 600		

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F 600	Continued From page 9	F 600		

months" and that was reported to the nurses, the Certified Nurse Aides (CNA), and the [redacted].

On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the [redacted], "[Resident #84] [redacted]. [Resident #84] always comes into our room. [Resident #84] [redacted] and this time [Resident #84] [redacted]. [Resident #84] had [redacted] my [redacted]. I told the staff a million times and nothing had been done".

On 07/01/24 at 12:35 PM, the surveyor, along with a second surveyor, then interviewed the [redacted], to whom Resident #94 reported the alleged [redacted] in the presence of the [redacted]. The [redacted] confirmed that Resident #94 reported the [redacted]. The [redacted] stated in the presence of the [redacted] that Resident #94 informed her that Resident #84 [redacted] Resident #94 in a "[redacted] for [redacted] way." The [redacted] confirmed to the [redacted], "I did not write it, that was Resident #94's perception."

On 07/01/24 at 12:58 PM, two surveyors interviewed the [redacted] regarding Resident #84's behavior. The [redacted] stated that Resident #84 [redacted]", and that staff would keep an eye and monitor the resident.

Review of Resident #94's medical record revealed no documented evidence of the alleged [redacted] by Resident #84. The surveyor interviewed the [redacted] who

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F 600	Continued From page 10 stated that she was not aware of the incident, and she stated that she arrived at that facility at 6:30 AM on 06/28/24, to start an investigation into the incident. On 07/01/24, the surveyor reviewed the electronic medical record (EMR) for Resident #94 which revealed: The Admission Summary revealed diagnoses which included but was not limited to; NJ Exec Order 26.4b1 [redacted] The Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26. [redacted], reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1 [redacted], indicating that the resident had an NJ Exec Order 26.4b1 [redacted]. Also the MDS revealed the resident was NJ Exec Order 26.4b1 [redacted] with activities of daily living (ADLs). The Care Plan (CP), initiated and revised on NJ Exec Order 26.4b1 [redacted], indicated that the resident had NJ Exec Orde [redacted], Educate about source of NJ Exec Or [redacted] Explore past NJ Exec Order 26.4b1 [redacted] and encourage resident to utilize NJ Exec Order 26.4b1 [redacted]. 2. On 07/01/24, at 9:30 AM, the surveyor reviewed the EMR Resident #84 which revealed: The Admission Summary revealed Resident #84 was admitted to the facility on NJ Exec Order 26.4b1 [redacted], with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]	F 600		

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

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NJ Exec Order 26.4b1 [redacted]

The Quarterly Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, reflected the resident had a BIMS score o NJ Exec Order 26.4b1, which indicated the resident was NJ Exec Order 26.4b1. The MDS also revealed that Resident #84 required NJ Exec Order 26.4b1 for activities of daily living (ADLs).

A review of a 41-page Care Plan which included current and canceled focus areas revealed the following focus areas:

- A focus area initiated on NJ Exec Order 26.4b1 fo NJ Exec Order 26. with a Goal that Resident #84 will not NJ Exec Order 26.4b1 through review date, with a Target Date of NJ Exec Order 26.4b1. The CP interventions included to apply [redacted] and check for proper function and placement, date initiated NJ Exec Order 26.4b1.

- A focus area initiated on NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 with a Goal, initiated NJ Exec Order 26.4b1 to "have a NJ Exec Order 26.4b1 til [until] next review, with a Target Date of NJ Exec Order 26.4b1". The CP interventions initiated NJ Exec Order 26.4b1 included to: Anticipated resident needs, arrange for NJ Exec Order 26.4b1 consult as ordered, Help me understand why the behavior is NJ Exec Order 26. , Intervene as necessary to NJ Exec Order 26 . Approach/Speak in a NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 and take to an NJ Exec Order 26.4b1 as needed, Intervene PRN [as needed] to ensure NJ Exec Order 26.4b1 (i.e., talk with resident in a NJ Exec Order 26.4b1), Monitor behavior to assist in determining the cause. This Focus area was initiated four months after it was initially documented on NJ Exec Order 26.4b1, when the resident NJ Exec Order 26.4b1 into another resident's room.

- A focus area initiated on NJ Exec Order 26.4b1, and revised NJ Exec Order 26.4b1, for I am at risk for NJ Exec Order 26.4b1 and/or NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. "Another resident allegedly NJ Exec Order 26.4b1". The Goal, initiated on NJ Exec Order 26.4b1, I will not experience any form of NJ Exec Order 26.4b1 n through review date. The CP interventions included, NJ Exec visits with me from all departments as needed, Initiated NJ Exec Order 26.4b1. Assess me for s/s [signs and symptoms] of NJ Exec Order) and report to appropriate resources, Initiated NJ Exec Order 26.4b1. I was in the and I accidentally NJ Exec Order 26.4b1 through the NJ Exec Order 26.4b1 and I NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 for three days, NJ Exec Order 26.4b1 for three days, NJ Exec Order 26.4b1 consult, Initiated NJ Exec Order 26.4b1. Investigate all allegations of NJ Exec Order 26.4b1 promptly, Initiated 04/19/24. My bathroom door has a sign to remind me which door to go back out through, Initiated 06/28/24. Place bigger sign on door with resident's name, Initiated 06/03/24. Please redirect me to an activity or distraction if you see me NJ Exec Order 26.4b1 Initiated NJ Exec Order 26.4b1

Further review of Resident #84's Medical Record

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revealed the following progress note entries:

- NJ Exec Order 26.4b1 timed 06:53:41 AM, Resident # 84 watching Television at HS [Hour of Sleep] and rearranging wall poster, nursing monitoring throughout the shift, resident emerged approximately at 5:00 AM, and began NJ Exec . The resident stated they were looking for the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to other resident's rooms. The resident was escorted away by staff, nursing continuing to monitor will endorse to day shift.

- NJ Exec Order 26.4b1 at 22:49:00 [10:49 PM], Resident was NJ Exec Order 26.4b1 both units all shift. Resident can be hard to redirect. Nursing attempted to offer NJ Exec Order 26.4b1 - resident NJ Exec Order 26.4b1 Resident was noted with NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 places again the resident was not easily redirected. NJ Exec Order 26.4b1 is in place and functioning.

- A nursing note created NJ Exec Order 26.4b1 timed 19:32:19 [7:32 PM] indicated the following: Resident continues to NJ Exec Order 26 around the facility into other residents rooms and was noted on more then one occasion leaving their cell phone unattended. Cell phone was placed in safe at reception for safe keeping.

- NJ Exec Order 26.4b1 at 14:58 [2:58 PM] Daily Skilled Documentation revealed the following: Received Resident walking around the unit. Resident NJ Exec Order 26.4b1 around attempting to walk into other residents' rooms, able to be redirected. Resident denies NJ Exec Order 26.4b1.

- A nursing note dated NJ Exec Order 26.4b1 at 06:54:17 revealed the following documentation: Resident up at 1:00 AM, going in and out of their room. At

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this time, the resident went into Room [redacted] and before we could get to the room, the resident was [redacted] in two laundry baskets. The resident was immediately redirected back to their room, they continued to go in and out of other resident rooms and up and down the halls for the rest of the night. Unable to redirect. No further behaviors noted.

- On [redacted] at 07:02:43 the following documentation was entered: Resident was up most of the night walking the halls and [redacted]. The resident was going into other resident's rooms and going behind the nurses' station. The resident needed redirection and [redacted] most of the night which was ineffective for this resident. The resident was monitored and redirected all shift.

- [redacted] timed 22:11:51 [10:11 PM] this note revealed: The resident pacing up and down hallways, difficult to redirect. Observed eating their dinner while standing and pacing around the nurse's station. Unable to sit for any length of time. Took medication without difficulty. Staff gave resident a [redacted] and [redacted]. Resident was observed going into other resident's rooms and [redacted]. Difficult to redirect resident from [redacted].

- Another entry with an effective Date of [redacted] at 12:55:00 PM, documented an incident dated [redacted] timed 20:22:20 PM [8:22 PM]: [Resident #79] seen another resident referring to [Resident #84], leaving their room, [Resident #79] said "What were you doing in my room? [redacted] nurse [redacted] the

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situation, reassured [Resident #79] that [US FOIA (b) (6)] from their room, [Resident #79] then proceeded to walk off towards the vending machine.

- [NJ Exec Order 26.4b1] timed 13:56 PM [1:56 PM], the nurse's notes revealed the following entry: alerted by staff, another Resident #152 [NJ Exec Order 26] [Resident #84] out of their room. Attempted to [NJ Exec Order 26.4b1] [NJ Exec Order] was called for assistance. [NJ Exec Order 26.4b1] assessment completed with [NJ Exec Order 26.4b1] noted. MD [medical doctor] and family notified of incident. Resident #152 was sent to NJ Exec Order 26.4b1. The above note was entered in the EMR on [NJ Exec Order 26.4b1] at 12:27:23 PM.

- [NJ Exec Order 2] timed 12:27 PM, a nurse's note revealed that Resident #152 [NJ Exec Order 26.4] Resident #84 causing Resident #84 [NJ Exec Order]. Further review of the progress note revealed, "notified by staff, resident [NJ Exec Order 26.4b1] ...."[Resident #84] stated Resident #152 [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] assessment completed and [NJ Exec Order 26.4b1] noted. [NJ Exec Order 26.4b1] . [NJ Exec Order 26.4b1] I checks (assessment of [NJ Exec Order 26.4b1] and [NJ Exec Order] , to determine if the [NJ Exec Order 26.4b1] is [NJ Exec Order 26.4b1] wnl [within normal limit] and [NJ Exec Order] initiated ...

- The skilled nurses note dated [NJ Exec Order 26.4b1] 06:36:46 revealed: [Resident #84] was [NJ Exec Order 26.4b1] at 12:00 AM. The resident became [NJ Exec Order 26.4b1] with aide and [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4] This AM [morning], the resident was going in and out of room [NJ Exec] going through room [NJ Exec] [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1. Redirection only effective at times, resident is NJ Exec Order 26.4b1 needing to be [NJ Exec Order 26.4b1]

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redirected.

- This nursing entry created on NJ Exec Order 26.4b1 at 13:41:01 PM, indicated: [Resident #84] observed walking in other residents' rooms and needs to be redirected.

The U.S. FOIA (b)(6) documented a progress note on NJ Exec Order 26.4, that reflected the U.S. FOIA (b)(6) that occurred on NJ Exec Order 26.4b1 at 6:30 AM: "Notified by staff that [Resident #84] entered Room NJ Exec through a NJ Exec Order 26.4b1 door and [Resident #94's NJ Exec Ord [Resident # 94] told [Resident #84] to leave. [Resident #84] left immediately via NJ Exec Order 26.4b1 [Resident #84] was brought to nurse's station, NJ Exec Order 26.4b assessment completed with NJ Exec Order 26.4b1 noted. MD [Medical Doctor] and NJ Exec made aware of incident.

The progress notes written by the U.S. FOIA (b)(6 did not include [Resident #94's] statement, in the presence of the U.S. FOI and two surveyors, that they were NJ Exec Order 26.4b1 in their NJ Exec Order 26.4b1 The U.S. FOIA (b) informed the surveyor that she arrived at 6:30 AM, and interviewed [Resident # 94]. The U.S. FOIA (b) did not address the statements made by Resident #94 to the U.S. FOI or the U.S. FOIA (b). The facility did not implement any interventions to NJ Exec Order 26 other residents from Resident #84 from NJ Exec Order 26.4 through NJ Exec Order .

On 07/01/24 at 8:30 AM, the surveyor interviewed the U.S. FOIA who worked the 11:00 PM to 7:00 AM shift on the unit when Resident #94 reported the NJ Exec Order 26.4b1 . The U.S. FOIA stated that she was told that Resident #84 NJ Exec Order 26.4b1 into Resident #94's room and NJ Exec Order 26.4 . She documented the incident in the

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EMR. The [redacted] stated that she was not aware of Resident #84's [redacted] behavior.

On 07/01/24 at 10:10 AM, the [redacted] provided an investigation summary (IS), dated [redacted]. The [redacted] confirmed the IS was completed and all of the investigative documents were attached. The IS revealed that on [redacted] at 6:30 AM, Resident #94 reported to the staff that Resident #84 [redacted]. The [redacted] then informed the survey team that the incident was reported to the Department of Health (DOH). The surveyor in the presence of the survey team reviewed the IS together with the [redacted]. At that time, the surveyor informed the [redacted], that Resident #94 reported the [redacted] on [redacted] at 7:30 AM to the [redacted] with the surveyor present. Further review of the IS revealed there was no statement from the [redacted] included with the investigation. The event documented in the IS by the [redacted] did not reflect the statement made by Resident #94 on [redacted] at 7:30 AM. The IS did not include a statement from the resident's [redacted] assessed by the facility as [redacted] with a BIMS of [redacted] who confirmed that Resident #84 had been [redacted] into their room [redacted]. The facility confirmed they did not interview the [redacted]

Review of the IS conclusion indicated that Resident #84 was [redacted], [redacted] assessment done, there was [redacted]. There was no plan put into place to prevent Resident #84 from continuing to [redacted] into other resident rooms and [redacted] Resident #84 from other residents.

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F 600	Continued From page 18 On 07/01/24 at 1:00 PM, during an interview with the [redacted] regarding the NJ Exec Order 26.4b1 she informed the survey team that she had been [redacted] at the facility for about [redacted], and she identified Resident #84 as a [redacted]. The surveyor then asked about the process that should have been in place to prevent Resident #84 from being [redacted] by others and to [redacted] by Resdient #84 to other residents. The [redacted] stated that she was aware that Resident #84 [redacted] in the hallway, and the plan was to redirect the resident by placing signage at the door and in the bedroom, and remove from location. The [redacted] stated that Resident #84 was [redacted] and "just walked in the hallway." The [redacted] also stated that she was not made aware of any NJ Exec Order 26.4b1 into other resident rooms and [redacted] in other resident rooms. If she had been made aware, she stated she would have asked for a [redacted] evaluation, NJ Exec Order 26.4b1 to rule out [redacted]. The [redacted] stated that the 11:00 PM-7:00 AM staff did not report any behavioral concerns for Resident #84. On 07/01/24 at 1:13 PM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding Resident #84's activity schedule. The [redacted] informed the surveyor that she did not have a schedule for Resident #84. The [redacted] added that Resident #84 would [redacted] and would [redacted] activity. She further stated that she had informed the nursing department in the morning meeting. On 07/01/24 at 1:35 PM, the surveyor observed an unidentified staff member at the entrance door	F 600		

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leading to Resident #84's room. Upon inquiry, the staff member informed the surveyor that she was asked to be at the door for a NJ Exec Order 26.4b1. The staff member could not indicate what behavior she was to monitor and where the behavior would be documented.

On 07/01/24 at 2:15 PM, the survey team asked for the 1:1 observation policy. The U.S. FOIA (b)(6) informed the survey team that the facility did not have a 1:1 policy.

On 07/01/24 at 3:00 PM, the U.S. FOIA (b)(6) indicated that he was not aware of all the details of the incident that occurred on NJ Exec Order 26.4b1. He stated he was told that Resident #84 NJ Exec Order 26.4b1 Resident #94 NJ Exec O.

On 07/02/24 at 9:02 AM, the surveyor observed Resident #84 in bed. A NJ Exec Order 26.4b1 was noted at the bedside. The surveyor interviewed the NJ Exec Order 26.4b1 who revealed that he came in at 7:00 AM and did not get report from the 11-7 staff. The NJ Exec Order 26.4b1 stated he was informed that an NJ Exec Order 26.4b1.

On 07/02/24 at 9:15 AM, the surveyor interviewed the U.S. FOI who revealed that he was not made aware of the NJ Exec Order 26.4b1. The U.S. FOI added, "If I had known, I will report to the administrative staff, implement NJ Exec Order procedure, investigate, implement NJ Exec, ensure all residents were safe". When asked if the U.S. FOIA had received education on reporting NJ Exec Order 2 the U.S. FOI stated, "I believe the staff had been educated on NJ Exec Order 26.4. A review of the U.S. FOIA file revealed that she had received education on NJ Exec Order 2. The surveyor then inquired regarding the NJ Exec Order 26.4b1 behavior documented in the EMR of Resident #84. The U.S. FOI stated that he

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F 600	Continued From page 20 was not aware that Resident #84 [redacted] into other residents' rooms. He was aware that Resident #84 [redacted] in the hallway. On 07/03/24 at 11:45 AM, the surveyor interviewed the LPN who wrote the progress notes dated [redacted]. The [redacted] confirmed Resident #84 [redacted] into other resident's rooms. When asked about Resident #84's [redacted], the [redacted] stated that Resident#84 would [redacted] rather than using a [redacted] or the [redacted]	F 600		
F 609 SS=D	NJAC 8:39 - 4.1 (a)(5) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		8/14/24

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F 609	Continued From page 21 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure they reported to the Department of Health (DOH) as required, a resident who was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, identified as being NJ Exec Order 26.4b1, and who NJ Exec Order 26.4b1 This deficient practice occurred for 1 of 9 residents reviewed for accidents (Resident #87) and was evidenced by the following: On 07/02/24 at 12:00 PM, the surveyor reviewed the electronic medical record for a resident NJ Exec Order 26.4b1, Resident #87. A Nurses Progress Note, created by a U.S. FOIA (b)(6) on NJ Exec Order 26.4b1 at 21:48 [8:21 PM] revealed Informed by an aide that the resident hadNJ Exec Order 26.4b1 and primary nurse and aide was with the resident. The nurse remained with the resident while staff brought the wheelchair out and brought the resident back in. U.S. FOIA (b)(6)) informed of incident. NJ Exec Order 26.4b1 still intact and functioning. On 07/02/24 at 1:15 PM, the surveyor asked the U.S. FOIA (b) if a resident NJ Exec Order 26.4b1. The U.S. FOIA (b) confirmed that Resident #87 NJ Exec Order 26.4b and NJ Exec Order 26.4b1 and it was witnessed by a nurse and aide. The U.S. FOIA (b) stated she completed an incident report and the surveyor requested a	F 609	1. Resident 84 was evaluated by a licensed nurse on NJ Exec Order 26.4b1 and had NJ Ex noted. 2. The facility reviewed the incidents in the center from 7/29/24 through 8/6/24 to ensure that if any met the requirements of a reportable event, that they were reported accordingly. No events were identified. 3. The Nursing Home Administrator or Director of Nursing will audit the incidents in the facility to ensure that if they meet the requirement of a reportable event, that the incident is reported accordingly. The Nursing Home Administrator will in-service all staff on the requirements for what constitutes a reportable event. New hires and agency staff will receive the in-servicing in orientation. 4. The Nursing Home Administrator or Director of Nursing will audit the incidents in the facility to ensure that if they meet the requirement of a reportable event, that the incident is reported accordingly. The audits will be conducted weekly for four	

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F 609	Continued From page 22 copy. The surveyor asked the [redacted] if the [redacted] was reported to the DOH. The [redacted] stated, no, "only US FOIA (b) (6) On 07/02/24 at 1:29 PM, the surveyor conducted an interview with the Unsampled Resident (UR) [redacted] of Resident #87 regarding the incident. The UR stated Resident #87 [redacted] and that the Certified Nuse Aide was in the room and then went out of the [redacted] after Resident #87 exited. On 07/02/24 at 2:30 the [redacted] provided statements regarding the incident which revealed "[redacted]. Alerted the aide and immediately followed out. Brought patient back. Dated [redacted] (untitled staff). Another statement, with Incident date: [redacted], Incident Time: 9:15 PM, revealed this nurse was coming down the hall when aide informed me that Resident #87 had [redacted] and nurse with resident outside ... The Incident Report dated [redacted] revealed that on [redacted] at approximately 9:15 PM, the assigned nurse for Resident #87 observed the resident [redacted] and the nurse followed outside of the [redacted] A review of Resident #87's electronic medical record revealed that the Admission Summary indicated, but was not limited to, the following diagnoses; [redacted]. An informed consent for use of a [redacted] (a [redacted] when a	F 609	weeks, then bi-weekly for four weeks, and then monthly for one month. The findings of that audits will be reviewed at the monthly QAPI meetings x three months.	

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F 609	Continued From page 23 resident NJ Exec Order 26.4b1), dated NJ Exec Order 26.4 revealed what assessed medical symptoms would be addressed by use of this NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ; What are the benefits of using a NJ Exec Order 26.4b1 for this resident and what is the likelihood of these benefits: Safety of the resident to prevent NJ Exec Order 26.4b1 outside of the facility. On 07/08/24 at 12:16 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the resident who NJ Exec Order 26.4b1 . The U.S. FOI stated there were brackets that prevented the window from opening all the way. The U.S. FOI stated Resident #87 'NJ Exec Order 26.4b1" that the screws were pulled out. On 07/08/24 at 3:10 PM, the U.S. FOIA (b)(6) responded to the surveyor concerns regarding Resident #87 NJ Exec Order 26.4b1 and the U.S. FOIA (b)(6) and stated we did not think it met the reportable requirement, "it was an anomaly."	F 609		
F 610 SS=H	NJSA 8:39-5.1(a) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		8/14/24

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F 610	Continued From page 24 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #s NJ 163250, NJ 170219 Based on observation, interview, record review and review of other pertinent documents, it was determined that the facility failed to ensure a thorough and complete investigation was completed to determine the causal factor of NJ Exec Order 26.4b1 to ensure that resident NJ Exec Order 26.4b1 had not occurred for: a) a resident (Resident #150) who was found on [redacted], with an NJ Exec Order 26.4b1 that required hospitalization on NJ Exec Order 26.4b1, and was diagnosed with NJ Exec Order 26.4b1 and again observed during routine NJ Exec Order 2 rounds on NJ Exec Order 26.4b1 with NJ Exec Order 26.4b [redacted] and required transfer to the hospital on the same day, and was diagnosed with a NJ Exec Order 26.4b1 [redacted] by Resident #94 that was reported to the U.S. FOIA (b)(6) [redacted], the facility did not investigate the allegation until NJ Exec Order 26.4 c) and for a resident who had a history of being NJ Exec Order 26.4b1 [redacted] reported new NJ Exec Order 26.4b1 [redacted] This deficient practice occurred for 3 of 3 residents reviewed for NJ Exec Order 2 (Resident # 81 and #150, Resident #94).	F 610	1. Resident number 150 no longer resides in the facility. Resident number 94 had a NJ Exec Order 26.4b1 check completed by the Director of nursing on NJ Exec Order 26.4b1 at 7am. It was NJ Exec Order 26.4b1 Resident number 94 had a NJ Exec Order 26.4b1 check completed on NJ Exec Order 26.4b1. All NJ Exec O checks were NJ Exec Order 26.4b1 and showed NJ Exec Order 26.4b1. Resident 81 was evaluated by the nurse on NJ Exec Order 2 when they NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. The evaluation showed NJ Exec Order 26.4b1. The evaluation showed NJ Exec Order 26.4b1. The Nurse Practitioner was made aware of the NJ Exec O and ordered a NJ Exec Order 26.4b1 that resulted on NJ Exec Order 2. The Nurse Practitioner evaluated resident 81 on NJ Exec Order 26.4b1. The NJ Exec Order 2 [redacted]. A repeat [redacted] On NJ Exec Order 26 the resident had an NJ Exec Order 26.4b1 that showed a NJ Exec Order 26.4b1 U.S. FOIA (b)(6) [redacted]. The facility reported the NJ Exec Order 26.4 as a NJ Exec Order 26.4b1 and began the	

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F 610	Continued From page 25 The deficient practice was as follows: Refer to F600K, F686G A) On 6/28/24, the surveyor reviewed the closed electronic medical record (EMR) for Resident #150. Review of the closed record revealed that Resident #150 was admitted to the facility with diagnoses which included but were not limited to; [redacted] According to the Annual Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #150 was identified as having [redacted]. Resident #150 scored [redacted] on the Brief Interview for Mental Status (BIMS). Resident #150 was [redacted] on staff for all Activities of Daily Living (ADLs). On 07/02/24 at 11:30 AM, the surveyor reviewed all progress notes which revealed a [redacted] nurse's [redacted] note indicating that Resident #150 had a [redacted] at the facility on the [redacted]. Interventions implemented for the [redacted] were [redacted] and [redacted]. The [redacted] and the facility did not document anything regarding the [redacted] condition in the EMR. There was no documentation in the EMR that indicated the physician was made aware of the condition of the [redacted]. Review of the Order Summary Report dated	F 610	investigation. 2. All residents have the potential to be affected. 3. The Nursing Home Administrator or Director of Nursing completed audit on residents with new changes using the 24 hour summary tool in the electronical medical system to ensure that an investigation is initiated immediately at the time of the acute change or alteration in condition. The Nursing Home Administrator or Director of Nursing completed audit on residents with new changes using the 24 hour summary tool in the electronical medical system to ensure that acute changes or alteration in conditions are documented immediately. The Nursing Home Administrator or Director of Nursing completed audit on residents with wounds to ensure they have preventative measures in place, to ensure they have documentation on the status of their wound, and to ensure that any changes in wound status are communicated to the physician and documented. The Nursing Home Administrator or Director of Nursing completed audit on residents with wandering behaviors by direct observation, resident interviews, staff interviews to ensure that residents who have the potential to wander into other residents' rooms have effective	

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F 610	Continued From page 26 NJ Exec Order 26.4, reflected an order dated NJ Exec Order 26.4b, to cleanse the NJ Exec Order 26 of the NJ Exec Order 26.4b1 every day shift for NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 had an order, dated NJ Exec Order 26.4b, to NJ Exec Order 26.4b1, do not NJ Exec Orde pat dry, NJ Exec Order 26.4b1 The staff initialed the Treatment Administraation Record (TAR) from NJ Exec Order 26.4b1 indicating that the NJ Exec Order 26 care was completed as ordered. On NJ Exec Order 26.4b1, at 21:15 [9:15 PM] Discharge Summary (NJ days later0, for a Date of Discharge from the facility on NJ Exec Order 26.4b1 revealed Resident #150 "...NJ Exec Order 26.4b1 Recommend patient be sent to hospital for possible NJ Exec Order 26.4b1" According to nursing notes, patient was admitted for NJ Exec Order 2 The Hospital record for Resident #150 for the NJ Exec Order 26.4b1 Admission which began on NJ Exec Order 26.4b1 was obtained by the Department of Health (DOH) and revealed: Emergency Department (ED) Provider Note dated NJ Exec Order 26.4b1 revealed:	F 610	interventions in place to prevent them from wandering into other residents' rooms and that abuse has not occurred. The Nursing Home Administrator or Director of Nursing completed audit on residents with injuries of unknown origin to ensure they have been thoroughly investigated to rule out abuse and neglect and identify the cause of the unknown origin. The Nursing Home Administrator or Director of Nursing completed in-servicing all staff on prompt initiation and documentation of investigation of residents with new changes or alterations in condition, ensuring residents with wounds have preventative measures in place, ensuring wound status documentation is in place, ensuring wound changes are communicated to the physician, ensuring that residents who have the potential to wander into other residents' rooms have effective interventions in place to prevent them from wandering into other residents' rooms, and thoroughly investigating injuries of unknown origin. New hires and agency staff will receive the in-servicing in orientation. 4. The Nursing Home Administrator or Director of Nursing completed audit on residents with new changes or alterations in condition using the 24 Hour Summary in the electronic medical system to ensure that an investigation is initiated at the time of the acute change or alteration in	

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F 610	Continued From page 27 -Initial Complaint: Patient presents with NJ Exec Order 26.4b1 coming from NJ Exec Order 26.4b1 [redacted] ... Past medical history of NJ Exec Order 26.4b1 currently living in a nursing home with NJ Exec Order 26.4b1 patient with know NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]. History and physical completed at the hospital upon NJ Exec Order 26.4b1 revealed the following: History of NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 [redacted] who presents from a Long Term Care Facility (name redacted) due to NJ Exec Order 26.4b1 [redacted]. Resident #150 was diagnosed with NJ Exec Order 26.4b1. The surveyor reviewed the facility Progress notes from NJ Exec Order 26.4b1 and was unable to locate any documentation regarding the NJ Exec Order 2 assessment entered by facility staff. Documentation regarding the NJ Exec Order 2 was entered every Tuesday by the NJ Exec Order 2 care team only. The hospital documentation revealed on NJ Exec Order 26.4b1, regarding the NJ Exec Order 2 prior to discharge back to the facility on NJ Exec Order 26.4b1. U.S. FOIA (b)(6) [redacted]: Active present on admission. NJ Exec Order 2 description NJ Exec Order 26.4b1 [redacted].	F 610	condition. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months. The Nursing Home Administrator or Director of Nursing completed audit on residents with wounds to ensure they have preventative measures in place, to ensure they have documentation on the status of their wound, and to ensure that any changes in wounds are communicated to the physician and documented. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months. The Nursing Home Administrator or Director of Nursing completed audit on residents with wandering behaviors by direct observation, resident interviews, staff interviews to ensure that residents who have the potential to wander into other residents" rooms have effective interventions in place to prevent them from wandering into other residents' rooms and that abuse has not occurred. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months. The Nursing Home Administrator or	

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F 610	Continued From page 28 NJ Exec Order 26.4b1 [redacted].	F 610	Director of Nursing completed audis on residents with injuries of unknown origin to ensure they have been thoroughly investigated to rule out abuse and neglect and identify the cause of the injury by using the reportable event checklist tool for injuries of unknown origin. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

The readmission History and Physical entered in the EMR by the facility physician on NJ Exec Order 26.4b1 indicated the following: "Resident #150 was readmitted to LTC (Long Term Care Facility) after an acute hospitalization after presenting with NJ Exec O NJ Exec Order 26.4b1. Imaging revealed NJ Exec Order 26.4b1 Resident #150 was started on an NJ Exec Order 26.4b1 which Resident #150 will complete on NJ Exec Order 26.4b1 Resident #150 was transferred back to the LTC facility in NJ Exec Order ".

