STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 12/16/22 Census:155 Sample: 31 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		12/30/22

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

Electronically Signed | 12/30/2022

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F 636	Continued From page 1 (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,	F 636		

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F 636	Continued From page 2 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to complete a resident assessment that accurately reflected the resident's status. This was identified during a review of the quarterly Minimum Data Set (MDS), an assessment tool to facilitate the management of care, for 1 of 31 residents reviewed (Resident #15). This deficient practice was evidenced by the following: On 12/07/22 at 10:54 AM, during tour, the surveyor observed Resident #15 sitting in a chair at bedside. The resident was observed with an EX Order 26.4B1 cushion on the wheelchair and an EX Order 26.4B1 mattress on the bed. The surveyor interviewed the resident at that time and Resident #15 stated that he/she had a EX Order 26.4B on the EX Order 26.4B1 and pointed to the EX Order 26.4B1 the EX Order 26.4B1 The resident was washed and dressed and had EX Order 26.4B on EX Order 26.4B1 Review of the resident medical record revealed the following: Review of the Admission Record (AR) reflected that Resident #15 was admitted to the facility with the diagnoses which included but was not limited to: [redacted]	F 636	I. Immediate Action a) Resident #15's EX Order 26.4B report was clarified on 12/12/2022 by the EX Order 26.4B1 care team to reflect the EX Order 26.4B type as EX Order 26.4B1 EX Order 26 on the EX Order 26.4B1 b) Resident #15's care plan was updated on 12/8/2022 to reflect an EX Order 26.4B1 on the EX Order 26.4B1 c) Resident #15's quarterly Minimum Data Set (MDS) was redone and section EX O corrected to reflect the NJ Exec. Order 26:4.b.1 on 12/09/22 Identification of Others a) The facility respectfully acknowledges that potentially all residents may be affected. b) A complete audit was performed on 12/12/22 of all residents with EX Order 26.4B1 and with scheduled MDS to ensure accuracy of EX Order 26.4B coding. No errors or miscoding identified. c) All findings were brought to the attention of the Administrator II. Systemic Changes a) The Policy and Procedure on Minimum Date Set (MDS) was reviewed on 12/12/22 by Administrator, Director of Nursing and Regional MDS Coordinator and it was found to be in compliance. b) All clinical personnel responsible for completion of section M of the Minimum	

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F 636	Continued From page 3 Review of the quarterly Minimum Data Set (MDS) and assessment tool utilized to facilitate the management of care, dated EX Order 26.4B1 reflected that Resident #15 was EX Order 26.4B1 and required Ex.Order 26.4(b)(1) with activities of daily living (washing, dressing, grooming and hygiene). Under section EX O Ex.Order 26.4(b)(1) " of the MDS revealed that the resident had an application Ex.