On 06/28/24 at 10:30 AM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding the process for Resident #150's NJ Exec Order 4 care as the resident was on the U.S. FOIA (b unit. The U.S. FOIA stated that all preventative measures would be in place and daily rounds would also be completed to ensure preventative measures were in place. The surveyor asked about documentation related to Resident #150's NJ Exec Order 4 and the U.S. FOI confirmed there was no narrative documentation completed to monitor NJ Exec Order 4 care and the staff would be responsible for initiating the treatment when it was applied to the NJ Exec Order 4. The U.S. FOI had no additional information to provide.

On 7/8/24 at 1:00 PM, the surveyor interviewed the NJ Exec Order 4 care U.S. FOIA (b)(6)) via telephone who stated that during NJ Exec Order 4 rounds she observed that the U.S. FOIA (b)(6) had a U.S. FOIA (b)(6) of NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 which was not documented or communicated to the NJ Exec Order 26 team. Subsequenty, the US FOI stated Resident #150 was then transferred to the hospital on NJ Exec Order 26.4 and diagnosed with NJ Exec Order 26.4b1). Resident #150 was treated wit NJ Exec Order 26.4b1 Resident #150 returned to the facility on NJ Exec Order 26.4.

On 07/08/24 at 1:10 PM, the U.S. FOIA (b)(6) was interviewed regarding what were the expectations for NJ Exec Order 26 care documentation for Resident #150. The U.S. FOIA (b) stated upon review of Resident #150, she had not been working at the facility and there was no documentation for the NJ Exec Order 2 other than what was already provided to the surveyor.

- A Nursing Documentation Progress Note entered as a "Late entry", dated NJ Exec Order 26.4b1 timed 06:12 and signed by a U.S. FOIA (b)(6) revealed NJ Exec Order 26.4b1, Resident #150 is displaying the following signs and symptoms of NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 with ADL's, NJ Exec O Resident #150 has an NJ Exec Order 26.4b1 . There is NJ Exec O There is NJ Exec Order 26.4 .

There was no documented evidence that the above findings were communicated to the physician or the NJ Exec Order 26.4b1 team prior to NJ Exec Order 26.4b1

On NJ Exec Order 26.4b1 again during NJ Exec Order2 rounds, the NJ Exec Order 26.4b1 U.S. FOIA (b)(6) identified, and

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documented, that Resident #150 required hospitalization because when she removed the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Resident #150 was transferred to the hospital and diagnosed with U.S. FOIA (b)(6).
The facility provided an incident report dated NJ Exec Order 26.4b1 with the following:
Nursing description: Noted during NJ Exec Order 26.4b1.
Due to NJ Exec Order 26.4b1 order obtained to send Resident #150 to hospital for evaluation.
Immediate action taken: Assessed by NJ Exec Order 2 care team
Obtain order to send to Emergency Room
Notify responsible party of changes.

A note from the Interdisciplinary Care Team dated NJ Exec Order 26.4b1 timed 8:09 AM, relayed the following:
Met to discuss recent NJ Exec Order 26.4b1 observed during NJ Exec Order 26.4b1. Resident currently on NJ Exec Order 26.4b1.
Turns for NJ Exec Order 26.4b1.
New Interventions to include sent to hospital.

The surveyor reviewed the hospital record from the hospitalization of NJ Exec Order 26.4b1, and the following were noted:

-Comments: NJ Exec Order 26.4b1 " ...

-A NJ Exec Order 26.4b1 Hospital NJ Exec Order 26.4b1 report revealed NJ Exec Order 26.4b1 ", additional clinical notes revealed, "now presents NJ Exec Orde from the skilled nursing facility because of NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 per hospital follow up with the facility the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and the facility had no documentation regarding NJ Exec Order 26.4b1 and found during weekly NJ Exec Order 26.4b1 for "a NJ Exec Order 26.4b1 "

On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the U.S. FOIA (b) regarding an investigation about the NJ Exec Order 26.4b1 development and related to NJ Exec Order 26.4b1. The U.S. FOIA (b) stated she was not at the facility and that there was nothing else to provide.

On 07/08/23 at 9:30 AM, during a telephone interview with the Resident #150's Representative (RR), she confirmed that Resident #150's NJ Exec Order 26.4b1, Resident #150 had an NJ Exec Order 26.4b1 was transferred to another LTC for aftercare. The RR also stated that she was not informed of any changes in the NJ Exec Order 26.4b1 or any NJ Exec Order 26.4b1

On 07/08/24 at 1:30 PM, the surveyor interviewed the physician in charge of the resident care at the LTC. The physician informed the surveyor that he was aware that Resident #150 having a NJ Exec Order 26.4b1. The physician stated he not informed that Resident #150's NJ Exec Order 26.4b1, nor that Resident #150 sustained any NJ Exec Order 26.4b1 at the facility prior to being informed by the hospital that Resident #150 was admitted NJ Exec Order 26.4b1

B) On 6/28/24 at 7:30 AM, the surveyor entered Resident #94's room to observe the Medication Pass Administration with the U.S. FOIA (b)(6) The Nurse checked the resident's NJ Exec Order 26.4b1 where the NJ Exec Order 26.4b1 device was to read the

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NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4 and informed the U.S. FOIA that another resident NJ Exec Order 26.4b1 in their room while they were sleeping, NJ Exec Order 26.4b1 [redacted]. Resident #94 identified the NJ Exec Order 26.4b1 as Resident #84 who NJ Exec Order 26.4b1. The NJ Exec O was about to exit the room, the surveyor asked the U.S. FOIA (b if she heard Resident #94's concerns. The U.S. FOIA (b confirmed that she heard Resident #94's concerns and stated, "Management was already made aware."

The surveyor continued with the Medication Administration and observed Resident #84 in the hallway near their room.

On 6/28/24 at 10:30 AM, the surveyor returned to the NJ Exec Orde hallway and observed Resident #94 in bed. Resident #84 was observed in their room.

On 6/28/24 at 12:15 PM, the surveyor reviewed Resident #94's electronic medical record (EMR) and noted that the incident regarding the NJ Exec Order 26. [redacted] was not documented. The U.S. FOIA (b informed the survey team she came in at 6:30 AM and started the investigation, there was no documentation in the clinical record regarding the U.S. FOIA (b)(6)

On 07/01/24 at 8:30 AM, the surveyor requested the investigation for the incident of NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) informed the surveyor that the allegation was reported to the New Jersey Department of Health (DOH).

On 07/01/24 at 10:10 AM, the U.S. FOIA (b provided the investigation. The surveyor reviewed the investigation with the U.S. FOIA (b and noted the U.S. FOIA (b)(

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

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statement was not included. The investigation did not reflect Resident #94's statement made on 6/28/24 at 7:30 AM, in the presence of the surveyor. The surveyor again asked the [redacted] for the [redacted] statement which was not included in the investigation. The [redacted] stated that she would provide the statement later.

On 07/01/24 at 10:30 AM, a follow-up interview in the presence of two surveyors was conducted with the [redacted] confirmed that Resident #94 reported [redacted]. She stated that Resident #94 reported that Resident #84 [redacted] in a [redacted] The [redacted] added that was Resident #84's perception.

On 07/01/24 at 12:30 PM, the survey team met with the [redacted] and requested the investigation for the [redacted] reported to the [redacted]. Both indicated that they were not aware of the [redacted]. The [redacted] stated that she was only made aware that Resident #84 [redacted] Resident #94's [redacted] She reported to the facility at [redacted], and started the investigation.

A note entered by the [redacted]) on [redacted] at 6:35 PM, revealed that the [redacted] met with Resident #94, and Resident #94 was able to explain what had happened. There was no documentation regarding being [redacted].

On 07/01/24 at 1:27 PM, the surveyor interviewed the [redacted] again regarding the [redacted] by Resident #94. The surveyor, in the presence of the survey team, asked if the [redacted] was aware. The [redacted] stated, "just now, she was

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made aware of it". The surveyor asked if the [U.S. FOI] spoke with the nurse who heard the allegation and the [U.S. FOI] stated she was not told about the nurse who overheard the allegation of NJ Exec Order 26.4b1 unit today. The surveyor asked if the [U.S. FOI] interviewed Resident #94 and she stated, "not yet." The surveyor asked if the allegation was considered [NJ Exec Order] and the [U.S. FOI] stated, "it is [NJ Exec Order 2] and the surveyor asked why? The [NJ Exec] stated, "if somebody NJ Exec Order 26.4b1 without your [NJ Exec Order 26.4b1] that is [NJ Exec Order 2] and stated, there are many types of [NJ Exec Order 2] and confirmed that Resident #84 [NJ Exec Order 26.4b1]

On 7/01/24 at 1:30 PM, the surveyor reviewed the facility's policy on abuse, neglect and misappropriation.

Under Reporting/ Response:
The facility will have written procedure that include:
Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement applicable) within specified timeframe:
a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or
b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

Assuring that reporters are free from retaliation or reprisal;
Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who

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reports a suspicion of a crime., This facility will post a conspicuous notice of employee rights including the right to file a complaint with the State Survey Agency if the employee believe the facility has retaliated against him/her for reporting a suspected crime and how to file a complaint.

The administrator will follow up with government agencies during business hours, to confirm the initial report was received, and to report results of the investigation when final within 5 working days of the incident, as required by state agencies.

C) A Reportable Event Record/Report (RER) was received by the Department of Health (DOH) on NJ Exec Order 26.4b1 regarding Resident #81 which revealed: Date of Event: NJ Exec Order 26.4b1 [redacted] Resident does ambulate NJ Exec Order 26.4b1 at times in room. Resident has a Dx. (diagnosis) NJ Exec Order 26.4b1 [redacted] 3. Resident was assessed for NJ Exec Order 26.4b1 and no NJ Exec Order 26.4b1 were noted. NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1) has been ordered for the site. Statements are being collected from staff from the past 72 hours.

On 06/27/24 at 1:01 PM, Resident #81 observed in a recliner chair in the room.

On 07/01/24 at 8:54 AM, the surveyor reviewed the requested completed investigation and supporting documents related to the RER for

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Resident #81 that were provided by the US FOIA (b) (6) [redacted]. The U.S. FOIA (b) confirmed the documents provided were all the documents that were part of the the completed investigation for the RER.

A review of Resident #81's electronic medical record revealed:

- The Quarterly Minimum Data set, dated NJ Exec Order 26.4b1, revealed that the function status section indicated Resident #81 required NJ Exec Order 26.4b1 of one staff for NJ Exec Order 26.4b1 [redacted].

-A Nursing Quarterly Evaluation, Effective NJ Exec Order 26.4b1, documented by a NJ Exec Order 26.4b1 [redacted] was checked; Skin condition #4, a. Skin is NJ Exec Order Activity: Degree of Physical Activity, NJ Exec Order 26.4b1 [redacted] during day, but for v NJ Exec Order 26.4b1 [redacted] with or without assistance. Spends majority of each shift in NJ Exec Order 26.4b1.

The NJ Exec Or Evaluation revealed:
A. Evaluation
1. Manner of expressing NJ Exec Ord
a. NJ Exec Order
2. Ask resident: "Have you had NJ Exec Order 26.4b1 at any time in the last 5 days?"
0. "NJ Exec
3. Ask resident: "How much of the time have you experienced NJ Exec Order 26.4b1 over the last 5 days?"
9. NJ Exec Order 26.4b1
4. Ask resident: "Over the past 5 days, has NJ Exec O made it NJ Exec Order 26.4b1 [redacted] ?"
0. "NJ Exec
5. Ask resident: " Over the past 5 days, have you

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NJ Exec Order 26.4b1 because of NJ Exec Order 0. NJ Exec 11. NJ Exec O is Rated by:
a. Numeric Rating Scale
11a. Numeric Rating Scale (00-10) Ask resident: "Please rate your NJ Exec Order 26.4b1 over the last 5 days on a zero to ten scale, with zero being NJ Exec Order 26 and ten as the NJ Exec Order 26.4b1 " (Show resident 00-10 pain scale). Enter two-digit response.
Enter 99 if unable to answer.
NJ E

NJ Exec Order 26.4b1 08:58 Nursing Evaluation Note (Structured Progress Note) Late Entry, The resident is NJ Exec Order 26.4b1. The resident is NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. The resident NJ Exec Order 26.4b1. The resident is NJ Exec Order 26.4b during care. The resident is NJ Exec Order 26.4b1. The resident takes NJ Exec Order 26.4b1 medication. The resident has no evidence of . Fall Risk Score: NJ Exec O
Fall Risk Category: NJ Exec Order 26.4b1 for Fall

NJ Exec Order 26.4b1 11:56 Nursing Late Entry: Note Text: Resident was noted in AM (morning) with NJ Exec Order 26.4b1 Resident was having difficulty Nursing examined resident she was noted with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was seen. Nursing informed Family, [Doctor], US FOIA (b) (6)]. Order placed for NJ Exec Order 26.4b1 However, resident was still having NJ Exec Or Resident family did not want sent to ER for NJ Exec Order 26.4b1. Follow up NJ Exec Order 2 ordered for the AM. PRN NJ Exec O medication administered.

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A [redacted] 07:05, Nursing Note Text: 11 to 7 skilled nurses note: resident was in [their] chair resting at beginning of shift, able to assist resident to [redacted] with some [redacted], resident favoring [redacted], they slept through most of the night with occasional [redacted], we were able to perform morning care and able to get resident into [redacted], also resident allowed me to apply [redacted]. will continue to monitor

4/6/2023 14:21 INTERACT SBAR (Situation, Background, Assessment, Summary- utilized with change in condition), Summary for Providers
Situation: The Change In Condition/s reported on this CIC Evaluation are/were: [redacted]
Resident/Patient is in the facility for: [redacted]
Primary Diagnosis is: [redacted]
Relevant medical history is: [redacted]
Resident/Patient had the following medications changes in the past week:
Outcomes of Physical Assessment: [redacted] eported on the resident/patient evaluation for this change in condition were:
- Functional Status Evaluation: [redacted] with ADLs [redacted]

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- Skin Status Evaluation: NJ Exec Order 26.4b1
- Pain Status Evaluation: Does the resident/patient have pain? NJ Exec
Nursing observations, evaluation, and recommendations are: Resident was noted on NJ Exec Order 2 with NJ Exec Order 26.4b1, no NJ Exec Order 26.4b1 seen at this time. On NJ Exec Order Resident was noted with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Family does not want resident to be sent out to ER (Emergency Room) at this time. Continue to NJ Exec Order 26.4b1 management in place.

On 07/01/24 at 8:54 AM, the surveyor reviewed the requested Investigation provided by the NJ Exec Order 26.4b1) that was related to the RER for Resident #81. The NJ Exec Ord confirmed the documents provided was the completed investigation and revealed the following:

Description of Event: At 11:10 AM on NJ Exec Order 26.4b1, notified that a NJ Exec Order 26.4b1 U.S. FOIA (b)(6)] during exam. Resident was noted with NJ Exec Order 26.4b1 Resident has NJ Exec Order 26.4b1 and does not speak NJ Exec Order 26.4 The Resident does NJ Exec Order 26.4b1 NJ Exec Order 26 at times in the room. Resident has a DX: NJ Exec Order 26.4b1.

Action:

NJ Exec Order 26.4b1 assessment completed on residents with NJ Exec Order 26.4b1 noted; Investigation immediately initiated ...

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F 610	Continued From page 40 Resident's Pertinent Medical Data: NJ Exec Order 26.4b1 f with a Brief Interview for Mental Status NJ Exec Order 26.4b1 Resident is an NJ Exec Order 26.4b1 with NJ Ex Activities of Daily Living. Diagnosis: NJ Exec Order 26.4b1 Events Preceding Incident: Resident demonstrated NJ Exec Order 26.4b1 area NJ Exec Order 26.4b1 ... Statement Summary: At 11:10 AM on NJ Exec Order 26.4b1, notified that a NJ Exec Ord U.S. FOIA (b when was doing exam. Resident was noted with NJ Exec O. [This contradicted the documented information in the Events Preceding Incident section and the medical record]. Resident has NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The resident does NJ Exec Order 26.4b1 at times in the room. Resident was interviewed with NJ Exec Order 26.4b1 assistance in NJ Exec Order 26.4b1 Resident stated that they NJ Exec but was NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1. An investigation was initiated, and statements were gathered from all staff that were assigned to resident from NJ Exec Order 26.4b1. No NJ Exec was reported ... Conclusions: The IDC [Interdisciplinary Team] met to discuss and review the incident and has determined that the cause of the NJ Exec Order was caused by an NJ Exec Order 26.4b1 A reasonable person would conclude that this was isolated incident and no NJ Exec Order 26.4b1 occurred. There was "no intent to NJ Exec Order 26.4b1." Investigational summary	F 610		

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F 610	Continued From page 41 completed by: [US FOIA (b) (6) A review of the attached statements revealed the following 13 Witness Statements: -Incident Date: [Left Blank], Type of Incident [Left Blank], Please provide a written description of what you observed section: "I [name NJ Exec Order 26 [Resident] on Sunday NJ Exec Order 26.4b1 and did not NJ Exec Order 26.4b1."; Name, Title /Relation to Resident: Signed, Certified Nurse Aide and [Date: Blank]. -Incident Date: NJ Exec Order 2 Type of Incident [Left Blank], Incident time- 11-7 shift; Please provide a written description of what you observed section: NJ Exec Order 26.4b1 occurred during my shift. Resident slept through the night with no [signs/symptoms] of NJ Exec Order 26.4b1. Name, Title /Relation to Resident: Signed, US FOIA (and Date: NJ Exec Order 26.4b -Incident Date: [Blank]; Type of Incident NJ Exec Orde , Please provide a written description of what you observed section: "I did not see any NJ Exec Order or Resident on my shift on NJ Exec Order 26.4b1, 3-11", Name, Title /Relation to Resident: Signed, [No Title and Date: Blank]. -Incident Date: NJ Exec ; Type of Incident NJ Exec Order 26.4 ; Please provide a written description of what you observed section: "I cared for resident on NJ Exec and I did not see any NJ Exec Order 26.4b1 Name, Title /Relation to Resident: Signed, [No Title and Date: Blank]. -Date: NJ Exec Order 26.4b1; Incident Date: [Left Blank]; Type of Incident "NJ Exec Order Please provide a written description of what you observed section: "I cared for resident on NJ Exec Order 26.4b1. No NJ Exec Order 26.4b1 change was reported. Resident in NJ Exec Order 26.4b1". Name, Title /Relation to Resident: Signed, [Licensed Practical Nurse (LPN) and Date:	F 610		

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F 610	Continued From page 42 NJ Exec Order 26.4b1]. -Incident Date: NJ Exec Order 26. Type of Incident " NJ Exec Order 26.4 Please provide a written description of what you observed section: "I cared for resident on NJ Exec and I did not see any NJ Exec Order 26.4b1 Name, Title /Relation to Resident: Signed, [No Title and Date: Blank]. -Incident Date: NJ Exec Order 2 ; Type of Incident " NJ Exec Order 26.4 Please provide a written description of what you observed section: "I cared for resident on NJ Exec and I did not see any NJ Exec Order 26.4b1 "; Name, Title /Relation to Resident: Signed, [No Title and Date: Blank]. -Incident Date: NJ Exec Order ; Type of Incident " NJ Exec Order 26.4 Please provide a written description of what you observed section: "No one brought to this writer's attention of any NJ Exec Order 26.4b1 on the shift" Name, Title /Relation to Resident: Signed, [No Title] and Date: NJ Exec Order 26.4b1 [Three months after incident]. -Incident Date: NJ Exec Type of Incident " NJ Exec Order 26 , Please provide a written description of what you observed section: "I was not informed of any NJ Exec O on the shift". Name, Title /Relation to Resident: Signed, [No Title and Date: Blank]. -Incident Date: NJ Exec Type of Incident NJ Exec Order 26.4b1 , Please provide a written description of what you observed section: "Was not aware of said NJ Exec Order 26.4b1 or it was not reported during this shift staff". Name, Title /Relation to Resident: Signed, US FOIA (Date: NJ Exec Order 26.4b1 . -Incident Date: NJ Exec ; Type of Incident " NJ Exec Order 26.4b1 , Please provide a written description of what you observed section: "I was not informed that resident had a NJ Exec Order 2 nor did I see a NJ Exec O to residents NJ Exec Order 26.4b1 Name, Title /Relation to Resident: Signed, LPN, Date: [undated]. -Incident Date: NJ Exec O Type of Incident " NJ Exec Order 26.4b1 , Please provide a written description of what	F 610		

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F 610	Continued From page 43 you observed section: "I did not notice any [NJ Exec Order] during care". Name, Title /Relation to Resident: Signed, [No Title and Date: Blank]. -Incident Date: [NJ Exec Order]; Type of Incident [NJ Exec Order 26] ", Please provide a written description of what you observed section: "I care for the Resident today [NJ Exec Order 26.4b2] I notice a [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b] I notify the US FOIA (b) (6) and nurse immediately informed". CNA Name, Date: Blank]. -Incident Date: [NJ Exec Order 26.] Type of Incident '[NJ Exec Order] Please provide a written description of what you observed section: "I care for the Resident today [NJ Exec Order 26.4b] I notice a [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4] I notify the US FOIA (b) (6) and nurse immediately informed". CNA Name, Date: Blank. -Incident Date: [NJ Exec Order]; Type of Incident [NJ Exec Order 26] ", Please provide a written description of what you observed section: "I was informed this shift by [US FOI] that resident had a NJ Exec Order 26.4b1. I am unaware of how/when this happened". Name, Title /Relation to Resident: Signed, [No Title and Date: [NJ Exec Order 26.4b1] On 07/03/24 at 1:43 PM, the surveyor interviewed the [US FOIA (b)] in the presence of the survey team. The surveyor asked what would be completed when a new symptom would occur with a resident as Resident #81 had NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and was diagnosed with a [NJ Exec] The [US FOIA (b)] stated typically the nurse would call the physician, regarding a change in condition would occur and notify family. The surveyor asked when the resident presented with NJ Exec Order 26.4b1 was that when the investigation began. The [US FOIA (b)] stated, "typically I go back from when baseline changed" and collect statements for "72 hours prior". The surveyor showed the [US FOIA (b)] the statements had missing	F 610		

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dates and they did not go back 72 hours from [redacted]. The [redacted] stated the U.S. FOIA (b)(6) would obtain the statements and they were responsible for interviewing staff. The surveyor asked how NJ Exec Order 26.4b1 was ruled out and the [redacted] did not offer a response. The surveyor asked the [redacted] who was responsible for reviewing the investigation and she stated she reviewed it. The surveyor requested a timeline of events leading up to Resident #81's U.S. FOIA (b)(6).

On 7/8/24 at 8:30 AM, the facility offered a one paged document which revealed on [redacted], a physician documented there was no [redacted]. On [redacted], nursing noted [redacted] was administered and was [redacted] ... During the investigation, the [family] was able to obtain some information of the cause of the [redacted] The resident's [family] stated that the resident stated they [redacted] and could not get any additional information. There was no statement from the family, no documentation regarding the alleged [redacted] and interviewing staff related to a [redacted] no additional statements were provided.

On 07/08/24 at 3:09 PM, the U.S. FOIA (b)(6) [redacted]) provided a one page document which included a paragraph that the facility investigated the [redacted] appropriately ... [redacted] ruled out ... The [redacted] provided no additional documented evidence related to the investigation to rule out NJ Exec Order 26.4b1 upon the reported NJ Exec Order 26.4b1 [redacted] by Resident #81. No statements were provided going back 72 hours as indicated in the RER and as confirmed by the [redacted] that they should have been completed.

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

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F 610	Continued From page 45 The Unexplained Injuries Policiy, Date Reviewed/Reviewed 11/29/23, revealed all unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated. Section 3. An incident report form shall be completed. If an allegation of abuse is made or if the injury is of unknown source, reporting and investigation procedures shall be implemented in accordance with the facility's abuse policies and procedures. The facility Abuse, Neglect and Exploitation policy dated 7/12/23, revealed Definitions: Neglect: means failure of the facility, its employees, or service providers to provide goods andservices to a resident that are necessary to avoid physical harm, pain, mental vanquish, or emotional distress. "Willful" means individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Section V. Identification of Abuse, Neglect and Exploitation, A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Whritten procedures for investigations include: 1. Identifying staff responsible for the investigation, 3. Identifying and interviewing all involved persons, including the alleged perpetrator, witnesses, and others who might have knowledge of the allegations, Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment ha occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.	F 610		

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F 610	Continued From page 46 The Incidents and Accidents Policy Date Reviewed/Revised: 7/17/23, revealed Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident refers to any unexpected or unintentional incident, which results or may result injury or illness to a resident. Icident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor , or staff member. The Policy Explanation: The purpose of incident reporting can include, Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care; Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Compliance Guidelines: 1. Incident/accident reports are part of the facility performance improvement process ... The Abuse, Neglect and Exploitation Policy Date Reviewed/Revised: 7/12/23, revealed: Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse, 3. Physical injury of a resident, of unknown source; Investigation of Alleged Abuse, Neglect and Exploitation; A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation, 3. Investigating different types of	F 610		

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F 610	Continued From page 47 alleged violations, 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations, 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.	F 610		
F 637 SS=D	NJAC 8:39 4.1 (a)(5), 27.1(a)(b) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to complete a Significant Change in Status Assessment using the Resident Assessment Instrument (RAI) process on a resident who elected hospice benefits. This deficient practice was identified for 1 of 2 residents reviewed for hospice (Resident #44). This deficient practice was evidenced by:	F 637	1. Resident 44 was not affected by the NJ Exec Order 26.4b1 minimum date set being completed [redacted] days late. 2. All residents have the potential to be affected. No other residents were identified as having a late minimum data set completed. 3. The Minimum date set coordinator will conduct an audit on the minimum data	8/14/24

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F 637	Continued From page 48 According to the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual, " A significant change in status assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later that the date of the hospice election statement, but not earlier than). The SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place." Resident #44 was admitted to the facility with diagnoses that included NJ Exec Order 26.4b1 . On 07/02/24 at 9:33 AM, the surveyor observed Resident #44 in the room. On 07/02/2024 at 8:49 AM the surveyor reviewed the resident's current physician's order sheet (POS). The POS revealed an order for NJ Exec Order 26.4 consult and treat dated NJ Exec Order 26.4 The POS reflected that NJ Exec Order 26.4b1 Review of the Significant Change in Status Minimum Data Set (SCSA-MDS), an assessment used to facilitate the management of care, revealed the Assessment Reference Date (ARD) was NJ Exec Order . The MDS was signed as completed by the US FOIA (b) (6) on NJ Exec Order 26.4 . On 07/03/24 at 9:00 AM, the surveyor interviewed the US FOIA (b) (6) who has been employed since NJ Exec Order 26.4b1 .The US FOIA (b) (6) confirmed that	F 637	sets to ensure they are completed and submitted timely. The Nursing Home Administrator or Director of Nursing in-serviced the US FOIA (b) (6) on the time requirements for completing and submitting minimum data sets. 4. The Minimum date set coordinator will conduct an audit on the minimum data sets to ensure they are completed and submitted timely. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months	

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F 637	Continued From page 49 the resident was admitted to NJ Exec Order 26.4b1 and confirmed that a SCSA-MDS was scheduled for NJ Exec Order 2 and completed on NJ Exec Order 26.4 She stated the SCSA-MDS should have been completed within 14 days of the election of NJ Exec Order 26.4 services. She confirmed that the SCSA-MDS for Resident #44 was completed NJ Ex days late. NJAC 8:39-11.2(i)	F 637		
F 677 SS=F	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure NJ Exec Order 26.4b1 residents were provided with routine and appropriate NJ Exec Order 26.4b1 in a timely manner. This deficient practice was identified for 8 of 8 residents reviewed for Activities of Daily Living Care (Residents #27, #30, #37, #41, #82, #94,# 95, and #155) and was evidenced by the following: 1) On 6/27/24 at 10:48 AM, surveyor #1 entered Resident #94's room and noted a NJ Exec Order 26.4b1 in the room. Resident #94 informed the surveyor that staff refused to assist with NJ Exec Order 26.4b1 Upon request, Resident #94's NJ Exec Order 26.4b1 activated the call bell. The U.S. FOIA (b)(6)) reported to the room immediately, and confirmed that Resident #94 NJ Exec Order 26.4b1.	F 677	1.Resident 27: On 7/3/24 the facility began an investigation regarding NJ Exec complaint o NJ Exec Order 26.4b1. The Director of Nursing and Nursing Home Administrator conducted the investigation. Resident 27 had a NJ Exec Order 26.4b1 check on NJ Exec Order by the Director of Nursing and it was NJ Exec Order 26.4b1. Resident 27 NJ Exec Order 26.4b1. Resident 30: The Director of Nursing completed a NJ Exec Order 26.4b1 check on resident 30 and it was NJ Exec Order 26.4b1. The Director of Nursing evaluated resident 30 for NJ Exec O and NJ Exec Order 26.4b1. The Director of Nursing reported the incident to the Department of Health on NJ Exec Order 26. at 9am. Resident 37: On NJ Exec Order 26., resident 37 was	8/14/24

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F 677	Continued From page 50 2) On 6/27/24 at 11:06 AM, surveyor #1 observed Resident #82 in bed with NJ Exec Order 26.4b1 [redacted]. The resident informed the surveyor that they would like their NJ Exec Order 26.4b1 [redacted]. A review of Resident #82's care plan indicated to check NJ Exec Order 26.4b1 [redacted] as necessary. 3) On 06/28/24 at 6:30 AM, the surveyor entered room [redacted] which was a NJ Exec Order 26.4b1 room and asked a random Certified Nurse Aide (CNA) to assist with NJ Exec Order 26.4b1 tour. The NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 in the hallway. The first 3 residents were NJ Exec Order 26.4b1.(Resident #82, #37 and #41.) 4) On 6/28/24 at 6:36 AM, during the NJ Exec Order 26.4b1 tour ([redacted] in the presence of CNA #3, surveyor #1 observed Resident #37 was NJ Exec Order 26.4b1. The surveyor interviewed CNA #1 who worked the 7:00 AM to 3:00 PM shift that day. CNA #1 stated that when the facility was short of staff, the residents would be NJ Exec Order 26.4b1 [redacted] 5) On 6/28/24 at 6:45 AM, during [redacted] in the presence CNA #1, the surveyor observed Resident #41 in bed, NJ Exec Order 26.4b1. 6) On 6/28/24 at 6:50 AM, during the [redacted] in the presence of CNA #1, the surveyor observed Resident #95 in bed, NJ Exec Order 26.4b1. The surveyor interviewed Resident #95. Resident #95 stated that they were provided with NJ Exec Order 26.4b1 [redacted] during the night only. 7) On 6/28/24 at 7:00 AM, Resident #30 was	F 677	provided with NJ Exec Order 26.4b1, had a [redacted] check by the Director of Nursing which was NJ Exec Order 26.4b1 [redacted] and denied [redacted] Resident 41: On [redacted], resident 41 was provided with NJ Exec Order 26.4b1 had a [redacted] check by the Director of Nursing which was NJ Exec Order 26.4b1 [redacted]. Resident 82: Resident 82's NJ Exec Order 26.4b1 [redacted] Resident 94: On [redacted], resident 94 was provided with NJ Exec Order 26.4b1 had a [redacted] check by the Director of Nursing which was NJ Exec Order 26.4b1 [redacted]. Resident 95: On [redacted], resident 95 was provided with [redacted], had a [redacted] check by the Director of Nursing which was NJ Exec Order 26.4b1 [redacted] Resident 155 no longer resides at the facility. 2. All residents have the potential to be affected. On 7/29/24, All residents nails were observed to ensure they were trimmed and cleaned and all incontinent residents were checked to ensure they were provided with incontinence care and were not wearing more than one brief. No other residents were identified as being affected.	

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F 677	Continued From page 51 noted in bed, fully covered. The CNA informed the resident of the procedure and the resident agreed to be checked. The CNA pulled the blanket and we both observed that Resident #30 was NJ Exec Order 26.4b1. The sheets were NJ Exec Order 26 Resident #30 had NJ Exec Order 26.4b1 gown. The NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 that were NJ Exec Order 26.4b1 the resident were NJ Exec Order 26.4b1 When the CNA attempted to assist Resident #30 with NJ Exec Order 26. we both observed that Resident #30 was wearing NJ Exec Order 26.4b1 that were NJ Exec Order 26.4b1 On 6/28/24 at 7:25 AM, the surveyor asked CNA #1 to call the NJ Exec Order 26.4b1 . On 6/28/24 at 7:35 AM, the U.S. FOIA (b)(6) entered Room NJ Ex and both observed the condition of the resident. The U.S. FOIA (b)(6) stated that he assumed the resident had not been NJ Exec Order 26.4b1 They both observed that Resident #30 had NJ E on which were NJ Exec Order 26.4b1 The U.S. FOIA (b) further stated that the expectation was that all residents would be NJ Exec Order 26.4b and maintained in a NJ Exec Order 26.4b1. On 6/28/24 at 7:50 AM, during an interview with the surveyor, CNA #1 stated that was not the first time she observed NJ Exec Order 26.4b1 on residents during care. The CNA went on to state that the facility had provided in-services (education) to not apply NJ Exec Order 26.4b1 on residents. However, she stated that if the facility was short handed during the 11:00 PM-7:00 AM shift, some residents would have NJ Exec Order 26.4b1 and would not be NJ Exec Order 26.4b1 in a	F 677	3. The Nursing Home Administrator or Director of Nursing will in-service the nursing staff on the incontinence care and nail care policy and assigning staff to assignments that will permit for timely incontinence and nail care. This in-servicing began on 6/28/24. New hires and agency staff will receive this in-servicing during orientation. The Nursing Home Administrator or Director of Nursing will conduct incontinence audits and nail care audits. 4. Resident 94, 30, 37, 41, 95, and 27 will be audited weekly for four weeks to ensure they receive timely and appropriate NJ Exec Order 26.4b1. Resident 82 will be audited weekly for four weeks to ensure NJ Ex received NJ Exec Order 26.4b1 The Nursing Home Administrator or Director of Nursing will conduct incontinence and nail care audits on five residents to ensure they are being provided with routine incontinence care. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months	

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F 677	Continued From page 52 timely manner. On 07/08/24 at 2:12 PM, surveyor #1 conducted a telephone interview with CNA #2 who cared for Resident #30 on [redacted] during the 11:00 PM to 7:00 AM shift. During the interview CNA #2 stated, "when I went to check them, I did not turn on the light, and fully open the [redacted] ". The CNA also stated that the facility was short handed, only 2 CNAs were assigned to care for 45 Residents. She checked the resident at 2:30 AM and did not realized that Resident #30 was [redacted]. The CNA added, "I was running late and I did not check them again." CNA #2 informed the surveyor that the 3:00 PM- 11:00 PM shift applied the [redacted] . On 07/08/24 at 2:15 PM, the surveyor again called CNA #3 who worked the 3:00 PM-11:00 PM shift on [redacted]. She did not return the call. The [redacted] informed the surveyor that CNA #3 confirmed that she provided care to Resident #30 around 10:30 PM and applied the [redacted] . 8) On 7/3/24 at 12:13 PM, surveyor #2 interviewed Resident #27. Resident #27 who is awake and [redacted] informed the surveyor that they were [redacted] sometime in [redacted] . Resident #27 could not recall the exact date, but remember that [redacted] care was provided around 10:00 PM, and was not [redacted] again until 10:00 AM on the next day. Resident #27 further stated that they were not offered [redacted] on the 11:00 PM - 7:00 AM shift. Resident #27 informed surveyor #3 that they reported the above concerns to the [redacted] and the [redacted] at that time, and had not seen that staff member	F 677		

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F 677	Continued From page 53 since; "I think she was NJ Exec Order 26.4b1 Resident #27 stated residents who were NJ Exec Order 26.4b1 on staff for care still had to wait over an hour before they could be NJ Exec Order 26.4b1 Resident #27 went on to state, "They still have to wait an hour or longer for NJ Exec Order 26.4b1". Resident #27 stated they just don't have enough help. 9) On 7/8/24 at 10:11 AM, surveyor #1 interviewed Resident #155's Representative (RR) (a NJ Exec Order 26.4b1). The RR stated that Resident #155 was NJ Exec Order 26.4b1 . The RR informed the surveyor that Resident #155 was NJ Exec Order 26.4b1 and could not participate with the interview. A review of the facility's policy titled, "Activities of Daily Living (ADL's), Support" revised March 2018, revealed the following: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living; Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. NJAC 8:39-27.1 (a)2(g)(h)	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		8/14/24

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F 686	Continued From page 54 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) implement interventions to prevent the development of a NJ Exec Order 26.4b1 b.) ensure individualized comprehensive care plan interventions were implemented to prevent NJ Exec Order 26.4b1 and c.) ensure daily observation during care was documented according to professional standards of Nursing practice to follow continuity of care, and d) alert physician of any change in the condition. This deficient practice occurred for 1 of 2 closed records reviewed for (Resident #150). Resident #150 was identified as having a NJ Exec Order 26.4b1 at the facility on , which measured which progressed to NJ Exec Order 26.4b1 which was identified during routine rounds by a consultant on and which resulted in a NJ Exec Order 26.4b1 days later. The evidence was as follows: On 6/28/24 at 12:30 PM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #150. Review of the closed record	F 686	1. Resident 150 no longer resides at the facility. 2. All residents at risk for wounds or with existing wounds have the potential to be affected. The Director of Nursing audited all residents on 8/1/24 with wounds and all residents at risk for wounds to ensure they had individualized interventions in place to prevent wounds and to prevent worsening of any existing wounds, ensure wound status documentation was in place, and that if there were any changes in wounds that the physician was notified and documentation occured during the shift the change was identified. No other residents were identified as being affected. 3. The Director of Nursing or designee has in-serviced all nursing staff on 8/14/24 who possess the ability to render wound care on implementing interventions to prevent the development of facility acquired pressure injuries, ensuring individualized comprehensive care plan interventions are implemented to prevent facility acquired pressure injuries from worsening, and ensuring observation	

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F 686	Continued From page 55	F 686		

revealed that Resident #150 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]

According to the Annual Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #150 was identified as having [redacted]. Resident #150 scored [redacted] on the Brief Interview for Mental Status (BIMS). Resident #150 was NJ Exec Order 26.4b1 on staff for all Activities of Daily Living (ADLs).

Further review of the MDS in section M, indicated that the resident had no history of an [redacted] and was at risk of developing a NJ Exec Order 26.4b1. Further review of section M indicated under NJ Exec Order 26.4b1 Treatments that the following were applied: NJ Exec Order 26.4b1 for bed, nutrition and application of NJ Exec Order 26.4b1
Review of the Order Summary Report((OSR) revealed a Physician Order (PO) dated [redacted], for a NJ Exec Order 26.4b1. Check placement and functioning every shift.
Review of the OSR revealed a PO dated [redacted], for NJ Exec Order 26.4b1 to be donned (put on) on the NJ Exec Order 26.4b1 to decrease risk of NJ Exec Order 26.4b1. [redacted] check every shift.

Review of the Order Summary Report (OSR) dated NJ Exec Order 26.4b1 revealed a physician's order (PO) dated [redacted], to NJ Exec Order 26.4b1 [redacted] or use NJ Exec Order 26.4b1 [redacted] daily, NJ Exec Order 26.4b1 [redacted] daily.

Another order dated [redacted], was to [redacted] the

during wound care was documented, and notifying the physician of any alteration in the condition or progression of a wound. New hires and agency staff will receive the in-servicing in orientation.

The Director of Nursing or designee will conduct audits weekly for four weeks, bi-weekly for four weeks, and monthly for one month on:

¿ Residents who are at risk for wounds to ensure preventive measures are in place to prevent wounds
¿ Ensuring residents with existing wounds have individualized comprehensive care plan interventions are implemented to prevent wounds from worsening
¿ Residents with wounds have documentation on the status of their wound
¿ Residents with wounds any alteration in the condition or progression of a wound have documentation of physician notification the same shift the condition or progression is identified

4. The Director of Nursing or designee will conduct audits weekly for four weeks, bi-weekly for four weeks, and monthly for one month on:

¿ Residents who are at risk for wounds to ensure preventive measures are in place to prevent wounds
¿ Ensuring residents with existing wounds have individualized comprehensive care plan interventions

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	315047	A. BUILDING _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

(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 686	Continued From page 56 NJ Exec Order 26.4b1, do not NJ Exec Orde or use NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 daily. Review of the Weekly NJ Exec O Review dated NJ Exec Order 26.4b, and signed by a US FOIA (b) (6) revealed a NJ Exec Order 26.4b which measured NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 days later), indicated "No NJ Exec O." No measurement was entered on the NJ Exec O assessment. On 11/16/23, NJ Exec Order 26.4b1. On NJ Exec Order 26.4b, NJ Exec Order 26.4b1 On NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 On NJ Exec Order 26.4b, Resident #150 was transferred to the hospital. During NJ Exec Order 26.4b1, the U.S. FOIA (b)(6) identified that the NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1. The resident was admitted to the hospital and treated for NJ Exec Order 26.4b1 Review of the electronic Treatment Administration Record (eTAR) from NJ Exec Order 26.4b1 revealed the eTAR was initialed to reflect that NJ Exec O checks were being completed on the Thursday evening shift. NJ Exec Order 26.4b1 were initialed as being done on the Monday and Thursday evening shift. Both were signed by the U.S. FOIA (b)(6)). There was no documentation in the progress notes regarding the NJ Exec Order 2 condition. The facility indicated that the U.S. FOIA (b)(6) was treated daily by staff, however, there	F 686	are implemented to prevent wounds from worsening ¿ Residents with wounds have documentation on the status of their wound ¿ Residents with wounds with any alteration in the condition or progression of a wound have documentation of physician notification Findings of the audits will be reviewed y the Nursing Home Administrator at the monthly QAPI meetings for three months.	

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F 686	Continued From page 57 was no documentation regarding that the [redacted]. Review of the eTAR for [redacted], reflected the [redacted] was being applied as ordered to [redacted]. On 07/01/24, the surveyor interviewed the [redacted] regarding the process for [redacted] care. He informed the surveyor that the nurses would initial the eTAR only. No narrative documentation was available regarding the [redacted]. [redacted] condition was documented weekly during [redacted]. On [redacted] Resident #150 was transferred to the hospital after the consultant [redacted] care practitioner informed the facility that the [redacted]. The nurses were to provide [redacted] care daily and document/report any change in the [redacted] condition. The physician and the [redacted] care team was not informed that the [redacted] was [redacted]. At the hospital on [redacted], the following documentation was entered in the electronic medical record (EMR) regarding the [redacted]: Active present on admission. [redacted] description [redacted]. [redacted] length (cm) [redacted] [redacted] width ([redacted] [redacted] (0.2 cm) [redacted] [redacted] (present on admission) Contributing Factors: [redacted]	F 686		

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F 686	Continued From page 58 Interventions/ recommendations: NJ Exec Order 26.4b1, cover with NJ Exec Order 26.4b1, change dressing every 3 days. NJ Exec Order 26.4b1 using foam wedge to maintain side-lying position. The resident was discharged to the facility on NJ Exec Order 26.4b1. The History and Physical entered in the EMR by the treating physician on NJ Exec Order 26.4b1, indicated the following: "Resident #150 was readmitted to NJ Exec Order 26.4b1 after an acute hospitalization after presenting with NJ Exec Order 26.4b1 NJ Exec Order 2. Imaging revealed NJ Exec Order 26.4b1. Resident #150 was started on an NJ Exec Order 26.4b1 which they will complete on NJ Exec Order 26.4b1 Resident #150 was transferred back to the NJ Exec O Review of the NJ Exec Or incident report dated NJ Exec Order 26., revealed the following: Interdisciplinary Team met to discuss recent NJ Exec Order 26.4b1, Resident currently on NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1, daily U.S. FOIA (b)(6) rounds. Upon surveyor inquiry, the facility was unable to provide the rationale for staff not documenting the NJ Exec Order 26 condition while care was being done daily. The facility did not identify any change in condition. Resident #150 was then readmitted to the facility on NJ Exec Order 26.4b1. The facility indicated that NJ Exec Order 2 care was being completed daily. However, on NJ Exec Order 26.4b1, again during NJ Exec Order 2 rounds, Resident #150 was found to have NJ Exec Order 26.4b1 upon assessment of the NJ Exec Order 2 by the consultant NJ Exec Order 26.4b1. On the same day, NJ Exec Order 26.4b1 Resident #150 was	F 686		

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F 686	Continued From page 59 transferred to the Emergency Department, and diagnosed with NJ Exec Order 26.4b1 . The surveyor reviewed the hospital record from the hospitalization of NJ Exec Order 26.4b1 and the following were noted: -Comments: NJ Exec Order 26.4b1 : NJ Exec Order 26.4b1 . Significant NJ Exec Order 2 on the NJ Exec Order 26.4b1 with 'NJ Exec Order 26.4b1" ... -A NJ Exec Order 26.4b1 Hospital NJ Exec Order 26.4b1 report revealed 'NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 ", additional clinical notes revealed, "now presents NJ Exec Order from the skilled nursing facility because of NJ Exec Order 26.4b1 , as well as NJ Exec Order 26.4b1] inserted NJ Exec Order 26.4b1)" per hospital follow up with the facility the NJ Exec Order 26 dressing was changed daily and the facility had no documentation regarding NJ Exec Order 26.4b1 and found during weekly NJ Exec Order 2 observation, NJ Exec Order 26.4b1 for "a NJ Exec Ord aka NJ Exec Order 26.4b1] on NJ Exec Orde ." On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the U.S. FOIA (b)(6)) regarding an investigation about the NJ Exec Order 26 development and related to NJ Exec Order 26.4b1 The U.S. FOIA (b stated she was not at the facility and that there was nothing else to provide. A review of a policy titled Unexplained Injuries last revised 11/29/23 revealed: All unexplained injuries, including NJ Exec Order 26.4 NJ Exec Order 26.4b1 and inquiries of unknown origin will be investigated.	F 686		

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F 686	Continued From page 60 Policy Explanation and Compliance Guidelines: Observations of any unexplained injuries shall be reported immediately to the resident's nurse. Care and treatment shall be provided to the resident as needed. This includes physician notification, and implementation of physician orders or facility protocols. Relevant information shall be documented in the resident's medical record, including but not limited to: physical assessment findings, including objective description of the injury. The facility shall modify the resident's plan of care as needed to prevent recurrence or to stabilize, reduce, or remove underlying risks factors contributing to the injury. The facility failed to follow their own policy. Resident #150 was found to have an NJ Exec Order 26.4b1 by the US FOIA (b) (6) during NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 again the U.S. FOIA (b)(6) identified during NJ Exec Order 2 round that Resident #150 had NJ Exec Order 26.4b1 On 07/08/24 at 11:33 AM, the surveyor interviewed the US FOIA (b) (6)) about Resident #150's NJ Exec Order 26 The US FOIA (b) (6 stated, "I talked to the family at some point", and reviewed the case later. The US FOIA (b) (6) had no additional information to provide. NJAC 8:39-27.1(a)	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		8/14/24

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F 688	Continued From page 61 range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for the application of NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 for one resident. The deficient practice was identified for 1 of 1 resident (Resident #71) reviewed for positioning and mobility, and was evidenced by the following: On 6/27/24 at 10:30 AM, the surveyor toured the unit. During the tour of the facility, Resident #71 reported some concerns with NJ Exec Order 26.4b1 and assistance with NJ Exec Order 26.4b1 to prevent further NJ Exec Order 26.4b1 to the NJ Exec O. The resident used the NJ Exec Order 26.4b1 under the cover and show the NJ Exec Order 26.4b1 to the surveyor. The NJ Exec Order 26.4b1 On 6/28/24 at 8:30 AM, the surveyor observed the resident in bed, the resident informed the	F 688	1. Resident 71 had an NJ Exec Order 26.4b1 on NJ Exec Order 26. Resident 71's NJ Exec Ord will be applied per the physician's orders. 2. All residents with splints and demonstrate a degree of movement or flexibility of a joint or body part that moves in various directions, referred to as range of motion, have the potential to be affected. The Director of Nursing and Therapy Director audited all residents with splints to ensure splints were applied as ordered. No other residents were identified as being affected. 3. The Director of Nursing or designee has in-serviced all nursing staff on 8/14/24 all nursing staff, until all nursing staff have been in-serviced on the degree of movement or flexibility of a joint or body part that moves in various directions, referred to as range of motion, and	

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F 688	Continued From page 62 surveyor that they did not get any assistance with U.S. FOIA (b) and the staff had not applied the NJ Exec Order 2 for months. On 6/28/24 at 11:15 AM, the surveyor reviewed Resident #71's Electronic Medical Record (EMR) The admission Face Sheet reflected that Resident #71 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 According to the Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order, Resident #71 was identified as having NJ Exec Order . Resident #71 scored NJ Exec Order 26.4b1 on the Brief Interview for Mental Status (BIMS) indicating the resident was NJ Exec Order 26.4b1 Additionally, the resident was NJ Exec Order 26.4b1 activities of daily living, and having NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. On 07/01/24 at 12:17 PM, the surveyor observed Resident #71 sitting in the bed, At that time, the surveyor did not observe the NJ Exec Order 26.4b1 applied to the resident. The resident informed the surveyor again, NJ Exec Order 26.4b1". On 07/02/24 at 10:10 AM, the surveyor entered the room and verified that the NJ Exec Order 26.4b1 was not applied. The surveyor reviewed the Treatment Administration Record (TAR) and verified that staff had initialed the TAR indicating that the NJ Exec had been applied even on the days the surveyor observed that Resident #71 did not have the NJ Exec Order 26.4b1	F 688	following splint orders and ensuring they apply splints and remove splints per the physician's orders. All in-servicing of nursing staff completed by completion date. New hires and agency staff will receive this in-servicing in orientation. The Director of Nursing or designee will conduct audits on residents with splints to ensure they are applied and removed per the physician's orders. 4. The Director of Nursing or designee will conduct audits weekly for four weeks, every other week for four weeks, and then monthly for one month on residents with splints to ensure they are applied and removed per the physician's orders. Findings of the audits will be reviewed by the Nursing Home Administrator at the monthly QAPI meetings for three months.	

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F 688	Continued From page 63 On 07/02/24 at 9:30 AM, the surveyor reviewed the Order Summary Report dated NJ Exec Order 26.4b1, which included a physician's order dated NJ Exec Order 26. for 'NJ Exec Order 26.4b1 [redacted] in the morning and remove at night before bed. With regular NJ Exec Or checks and NJ Exec Order 26.4b1 every morning and at bedtime". The surveyor also reviewed Resident #71's NJ Exec Or [redacted],Treatment Administration Record (TAR). The physician order was noted on the TAR which required the nurse's signatures for the 8:00 a.m. application and the 21:00 (9:00 p.m.) removal of the NJ Exec Order 26.4b1 each day. From NJ Exec Order 26.4b1, the TAR revealed the nurses initialed the TAR indicative that the NJ Exec [redacted] was applied. On 07/08/24 at 9:30 AM, the surveyor observed the resident in bed, the resident showed the NJ Exec O [redacted] to the surveyor and indicated again that they had not had the NJ Exec Order 26.4b1. The surveyor left the room and accompanied the U.S. FOIA (b)(6) to the room. In the presence of the U.S. FOIA (b)(6), the resident stated that they had not received any assistance with NJ Exec Order 26.4b1 [redacted] for months, and the Staff had not applied the NJ Exec Order 26.4b1 for months. The Resident informed the U.S. FOIA (b)(6) in the presence of the surveyor that the NJ Exec Order could be possibly in the top dresser. The U.S. FOIA (b)(6) opened the dresser and noted that the NJ Exec Orde was in the dresser. The surveyor reviewed the Progress notes from NJ Exec Order 26.4b1, there was no documentation regarding NJ Exec Order 26.4b1. The surveyor further reviewed the Nursing	F 688		

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F 688	Continued From page 64 Progress Notes from NJ Exec Order 26.4b1. The Nursing Progress Notes did not reveal that Resident #71 'NJ Exec Order 26.4b1 [redacted] The surveyor reviewed Resident #71's ongoing Care Plan (CP). The CP revealed an area of "Focus" related to "Activities of Daily Living(ADL) NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1, initiated [redacted] last revised [redacted]. The CP further reflected an intervention dated [redacted] for "NJ Exec Order 26.4b1 [redacted] during the day". Please put on in the morning and remove at night before bed". Review of the facility's policy titled, " Range of Motion last revised 11/29/23 included the following: Residents who enter the facility without limited range of motion, will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Appropriate Care Planning Based on the comprehensive assessment, the facility will provide interventions, exercises and /or therapy to maintain and improve range of motion. The facility will provide treatment and care in accordance with professional standards of practice.. This includes but not limited to: Appropriate services (specialized rehabilitation, restorative, maintenance) Appropriate equipment (braces, splint) Assistance as needed (active assisted, passive, supervision) The policy was not being followed . NJAC 8:39-27.1 (a)	F 688		

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F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to have a system in place to ensure a consistent and safe [redacted] process for 17 residents who were identified as [redacted] by failing to ensure a) provision of adequate and consistent supervision for residents who were assessed and identified as [redacted] b) residents who required [redacted] when [redacted] did not keep their own [redacted] and then used it to [redacted] other residents' [redacted] (Resident #30 and #72), c) residents who required [redacted], were assisted and supervised to prevent [redacted] from the [redacted] from causing [redacted] and ensuring the [redacted] was not rested on the [redacted] causing [redacted] type marks (Resident #29), and d.) [redacted] into appropriate receptacles and that [redacted] were appropriately disposed of. This deficient practice was identified for 5 of 17 residents (Resident #29, #39, #72, #87 and #32) reviewed for safe [redacted] and posed the likelihood of serious injury, serious impairment or harm to all residents who resided at the facility.	F 689	1. On [redacted] at 1pm the Nursing Home Administrator met with resident 72 and asked if they had [redacted] on them and they said no. Resident 72 gave the Nursing Home Administrator consent to audit their room for [redacted] and none were found. On [redacted] at 12:20pm, Resident 72 was educated by the unit manager on not having [redacted] on their person and not [redacted] other residents [redacted] On [redacted] 4 resident 29 was issued a new [redacted]. On [redacted], the licensed nurse completed a new [redacted] assessment. Resident 29 will use a [redacted] to prevent their [redacted] from [redacted]. The [redacted] on the bushes were removed on 7/2/2024. Resident 39 was educated on not [redacted] for other residents and not assisting them with [redacted] Resident 72 was educated on not [redacted]	8/14/24

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F 689	Continued From page 66 On 7/1/2024, the surveyor observed Resident #39 [redacted] resident #29's [redacted], leave the [redacted] area and enter the facility while in possession of the [redacted] material. Resident #29, a resident with [redacted] who was assessed as requiring [redacted] was not adequately [redacted] and staff did not assist the resident while [redacted] The [redacted] was [redacted], then the resident rested their [redacted] on their [redacted], then picked up the [redacted] again and continued to [redacted] The surveyor then observed a Certified Nurse Aide (CNA) take Resident #29's [redacted] and disposed the [redacted] over the patio and into the bushes. On 7/2/2024, Resident #72 was observed by surveyors [redacted], and other residents' [redacted] (including Resident #29) with a [redacted]. The surveyors observed six [redacted] located directly on the bushes below the [redacted] balcony. During an interview, Resident #29 stated their clothing had [redacted]. The surveyors again observed Resident #29 resting their [redacted] which remained [redacted] throughout and [redacted] in several areas. The IJ situation began on 7/1/2024 and was identified on 7/2/2024. The [redacted] was notified on 07/02/2024 at 2:46 PM. The facility provided an Immediate Jeopardy Removal Plan (RP) that was accepted on 7/3/24 at 10:00 AM, indicating the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective	F 689	[redacted] for other residents. Resident 87 was educated on [redacted] in appropriate receptacles and [redacted] must be appropriately disposed of. Resident 32 will have an [redacted] for [redacted]. 2. All residents have the potential to be affected. 3. On 7/1/2024 at 1pm, the Director of Nursing or Nursing Home Administrator or designee has in-serviced all nursing staff on 8/14/24 all facility staff on the current smoking policy. On 7/2/2024 at 3pm, the Director of Nursing or Nursing Home Administrator or designee has in-serviced all nursing staff on 8/14/24 all facility staff on: " Ensuring residents who require close supervision when smoking do not keep their own lighting materials " Ensuring residents do not light other resident cigarettes " Ensure that cigarettes are not resting on anything including smoking aprons " Disposing ashes in the smoking receptacle " Ensuring cigarettes are only extinguished in the smoking receptacle " Ensuring residents do not keep their lighting materials on their person " Ensuring ashes and cigarettes are not	

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F 689	Continued From page 67 action plan to remediate the deficient practice which included: 1. On NJ Exec Order at 1:00 PM, the US FOIA (b) (6) met with Resident #72 and was asked if they had NJ Exec Order 26 material and was given permission to audit the resident's room for NJ Exec Order 26 material and none were found. On NJ Exec Order at 12:20 PM, Resident #29 was issued a new NJ Exec Order 26.4b1 and the licensed nurse completed a new NJ Exec Order 26.4b assessment. The resident was educated by the US FOIA (b) (6) on not having NJ Exec Order 26 materials on their person and not NJ Exec Order 26 other residents' NJ Exec Order 26.4b1. The resident will use a NJ Exec Order 26.4b1 to prevent their NJ Exec Order 26.4b1 The 6 NJ Exec Order 26.4b1 NJ Exec Ord on the bushes were removed on NJ Exec Order. 2. All residents who smoke have the potential to be affected. All residents who currently smoked were evaluated by a licensed nurse on 7/2/2024, and had a new smoking assessments completed, were checked to ensure they did not have lighting materials on them and were educated on the smoking policy. 3. On 7/1/2024 at 1:00 PM, the US FOIA (b) (6) or designee began in-servicing all facility staff on the smoking policy. On 7/2/2024 at 3:00 PM, the US FOIA (b) (6) or designee began in-servicing all facility staff on: Ensuring residents who require close supervision when smoking do not keep their own lighting materials; Ensuring residents do not light other resident cigarettes; Ensure that cigarettes are not resting on anything including smoking aprons; Disposing ashes in the smoking receptacle; Ensuring cigarettes are only	F 689	disposed of in the bushes " If burn holes are observed on resident clothing to immediately notify the nursing supervisor, Director of Nursing, or Nursing Home Administrator New hires and agency staff will receive this in-servicing in orientation. New residents who smoke will have a smoking evaluation completed to determine their need for supervision and/or adaptive equipment. There will be a staff member assigned to the smoking break and they will be outside with the residents providing the necessary supervision. The Nursing Home Administrator or Director of Nursing will audit the smoking breaks using a facility developed auditing tool to ensure the smoking policy is being followed. 4. The Director of Nursing or Nursing Home Administrator or Designee will observe the residents and staff during one smoke break daily to ensure that the smoking policy is being followed. This audit will be conducted once a day weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. Findings of the audits will be reviewed by the Quality Assurance Committee at the monthly QAPI meetings x three months.	

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F 689	Continued From page 68 extinguished in the smoking receptacle; Ensuring residents do not keep their lighting materials on their person; Ensuring ashes and cigarettes are not disposed of in the bushes; If burn holes are observed on resident clothing to immediately notify the nursing supervisor, U.S. FOIA (b)(6) [redacted] Two staff members will be assigned to supervise each smoking time; Staff will be in-serviced prior to starting their assignments. 4. The U.S. FOIA (b)(6) [redacted] observe the residents and staff during one smoke break daily to ensure that the current policy is being followed. This audit will be conducted once a day- weekly for four weeks, then bi-weekly X four weeks, and then monthly X one month. Findings of the audits will be reviewed by the Quality Assurance Committee at the monthly QAPI meetings X three months. The survey team verified the removal plan on-site and the IJ was removed on 7/3/2024 at 1:16 PM. The evidence was as follows: Reference: Review of the manufacturer specification for the smoking apron [brand name redacted] included: Warning, the webbing closure around the neck and binding around the circumference of the apron is fire rated CA 117 and will melt/self-extinguish when exposed to ash or flame. Both of these components are not certified NFPA 701. Reference: https://www.nfpa.org/codes-and-standards/nfpa-701-standard-development/701. This standard establishes test methods to assess the propagation of flame of various textiles and films	F 689		

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F 689	Continued From page 69 under specified fire test condition. Review of the facility policy for Resident Smoking, dated/revised, 7/17/23, reflected under policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Policy Explanation and Compliance Guidelines included the following: 6. Residents who smoke will be further assessed using an assessment to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10. All safe smoking measures will be documented on each residence care plan and communicated to all ... supervision will be provided as indicated on each resident's care plan and subsection. 13. Smoking materials of the residents requiring supervision while smoking will be maintained by nursing staff. On 06/27/24 at 11:14 AM, a surveyor toured the activity room and observed a patio door that led to a balcony that residents utilized for [redacted]. There was an obstructed view of the [redacted] area from the activity room and the surveyor observed a table inside the room that contained a box with several [redacted] packages and no [redacted]. The U.S. FOIA (b)(6) was present and stated she held the [redacted] but did not have a [redacted], she stated that some residents had their [redacted] and identified Resident #72 as having a [redacted]. The [redacted] stated she was '[redacted] and it was hard to manage Resident #72". The [redacted] stated Resident #72 [redacted]. On 7/1/24 at 9:33 AM, during an interview with the surveyor, a U.S. FOIA (b)(6)	F 689		

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F 689	Continued From page 70 confirmed Resident #29 NJ Exec Order 26.4b1. The U.S. FOIA (stated that the assigned Certified Nursing Assistant (CNA) would walk the resident to the NJ Exec Order 26.4b1 and leave the resident with the recreation staff who monitored the residents NJ Exec Order 26.4b1 On 7/1/24 at 11:03 AM, the surveyor observed Resident #29 seated on a wheelchair holding their NJ Exec Order 26.4b1. CNA #1 then pushed Resident #29's wheelchair through the hallway and into the dayroom. On 7/1/24 at 11:06 AM, the U.S. FO, who was standing next to the sliding door entrance of the NJ Exec Order 26.4b area, provided NJ Exec Order 26.4b1 to Resident #29. CNA #1 then continued to push the resident's wheelchair past the glass sliding door, past the other NJ Exec Order 26.4b1, towards the end of the patio where Resident #39 was standing. Resident #39 was then observed NJ Exec Order 26.4b1 Resident #29's NJ Exec Order 26.4b1 in the presence of the CNA #1. At that time, CNA #1 exited the NJ Exec Order 26.4b area and the day room and the NJ Exec remained inside the activity room. Another resident (unsampled resident) NJ Exec Order 26.4 along with Residents #29 and Resident #39. All three residents were NJ Exec Order 26.4b1 while the activity staff was inside the activity room and no staff were observed in the NJ Exec Order 26.4b1 monitoring the residents. The NJ Exec Order 26.4b1 was a lengthwise porch that had two sets of windows divided by a small brick wall that protruded and was on a balcony with bushes in front. All areas were not visible from inside of the activity room. On 7/1/24 at 11:08 AM, two activity staff were then observed inside the activity room looking outward. One of the staff was observed looking	F 689		

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through the glass sliding door while the other staff observed through the first set of windows adjacent to the sliding door and was looking outward into the NJ Exec Order 26.4b area while the residents [redacted]

At that time, during an interview with the surveyor, the US FOIA (b) (6)) stated they normally remained inside the facility activity room (dayroom), and watched the NJ Exec Order 26.4b1 residents who were outside the patio. At that time, the surveyor and the US FOI observed Resident #29's NJ Exec Order 26.4b1 [redacted]. Resident #29 then picked the NJ Exec Order 26.4b1 [redacted].

At that time, the U.S. FO informed the surveyor that Resident #29 usually NJ Exec Order 26.4 without anyone around and that Resident #29 normally would NJ Exec Order 26.4b1 [redacted]. The NJ Exec was unsure if she had informed anyone about the resident dropping the NJ Exec Order 26.4b1 . The U.S. FOI stated that "if a resident NJ Exec Order 26.4b1 [redacted]"

On 7/1/24 at 11:12 AM, the surveyor and the U.S. FO observed CNA #1 who had returned to the NJ Exec Order 26.4b area during the interview with the U.S. FO, remove Resident #29's NJ Exec Order 26.4b1 from the resident and then NJ Exec Order 26.4b1 from the NJ Exec Order 26.4b1 over the balcony and directly onto the bushes below. At that time, Resident #39 was observed leaving the NJ Exec Order 26.4b area and was then pushing Resident #29's wheelchair passed the activity staff and exited the dayroom. The activity staff did not request the

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NJ Exec Order that Resident #39 used to NJ Exec Or Resident #29's NJ Exec Order 26.4b1.

On 7/1/24 at 11:17 AM, the surveyor observed the NJ Exec Order 26.4b1 boxes in a container next to the recreation staff and the container did not have a NJ Exec Order. At that time, the recreation staff confirmed Resident #39 had a NJ Exec Order 2. The U.S. FO confirmed that the activity staff had not asked for the NJ Exec Order to be returned to the activity staff when the resident re-entered the facility from the NJ Exec Order 26.4b area. The U.S. FOI stated that the residents "NJ Exec Order 26.4 " when asked for the NJ Exec Order and that she previously communicated this to the U.S FOIA (and the U.S. FOIA (b)(6)

The surveyor reviewed the medical record for Resident #29.

According to the resident's Admission Record (AR), Resident #29 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1

A review of Resident #29's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 2 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex , which indicated that Resident #29's NJ Exec Order 26.4b1. Additionally, the resident's functional range of motion for NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1.

A review of Resident #29's individualized Care

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Plan (CP) reflected that the resident liked to [redacted]. Interventions initiated on [redacted], included "[redacted] while [redacted] in the [redacted] area", observe [redacted] for signs of U.S. FOIA (b)(6), [redacted] and staff to [redacted].

On 07/01/24 at 12:21 PM, LPN #1 provided Resident #29's most recent [redacted] assessment dated [redacted]. The assessment revealed: Resident #29's ability to [redacted]. The resident needed direction in [redacted] and disposal of [redacted] in the [redacted] and in [redacted] a [redacted]. Resident #29 took medications with [redacted] that affected [redacted]. The resident was documented to "have had a [redacted]" in the past [redacted] months and required [redacted]. The determination score was [redacted] out of 10 which indicated "[redacted]" per the document. The additional comments section contradicted the score and included the resident [redacted] and [redacted] included [redacted].

The surveyor reviewed the medical record for Resident #39.

According to the AR Resident #39 had diagnoses which included, but were not limited to, [redacted].

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NJ Exec Order 26.4b1 [redacted]

A review of Resident #39's most recent quarterly MDS, dated [redacted], reflected that the resident had a BIMS score of [redacted], which indicated that Resident #39's [redacted]. Additionally, the resident's activities for daily living required NJ Exec Order 26.4b1 [redacted] where in the resident completed the activity and the [redacted] to or [redacted] the activity.

A review of Resident #39's individualized CP reflected that the resident NJ Exec Order 26.4b1 and had a "NJ Exec Order 26.4b1". Interventions included, NJ Exec Order 26.4b1 [redacted], "ensure that there is no NJ Exec Order 26.4b1 at bedside; staff will provide such during [redacted] time in the [redacted] room. Monitor for compliance with NJ Exec Order 26.4b1 and to notify the charge nurse immediately, when the resident was suspected of [redacted] facility NJ Exec Order 26.4b1, initiated on dated [redacted].

Further review of the resident's CP included another focus area that reflected the resident had NJ Exec Order 26.4b1 [redacted] to help manage symptoms. Interventions included give NJ Exec Order 26.4b1 medication ordered by physician, monitor, document side effects, and effectiveness. NJ Exec Order 26.4b1 side effects included, NJ Exec Order 26.4b1 [redacted]

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F 689	Continued From page 75 A review of Resident #39's most recent NJ Exec Order 26.4b assessment dated NJ Exec Order 2, contained the Resident's NJ Exec Order 26.4b1 [redacted]. The resident's NJ Exec Order 26.4b1 [redacted] The resident took medications NJ Exec Order 26.4b1, judgement and safety but had NJ Exec Order 26.4b1 and in the past NJE months and had NJ Exec Order 26.4b1. The determination score was one NJ Exec Order 26.4b1 which indicated no supervision was required for the resident. The NJ Exec Order 26.4b assessment did not address the resident's NJ Exec Order 26.4b1 [redacted] other resident's NJ Exec Order 26.4b1 [redacted]. The surveyor reviewed the medical record for Resident #72. According to the AR, Resident #72 had diagnoses which, included but were not limited to; unspecified NJ Exec Order 26.4b1 [redacted]. A review of Resident #72's most recent quarterly MDS dated NJ Exec Order 26, reflected that the resident had a BIMS score of NJ Exec Orde, which indicated that Resident #72's NJ Exec Order 26.4b1. Additionally, the resident was NJ Exec Order 26.4b1 for activities for daily living and had NJ Exec Order 26.4b1 of a NJ Exec A review of Resident #72's individualized CP reflected that the resident liked NJ Exec Order 26.4b1, with a NJ Exec Order 26.4b1. Interventions initiated on	F 689		

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NJ Exec Order 26.4, included "NJ Exec Order 26.4b1 [redacted]", monitor for compliance with NJ Exec Order 26.4b policy and to notify charged nurse immediately if the resident is suspected to violate facility NJ Exec Order 26.4b policy.

Further review of the CP reflected the resident was at NJ Exec Order 26.4b1 initiated on NJ Exec Order 26.4b, and was related to NJ Exec Order 26.4b1 [redacted]. NJ Exec Order 26.4b1 [redacted] and use of NJ Exec Order 26.4b1 [redacted]. Interventions included to anticipate resident's needs.

Additionally, the resident can be NJ Exec Order 26.4b1 with medication administration, NJ Exec Order 2 treatment, other treatment, NJ Exec Order 26.4b1 [redacted] needs. NJ Exec Order 26.4b1 [redacted], and of risk factors. Interventions included inform the resident, family and caregiver about the risk associated with NJ Exec Order 26.4b1 initiated, on NJ Exec Order [redacted].

A review of Resident #72's most recent NJ Exec Order 26.4b assessment dated NJ Exec Order [redacted], contained the Resident's ability to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]. The resident's NJ Exec Order 26.4b1 required direction. The Resident's ability to NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 [redacted]. Resident #72 took medications with NJ Exec Order 26.4b1 that affected NJ Exec Order 26.4b1 [redacted] and in the past [redacted] months had NJ Exec Order 26.4b1 [redacted]. The determination score was NJ Exec Order 26.4b1 which indicated NJ Exec Order 26.4b1 was required for the resident.

The surveyor reviewed the medical record for

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F 689	Continued From page 77 Resident #87. According to the resident's AR, Resident #87 was a NJ Exec Order 26.4b1 resident at the facility and had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . A review of Resident #87's most recent quarterly MDS dated NJ Exec Order 26., reflected that the resident had a BIMS score of NJ Exec Order 26.4b1, which indicated that Resident #87's NJ Exec Order 26.4b1 . Additionally, the resident required NJ Exec Orde assistance for nd NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 assistance with NJ Exec Order 26.4b and NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 assistance for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . A review of Resident #87's individualized CP reflected that the resident like to NJ Exec Order 26.. Interventions included assess resident's ability to NJ Exec Order 2 independently/safely, monitor for compliance with NJ Exec Order 26.4b1 and notify charge nurse immediately if resident is suspected to violate facility NJ Exec Order 26.4b1. Further review of the CP, reflected the resident was at NJ Exec Order 26.4b1 related to use of NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 and NJ Exec Order 26 . Interventions include monitor NJ Exec Order 26.4 medications, encourage use of NJ Exec Order 26. . Additionally, Resident #87 was at NJ Exec Order 26.4b1 with opportunity. Interventions included NJ Exec Order 26.4b1 , initiated on NJ Exec Order 26.4b1	F 689		

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A review of Resident #87's most recent NJ Exec Order 26.4b1 assessment dated NJ Exec Order 26.4 contained the Resident's ability to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . The resident's NJ Exec Order 26.4b1 . The resident took medications affecting NJ Exec Order 26.4b1 but had no NJ Exec Order 26.4b1 and in the past NJ Exec months had no NJ Exec Order 26.4b1 . The determination score was one NJ Exec Order 26.4b1 which indicated NJ Exec Order 26.4b1 was required for the resident.

The surveyor reviewed the medical record for Resident #32.

According to the AR, Resident #32 had diagnoses which included, but were not limited to; NJ Exec Order 26.4b1

A review of Resident #32's most recent quarterly MDS dated NJ Exec Order 26.4 reflected that the resident had a BIMS score of NJ Exec Order 26.4b1 , which indicated that Resident #32's NJ Exec Order 26.4b1 . The resident required NJ Exec Order 26.4b1 or NJ Exec Order 26.4b assistance for NJ Exec Order 2 NJ Exec Order 26.4b1 assistance for NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 , and was NJ Exec Order 26.4b1 . The resident NJ Exec Order 26.4b1

A review of Resident #32's individualized CP

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reflected that the resident liked to [redacted] potential for [redacted] Interventions initiated on [redacted] included NJ Exec Order 26.4b1 [redacted], ensure that there is no NJ Exec Order 26.4b1 at bedside; staff will provide such during [redacted] time in the [redacted] room. Monitor for compliance with [redacted] policy. Notify charge nurse immediately if resident is suspected to violate smoking policy. Observe NJ Exec Order 26.4b1 for signs of NJ Exec Order 26.4b1 [redacted]

A review of Resident #32's most recent [redacted] assessment dated [redacted] revealed that the Resident's ability to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] The resident's [redacted] and the NJ Exec Order 26.4b1 [redacted] in NJ Exec Order 26.4b1 [redacted]. Resident #32 took medications that [redacted] with no NJ Exec Order 26.4b1. The resident was documented to not have had a NJ Exec Order 26.4b1 in the [redacted] months. The determination score was [redacted] which indicated NJ Exec Order 26.4b1. However, according to the instructions of the [redacted] assessment the tabulation was the addition of questions 3 to 8 in which the sum was [redacted] (excluding section 7, wherein the medication had NJ Exec Order 26.4b1). According to the [redacted] assessment instructions a total score of [redacted] or greater would be [redacted] and needed NJ Exec Order 26.4b1 [redacted]. Additional comments included, the resident required a NJ Exec Order 26.4b1, someone to NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 per policy.

On 7/2/24 at 10:01 AM, during an interview with

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two surveyors the US FOIA (b) (6) stated everyone who NJ Exec Order 26.4 had a NJ Exec Order 26.4b assessment conducted by nursing. The assessment included the ability of the resident to hold their NJ Exec Order 26.4b1 or if extra precaution was needed to see if they needed assistance in holding their NJ Exec Order 26.4b1. The US FOIA (b) also stated that residents do not hold or keep their NJ Exec Order 26.4b1. During the day shift the recreation staff helped with monitoring the NJ Exec Order 26.4b residents. The U.S. FOIA (b)(6) stated on the night shift a CNA who worked the 3:00 to 11:00 PM, shift would monitor. The U.S. FOIA (b)(6) stated, "there was no definitive assignment, it was whoever was available." The U.S. FOIA (b)(6) stated the person assigned to monitor was responsible to provide a NJ Exec Order 26.4b1 monitor, assist when needed, watch the residents ensure that all are safe and that residents were NJ Exec Order 26.4b in a safe manner. Each resident who needed an NJ Exec Order had their own. Nursing would let activity staff know about the resident's assessment. The U.S. FOIA (b)(6) stated she was not sure how the NJ Exec Order 26.4b1 were supposed to be lit. The surveyor asked who was responsible to oversee the NJ Exec Order 26.4b program and the NJ Exec Order 26.4b1 replied, "I'm assuming the NJ Exec Orde." The NJ Exec O stated that residents who experienced a NJ Exec Order 26.4b1 should be reassessed, reevaluated with new safety precautions in place. Accidents should be documented by having a new assessment, a nursing note. and the physician should be informed. The NJ Exec Order 26.4b1 continued and stated that "any staff should intervene and ensure that another resident does not NJ Exec O another resident's NJ Exec Order 26.4b but was not sure how NJ Exec Order 26.4b1 should be lit." The U.S. FOIA (b)(6) stated that a resident deemed shaky and not able to hold their own NJ Exec Order 26.4b would need assistance then staff would need to hold on to their NJ Exec Order 26.4b1.

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F 689	Continued From page 81 On 7/2/24 at 10:34 AM, the surveyor asked Resident #29 for permission to view their NJ Exec Order 26.4b1 and the resident was agreeable. The front of the NJ Exec Order 26.4b1 was visibly NJ Exec O in the NJ Exec Order 2 part with defined NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The reverse side of the NJ Exec Order 26.4b1 was a NJ Exec Order NJ Exec Order 26.4b1 in the NJ Exec Order 26 less NJ Exec Order 26.4b1 type NJ Exec Order and NJ Exec Order 26.4b1 on the same area. On 7/2/24 at 10:52 AM, in the presence of two surveyors, CNA #1 confirmed Resident #39 NJ E Resident #29's NJ Exec Order 26.4b1. The CNA stated they did not know if that was the usual process because she had usually dropped them off. "I realized activities [staff] were not outside that is why I went back outside". "I saw them putting NJ Exec Order 26.4b1 on their NJ Exec Orde, I did not think that was safe. The CNA stated she told her US FOIA (b) (6) and the US FOIA (b) (6) On 7/2/24 at 11:01 AM, in the presence of two surveyors, Resident #72 was observed NJ Exec Order 26.4 Resident #29's NJ Exec Order 26.4b1. On 7/2/24 at 11:06 AM, the surveyors observed Resident #72 exit the NJ Exec Order 26.4b area and returned into the facility. On 7/2/24 at 11:06 AM, during an interview with the activity staff who was standing next to the sliding doors and while looking out toward the NJ Exec Order 26.4b1 area, she stated that Resident #72 always NJ E the resident's NJ Exec Order 26.4b1. "I gave them the NJ Exec Order 26.4 and they NJ Exec Order 26.4b1 residents' NJ Exec Order 26.4b1." At that time, the activity staff confirmed that she had not taken the NJ Exec Order	F 689		

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back from Resident #72 yesterday. During a subsequent interview with two surveyors, the activity staff stated that she had given Resident #72 the NJ Exec Order 26.4b1 and Resident #72 would NJ Exec O all the NJ Exec Order 26.4b1 resident's NJ Exec Order 26.4b1 "Resident #72 always does". The activity staff confirmed she did not retrieve the NJ Exec Order 2 from Resident #39 yesterday.

On 7/2/24 at 11:16 AM, in the presence of the survey team, the U.S. FOIA (b)(6 stated that when a resident passed their NJ Exec Order 26.4b assessment the resident was able to NJ Exec O their own NJ Exec Order 26.4b1 and they should not NJ Exec Or another resident's NJ Exec Order 26.4b1 "we should be doing it". The U.S. FOIA (b)(6 stated that there was a three-tier process for those who do not follow the NJ Exec Order 26.4b1 policy which can lead to revoked NJ Exec Order 26.4b privileges. "I have not had anyone" initiated that I can recall since I was here, for NJ months. After surveyor inquiry, the U.S. FOIA (b)(6 stated he had NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 yesterday from Resident #22 and #72 and asked the two residents randomly. The US FOIA (b) (6 confirmed he had no prior knowledge before 07/01/24 that residents held their own NJ Exec Order 26 and that staff allowed the residents to NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6 stated he was glad it was brought to his attention since he was not aware of residents NJ Exec Order 26 other residents' NJ Exec Order 26.4b1 or holding their own NJ Exec Order 26 and informed the surveyors that he would start an investigation.

On 7/2/24 at 12:12 PM, during an interview with two surveyors, Resident #72 stated "I was doing it all the time" and was told twenty minutes ago by the U.S. FOIA (b)(6) that they can't NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b residents anymore.

On 7/02/24 at 12:16 PM, during an interview with

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F 689	Continued From page 83 two surveyors, Resident #29 informed the surveyors that his/her NJ Exec Order 26.4b1 by the aide and Resident #72 and they did not have a NJ Exec Order. The resident stated that had not NJ Exec Order 26 NJ Exec Order 26.4 but sometimes an NJ Exec Order 26.4b1 and cause a NJ Exec Order 26.4b1. Resident #29 stated that sometimes staff, and other residents helped him/her but NJ Exec Order 26.4b1 On 7/02/24 at 12:36 PM, during an interview with two surveyors, the housekeeping staff (HK) stated he/she observed NJ Exec Order 26.4b1 on Resident #29's NJ Exec Order and believed the NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1. The HK staff also stated that Resident #32 also had NJ Exec Orde on his/her NJ Exec Order 26.4b1 On 7/02/24 12:53 PM, the two surveyors observed NJ Exec Order 26.4b1 in a bush located immediately in-front of the NJ Exec Order 26.4b1. No fire extinguisher was observed. On 7/2/24 at 1:27 PM, in the presence of the survey team, the U.S. FOIA (b)(6) stated he had met with all NJ Exec Order 26.4b1 to check if they had NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) also stated that the residents no longer had NJ Exec Order 26.4b1 in their possession and he has heard the concerns presented by the survey team and fully investigated the matter. On 7/8/24 at 3:10 PM, during a meeting with the survey team, and the U.S. FOIA (b)(6) U.S. FOIA) and the U.S. FOIA (b)(6) did not provide any further information which included an investigation. NJAC 8:39-27.1(a), 31.6(e)(2)	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		8/14/24

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F 692	Continued From page 84 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent documents it was determined that the facility failed to ensure the facility followed-up regarding resident goals and preferences regarding [redacted] and to ensure a comprehensive [redacted] assessment accurately reflected resident goals. The deficient practice was evidenced for 1 of 1 resident reviewed for receiving NJ Exec Order 26.4b1 (Resident #75) and was evidenced by the following: Reference It is the position of the Academy of Nutrition and Dietetics that all Americans aged 60 years and	F 692	1. Resident 75 will have a [redacted] evaluation to identify the resident's goals and to document the plan to meet the resident's goals. Resident 75 was evaluated by the NJ Exec Order 26.4b1. Resident 75 will have [redacted] to determine if [redacted] can be ordered and to identify what type of [redacted] to give for the NJ Exec Order 26.4b1. Resident 75 had a modified [redacted] 2. All residents receiving enteral feeding have the potential be affected. [redacted] other residents received an enteral feeding. The	

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F 692	Continued From page 85 older receive appropriate nutrition care; have access to coordinated, comprehensive food and nutrition services; and receive the benefits of ongoing research to identify the most effective food and nutrition programs, interventions, and therapies. Health, physiologic, and functional changes associated with the aging process can influence nutrition needs and nutrient intake. The practice of nutrition for older adults is no longer limited to those who are frail, malnourished, and ill. The population of adults older than age 60 years includes many individuals who are living healthy, vital lives with a variety of nutrition-related circumstances and environments. Access and availability of wholesome, nutritious food is essential to ensure successful aging and well-being for the rapidly growing, heterogeneous, multiracial, and ethnic population of older adults. To ensure successful aging and minimize the effects of disease and disability, a wide range of flexible dietary recommendations, culturally sensitive food and nutrition services, physical activities, and supportive care tailored to older adults are necessary. National, state, and local strategies that promote access to coordinated food and nutrition services are essential to maintain independence, functional ability, disease management, and quality of life. Those working with older adults must be proactive in demonstrating the value of comprehensive food and nutrition services. To meet the needs of all older adults, registered dietitians and dietetic technicians, registered, must widen their scope of practice to include prevention, treatment, and maintenance of health and quality of life into old age. Journal of the Academy Nutrition and Dietetics. 2012;112:1255-1277.	F 692	NJ Exec residents were not affected. The dietitian evaluated the NJ Exec other residents receiving an enteral feeding to ensure the resident's goals were identified and being met. All of the resident's goals were documented and being met. The dietitian reviewed the goals of residents who cannot communicate to ensure their goals were documented and being met. All were documented and being met. 3. The Director of Nursing or designee in-serviced the US FOIA (b) (6) on 8/1/24 and began in-servicing nursing staff on 8/1/24 on following up on resident goals and preferences regarding nutrition, and ensuring comprehensive nutritional assessments accurately reflect resident goals. The dietitian or designee will complete an audit using a facility developed auditing tool on at least three resident goals with altered diets and preferences regarding nutrition to ensure they are being followed up on. The Regional Dietitian will audit at least three resident nutritional assessments on residents with altered diets to ensure they accurately reflect resident goals. 4. The dietitian or designee will complete an audit using a facility developed auditing tool on residents with altered diets on their goals and preferences regarding nutrition to ensure they are being followed up on. The audit will be completed on three residents with altered diets weekly for four	

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F 692	Continued From page 86 On 06/27/24 at 10:49 AM, a surveyor interviewed resident #75 regarding NJ Exec Order 26.4b1 while an NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 was being administered. The resident stated that he/she asked the nurse about receiving NJ Exec Order 26.4b1 and stated, "I'm ready for NJ Exec Order 26.4b1 Resident #75 stated that the NJ Exec Order 26.4b1 took the NJ Exec Order 26.4b1 and "I'm ready for it, and I NJ Exec Order 26.4b1 ." On 07/02/24 at 10:50 AM, the surveyor reviewed a NJ Exec Order 26.4b1 he note revealed: Note Text: Resident continues to be followed by NJ Exec Order 26.4b1 + NJ Exec Order 26.4b1], NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . PMHx: NJ Exec Order 26.4b1 . NUTRITION STATUS: NJ Exec Order 26.4b1 not including NJ Exec Order 26.4b1 Increased needs [result to] r/t unchanged NJ Exec Order 26.4b1 NJ Exec Order 26.4b1] + NJ Exec Order 26.4b1 . May benefit from NJ Exec Order 26.4b1 to meet mid range of NJ Exec Order 26.4b1 . US FOI met w/ res [resident]who NJ Exec Order 26.4b1 and is NJ Exec Order 26.4b1 US FOI called family to make aware as well. No questions/concerns at this time. Res may also	F 692	weeks, then bi-weekly for four weeks, and then monthly for one month. The Regional Dietitian will use a facility developed auditing tool to audit resident's with altered diets nutritional assessments to ensure they accurately reflect resident goals. The audit will be completed on three residents weekly for four weeks, then bi-weekly for four weeks, and then monthly for one month. Findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

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F 692	Continued From page 87 benefit from NJ Ex Order 26.4b1 to further support NJ Exec Order 26 healing. GOALS: Resident would benefit from NJ Ex Order 26.4b1 toward NJ Ex Order 26.4b1 Continued NJ Ex Order 26.4b1 Maintain adequate NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 to support improvement of NJ Exec Order 2 status as able INTERVENTIONS: 1) Rec update NJ Ex Order 26.4b1 as follows: NJ Exec Order 26.4b1 @NJ Ex Order 26.4b1 supplement, provides: NJ Ex Order 26.4b1) 2) Rec continue NJ Ex Order 26.4b1 days, rec [recommend] NJ Ex Order 26.4b1 days; continue NJ Ex Order 26.4b1 3) Monitor NJ Ex Order 26.4b1 as available. POC [plan of care] updated; continue POC. Assessment & Plan -Has history of NJ Ex Order 26.4b1 and is on NJ Exec Order 26.4b1 4p to 10a, NJ Ex Order 26.4b1 per 24 hours. -Family also states is allowed NJ Ex Order 26.4b1" daily with NJ Ex Order 26.4b1. A review of the Order Summary Report for all orders active as of NJ Ex Order 26.4b1 revealed the Diet Order for NJ Ex Order 26.4b1	F 692		

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F 692	Continued From page 88 consistency, for Diet remained in place. The Care Plan revealed a Focus: I have a NJ Ex Order 26.4b1 or potential NJ Ex Order 26.4b1 [redacted] Date Initiated: NJ Ex Order 26.4b1 Revision on: NJ Ex Order 26.4b1 Target Date: NJ Ex Order 26.4b1 Interventions: Provide and serve diet as ordered: NJ Ex Order 26.4b1] NJ Ex Order 26.4b1 [redacted] & hydration. NJ Ex Order 26.4b1 [redacted] Date Initiated: NJ Ex Order 26.4b1 Revision on: NJ Ex Order 26.4b1 Diet Provide and serve NJ Ex Order 26.4b1 as ordered: NJ Ex Order 26.4b1 [daily] Date Initiated: NJ Ex Order 26.4b1 Revision on: NJ Ex Order 26.4b1 US FOIA to evaluate and make NJ Ex Order 26.4b1 recommendations PRN. Date Initiated: NJ Ex Order 26.4b1 Revision on: NJ Ex Order 26.4b1 The Care Plan did not address the resident's wishes or history of consuming NJ Ex Order 26.4b1 [redacted]. On 07/03/24 at 10:31 AM, the surveyor interviewed the facility US FOIA (b)(6) [redacted] U.S. FOIA) regarding Resident #81. The surveyor asked if the U.S. FO met with Resident #81 as she indicated she was at the facility three days per week. The	F 692		

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	315047	A. BUILDING _____ B. WING _____	C 07/15/2024

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F 692		F 692		

Continued From page 89

US FOIA stated that she increased Resident #81's NJ Exec Ord

The interview continued and the surveyor asked if the U.S. FOIA reviewed hospital records and progress notes also, and she had confirmed that she did. The U.S. FO confirmed that she met with Resident #81 and "he/she asked about NJ Ex Order 26.4b1", but the U.S. FO stated he/she was agreeable for increasing the NJ Ex Order 26.4b1 as it may be beneficial for nutrition for NJ Exec Order 2 and the resident was agreeable. The U.S. FO stated the resident had NJ Ex Order 26.4b1 many times, and confirmed the resident had NJ Ex Order 26.4b1 at one point. The U.S. FOIA stated she asked about the diet to the U.S. FOIA (b)(6) and confirmed she did not review any NJ Ex Order 26.4b1 if they were available. The surveyor asked if the U.S. FO communicated with the physician regarding the resident's request and the U.S. FO stated, "I have not spoken with the physician". The surveyor asked if the NJ Ex Order 26.4b1 were discussed with the interdisciplinary team and the U.S. FO stated it was and "it is not documented." The surveyor asked about any documentation from the US FOIA (b)(6) and the U.S. FO stated she spoke with the US FOIA (b)(6) and "it was not documented." The U.S. FO confirmed that there was no rationale why the resident was not receiving the NJ Ex Order 26.4b1 and was not documented as part of the NJ Ex Order 26.4b1.

On 07/08/24, the Facility U.S. FOIA (b)(6) provided a copy of a NJ Exec Order 26.4b1) which revealed Recommendations: 1. 3. Refer for NJ Exec Order 26.4b1

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F 692	Continued From page 90 U.S. FOIA (b)(6)). A type written timeline provided by the facility revealed that upon the resident's "discharge on NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 were ultimately deferred at this time until U.S. FOIA (b)(6) study can be scheduled through the VA. As of NJ Ex Order 26.4b1 we are still waiting for the VA to schedule the NJ Exec Order 26.4b1 On 07/08/24 at 1:10 PM, the surveyor informed the U.S. FOIA (b)(6) regarding Resident #81's request for NJ Ex Order 26.4b1 and no documented evidence regarding follow-up on the resident's wishes was provided. The facility was unable to provide the surveyor with any documented evidence regarding the follow up NJ Ex Order 26.4b1. The Nutritional Management Policy, revised 04/09/24 revealed 5. Monitoring/revision: e. Nutirional recommendations made by the dietitian based on the resident's preferences, goals, clinical condition or other factors and followed up with the physician/practitioner for orders as per facility policy. NJAC 8:39-27.1(a)	F 692		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		8/14/24

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F 725	Continued From page 91 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint #167264 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure sufficient and competent staff were available to a) provide timely and appropriate NJ Ex Order 26.4b1 for residents who were NJ Ex Order 26.4b1 on staff for Activities of Daily Living (ADL's) care (Residents #94, #30, #37, #41, #95, and #27), b) provide [redacted] for a resident who was NJ Ex Order 26.4b1 of staff for ADL's (Resident #82) and c) ensure staff were competent to accurately document an NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 and alert the supervisor. The deficient practice had the potential to affect all residents and was evidenced by the following: Refer to 600 K and 677F	F 725	1. Resident 27: On 7/3/24 the Nursing Home Administrator and Director of Nursing conducted an investigation regarding their complaint of being NJ Exec [redacted] by interviewing the resident, interviewing the Human Resources Director to determine if any staff members were terminated due to resident 27 not being provided with NJ Exec Order 26.4b1 interviewing three alert and oriented residents on NJ Exec Order 26.4b1, conducting NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 [redacted] residents to identify NJ Ex Ord changes that would indicate lack of NJ Exec Order 26.4b1, and interviewing staff members about resident 27. Resident 27 had a NJ Exec Order 26.4b1 check by the Director of Nursing on 7/2/24 and it was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1.	

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F 725	Continued From page 92 a) On 6/27/24 at 10:48 AM, surveyor #1 was doing the initial tour of the facility and was informed by Resident #94 that staff refused to NJ Ex Order 26.4b1. The surveyor noted a NJ Exec Order 26.4b1 in the room. The call bell was activated by the roommate and the U.S. FOIA (b)(6) reported to the room immediately and confirmed Resident #94 was NJ Exec Order 26.4b1. On 6/28/24 between the hours of 6:30 AM and 6:50 AM, surveyor #1 observed a care tour in the presents of the U.S. FOIA (b)(6)). At 6:30 AM, surveyor #1 and the US FOIA (b) observed Resident #30 NJ Exec Order 26.4b1 that had NJ Exec Order 26.4b1, the bed protector, and the sheets of the bed. The U.S. FOIA (b)(6) were called to the room, and both confirmed the status of the resident's condition and that the resident was NJ Exec Order 26.4b1. The U.S. FOIA (b) stated that her expectations would be that all residents would be changed and maintained in a NJ Exec Order 26.4b1. The US FOIA (b) revealed that was not the first occurrence of a resident being NJ Exec Order 26.4b1. The US FOIA (b) further stated that if the unit was short of staff the resident would be NJ Exec Order in the morning. On 06/28/24 at 7:25 AM, the surveyor asked the NJ Ex Orde to call the U.S. FOIA (b)(6), both observed the condition that the resident was left in. At that time, an interview with the U.S. FOI revealed that he assumed that the resident had been changed. Both also observed that Resident was wearing NJ Exec Order 2 During an interview with the U.S. FOIA (b), she stated that her expectations would be	F 725	Resident 27 NJ Ex Order 26.4b1. Resident 30: The Director of Nursing completed a NJ Exec Order 26.4b1 check on resident 30 and it was NJ Ex Order 26.4b1. The Director of Nursing evaluated resident 30 for NJ Ex Ord and they NJ Ex Order 26.4b1. The Director of Nursing reported the incident to the Department of Health on 6/28/24 at 9am. The Director of Nursing began the investigation and completed the assessment and determined the outcome. Resident 82 s NJ Exec Order 26.4b1. Resident 37: On 6/28/24, resident 37 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 check by the Director of Nursing which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1. Resident 41: On 6/28/24, resident 41 was provided with NJ Exec Order 26.4b1, had a NJ Ex by the Director of Nursing which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1 Resident 94: On 6/27/24, resident 94 was provided with NJ Exec Order 26.4b1, had a NJ Ex by the Director of Nursing which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1. Resident 95: On 6/28/24, resident 95 was provided with NJ Exec Order 26.4b1, had a NJ Ex check by the Director of Nursing which was NJ Ex Order 26.4b1 without	

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F 725	Continued From page 93 that all residents would be changed and maintained in a [redacted] manner. The [redacted] further stated that she would investigate. At that time, an interview with the [redacted] revealed that that was not the first time resident's had been found with [redacted] on and they received in-service on not to have [redacted] on the residents. The [redacted] further stated that if the unit was short of staff the resident would be [redacted] in the morning. On 7/8/24 at 2:12 PM, surveyor #1 interviewed the [redacted] who cared for Resident #30 on 6/28/24 on the 11:00 PM to 7:00 AM shift. The [redacted] stated, "when I went to check him/her, I did not open the [redacted] The [redacted] also stated there was only 2 [redacted] working that night and Resident #30 was last checked at 2:30 AM. The [redacted] stated, "I was running late and did not check them again." At 6:36 AM, surveyor #1 and the [redacted] observed Resident #37 was [redacted]. The [redacted] stated that when the facility was short of staff the resident would be [redacted] At 6:45 AM, surveyor #1 and the [redacted] observed Resident #41 in [redacted]. At 6:50 AM, surveyor #1 and the [redacted] observed Resident #95 in bed and was [redacted] During the interview with Resident #95, the resident stated they were changed last night and had not been changed that morning. On 7/3/24 at 12:13 PM, surveyor #2 interviewed Resident #27 who stated that sometime in September they were [redacted] from 10:00 PM and was not changed until the next day around 10:00 PM. The Resident could not remember an	F 725	[redacted]. 2.All residents have the potential to be affected. 3. The Nursing Home Administrator or Director of Nursing has in-serviced all nursing staff on 8/14/24 to all nursing staff on providing prompt incontinence care and nail care for all residents, documenting and reporting resident allegations, and ensuring the resident assignments have staff assigned evenly based off of acuity to ensure residents receive prompt incontinence care and nail care. All in-servicing completed by completion date. New hires and agency staff will receive this in-servicing in orientation. The Director of Nursing reviewed the facility's nurse and aide competencies on incontinence care and nail care on 8/1/24 to ensure they were completed. They were all completed. The Nursing Home Administrator or Director of Nursing will conduct audits on incontinence care and nail care. 4. Resident 94, 30, 37, 41, 95, and 27 will be audited weekly for four weeks to ensure they receive prompt [redacted] Resident 82 will be audited weekly for four weeks to ensure [redacted] The Nursing Home Administrator or Director of Nursing will conduct	

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F 725	Continued From page 94 exact date, but he/she did not have care provided by the 11:00 PM to 7:00 AM shift [redacted]. The Resident stated that the [redacted] were notified of the situation and did not see the [redacted] after that day. Resident #27 stated, "I think she was terminated." Resident #27 further stated still finds that they are waiting an hour or longer for [redacted]. The Resident also stated that the [redacted]'s are doing there best, but they just don't have enough help. b) On 6/27/24 at 11:06 AM, surveyor #1 observed Resident #82 in bed with [redacted], [redacted]. The resident stated that they would like their [redacted] to be cleaned. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and	F 725	incontinence care and nail care audits on five residents to ensure they are being provided with routine incontinence care and nail care. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month. The findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

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F 725	Continued From page 95 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. Staffing had been calculated for the following time frames and revealed the following: 1. For the 2 weeks of staffing from 06/25/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -06/25/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/29/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -06/30/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -07/01/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -07/02/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/08/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. 2. For the 2 weeks of staffing from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -07/30/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/05/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/06/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/07/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/12/23 had 10 CNAs for 109 residents on the	F 725		

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F 725	Continued From page 96 day shift, required at least 14 CNAs. 3. For the 4 weeks of staffing from 11/19/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 13 of 28 day shifts as follows: -11/19/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -11/25/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/26/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/27/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/29/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/30/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/02/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -12/03/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -12/07/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/09/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/10/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/12/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/16/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. 4. For the 2 weeks of staffing prior to survey from 06/09/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -06/15/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.	F 725		

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-06/16/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-06/21/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-06/22/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.

c) On 6/28/24 at 7:30 AM, in the presence of the surveyor, Resident #94 told the U.S. FOIA (b)(6) that they were upset that [Resident #84] came into their room NJ Exec Order 26.4b1 The surveyor then asked the U.S. FOIA if she heard what Resident #94 had said. The U.S. FOIA stated, "I heard it, management was already made aware." Resident #84 resided in the adjacent room connected through a shared bathroom from Resident #94.

On 07/01/24 at 12:29 PM, the surveyor interviewed Resident #71 who was Resident #94's roommate. Resident #71 stated, "my roommate got NJ Exec Order 26.4b1 [Resident #84] last night" and that the facility informed the resident that Resident #84 was allowed to NJ Exec Order 26 because the resident was NJ Exec Order 26.4b1. Resident #71 further stated, NJ Exec Order 26.4b1 and we are not sure of what [Resident #84] is capable of doing." Resident #71 further stated that Resident #84 had been NJ Exec Order 26.4b1 and that was reported to the nurses, the Certified Nurse Aides (CNA), and the US FOIA (b)

On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the U.S. FOI, "[Resident #84] NJ Exec Order 26.4b1. [Resident #84] always comes into our room. [Resident #84] NJ Exec Order 26.4b1 and this time [Resident #84]

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F 725	Continued From page 98 NJ Exec Order 26.4b1 [Resident #84] had NJ Exec Order 26.4b1. I told the staff a million times and nothing had been done". On 07/01/24 at 12:35 PM, the surveyor, along with a second surveyor, then interviewed the U.S. FOIA (b), whom Resident #94 reported the NJ Exec Order 26.4b1 in the presence of the U.S. FOI. The U.S. FOIA (b) confirmed that Resident #94 reported the NJ Exec Order 26.4b1. The U.S. FOIA stated in the presence of the U.S. FOIA that Resident #94 informed her that Resident #84 NJ Exec Order 26.4b1 Resident #94 in a "[redacted NJ Exec Order 26.4b1 way." The U.S. FOIA confirmed to the U.S. FOI, "I did not write it, that was Resident #94's perception."	F 725		
F 755 SS=E	NJAC 8:39-4.1 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.	F 755		8/14/24

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F 755	Continued From page 99 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a.) prescription medications were labeled and accounted for, b.) expired supplies were identified and removed from active inventory, c.) supplies that required dating were dated and d.) to consistently maintain accurate administration, reconciliation, and accountability of dispensed controlled dangerous substance (narcotic medication) stored within the electronic back-up machine (EBM). This deficient practice was identified for one (1) of two (2) medication rooms, two (2) of eight (8) medication carts and one (1) of one (1) EBM inspected for the medication storage and labeling. The evidence was as follows:	F 755	1. Resident 27 was not affected. 2. All residents have the potential to be affected. 3.The Director of Nursing or designee conducted in-servicing, beginning on 8/1/24 and completed on 8/14/24, with the nursing staff on the following procedures: ensuring prescription medications are labeled and accounted for, expired supplies were identified and removed from active inventory, supplies that required dating were dated, to consistently maintain accurate administration, reconciliation, and accountability of dispensed controlled dangerous substance (narcotic medication) stored within the electronic back-up machine (EBM) to include ensuring the physician order matches the dose of the medication	

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F 755	Continued From page 100 Reference: 21 CFR 1306.24(b) If the prescription is filled at a central fill pharmacy, the central fill pharmacy shall affix to the package a label showing the retail pharmacy name and address and a unique identifier, (i.e. the central fill pharmacy's DEA registration number) indicating that the prescription was filled at the central fill pharmacy, in addition to the information required under paragraph (a) of this section. 21 CFR 205.50(a)(3) a) Facilities. All facilities at which prescription drugs are stored, warehoused, handled, held, offered, marketed, or displayed shall: Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in immediate or sealed, secondary containers that have been opened ... 1.) On 7/1/24 at 10:23 AM, in the presence of the Licensed Practical Nurse (LPN #1) the surveyor began the medication room inspection located in the [redacted] wing. At 10:16 AM, during the inspection of the back-up over the counter medication stored in the medication room the surveyor observed an undated, unlabeled, prescription medication, Lidocaine Prilocaine 2.5%/2.5% Cream (indicated for local anesthesia). At that time, the LPN #1 stated that prescription medication should have been delivered with a label even if it was for back-up use. The LPN also stated that she would remove the item, inform the	F 755	being administered. Policies regarding medication labeling and storage, medication administration, controlled substances and discarding and destroying medications utilized in education. All in-services completed by completion date. New hires and agency staff will receive this in-servicing in orientation. The Director of Nursing or designee will conduct audits on the medication carts and medication rooms to ensure supplied are dated accordingly. The Director of Nursing or designee will conduct audits on the controlled dangerous substance medication inventory and use to ensure accurate administration, accountability, and reconciliation, of medications. 4. The Director of Nursing or designee will conduct audits on the medication carts and medication rooms to ensure supplied are dated accordingly. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then monthly for one month The Director of Nursing or designee will conduct audits on the controlled dangerous substance medication inventory and use to ensure accurate administration, accountability, and reconciliation, of medications. This audit will be conducted weekly for four weeks, bi-weekly for four weeks, and then	

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F 755	Continued From page 101 US FOIA (b)(6)) and give the US FOIA the item. 2.) At 10:31 AM, the surveyor and the LPN #1 observed the following expired supplies in the medication room: -one (1), 3ml syringe with hypodermic safety needle 21gauge x 1" inch, with an expiration date of 8/31/23. -two (2) luer lock disposable syringe without safety needle 30ml, one (1) of which had a brownish/red stain on the packaging, with an expiration date of 3/10/24. -nine (9) Insyte Autoguard needles 22gauge x 1 inch, with an expiration date of 2/29/24. -two (2) Insyte Autoguard needles 22gauge x 1 inch, with an expiration date of 3/31/24. -one (1) Insyte Autoguard needles 22gauge x 1 inch, with an expiration date of 4/30/24. At that time, the LPN #1 informed the surveyor that the luer lock disposable syringe without NJ Exec Order 26.4b1 was used to flush, and administer medications to residents who had a NJ Exec Order 26.4b1 At that time, the US FOIA (b) stated that she would remove the expired supplies and inform the US FOIA 3.) On 7/1/24 at 11:23 AM, in the presence of LPN #2, the surveyor began the medication cart inspection of cart #2, located on the NJ Exec Orde wing. At 11:27, the surveyor and LPN #2 observed an opened blood glucose (bg) test strip bottle (used with a glucometer to provide immediate reading of blood sugar, or glucose level). The packaging	F 755	monthly for one month. Findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

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F 755	Continued From page 102	F 755		

indicated "use within 6 months after first opening).

At that time, LPN #2 confirmed the bg test strip bottle should have been dated. LPN #2 stated she had opened the bottle last night but forgot to date the bottle.

On 7/1/24 at 11:46 AM, in the presence of LPN #3, the surveyor began the medication cart inspection of cart 1, located on the [redacted] wing.

At that time, the surveyor and LPN #3 observed an opened bg test strip bottle.

At that time, LPN #3 confirmed the bg test strip bottle should have been dated, to know the 6-month period from the time the bottle was opened.

At that time, LPN #3 stated she would discard the opened, undated bg test strip bottle and would inform her [redacted]

4.) On 7/1/24 at 2:51 PM, during the inspection of the EBM, in the presence of the [redacted] and the [redacted] the surveyor observed the Back-Up [redacted] Administration log of [redacted] had two (2) doses removed on [redacted] for Resident #27.

At that time, the [redacted] informed the surveyor that the nurse on that shift had removed two doses of the [redacted].

At that time, the surveyor and the [redacted] reviewed the electronic Medication Administration Record (eMAR) together. Resident #27's Order Summary

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F 755	Continued From page 103 Record, did not reflect and order for NJ Exec Order 26.4b1 mg but did have an order for the NJ Exec Order 26.4b1. Further review of the eMAR reflected the administration was signed on NJ Exec Order 26.4 instead of NJ Exec Order 26. At that time, the surveyor asked the US FOIA (b) if there was an investigation or an incident report regarding the administration of NJ Exec Order 26.4b1 without a physician's order. At that time, the US FOIA (b) stated she would get back to the surveyor. On 7/3/24 at 9:15 AM, during a follow -up interview with the surveyor, the US FOIA (b) stated that the accountability for discrepancies was the responsibility of the US FOI, Supervisors and herself, At that time, the surveyor asked the US FOIA (b) why the discrepancy was identified on NJ Exec Order, during the medication inspection, instead of when it occurred on NJ Exec Order 26. or the day after NJ Exec Order 26. At that time, the US FOIA (b)(6 stated that it had occurred on the weekend and that she would have discovered the error that Monday on NJ Exec Order. At that time, the US FOIA (b) acknowledged that a US FOIA or a Supervisor was on staff but was unsure how they received the report on the weekend. The concern was conveyed to the US FOIA (b) regarding the inaccurate administration, dispensing, missing reconciliation for the NJ Exec Order 26.4b1 discrepancy. On 7/8/24 at 1:32, the surveyor discussed the concerns regarding the unlabeled prescription medication intermingled with the over-the-counter	F 755		

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F 755	Continued From page 104 medication, expired supplies, undated bg test strips and lack of accountability, reconciliation for the administration, and dispensing of [redacted] mg without a physicians' order for Resident # 27. No further information was provided. A review of the facility policy provided, dated/revised on 4/16/24, Included the following under Policy Explanation and Compliance Guidelines: 2. Narcotics and Controlled Substances c. Any discrepancies which cannot be resolved must be reported immediately as follows: ii. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted. iv. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies. 8. Unused medications: the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn illegible, or missing labels. NJAC 8:39-29.4 (a)(c) (g) (k),29.7(c)	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		8/14/24

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F 758	Continued From page 105 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 106 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure adequate indication, and a gradual dose reduction (tapering towards an optimal dose) of NJ Ex Order 26.4b1 was attempted annually to establish an optimal dose, for a NJ Exec Order 26.4b1 resident with NJ Exec Order 26.4b1 (Resident #62). This deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications and was evidenced as follows. Reference: A review of the manufacturer's specifications for Seroquel (quetiapine) under the black box warning reflected "Warning: Increased Mortality In Elderly Patient with dementia related psychosis and suicidal thoughts and behaviors. Section 1 Indications and Usage included schizophrenia, bipolar disorder, and special considerations in treating pediatric schizophrenia and bipolar 1 disorder. Section 5.1 included, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death ... Section 5.3 Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis ... Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis.	F 758	1. Resident 62 had a NJ Ex Order 26.4b1 for an evaluation for a gradual dose reduction. Resident 62 gradual dose reduction to the medication NJ Ex Order 26.4b1. 2. All residents receiving antipsychotics have the potential to be affected. The Director of Nursing and Psychiatry Nurse Practitioner reviewed residents receiving antipsychotics to determine if they were affected. None were identified as being affected. 3.The Director of Nursing or designee has in-serviced all nursing staff on 8/14/24 on ensuring adequate indication and a gradual dose reduction of an antipsychotic medication is attempted annually,pharamcy consultant included in in-servicing process. New hires and agency staff will receive this in-servicing during orientation. The Director of Nursing or designee completed an audit on residents with antipsychotics to ensure a gradual dose reduction is attempted annually unless medically contraindicated. If the resident is due for consideration of a gradual dose reduction, the Psychiatry Nurse Practitioner will be responsible for evaluating the resident and documenting the resident's plan to trail a dose reduction or not and if not, document the medical contraindication. Residents deemed appropriate by evaluation for a gradual	

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F 758	Continued From page 107 On 7/3/24 at 10:21 AM, the surveyor entered the resident's room. The resident was observed in bed, the head of the bed was inclined, and the bed was in a low position. Resident #62 spoke in [dialect redacted] and asked the surveyor to come closer. On 7/3/23 at 10:23 AM, the US FOIA (b)(6) [redacted] entered the room and stated the resident was picked up by NJ Ex Order 26.4b1 [redacted] The surveyor reviewed the medical record for Resident #62. According to the resident's (AR; or face sheet, an admission summary) reflected that that resident was a NJ Ex Order 26.4b1 resident at the facility and had diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of Resident #62' s most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order [redacted], reflected that the resident had [redacted] that required [redacted] (NJ Ex Order 26.4b1 [redacted] and was NJ Ex Order 26.4b1 understood. The Brief Interview for Mental Status (BIMS) score was NJ Exec Order 26.4b1 which indicated the resident was NJ Ex Order 26.4b1 the	F 758	dose reduction per psychiatry consult by Psychiatric Nurse Practitioner have been completed. 4. The Director of Nursing or designee completed an audit on residents with antipsychotics to ensure a gradual dose reduction is attempted annually unless medically contraindicated. The audit will be completed on three residents weekly for four weeks, then bi-weekly for four weeks, and then monthly for one month. Findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

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interview. The resident had not exhibited symptoms of NJ Exec Order 26.4b1 .
Further review of the qMDS revealed the resident received an NJ Exec Order 26.4b1 without an attempted NJ Exec Ord; According to the qMDS, the physician documented on NJ Ex Order 26.4b1 that a was contraindicated.

A review of the resident's most recent individualized Comprehensive Care Plan (care plan) reflected that the resident had NJ Exec Order 26.4b1 . Interventions included provide consistency with caregivers/routine, reorient as needed and to offer praise and encouragement.

Further review of the resident's care plan reflected the resident had NJ Ex Order 26.4b1 and received NJ Ex Order 26.4b1 to help NJ Ex Order 26.4b1, dated/revised on NJ Ex Order 26.4b. Interventions included consult with pharmacy, and physician to consider dosage reduction when clinically appropriate. Family, not interested in NJ Ex Order 26.4b1 at this time due to NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , dated/revised on NJ Ex Order 26.4b1. The resident's care plan was not updated since.

A review of the resident's Order Summary Report for NJ Ex Order 26.4b included a physician's order for NJ Exec Order 26.4b1), give 1 tablet by mouth at bedtime for NJ Exec Order 26.4b1 with an order date from NJ Exec Order 26.

A review of the resident's monthly NJ Exec Order 26.4b1 Review from NJ Exec Order 26.4b1, did not reflect NJ Ex Order 26.4b1 by the resident associated with the physician's order for NJ Exec Order 26.4b1

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F 758	Continued From page 109 ([redacted]).	F 758		

A review of the [redacted] Progress Note dated [redacted], included that the patient was received lying in bed calm, cooperative during visit, able to [redacted] and denied [redacted]; diagnoses were [redacted]

The plan consisted of the following:
1. Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement.
Treat medical issues including [redacted] Encourage participation in activities, as tolerated and as possible for psychosocial well-being.
2. continue medication regimen benefit greater than risk.
3. continue to observe [redacted]
4. will follow
-Have considered the risk of and benefit associated with [redacted] at this time, the benefits outweigh the risk of treatment.
-[redacted] would likely result in an [redacted].
-contraindicated, due to noted efficacy and improvement in [redacted] with current treatment
[redacted] requiring management/risk assessment (effectiveness/side effects monitored). (moderate).

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A review of the NJ Exec Order 26.4b1 Progress Note dated NJ Ex Order 26.4b, which included that the resident was doing NJ Ex Order 26.4b1 reported by staff. Evaluation is limited due to NJ Ex Order 26.4b1; diagnoses were NJ Exec Order 26.4b1

The plan consisted of the following:
1.) to Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including NJ Ex Order 26.4b1. Encourage participation in activities, as tolerated and as possible for psychosocial well-being.
2. continue medication regimen benefit greater than risk.
3. continue to observe NJ Ex Order 26.4b1
4. will follow
-Have considered the risk of and benefit associated with NJ Ex Order 26.4b1 at this time, the benefits outweigh the risk of treatment.
-NJ Ex Order 26.4b1 would likely result in an NJ Ex Order 26.4b1.
-NJ Ex Order 26.4b1 due to noted efficacy and improvement in NJ Ex Order 26.4b1 with current treatment
NJ Ex Order 26.4b1 medications requiring management/risk assessment (effectiveness/side effects monitored). (moderate).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING _____ B. WING _____	C 07/15/2024

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

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F 758	Continued From page 111 A review of the NJ Exec Order 26.4b1 Progress Note dated NJ Exec Order, included: As per staff patient doing NJ Ex Order 26.4b1, evaluation limited due to NJ Ex Order 26.4b1; diagnoses were NJ Exec Order 26.4b1 The plan consisted of the following: 1.) to Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including NJ Ex Order 26.4b1. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well-being. 2. continue medication regimen benefit greater than risk. 3. will follow -Have considered the risk of and benefit associated with NJ Ex Order 26.4b1. NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 -NJ Ex Order 26.4b1 would likely result in an NJ Ex Order 26.4b1. -NJ Ex Order 26.4b1 due to noted efficacy and improvement in NJ Ex Order 26.4b1 with current treatment NJ Ex Order 26.4b1 requiring management/risk assessment (effectiveness/side effects monitored). (moderate). A review of the NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 Progress	F 758		

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F 758	Continued From page 112 Note dated NJ Ex Order 26.4b, which included that the patient was NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1 concerns reported by staff; diagnoses were NJ Exec Order 26.4b1 . The plan consisted of the following: 1.) to Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including NJ Ex Order 26.4b1 . Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well-being. 2. continue medication regimen benefit greater than risk. -Have considered the risk of and benefit associated with NJ Ex Order 26.4b1 . NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 the benefits outweigh the risk of treatment. -NJ Ex Order 26.4b1 would likely result in an NJ Ex Order 26.4b1 . -NJ Ex Order 26.4b1, due to noted efficacy and improvement in NJ Ex Order 26.4b1 with current treatment NJ Ex Order 26.4b1 requiring management/risk assessment (effectiveness/side effects monitored). (moderate). A review of the U.S. FOIA (b)(6)) Resident's Evaluation from NJ Exec Order 26.4b1 , did not reflect recommendation for gradual dose reduction for in consideration to the resident's monthly NJ Exec Order 26.4b1 review which revealed the resident had NJ Ex Order 26.4b1 .	F 758		

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F 758	Continued From page 113 Further review of the U.S. FOIA (b) monthly medication review did not reflect a clarification for the indication of NJ Exec Order 26.4b1 in which NJ Exec Order 26.4b1 was not a manufacturer's indication. On 7/3/24 at 1:33 PM, during a meeting with the survey team, the U.S. FOIA (b)(6) the U.S. FOIA (b)(6), the surveyor discussed the concern regarding the indication, and the missed annual opportunity for NJ Exec Order 26.4b1 in the last year of (physician order date of NJ Exec Order 26.), to ensure the resident received the optimal dose for Resident #62 ,who had NJ Ex Order 26.4b1 , and no history of NJ Exec Order 26.4b1 . On 7/8/24 at 9:45 AM, during a telephonic interview with two (2) surveyors, the US FOIA (b) stated they had taken over the building on NJ Exec Order 2. At that time, the US FOIA (b) stated that the manufacturer's indications for NJ Exec Order 26.4b1 and other special considerations. At that time, the US FOIA (b) stated that the NJ Exec Order 26.4b1 reflected that a NJ Exec Orde was contraindicated and because of that she had deferred to NJ Exec Order 26.4b1 and had not recommended a NJ Exec Ord. At that time, the US FOIA (b) stated that even when there were NJ Ex Order 26.4b1 , she deferred to NJ Exec Order 26.4b1 On 7/8/24 at 11:02 AM, during a telephonic interview with the surveyor, the US FOIA (b)(6) stated she was familiar with the resident and had been	F 758		

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F 758	Continued From page 114	F 758		

seeing her since the resident entered the facility.

At that time, the surveyor asked why the resident was receiving NJ Exec Order 26.4b1 with a diagnosis for U.S. FOIA (b)(6) , with consideration to the NJ Ex Order 26.4b1 the manufacturer's guideline of indication, and the resident's NJ Exec Order 26.4b1 . The US FOIA (b) stated that the reason was the resident had previously failed a NJ Exec Ord but could not indicate the date. The US FOIA (b) stated she would get back to the surveyor. The US FOIA (b)(6) also stated that the family was against the NJ Exec Ord.

On 7/8/24 at 11:10 AM, during a telephonic interview with the surveyor, the resident representative stated that she received a call a few days ago and was asked if she wanted the resident to continue or discontinue the use of NJ Exec Order 26.4b1. The patient representative stated that a NJ Exec Order 26.4b1 or tapering of NJ Exec Order 26.4b1 was not explained to her as an alternative; she did state that the resident was doing good.

On 7/8/23 at 1:33 PM, the U.S. FOIA (b)(6) U.S. FOIA (b)(6)) called back instead of the US FOIA (b)(6). During a telephonic interview with the surveyor, the US FOIA stated that they have been a provider for the facility for the last two (2) years. The US FOIA stated that the resident entered the facility with the medication NJ Exec Order 26.4b1 in 2020 wherein the resident exhibited NJ Exec Order 26.4b1 . Currently the resident is under control and is NJ Ex Order 26.4b1 and would not want to NJ Ex Order 26.4b1.

At that time, the surveyor asked the US FOIA about the NJ Ex Order 26.4b1 , the US FOIA stated that there is no evidence that the medication is problematic, contraindication is due

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F 758	Continued From page 115 to NJ Ex Order 26.4b1. We are improving the NJ Ex Order 26.4b1 in a positive way. The surveyor then asked about the unlabeled usage (indication), since the resident was neither NJ Exec Order 26.4b1, the U.S. FOIA stated "the position was that the resident had NJ Ex Order 26.4b1." The surveyor asked how an optimal dose could be achieved without trying a NJ Exec Order 26.4b1. The U.S. FOI then stated because the resident is under control, we would not want to remove. On 7/8/24 at 3:10 PM, in the presence of the survey team, the U.S. FOIA (b)(6), did not provide a response to the concerns. A review of the facility provided policy, Gradual Dose Reduction of Psychotropics dated/revised 4/15/24 under Policy Explanation and Compliance Guidelines included subsection 3. After the first year, a GDR will be attempted annually, unless clinically contraindicated. No further information was provided.	F 758		
F 835 SS=F	N.J.A.C. 8:39-27.1 (a) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 835	1. Resident 94 had a NJ Exec Order 26.4b1	8/14/24

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F 835	Continued From page 116 review it was determined that the US FOIA (b)(6) failed to ensure the facility operated in a manner to ensure residents were consistently provided with care to maintain their highest practicable physical, mental, and psychosocial well-being by failing to ensure: a) a process was in place to ensure a resident (Resident #84) with known NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 was effectively NJ Ex Order 26.4b1 to prevent the resident from sustaining an injury and preventing the resident from NJ Exec Order 26.4b1 another resident (Resident # 94, b) adverse and significant events were thoroughly investigated (Resident #81 and #150, Resident #94), c) NJ Exec Order 2 care was consistently documented to ensure that staff were able to identify and report any change in a NJ Exec Order 2 condition to the physician. Resident #150 developed a NJ Exec Order 26 at the facility which progressed to the NJ Exec Order 26.4b1 which then required an NJ Exec Order 26.4b1. d) an NJ Exec Order 26.4b1 was reported to the Department of Health as required, e) staffing was adequate to meet NJ Ex Order 26.4b1 residents activity of daily living care including NJ Exec Order 26.4b1 for 8 of 8 residents reviewed (Residents #27, #30, #37, #41, #82, #94,# 95, and #155), and f) an effective Quality Assurance and Performance Improvement Program was compressive and self-identified concerns, including residents who required close supervision when NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1 and who discarded NJ Exec Order 26.4b1 in the bushes. This deficient practice had the potential to effect all residents who resided in the facility was evidenced by the following: Refer to: 600 K, 609D, 610H, 686H, 689L, 725F, 865F	F 835	completed on 6/28/2024 at 6:35am and it did not show NJ Ex Order 26.4b1. Resident 94 had a NJ Exec Order 26.4b1 evaluation on 6/28/2024 and the evaluation stated that NJ Ex Order 26.4b1 were noted. Resident 94 was evaluated by NJ Exec Order 26.4b1 Resident 94 was visited by the NJ Exec Order 26.4b1 Resident 30: The Director of Nursing completed a NJ Exec Order 26.4b1 on resident 30 and it was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1. The Director of Nursing evaluated resident 30 for NJ Exec O and NJ Exec Order 26.4b1. The Director of Nursing reported the incident to the Department of Health on 6/28/24 at 9am. Resident 37: On 6/28/24, resident 37 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 which was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1, and denied NJ Exec O. Resident 41: On 6/28/24, resident 41 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 check which was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1. Resident 95: On 6/28/24, resident 95 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 check which was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1. Resident 27: On 7/3/23 the facility began an investigation regarding NJ Exec complaint of being NJ Exec Order 26.4b1. Resident 27 had a NJ Exe and it was	

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F 835	Continued From page 117 a) On 06/27/24 during the facility entrance conference conducted with the U.S. FOIA (b)(6) he facility Quality Assurance and Performance Improvement Policies were requested and provided by the NJ Exec Order. An Immediate Jeopardy (IJ) situation began on NJ Ex Order 26.4b1, and was identified on 07/01/24. Resident #84 had a documented history of NJ Exec Order 26.4b1 into other resident rooms that began on NJ Exec Order 26.4b1 On NJ Ex Order 26.4b1, Resident #84 NJ Exec Order 26.4b1 into Resident #152's room. Resident #152 then NJ Ex Order 26.4b1 Resident #84 which caused Resident #84 NJ Exec Order 26.4b1. On 06/28/24 at 7:30 AM, Resident #94 in the presence of the surveyor, told the U.S. FOIA (b)(6) that they were NJ Exec Order 26 that Resident #84 NJ Exec Order 26.4b1 into their room, placed NJ Ex Order 26.4b1, and NJ Exec Order 26.4b1 Resident # 94's NJ Exec Order 26.4b1. This failure to adequately supervise a resident with a known history of NJ Exec Order 26.4b1 into other resident rooms and NJ Exec Order 26.4b other residents in an NJ Exec Order 26.4b1 placed all residents at an increase risk for the likelihood of serious injury or serious physical or psychosocial harm. This resulted in an Immediate Jeopardy (IJ) situation. b)The facility failed to ensure a thorough and complete investigation was completed to determine the causal factor of NJ Ex Order 26.4b1 to ensure that resident abuse or neglect	F 835	unremarkable NJ Exec Order 26.4b1. Resident 27 NJ Exec Order 26.4b1. Resident 155 no longer resides at the facility. Resident 81 was evaluated. Resident 81 NJ Exec Order 26.4b1. Resident 82: Resident 82□s NJ Exec Order 26.4b1 Resident 150 no longer resides at the facility. Resident 84 was placed on a NJ Exec Order 26.4b1 on 7/1/2024 at 1:45pm. Resident 84 had a NJ Exec Order 26.4b1 and it NJ Ex Order 26.4b1 Resident 84 remained on a NJ Exec Order 26.4b1 until discharged from facility on 2. All residents in the center have the potential to be affected. No residents were identified. 3. The Regional Director of Operations educated the US FOIA (b)(6) on: ¿ Ensuring a process is in place to ensure residents with known wandering behaviors are effectively supervised to prevent residents from sustaining injuries and preventing such residents from abusing another residents ¿ Ensuring adverse and significant events are thoroughly investigated ¿ Ensuring wound care is consistently documented to ensure that staff are able	

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F 835	Continued From page 118 had not occurred for: a) a resident (Resident #150) who was found on NJ Exec Order 26.4b1 with an NJ Exec Order 26.4b1 that required hospitalization on NJ Exec Order 26.4b1, and was diagnosed with NJ Exec Order 26.4b1 and was diagnosed with NJ Exec Order 26.4b1 an by Resident #94 that was reported to the U.S. FOIA (b)(6) on NJ Ex Order 26.4b at 7:30 AM, the facility did not investigate the allegation until NJ Ex Order 26.4 c) and for a resident who had a history of being NJ Exec Order 26.4b1 , and comminuted NJ Exec Order 26.4b1 at the . This deficient practice occurred for 3 of 3 residents reviewed for NJ Exec Order 2 (Resident # 81 and #150, Resident #94). On 07/08/24 at 3:12 PM, the U.S. FOIA (b)(6) stated regarding the documentation for Resident #150's NJ Exec Order 26.4b1, that "we need to keep up on documentation", "the nurses that did treatments did not document". The US FOIA (b)(6) had no additional information to provide regarding the progressing to a NJ Exec Order 26.4b1 and Resident #150 NJ Exec Order 26.4b1 . c) The facility failed to: a.) implement interventions to prevent the development of a NJ Ex Order 26.4b1, b.) ensure individualized comprehensive care plan interventions were implemented to prevent facility acquired NJ Exec Order 26.4b1, and c.) ensure daily observation during NJ Exec Order 26	F 835	to identify and report any changes in a wound condition to the physician. ¿ Ensuring elopements are reported to the Department of Health as required, ¿ Ensuring staffing is adequate to meet dependent residents activity of daily living care ¿ Ensuring there is an effective Quality Assurance and Performance Improvement Program is comprehensive and self-identifies concerns All nursing staff received this education by completion date. New hires and agency staff will receive this in-servicing in orientation. The Director of Nursing reviewed the facility's current nurse and aide competencies to ensure they were completed. All residents have a elopement risk evaluation completed at the time of admission to the facility to determine elopement risk. If a resident is identified as an elopement risk the physician is notified, plan of care reflects elopement risk, behavior monitoring conducted every shift, scheduled activities, elopement prevention device applied if ordered by physician, increased supervision, redirection techniques, and Bi-weekly interdisciplinary meetings. The Nursing Home Administrator or Director of Nursing will complete audits on residents who wander to ensure they are effectively supervised, Adverse and significant events to ensure they are thoroughly investigated, Wound care to	

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F 835	Continued From page 119 care was documented according to professional standards of Nursing practice to follow continuity of care, and d) alert physician of any change in the [redacted] condition. This deficient practice occurred for 1 of 2 closed records reviewed for [redacted] (Resident #150). Resident #150 was identified as having a NJ Exec Order 26.4b1 [redacted] which progressed to NJ Exec Order 26.4b1 [redacted] which was identified during routine [redacted] rounds by a consultant on [redacted], and which resulted in a NJ Exec Order 26.4b1 [redacted] three days later. The evidence was as follows: On 6/28/24 at 12:30 PM, the surveyor reviewed the closed medical record for Resident #150. On 6/28/24, the surveyor reviewed the closed electronic medical record (EMR) for Resident #150. Review of the closed record revealed that Resident #150 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] According to the Annual Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #150 was identified as having [redacted] Resident #150 scored [redacted] on the Brief Interview for Mental Status (BIMS). Resident #150 was NJ Ex Order 26.4b1 staff for all Activities of Daily Living (ADLs). Further review of the MDS in section M, indicated that the resident had no history of an [redacted]	F 835	ensure that wound care is consistently documented to ensure that staff are able to identify and report any changes in a wound condition to the physician, Elopements to ensure they are reported to the Department of Health as required, Staffing to ensure it is adequate to meet dependent residents care, The Monthly QAPI meetings to ensure it is comprehensive and self identifies concerns. 4. The Nursing Home Administrator or Director of Nursing will complete audits on residents who wander to ensure they are effectively supervised, Adverse and significant events to ensure they are thoroughly investigated, Wound care to ensure that wound care is consistently documented to ensure that staff are able to identify and report any changes in a wound condition to the physician, Elopements to ensure they are reported to the Department of Health as required, Staffing to ensure it is adequate to meet dependent residents care, incontinence care on five residents weekly for four weeks, every other week for four weeks, and then monthly for one month to ensure it is completed, and The Monthly QAPI meetings to ensure it is comprehensive and self identifies concerns. These audits will be completely weekly for four weeks, then bi-weekly for four weeks, and then monthly for one month. Findings of these audits will be reviewed at the monthly QAPI meetings for three months.	

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F 835	Continued From page 120 NJ Exec Order 26.4b1 [redacted]. Further review of section M indicated under NJ Exec Order 26.4b1 [redacted] that the following applied: NJ Ex Order 26.4b1 [redacted]. Review of the Order Summary Report (OSR) dated NJ Ex Order2 [redacted], revealed a physician's order (PO) dated NJ Exec Order 26.4b1 [redacted], to NJ Exec Order 26.4b1 [redacted] do not scrub or use excessive force, apply NJ Exec Order 26.4b1 [redacted] daily, covered with a NJ Exec Order 26.4b1 [redacted] daily. Another order dated NJ Exec Order 26.4b1 [redacted] was to cleanse the NJ Exec Order 26.4b1 [redacted], do not scrub or use excessive force. Apply NJ Exec Order 26.4b1 [redacted] NJ Ex Order 26.4b1 [redacted] covered with a NJ Exec Order 26.4b1 [redacted] daily. Review of the OSR revealed a PO dated NJ Exec Order 26.4b1 [redacted] for blue pillow wrap to be donned (put on) on the NJ Exec Order 26.4b1 [redacted] to [redacted] NJ Ex Order 26.4b1 [redacted] every shift. Review of the OSR revealed a PO dated NJ Ex Order 26.4b1 [redacted]. Check placement and functioning every shift. Review of the Weekly NJ Ex Ord [redacted] Review dated NJ Ex Order 26.4b1 [redacted], and signed by a U.S. FOIA (b)(6) [redacted] revealed a NJ Exec Order 26.4b1 [redacted]. On NJ Ex Order 26.4b1 [redacted] (7 days later), indicated " NJ Ex Order 26.4b1 [redacted] No measurement was entered on the NJ Ex Order 26.4b1 [redacted]. The Resident's [redacted] progressed to the	F 835	The Regional Director of Operations or Regional Director of Clinical Services will audit the findings of the Nursing Home Administrator and Director of Nursing's audits weekly for four weeks and then biweekly for four weeks. Findings of these audits will be reviewed at the monthly QAPI meetings for two months.	

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following and there was no investigation to determine why the [redacted] progressed to having a weekly [redacted] consultant identify [redacted] which was not identified by staff at the facility.

A [redacted] Hospital [redacted] report revealed "[redacted] of the [redacted], additional clinical notes revealed, "now presents [redacted] from the skilled nursing facility because o [redacted] per hospital follow up with the facility the [redacted] daily and the facility had no documentation regarding [redacted] and found during weekly [redacted] for "a Right aka [redacted]] on [redacted]"

On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the [redacted] regarding an investigation about the [redacted] development and related [redacted]. The [redacted] stated she was not at the facility and that there was nothing else to provide.

d.) On 07/02/24 at 1:15 PM, the surveyor asked the [redacted] if a resident [redacted]. The [redacted] confirmed that Resident #87 "[redacted] and [redacted] and it was witnessed by a nurse and aide. The [redacted] stated she completed an incident report and the surveyor requested a copy. The surveyor asked the [redacted] if the [redacted] was reported to the DOH. The [redacted] stated, no, "only [redacted]".

On 07/02/24 at 1:29 PM, the surveyor conducted

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an interview with the Unsampled Resident (UR) roommate of Resident #87 regarding the incident. The UR stated Resident #87 NJ Exec Order 26.4b1 and that the US FOIA (b)(6) was in the room and then went out of the window after Resident #87 exited.

On 07/02/24 at 2:30 the U.S. FOIA (b) provided statements regarding the incident which revealed NJ Exec Order 26.4b1 . Alerted the aide and immediately followed out. NJ Exec Order 26.4b1. Dated NJ Ex Order 26.4b1 (untitled staff). Another statement, with Incident date: NJ Ex Order 26.4b1, Incident Time: 9:15 PM, revealed this nurse was coming down the hall when aide informed me that Resident #87 had NJ Exec Order 26.4b1 and nurse with resident outside ... The Incident Report dated NJ Exec Order 26.4b1 revealed that on NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 the assigned nurse for Resident #87 observed the resident NJ Exec Order 26.4b1 , then saw the NJ Exec Order 26.4b1 and saw the resident NJ Exec Order 26.4b1 and the nurse followed outside of the window.

On 07/08/24 at 12:16 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the resident who NJ Ex Order 26.4b1 . The U.S. FOI stated there were brackets that prevented the window from opening all the way. The U.S. FOI showed the surveyor a cut metal bracket with one screw through the bracket and the U.S. FOI confirmed that was a facility derived device. The U.S. FOI stated Resident #87 "NJ Exec Order 26.4b1

On 07/08/24 at 3:10 PM, the U.S. FOIA (b)(6) responded to the surveyor concerns regarding Resident #87 NJ Exec Order 26.4b1 and the U.S. FOIA (b)(6) stated we

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did not think it met the reportable requirement, "it was an anomaly."

e.) a) On 6/27/24 at 10:48 AM, surveyor #1 was doing the initial tour of the facility and was informed by Resident #94 that staff refused to change them. The surveyor noted NJ Exec Order 26.4b1 The call bell was activated by the roommate and the U.S. FOIA (b)(6) reported to the room immediately and confirmed Resident #94 was NJ Exec Order 26.4b1.

On 6/28/24 between the hours of 6:30 AM and 6:50 AM, surveyor #1 observed a care tour in the presence of the U.S. FOIA (b)(6)

At 6:30 AM, surveyor #1 and the U.S. FOIA (b) observed Resident #30 NJ Exec Order 26.4b1 that had NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 The U.S. FOIA (b)(6) were called to the room, and both confirmed the status of the resident's condition and that the resident was NJ Exec Order 26.4b1. The U.S. FOIA (b) stated that her expectations would be that all residents would be changed and maintained in a NJ Exec Order 26.4b manner. At that time, an interview with the U.S. FOI revealed that he assumed that Resident #30 did not receive NJ Exec Order 26.4b1 during the 11:00 PM-7:00 AM shift. The U.S. FOIA (b) revealed that was not the first occurrence of a resident being NJ Exec Order 2 and they received in-service on not to have NJ Exec Order 26.4b1 on the residents. . The U.S. FOIA (b) further stated that if the unit was short of staff the resident would be NJ Exec Order 2 in the morning.

On 7/8/24 at 2:12 PM, surveyor #1 interviewed the NJ Exec Or who cared for Resident #30 on NJ Exec Order 26.4

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on the 11:00 PM to 7:00 AM shift. The [U.S. FOIA (b)] stated, "when I went to check him/her, I did not open the [redacted] fully." The [NJ Exec Ord] also stated there was only 2 [NJ Exec Order 26] working that night and Resident #30 was last checked at 2:30 AM. The [U.S. FOIA (] stated, "I was running late and did not check them again."

At 6:36 AM, surveyor #1 and the [U.S. FOIA (] observed Resident #37 was NJ Exec Order 26.4b1. The [U.S. FOIA (] stated that when the facility was short of staff the resident would be NJ Exec Order 26.4b1 .

At 6:45 AM, surveyor #1 and the [U.S. FOIA (] observed Resident #41 in bed and was NJ Exec Order 26.4b1

At 6:50 AM, surveyor #1 and the [U.S. FOIA (] observed Resident #95 in bed and was NJ Exec Order 26.4b1 . During the interview with Resident #95, the resident stated they were NJ Exec Order 26.4b1 and had not been NJ Exec Order 26.4b1.

On 7/3/24 at 12:13 PM, surveyor #2 interviewed Resident #27 who stated that sometime in [NJ Ex Order 26.4b1] they were NJ Exec Order 26.4b1 [redacted] The Resident could not remember an exact date, but he/she did not have care provided by the 11:00 PM to 7:00 AM shift [U.S. FOIA (]. The Resident stated that the U.S. FOIA (b)(6) were notified of the situation and did not see the [U.S. FOIA (] after that day. Resident #27 stated, "I think she was terminated." Resident #27 further stated still finds that they are waiting an hour or longer for NJ Exec Order 26.4b1. The Resident also stated that the [NJ Exec Order] are doing there best, but they just don't have enough help.

The facility provided Administrator Job

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F 835	Continued From page 125 Description updated May 2023 revealed: Major Duties and Responsibilities: Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance wish current state and federal laws and regulations. Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indictors. Establishes and ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility. Evaluates key performance indicator outcomes with department heads to determine the need for action from leadership and/or management such as re-reduction or revisions related to the facility's outcomes, regulatory compliance and/or customer satisfaction. Ensures delivery of compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover, general cleanliness, physical plant condition, and optimal resident functioning-physically and psychosocially. Identifies and collaborates with members of the interdisciplinary team, physicians, consultants, and community agencies to identify to identify opportunities for enhanced services to the residents and/or resolve issues. Performs rounds to observe residents and ensure overall needs are being met ... f.) On 06/27/24 during the facility entrance conference conducted with the U.S. FOIA (b)(6) [redacted] the facility Quality Assurance and Performance Improvement Policies were requested and provided by the US FOIA (b)(6) [redacted].	F 835		

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F 835	Continued From page 126 The Quality Assurance and Performance Improvement Policy (QAPI), Date reviewed/Revised 02/20/23 revealed: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. An adverse Event is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof. 2c. Develop and implement appropriate plans of actions to correct quality deficiencies. d. Regularly review and analyze date, including data collected under the QAPI program and data resulting from drug regiment reviews, and act on available data to make improvements. 3. The QAPI plan will address the following elements: c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i. Tracking and measuring performance, ii. Establishing goals and thresholds for performance improvements, iii. Identifying and prioritizing quality deficiencies, iv. Systematically analyzing underlying causes of systemic quality deficiencies, v. Developing and implementing corrective action or performance improvement activities, vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. D. A prioritizations of program activities that focus on resident safety, health outcomes, autonomy, choice and quality of care, as well as, high- risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units,	F 835		

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programs, departments and unique population the facility serves. The facility must also consider the incidents, prevalence, and severity of problems or potential problems identified.

The [redacted] also provided signature sheets for a two QAPI meetings, one on 01/18/24 and 05/16/24 and he was signed in as the [redacted] and no other representation as a [redacted] was documented as being in attendance.

On 07/08/24 at 8:20 AM, the surveyor requested the [redacted] to provide all current active QAPI for review with survey team.

On 07/08/24 at 10:27 AM, the surveyor interviewed the [redacted] in the presence of two surveyors. The surveyor asked the [redacted], who stated he has been the [redacted] since 12/2023. The surveyor inquired what QAPIs had he transitioned from the former [redacted], and what he identified as concerns to be reviewed at QAPI. The [redacted] stated pharmacy presents at QAPI and the surveyor asked asked exactly what the facility is monitoring that is measurable and quantifiable for QAPI, and what were the QAPIs that were identified and initiated since he assumed the [redacted] role. The [redacted] stated falls, food quality, and stated food quality was transitioned from the former [redacted]. The [redacted] stated food service was a high priority issue. The [redacted] stated palatability of the food was a concern and also tray tickets not matching what was served. The surveyor asked about the concerns identified during the survey, which included the known [redacted] resident with the subsequent [redacted], the resident who wore [redacted] and the concerns regarding

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NJ Exec Order 26.4b1, the residents who held their own lighters and safe smoking concerns and the resident The U.S. FOIA (b)(6) stated he was never aware of residents having NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) confirmed that the issue of smoking was never brought to QAPI as he was unaware. The surveyor asked if any adverse, significant or reportable events had been brought to QAPI. The U.S. FOIA (b)(6) stated "they don't review" significant or reportable events at QAPI. The U.S. FOIA (b)(6) added that significant events were not reviewed, but "I can certainly add them." The surveyor asked if wounds were reviewed at QAPI and the U.S. FOIA (b)(6) reviewed his QAPI binder and stated NJ Ex Order 26.4b1 were not part of QAPI. The surveyor asked the U.S. FOIA (b)(6) if he was an U.S. FOIA (b)(6) and he stated yes and informed the surveyor of his training.

On 07/08/24 at 11:33 AM, the surveyor asked specifically about a review of the [redacted] for Resident #150 and the U.S. FOIA (b)(6) stated, " I talked to the family at some point" and then I reviewed the case later.

On 07/08/24 at 1:10 PM, the survey team met with the U.S. FOIA (b)(6)
The surveyor reiterated the concerns regarding the incomplete investigations and Resident #84 the known to be a NJ Exec Order 26.4b1 and the surveyor asked about a root cause analysis completed and was this brought to QAPI. The U.S. FOIA (b)(6) stated no.

On 07/08/24 at 3:12 PM, the U.S. FOIA (b)(6) stated regarding the documentation for Resident #150's NJ Exec Order 2 care, that "we need to keep up on documentation", "the nurses that did treatments did not document".

The surveyor reviewed the QAPI program

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F 835	Continued From page 129 provided by the [redacted] for review and the identified concerns were not addressed in QAPI. NJAC 8:39-27.1(a)	F 835		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and	F 865		8/14/24

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F 865	Continued From page 130 evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F 865		

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F 865	Continued From page 131 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to have an effective systems and procedures for feedback in place to self identify areas for Quality Assurance and Perforamance Improvement (QAPI) for: a)a resident documented as NJ Ex Order 26.4b1 that NJ Exec Order 26.4b1 into other resident rooms since	F 865	1.Resident 84 was placed on a one to one (NJ Exec Order 26.4b1 [redacted]. Resident 84 had a U.S. FOIA (b)(6) check on 6/28/2024 at 6:35am and it NJ Ex Order 26.4b1 [redacted]. Resident remained on a NJ Exec Order 26.4b1 discharged on NJ Exec Order 2	

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F 865	Continued From page 132 NJ Ex Order 26.4b1, had a history of being NJ Ex Order 26.4b1 another resident after NJ Exec Order 26.4b1 into another resident room and then NJ Exec Order 26.4b1 another resident (Resident #94) on NJ Exec Order 26.4b1 b) residents who NJ Exec Order 26.4b1 y(Resident #29, #39, #72, #87 and #32), c) ensuring residents were provided with appropriate NJ Exec Order 26.4b1 and activity of daily living care for 8 of 8 residents reviewed (Residents #27, #30, #37, #41, #82, #94,# 95, and #155), and d) adverse events and reportable events for residents with NJ Exec Order 26.4b1 (Resident #81 and #150) . This deficient practice was identified during an on-site survey conducted from 06/25/24-07/15/24 and had the potential to affect all residents and was evidenced by the following: Refer to 600K, 610H, 689L, 686H, and 677F On 06/27/24 during the facility entrance conference conducted with the U.S. FOIA (b)(6) the facility Quality Assurance and Performance Improvement Policies were requested and provided by the LNHA. The Quality Assurance and Performance Improvement Policy (QAPI), Date reviewed/Revised 02/20/23 revealed: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. An adverse Event is an	F 865	Resident 94 had NJ Exec Order 26.4b1 and it NJ Ex Order 26.4b1. Resident 94 had a NJ Exec Order 26.4b1 evaluation on U.S. FOIA (b)(6) and the evaluation stated that NJ Ex Order 26.4b1 were noted. Resident 94 was evaluated by NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. Resident 94 was visited by the social worker for NJ Exec Order 26.4b1 on 6/28/2024 and 7/1/2024. On 7/2/2024 resident 29 was issued a NJ Exec Order 26.4b1 On 7/2/2024, the licensed nurse completed a new NJ Ex Order 26.4b1 assessment. Resident 29 will use a NJ Exec Order 26.4b1 r to prevent his NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1. Resident 30: The Director of Nursing completed a NJ Exec Order 26.4b1 on resident 30 and it was NJ Ex Order 26.4b1. The Director of Nursing evaluated resident 30 for NJ Exec Ord. The Director of Nursing reported the incident to the Department of Health on 6/28/24 at 9am. Resident 37: On 6/28/24, resident 37 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 which was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 Resident 41: On 6/28/24, resident 41 was provided with NJ Exec Order 26.4b1, had a NJ Ex which was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1. Resident 95: On 6/28/24, resident 95 was provided with NJ Exec Order 26.4b1, had a full	

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F 865	Continued From page 133 untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof. 2c. Develop and implement appropriate plans of actions to correct quality deficiencies. d. Regularly review and analyze date, including data collected under the QAPI program and data resulting from drug regiment reviews, and act on available data to make improvements. 3. The QAPI plan will address the following elements: c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i. Tracking and measuring performance, ii. Establishing goals and thresholds for performance improvements, iii. Identifying and prioritizing quality deficiencies, iv. Systematically analyzing underlying causes of systemic quality deficiencies, v. Developing and implementing corrective action or performance improvement activities, vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. D. A prioritization of program activities that focus on resident safety, health outcomes, autonomy, choice and quality of care, as well as, high- risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves. The facility must also consider the incidents, prevalence, and severity of problems or potential problems identified. The U.S. FOIA (b)(6) also provided signature sheets for a two QAPI meetings, one on 01/18/24 and 05/16/24 and he was signed in as the U.S. FOIA (b)(6) and no other representation as a U.S. FOIA (b)(6)	F 865	NJ Exec Order 26.4b1 which was NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 . Resident 27: On 7/3/23 the facility began an investigation regarding her complaint of being NJ Exec Order 26.4b1. Resident 27 had a NJ Exec Order 26.4b1 and it was NJ Ex Order 26.4b1 . Resident 27 NJ Exec Order 26.4b1. Resident 39 was NJ Exec Order 26.4b1 . Resident 72 was NJ Exec Order 26.4b1 Resident 155 no longer resides at the facility. Resident 81 was evaluated. Resident 81 NJ Exec Order 26.4b1. Resident 87 has not NJ Ex Order 26.4b1 facility. Resident 82: Resident 82□s NJ Exec Order 26.4b1 . Resident 150 no longer resides at the facility. Resident 32 will have an NJ Exec Order 26.4b1 2. All residents have the potential to be affected. None were identified. 3. The Regional Director of Operations or Regional Director of Clinical Services will in-service the US FOIA (b)(6) on the QAPI policy. The Nursing Home Administrator or Director of Nursing will audit the QAPI	

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F 865	Continued From page 134 was documented as being in attendance. a) On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the [redacted], "[Resident #84] [redacted]. [Resident #84] always comes into our room. [Resident #84] [redacted] and this time [Resident #84] [redacted] [Resident #84] had [redacted]. I told the staff a million times and nothing had been done". A review of the electronic medical record for Resident #84 revealed (EMR): -[redacted] timed 06:53:41 AM, Resident # 84 watching Television at HS [Hour of Sleep] and rearranging wall poster, nursing monitoring throughout the shift, resident emerged approximately at 5:00 AM, and began exit seeking. The resident stated they were looking for the way out, [redacted] to other resident's rooms. The resident was escorted away by staff, nursing continuing to monitor will endorse to day shift. - A nursing note created [redacted] timed 19:32:19 [7:32 PM] indicated the following: Resident continues to [redacted] around the facility into other residents rooms and was noted on more then one occasion leaving their cell phone unattended. [redacted] timed 13:56 PM [1:56 PM], the nurse's notes revealed the following entry: alerted by staff, another Resident #152 [redacted] [Resident #84] out of their room. Attempted to [redacted] with [redacted] was called for assistance. Full body assessment completed with [redacted] noted. [redacted] and family	F 865	meetings to ensure effective systems and procedures for feedback are in place to self-identify areas for Quality Assurance and Performance Improvement. The facility will use the facility assessment to audit processes in the center to self identify areas for quality assurance. The Director of Nursing or designee will complete an audit on residents with antipsychotics to ensure a gradual dose reduction is attempted annually unless medically contraindicated. 4. The Nursing Home Administrator or Director of Nursing will audit the QAPI meetings to ensure an effective systems and procedures for feedback is in place to self-identify areas for Quality Assurance and Performance Improvement. The audit will be completed monthly for three months. Findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

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notified of incident. Resident #152 was sent to NJ Ex Order 26.4b1. The above note was entered in the EMR on NJ Ex Order 26.4b1 at 12:27:23 PM.

On 07/01/24 at 12:29 PM, the surveyor interviewed Resident #71 who was Resident #94's roommate. Resident #71 stated, "my roommate got NJ Exec Order 26.4 by [Resident #84] last night" and that the facility informed the resident that Resident #84 was allowed to NJ Exec Order 26 because the resident was NJ Exec Order 26.4b1. Resident #71 further stated, "we were half asleep and we are not sure of what [Resident #84] is capable of doing." Resident #71 further stated that Resident #84 had been "NJ Exec Order 26.4b1 and that was reported to the nurses, the U.S. FOIA (b)(6).

On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the UM, "[Resident #84] NJ Ex Order 26.4b1 [Resident #84] always comes into our room. [Resident #84] NJ Exec Order 26.4b1 and this time [Resident #84] NJ Exec Order 26.4b1 [Resident #84] had NJ Exec Order 26.4b1. I told the staff a million times and nothing had been done".

b) On 7/1/2024, a surveyor observed Resident #39 NJ Exec Or resident #29's NJ Exec Order 26.4b1, leave the NJ Exec Order 26.4b1 and entered the facility while in possession of the NJ Exec Order 26 material. Resident #29, a resident with NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 who was assessed as requiring close supervision while NJ Exec Order 26.4b was not adequately supervised, and staff did not assist the resident while NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was

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[redacted], then the resident rested their [redacted] on their NJ Exec Order 26.4b1 [redacted], then picked up the [redacted] again and continued to [redacted]. The surveyor then observed a US FOIA (b)(6) [redacted]) take Resident #29's NJ Exec Order 26.4b1 and disposed the [redacted] over the patio and into the bushes.

On 07/02/24 at 11:16 AM, the concerns related to residents who [redacted], held their own [redacted] and NJ Exec Order 26.4b1 was discussed with the [redacted]. The [redacted] stated that residents should not be NJ Exec Order 26.4b1 [redacted].

c) On 06/27/24 and 06/28/24 during multiple observations surveyors observed:

-6/27/24 at 10:48 AM, surveyor #1 entered Resident #94's room and noted NJ Ex Order 26.4b1 [redacted] in the room. Resident #94 informed the surveyor that staff refused to assist with NJ Exec Order 26.4b1. Upon request, Resident #94's roommate activated the call bell. The U.S. FOIA (b)(6) [redacted] reported to the room immediately, and confirmed that Resident #94 needed to be changed.

- 6/27/24 at 11:06 AM, surveyor #1 observed Resident #82 in bed with NJ Exec Order 26.4b1 [redacted] The resident informed the surveyor that they would like their NJ Exec Order 26.4b1 and [redacted] A review of Resident #82's care plan indicated to check NJ Exec Order 26.4b1, [redacted] on bath day, as necessary.

-06/28/24 at 6:30 AM, the surveyor entered [redacted] which was a four bedded room and asked a random U.S. FOIA (b)(6) [redacted] to

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assist with NJ Exec Order 26.4b1 care tour. The NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 in the hallway. The first 3 residents were NJ Exec Order 26.4b1.(Resident #82, #37 and #41.)

- 6/28/24 at 6:36 AM, during the NJ Exec Order 26.4b1 (IC), in the presence of CNA #3, surveyor #1 observed Resident #37 was NJ Exec Order 26.4b1. The surveyor interviewed CNA #1 who worked the NJ Ex Order 26.4b1 day. CNA #1 stated that when the facility was short of staff, the residents would be NJ Exec Order 26.4b1. On 07/03/24 at 1:43 PM, the surveyor interviewed the U.S. FOIA (b)(in the presence of the survey team regarding an investigation for Resident #82's NJ Exec Order 26.4b The surveyor asked what would be completed when a new symptom would occur with a resident as Resident #81 had new complaint of NJ Exec Order 26.4b1 . The US FOIA (b) stated typically the nurse would call the physician, re: don, and new symptom would occur and notify family. The surveyor asked when the resident presented with NJ Exec Order 26.4b1 was that when the investigation began. The NJ Exec Orc stated, "typically I go back from when baseline changed" and collect statements for "72 hours prior". The surveyor showed the U.S. FOIA (b the statements had missing dates and they did not go back 72 hours from NJ Ex Order 26 and that the U.S. FOIA (b)(6) would obtain the statements and they were responsible for interviewing staff. The surveyor asked how abuse/neglect was ruled out and the U.S. FOIA (b did not offer a response. The surveyor asked the U.S. FOIA (b who was responsible for reviewing the investigation and she stated she reviewed it.

d)1. On 07/02/24 at 11:30 AM, the surveyor reviewed all progress notes which revealed a

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NJ Ex Order 26.4b1 note indicating that Resident #150 had a NJ Exec Order 26.4b1 at the facility on the NJ Exec Order 26.4b1 The NJ Exec Order 26.4 measuring 2 cm x 2 cm x 0.2 cm. Interventions implemented for the NJ Exec Order 2 were NJ Ex Order 26.4b1, NJ Exec Order 2. The NJ Exec Order 2 had worsened and the facility did not document anything regarding the NJ Exec Order2 condition in the EMR. There was no documentation in the EMR that indicated the physician was made aware of the condition of the NJ Exec Order 26

Review of the Order Summary Report dated NJ Exec Order 26.4, reflected an order dated NJ Exec Order 26.4b to cleanse the NJ Exec Order 26.4b1 topically every day shift for NJ Exec Order 26, cleanse with NJ Exec Order 26.4b1, do not scrub or use NJ Exec Order 26.4b1. pat dry, apply NJ Exec Order 26.4b1 base, cover with a NJ Ex Order 26.4b1.

The NJ Exec Order 26.4b1 had an order, dated NJ Ex Order 26.4b1 to cleanse with NJ Exec Order 26.4b1, do not scrub or use excessive force, pat dry, apply NJ Exec Order 26.4b1 base cover with a NJ Ex Order 26.4b1 The staff initialed the Treatment Administraation Record (TAR) from NJ Ex Order 26.4b1 indicating that the NJ Exec Order 2 care was completed as ordered.

On 12/05/23, at 21:15 [9:15 PM] Discharge Summary, for a Date of Discharge from the facility on NJ Exec Order 26.4b1 revealed Resident #150 "... NJ Exec Order 26.4b1 ...", "... NJ Exec Order 26.4b1

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[NJ Ex Order 26.4b1] due to the patient being severely NJ Ex Order 26.4b1 . Recommend patient be sent to hospital for NJ Exec Order 26.4b1 " According to nursing notes, patient was admitted for NJ Exec Order 26.4b1

The Hospital record for Resident #150 for the NJ Exec Order 26.4b1 Admission which began on NJ Exec Order 26.4b1 was obtained by the Department of Health (DOH) and revealed:

Emergency Department (ED) Provider Note dated NJ Ex Order 26.4b1 at 11:00 revealed:

-Initial Complaint:
Patient presents with NJ Exec Order 26.4b1 infection coming from rehab with a NJ Exec Order 26.4b1 .. Past medical history of NJ Ex Order 26.4b1 currently living in a nursing home with NJ Ex Order 26.4b1 patient with know NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 . History and physical completed at the hospital upon admission on NJ Exec Order 26.4b1 revealed the following: History of NJ Ex Order 26.4b1 , who presents from a Long Term Care Facility (name redacted) due to NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 . Resident #150 was diagnosed with NJ Exec Order 26.4b1 .

The surveyor reviewed the hospital record from the hospitalization of NJ Ex Order 26.4b1 and the following were noted:

-Comments: NJ Exec Order 26.4b1 Significant NJ Exec Order 2

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F 865	Continued From page 140 -A NJ Ex Order 26.4b1 Hospital NJ Exec Order 26.4b1 report revealed NJ Exec Order 26.4b1 additional clinical notes revealed, "now presents NJ Ex Order 2 from the skilled nursing facility because of NJ Exec Order 26.4b1, as wall as NJ Exec Order 26.4b1)" per hospital follow up with the facility the NJ Exec Order 2 NJ Ex Order 26.4b1 and the facility had no documentation regarding NJ Exec Order and found during weekly NJ Exec Order 2 observation, NJ Ex Order 26.4b1 plans for "a NJ Exec Order 26.4b1 . On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the U.S. FOIA (b)(with the U.S. FOIA (b)(6 present, regarding an investigation about the NJ Exec Order 26 development and then related to NJ Exec Order 26.4b1. The US FOIA (b)(6 stated she was not at the facility and had nothing to provide other than what was already provided. When inquired to the US FOIA (b)(6 stated he was aware of Resident #150 having NJ Exec Order 26.4b1 and stated resident was NJ Exec Order 26.4b NJ Ex Order 26.4b1 and provided no addition information. 2. A Reportable Event Record/Report (RER) was received by the Department of Health (DOH) on NJ Ex Order 26.4b1 regarding Resident #81 which revealed: Date of Event: NJ Ex Order 26.4b1, Time of Event: 11:10 AM. 1. Narrative: At 11:10 AM on NJ Ex Order 26.4b1, notified that a NJ Exec Order 26.4b1 Resident has NJ Exec Order 26.4b1. Resident does NJ Ex Order 26.4b1 at times in room. Resident has a Dx. (diagnosis) NJ Exec Order 26.4b1 3. Resident was assessed for further injuries and NJ Ex Order 26.4b1 were noted.	F 865		

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NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 . Statements are being collected from staff from the past 72 hours. On 7/8/24 at 8:30 AM, the facility offered a one paged document titled which revealed on NJ Exec Order 26.4b1 a physician documented there was NJ Ex Order 26.4b1 changes".

On NJ Ex Order 26.4b1 nursing noted NJ Exec Order 26.4b1 at 11:00 AM, NJ Exec Order 26.4 was administered and was ineffective. ... During the investigation, the [family] was able to obtain some information of the cause of the NJ Exec Order 26.4. The resident's [family] stated that the resident stated they NJ Exe and could not get any additional information. There was no statement from the family, no documentation regarding the NJ Exec Order 26.4b1 and interviewing staff related to a J.S.FOI no additional statements were provided.

On 07/08/24 at 8:20 AM, the surveyor requested the U.S. FOIA (b)(6) to provide all current active QAPI for review with survey team.

On 07/08/24 at 10:27 AM, the surveyor interviewed the U.S. FOIA (b)(6 in the presence of two surveyors. The surveyor asked the U.S. FOIA (b)(6, who stated he has been the U.S. FOIA (b)(6 since NJ Ex Order 26.4b1. The surveyor inquired what QAPIs had he transitioned from the former U.S. FOIA (b)(6, and what he identified as concerns to be reviewed at QAPI. The U.S. FOIA (b)(6 stated pharmacy presents at QAPI and the surveyor asked asked exactly what the facility is monitoring that is measurable and quantifiable for QAPI, and what were the QAPIS that were identified and initiated since he assumed the

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F 865	Continued From page 142 U.S. FOIA (b)(6) role. The U.S. FOIA (b)(6) stated falls, food quality, and stated food quality was transitioned from the former U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated food service was a high priority issue. The U.S. FOIA (b)(6) stated palatability of the food was a concern and also tray tickets not matching what was served. The surveyor asked about the concerns identified during the survey, which included the known NJ Exec Order 26.4b1 resident with the subsequent allegation of NJ Exec Order 2 , the resident who wore NJ Exec Order 2 and the concerns regarding NJ Ex Order 26.4b1, the residents who held their NJ Ex Order 26.4b1 concerns and the resident The U.S. FOIA (b)(6) stated he was never aware of residents having NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6) confirmed that the issue of smoking was never brought to QAPI as he was unaware. The surveyor asked if any adverse, significant or reportable events had been brought to QAPI. The U.S. FOIA (b)(6) stated "they don't review" significant or reportable events at QAPI. The U.S. FOIA (b)(6) added that significant events were not reviewed, but "I can certainly add them." The surveyor asked if NJ Ex Order 26.4b1 were reviewed at QAPI and the U.S. FOIA (b)(6) reviewed his QAPI binder and stated NJ Exec Order 26.4 were not part of QAPI. The surveyor asked the U.S. FOIA (b)(6) if he was an U.S. FOIA (b)(6) and he stated yes and informed the surveyor of his training. On 07/08/24 at 11:33 AM, the surveyor asked specifically about a review of the NJ Exec Order 26.4b for Resident #150 and the U.S. FOIA (b)(6) stated, " I talked to the family at some point" and then I reviewed the case later. On 07/08/24 at 1:10 PM, the survey team met with the U.S. FOIA (b)(6) The surveyor reiterated the concerns regarding the incomplete investigations and Resident #84	F 865		

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	315047	A. BUILDING _____ B. WING _____	C 07/15/2024

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F 865	Continued From page 143 the known to be a [NJ Exec Order 26.4b1] and the surveyor asked about a root cause analysis completed and was this brought to QAPI. The [U.S. FOIA (b)(6)] stated no. On 07/08/24 at 3:12 PM, the [U.S. FOIA (b)(6)] stated regarding the documentation for Resident #150's [NJ Exec Order 2] care, that "we need to keep up on documentation", "the nurses that did treatments did not document". The surveyor reviewed the QAPI program provided by the [US FOIA (b)(6)] for review and the identified concerns were not addressed in QAPI. NJAC 8:39-33.2(a)(b)(c)1,3	F 865		
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	F 880		8/14/24

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F 880	Continued From page 144 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 145 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to minimize the potential spread of infection to residents during medication administration for 1 of 2 nurses observed during the medication pass on 1 of 2 units (North Wing). This deficient practice was observed and evidenced by the following: On 6/28/24 at 7:00 AM, the surveyor observed signage posted at the entrance door which read: "Enhanced Barriers Precautions" Stop. Everyone must clean their hands before entering and exiting the room. Providers and suppliers must also wear gloves and gown during high contact Resident Cares activities, or devices care. On 06/28/22 at 7:15 AM, the surveyor observed the U.S. FOIA (b)(6)) prepare medications for Resident #71. The U.S. FOIA opened the top drawer of the medication cart, retrieved the NJ Ex Order 26.4b1, don (put on) gloves and a Personal Protective Equipment (PPE) gown and entered Resident #71's room. The U.S. FOIA went to the room, informed the resident of the procedure, and checked the resident NJ Ex Order 26.4b1. The U.S. FOIA exited the room, removed the gloves and gown, disposed of them in the receptacle bin attached to the medication cart, returned to the computer and entered the result. The U.S. FOIA retrieved a syringe from the medication cart then	F 880	1. Resident 71 was not affected. 2.All residents have the potential to be affected. None were identified. 3. The Director of Nursing or designee will in-service the nursing staff on the hand hygiene policy. New hires and agency staff will receive this in-servicing in orientation. The Director of Nursing or designee will conduct hand hygiene observation audits to ensure staff follow the policy for how and when to wash their hands. . 4.The Director of Nursing or designee will conduct hand hygiene observation audits on five staff members to ensure they follow the policy for how and when to wash their hands. The audit will be conducted weekly for four weeks, then bi-weekly for four weeks, and then monthly for one month. Findings of the audits will be reviewed at the monthly QAPI meetings for three months.	

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F 880	Continued From page 146	F 880		

realized there was no [NJ Ex Order 26] available on the cart for Resident #71. The [U.S. FOIA (b] stated that she needed to go to the medication storage room to obtain the [NJ Ex Order 26.4b]. The [U.S. FOIA] went to the storage room and returned with the [NJ Ex Order 26] which was stored in a plastic bag. The [U.S. FOIA (b] returned to the medication cart, prepared and administered the [NJ Ex Order 26] without performing hand hygiene. The [U.S. FOIA] exited the room, removed and disposed of the soiled PPE in the receptacle bin, signed for the medication administered and again did not perform hand hygiene.

At 7:25 AM, the [U.S. FOIA (b] started to check the medication for the resident in the next bed. The [U.S. FOIA (b] donned gloves and a gown in the hallway prior to entering the room. The [U.S. FOIA (b] entered the room, retrieved a device on the resident table and checked their [NJ Ex Order 26.4b1]. The [U.S. FOIA (b] returned the device to the table, exited the room without performing hand hygiene.

The [U.S. FOIA (b] returned to the medication cart, removed the soiled PPE and proceeded to prepare medication for the resident. The surveyor observed the [U.S. FOIA] did not perform hand hygiene after she removed the soiled PPE. The [U.S. FOIA] did not perform hand hygiene before she continued to prepare other medications for administration.

At 7:25 AM, the [U.S. FOIA (b] entered the resident's room and handed the resident the cup of medication. She then picked up a disposable cup that contained water that was on the overbed table while wearing gloves and handed it to the resident. She removed the gloves in the room, went to the sink and washed her hands. The [U.S. FOIA (b] returned to the medication cart, removed the soiled gown, and did not perform hand hygiene.

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F 880	Continued From page 147	F 880		

She returned to the medication cart and utilized the computer, as she signed out the medications that were administered in the electronic medical record.

At 7:40 AM, the surveyor interviewed the [redacted] regarding the signage observed at the entrance of the resident's door. The [redacted] informed the surveyor that both residents were on Enhanced Barrier Precautions and staff were to don and doff (remove) prior to entering and exiting the room and perform hand hygiene. The surveyor then asked the [redacted] if she should follow the protocol during medication administration. The [redacted] stated, "I thought that I should perform hand hygiene only when moving from one resident to the other." The surveyor then asked the [redacted] if she should wash her hands after removing PPE and she stated, "Yes, I should have." When asked for the rationale why she should perform hand hygiene after removing soiled PPE, she stated that by not washing her hands or performing hand hygiene prior to and after medication administration, she risked the spread of infection.

On 06/28/24 at 10:00 AM, the surveyor interviewed the [redacted] who stated that staff were required to perform hand washing prior to medication administration and could have used hand sanitizer up to three times before performing hand hygiene with soap and water. He stated that cross-contamination could result if hands were not washed prior to handling medications, the computer keyboard and the medication cart.

On 06/28/24 at 11:02 AM, the [redacted]) provided an in-service education sheet to

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F 880	Continued From page 148 the surveyor. Upon inquiry, the U.S. FOIA (b)(stated that the U.S. FOIA reported that she omitted to wash her hands during the medication administration pass. The surveyor then interviewed the U.S. FOIA (b)(who stated that she expected nursing to wash their hands or use Alcohol Based Hand Rub (ABHR) prior to handling medications, as it was an "infection issue" if hand hygiene was not performed first. The U.S. FOIA (b)(stated that nursing should also sanitize their hands after they left the resident's room, after medication administration, and before they did anything else. She stated that staff were instructed to sanitize their hands after they doffed their gloves to ensure that both staff and residents were safe from infection. The surveyor requested the policy for hand hygiene for review. On 07/03/24 at 11:25 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that he expected that nursing would have utilized ABHR in between each resident during medication pass. She stated that nursing was also required to wash their hands prior to donning and after doffing gloves. The U.S. stated that that cross-contamination could result if hands were not washed prior to handling medications, the computer keyboard and the medication cart. The surveyor reviewed the facility policy titled, "Hand Hygiene" last revised, 5/29/24 which revealed the following: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility.	F 880		

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F 880	Continued From page 149 Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. NJAC 8:39-19.4 (a)	F 880		

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	060314	A. BUILDING: _____ B. WING _____	C 07/15/2024

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint # NJ's 167264, NJ165558, NJ170219 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 and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1. Staffing Coordinator and Administrator review staffing schedules to ensure adequate staffing ratios. Facility efforts will include a focus on hiring staff, use of agency, and incentives. 2. Resident 27: On 7/3/24 the facility began an investigation regarding [redacted] complaint of being [redacted]. Resident 27 had a [redacted] check by the Director of Nursing on 7/2/24 and it was unremarkable [redacted]. Resident 27 [redacted] Resident 30: The Director of Nursing completed a [redacted] check on resident 30 and it was [redacted]	8/14/24

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

Electronically Signed | 08/06/24

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of Complaint staffing from 06/25/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -06/25/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -06/29/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -06/30/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -07/01/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -07/02/23 had 9 CNAs for 95 residents on the day	S 560	without impairments. The Director of Nursing evaluated resident 30 for U.S. FOIA (b)(6) [redacted]. The Director of Nursing reported the incident to the Department of Health on 6/28/24 at 9am. The Director of Nursing began the investigation and completed the assessment and determined the outcome. Resident 82: Resident 82□s NJ Exec Or were NJ Exec Order 26.4b1 [redacted] by a licensed nurse. Resident 37: On 6/28/24, resident 37 was provided with NJ Exec Order 26.4b1, had a full NJ Ex Order 26.4b1 by the Director of Nursing which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident 41: On 6/28/24, resident 41 was provided with NJ Exec Order 26.4b1, had a full NJ Ex Order 26.4b1 by the Director of Nursing which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1 [redacted]. Resident 94: On 6/27/24, resident 94 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 by the Director of Nursing which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1 [redacted] Resident 95: On 6/28/24, resident 95 was provided with NJ Exec Order 26.4b1, had a full NJ Exec Order 26.4b1 by the U.S. FOIA (b)(6) [redacted] which was NJ Ex Order 26.4b1 without NJ Exec Order 26.4b1 [redacted]. 3. Staffing Coordinator and Administrator will implement a facility focus on hiring nursing staff, offering shift incentives to	

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S 560	Continued From page 2 shift, required at least 12 CNAs. -07/08/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. 2. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of Complaint staffing from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -07/30/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -08/05/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/06/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/07/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/12/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. 3. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of Complaint staffing from 11/19/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 13 of 28 day shifts as follows: -11/19/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -11/25/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/26/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/27/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/29/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/30/23 had 11 CNAs for 96 residents on the	S 560	facility staff to encourage extra pick up shifts and the use of agency staff if ratios cannot be met with facility staff. Facility staffing and recruitment methods will be monitored in a weekly meeting. 4. Weekly meeting information will be presented to QAPI committee monthly for three months to ensure staffing ratios are maintained.	

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S 560	Continued From page 3	S 560		

day shift, required at least 12 CNAs.
-12/02/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs.

-12/03/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-12/07/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-12/09/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs.

-12/10/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-12/12/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-12/16/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.

4. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing prior to survey from 06/09/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:

-06/15/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.

-06/16/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-06/21/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-06/22/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.

On 7/2/24 during an interview with the surveyor, the staffing coordinator (SC) who also worked in human resources (HR) stated she was aware of the CNA staffing ratios. She stated that the ratios were as follows:
For the 7:00 AM to 3:00 PM shift the ratios were 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060314	A. BUILDING: _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCA	1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 CNA:8 residents; For the 3:00 PM to 11:00 PM shift the ratios were 1:10; For the 11:00 PM to 7:00 AM shift the ratios were 1:14. At that time, the SC stated that she does the best she can to do to staff for the ratios and "it sometimes works."	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
315047 Y1	A. Building B. Wing Y2	9/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077

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 F0600	Correction	ID Prefix F0610	Correction	ID Prefix F0677	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	08/14/2024	LSC	08/14/2024	LSC	08/14/2024
ID Prefix F0686	Correction	ID Prefix F0725	Correction	ID Prefix F0835	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.70	Completed
LSC	08/14/2024	LSC	08/14/2024	LSC	08/14/2024
ID Prefix F0865	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/14/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/15/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060314	A. Building B. Wing	9/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/14/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/15/2024	☐ 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
	315047	A. BUILDING **01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE** **CINNAMINSON, NJ 08077**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/12/2024 and 07/15/2024, and Wynwood Rehabilitation and Healthcare Center 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 The facility is a two-story building with a basement that was built in 1965. It is composed of Type II protected construction. The facility is divided into 4-smoke zones. The facility has a Natural Gas Emergency Generator that supplies electrical power to approximately 50 percent of the building according to the Director of Maintenance The facility is Licensed for 114 beds. The census was 103.	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07//12/2024 and 07/15/2024 in the presence of	K 271	1. No residents were affected. 2 Residents of the center had the	8/5/24

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

Electronically Signed | 08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING **01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE** **CINNAMINSON, NJ 08077**

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K 271	Continued From page 1 facility management, it was determined that the facility failed to provide 1 of 11 exit discharges with a stable, hard packed all-weather travel surface and maintain a level walking surface, free of all obstructions and impediments to reach a public way (street or parking lot) in the case of fire or other emergency in accordance with National Fire Protection Association (NFPA) 101:2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient practice had the potential to affect any resident utilizing this exit and was evidence by the following: Starting at approximately 9:19 AM on 07/12/2024 and continued on 07/15/2024 in the presence of the U.S. FOIA (b)(6) during a tour of the facility, the surveyor observed outside of 11 designated exit discharge doors the following: On 07/12/2024 at approximately 9:24 AM an inspection of a basement designated exit (illuminated exit signs above the door) discharge door was performed. The surveyor observed, measured and recorded a 24 foot long grassy sloped unstable walking surface to reach a public way (sidewalk). In an interview at the time, the he U.S. FOIA (b)(6) confirmed the findings. The U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 07/15/2024 at approximately 12:58 PM. NJAC 8:39-31.1(e)	K 271	potential to be affected. 3 Exit discharges will have a stable, hard packed. all- weather travel surface and maintain a level walking surface, free of obstructions. A permanent concrete walkway was installed at identified area as of 8/5/24. All other walkways have had packed allweather travel surfaces free from obstructions 4. As quality assurance measure, on a quarterly basis for 4 quarters, the Facility Manager or Designee will observe will observe five exits to ensure surface is hard packed level and free from obstructions. results of quarterly observations will be forwarded to the quality assurance committee for review and revisions will be made as necessary Pictures uploaded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 2	K 281		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 07/12/2024 and 07/15/2024 in the presence of U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that all means of egress were provided with continuous lighting with two lamps for 3 of 11 designated exit discharge doors in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. This deficient practice had the potential to affect was evidenced by the following: A review of the facility provided lay-out identified the facility is a two-story (2) building with eleven (11) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:19 AM on 07/12/2024 and continued on 07/15/2024 in the presence of the facilities' U.S. FOIA (b [redacted] an inspected outside of the building of 11 designated exit discharge doors for continuous emergency lighting and observed the following, On 07/12/2024:	K 281	1.1. No residents were affected. 2 Residents of the center had the potential to be affected. 3 Areas identified as a path of egress will have continuous lighting with 2 lamps. Areas with a single lamp were corrected 08/01/2024 4 As Quality Assurance measure on a weekly basis for 4 weeks, then a monthly basis for 2 months, then a quarterly basis for 2 quarters, the Facilities Manager or Designee will observe 5 exit discharges to ensure that areas of egress have continuous lighting with 2 lamps. Results of quarterly observations will be forwarded to the Quality Assurance committee for review and revisions will be made as necessary. Pictures uploaded.	8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 3 1) At approximately 9:24 AM, the surveyor observed outside of the basement level designated (illuminated exit sign) exit discharge door a one single bulb light fixture. There was no supplemental light to ensure area is illuminated should the single bulb or single bulb light fixture fail. 2) At approximately 10:59 AM, the surveyor observed outside of the Physical Therapy designated exit discharge (illuminated exit sign) door no evidence of a light fixture. On 07/15/2024: 3) At approximately 10:41 AM, the surveyor observed outside the employee designated exit discharge door (next to Resident room #33) had no evidence of a light fixture. In interviews at the times of observations, the U.S. FOIA (b) confirmed the findings. The U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code survey exit on 07/15/2024 at approximately 12:58 PM.	K 281		
K 324 SS=E	NJAC 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		8/5/24

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K 324	Continued From page 4 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation on 07/12/2024 and 07/15/2024 in the presence of facility management, it was determined that the facility failed to inspect the kitchen range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. The deficient practice had the potential to affect all residents and was evidenced by the following: At approximately 12:20 PM, a review of the facility's range-hood fire suppression system inspections for the previous 19 months identified the system had three (3) semi-annual inspections on the following dates: - February 28, 2023. August 31, 2023 and July 13, 2024 (10-months later)	K 324	1. No residents were affected. 2 Residents of the center had the potential to be affected. 3 The kitchen range-hood fire suppression system will be inspected semi-annually (every 6 months). Range hood inspections will be scheduled and completed accordingly. 4 As quality assurance measure, for one year on a semi- annual basis in July and January, the Facilities Manager or Designee will confirm scheduling and completion of range-hood fire suppression system. Results of semi-annual observations will be forwarded to the quality assurance committee for review and revisions will be made as necessary.	

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K 324	Continued From page 5 In an interview at 1:35 PM, the U.S. FOIA (b) stated there had been no additional semi-annual Kitchen suppression system inspections. The U.S. FOIA (b)(6) confirmed the findings at the times of observations. The U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code survey exit on 07/15/2024 at approximately 12:58 PM. NJAC 8:39-31.2(e) NFPA 96	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 07/12/2024 and 07/15/2024 in the presence of the facility management, it was determined that the facility failed to ensure smoke detection sensitivity was tested every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire	K 345	1. No residents were affected. 2 Residents of the center had the potential to be affected. 3 Smoke detection sensitivity testing for the 101 smoke detectors in the facility will be completed every alternate year. As of 07/08/2024, all smoke detectors have had sensitivity testing performed. 4. As quality assurance measure, on an annual basis in July, the director of	8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 6 alarm systems, had the potential to affect all residents and was evidenced by the following: A review of the facility provided mandatory fire alarm system Semi-annual inspections for the previous 19 months at approximately 11:58 AM, revealed the following: - 12/19/2022, no documentation of sensitivity testing performed. - 06/09/2023, no documentation of sensitivity testing performed. - 12/21/2023, no documentation of sensitivity testing performed. - 06/10/2024, no documentation of sensitivity testing performed. This review of the testing reports revealed no reference to a smoke detection sensitivity testing performed for the 101 smoke detectors in the facility. On 07/12/2024 at approximately 1:35 PM, a request was made to the U.S. FOIA (b)(6) that the facility may have to place a telephone call to the Contracted Vendor (CV) for the Fire Alarm and Detection System Inspections and request to get a copy of the last smoke detector sensitivity testing. On 07/15/2024 the facility could not provide evidence of a smoke detector sensitivity testing. In an interview at the time of review, the U.S. FOIA (b) confirmed the findings. The U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code survey exit on 07/15/2024 at approximately 12:58	K 345	maintenance or designee will review documentation and confirm sensitivity testing for all smoke detectors is current. Results of annual observation will be forwarded to the quality assurance committee for review and revisions will be made as necessary. Report uploaded.	

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K 345	Continued From page 7 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		8/5/24

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WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE** **CINNAMINSON, NJ 08077**

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K 363	Continued From page 8 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility provided documentation on 07/12/2024 and 07/15/2024 in the presence of facility management, it was determined that the facility failed to ensure that 3 of 27 corridor doors observed and inspected were able to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice had the potential to affect was evidenced by the following: On 07/12/2024 during the survey entrance at approximately 9:04 AM, a request was made to the U.S. FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms, offices and common areas in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building. The first floor has 56 Resident sleeping rooms and common areas. The second floor is administrative offices. Observations starting at approximately 9:19 AM on 07/12/2024 and continued on 07/15/2024 in the presence of the facility's U.S. FOIA (b) revealed the the following doors were not smoke resistant: On 07/12/2024: 1. At approximately 10:18 AM, the surveyor	K 363	1. No residents were affected. 2 Residents of the center had the potential to be affected. 3 Corridor doors will be configured and installed to resist passage of smoke. Resident rooms #16 and 19 and South Wing Supervisor's Office doors were adjusted on 08/02/2024. 4. As quality assurance measure, on an quarterly basis for 4 quarters, the Facilities Manager or designee will observe 10 corridor doors to ensure doors are configured and installed to prevent the passage of smoke. Results of quarterly observations will be forwarded to the quality assurance committee for review and revisions will be made as necessary. Photos uploaded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315047	A. BUILDING **01** B. WING _____	**07/15/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 9 observed during a closure test of Resident room #19. The door did not latch into its frame, leaving a 1-inch open gap between the door and frame. 2. At approximately 10:21 AM, during a closure test of the resident room #16, when the corridor door was in the closed position, the surveyor observed a 1/4" gap along the doors top edge. 3. At approximately 11:03 AM, during a closure test of the [redacted] Wing Nursing Supervisors office, the door did not close into its frame. Code requires doors protecting corridors have gaps no larger than 1/8 of an inch around the doors frame and no more than one (1) inch along the doors bottom edge. In an interview at the time of observations, the [redacted] confirmed the findings. The [redacted] was informed of the deficient practice during the Life Safety Code survey exit on 07/15/2024 at approximately 12:58 PM.	K 363		
K 374 SS=E	NJAC 8:39-31.1(c), 31.2(e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		8/5/24

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K 374	Continued From page 10 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility provided documentation on 07/12/2024 and 07/15/2024 in the presence of facility management, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for 2 of 5 sets of corridor double smoke barrier doors tested, had the potential to affect all residents on the 1st. floor and was evidence by the following: Observations during a two (2) day tour, revealed the U.S. FOIA (b) performed closure tests of five (5) sets of double smoke doors with the following results: On 07/12/2024: 1) At approximately 10:01 AM, during a closure test of a set of corridor double smoke doors near the South Unit Nursing station, the U.S. FOIA (b) released the doors from their magnetic hold open devices and allowed the doors to self-close. The surveyor observed, measured and recorded a 1/2 -inch wide by 3-inch long gap near the bottom meeting edges of the doors. 2) At approximately 11:08 AM, during a closure test of a set of corridor double smoke doors on the North Unit (next to Resident room #49), the U.S. FOIA (b)(6) released the doors from the magnetic hold	K 374	1. No residents were affected. 2 Residents of the first floor had the potential to be affected. 3 Smoke Barrier doors will be configured and installed to resist passage of smoke: set of corridor double smoke doors near the South Unit Nursing station measured and recorded a 1/2 -inch wide by 3-inch long gap near the bottom meeting edges of the doors. Next, the double smoke doors on the North Unit (next to Resident room #49) measured and recorded a 1-inch gap along the doors bottom edge. Both of these sets of doors were adjusted on 08/02/2024. 4. As quality assurance measure, on a quarterly basis for 4 quarters, the Facilities Manager or designee will observe 10 corridor doors are configured and installed to prevent the passage of smoke. Results of quarterly observations will be forwarded to the quality assurance committee for review and revisions will be made as necessary.	

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K 374	Continued From page 11 open device and allowed to self close into their frame. The surveyor observed, measured and recorded a 1-inch gap along the doors bottom edge. In an interview at the time of observations, the U.S. FOIA (b) confirmed the findings. The U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 07/15/2024 at approximately 12:58 PM.	K 374		
K 741 SS=D	N.J.A.C. 8:39-31.1(c), 31.2(e) Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	K 741		8/5/24

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K 741	Continued From page 12 (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 07/12/2024, the facility failed to ensure ashtrays of noncombustible material and safe design, and a metal container with a self-closing cover device into which ashtray could be emptied, were readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5)(6). This deficient practice had the potential to affect all residents who were smokers and utilized the smoking area and was evidenced by the following: A review of the facility policy titled, " Resident Smoking Policy" dated July 17, 2023 read in part: " 2. Safety measures for the designated smoking area will include, but not limited to: B, Provisions of ashtrays made of noncombustible material and safe design. C. Accessible metal containers with self-closing covers into which ashtrays can be emptied." An observation on 07/12/2024 at 11:07 AM revealed the smoking area had one (1) freestanding plastic cigarette butt receptacles and did not have an ashtray of noncombustible material and a metal container with a self-closing cover device. During an interview at the time of the observation,	K 741	1. No residents were affected. 2 Residents utilizing the smoking area had the potential to be affected. 3 Ashtrays made of noncombustible materials provided on 8/1/2024 as well as a metal container with self closing lid available for the emptying of ashtrays 8/1/2024. 4. As a quality assurance measure, an audit will be conducted on a weekly basis for 4 weeks, then a monthly basis for 2 months, the Director of nursing or designee will observe smoking areas for the presence of ashtrays made of noncombustible materials and metal containers with self-closing covers. Results of observations will be forwarded to the quality assurance committee for review and revisions will be made as necessary.	

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K 741	Continued From page 13 the US FOIA (b)(confirmed there was not an ashtray of noncombustible material and a metal container with a self-closing cover device in the designated smoking area. NJAC 8:39-31.2(e), 31.6(e)	K 741		
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	K 918		8/5/24

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K 918	Continued From page 14 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/15/24, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that EES electrical panels and circuits were marked, and readily identifiable in accordance with NFPA 70: 2011 edition, Section 700.10. This deficient practice had the potential to affect all the residents and was evidenced by the following: An observation on 7/15/24 at 11:13 AM with the U.S. FOI [redacted] revealed that the emergency electrical panel next to the emergency generator contained 20 circuit breakers. One of the 20 circuit breakers was labeled with a sticker identifying it as "Phone System". The remaining 19 circuit breakers were unidentifiable. An empty electrical circuit directory holder was attached to the panel door. An interview was conducted during the time of the observation with the U.S. FOIA [redacted] who confirmed that the circuit breakers were not labeled, and stated that the breakers should be for the subpanels and other things but was not exactly sure since the breakers were not labeled. The U.S. FOIA (b)(6) [redacted] were notified of the deficient practice at the Life Safety Code exit conference at 12:58 PM. 8:39-31.2 (e), 31.2 (i)	K 918	1. No residents were affected. 2 Residents of the center had the potential to be affected. 3 Circuit Breakers on the emergency electrical panel have been mapped to the corresponsding areas and are labeled and are identifiable. 4. As quality assurance measure, on a quarterly basis for 4 quarters, the director of maintenance or Designee will observe electrical panels for labels readily identifying respective circuit breakers. Results of quarterly observations will be forwarded to the quality assurance committee for review and revisions will be made as necessary. Photo uploaded.	

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K 918	Continued From page 15 NFPA 70	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315047 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077

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	K0271	08/05/2024	LSC	K0281	08/05/2024	LSC	K0324	08/05/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0345	08/05/2024	LSC	K0363	08/05/2024	LSC	K0374	08/05/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0741	08/05/2024	LSC	K0918	08/05/2024	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/15/2024	☐ YES ☐ NO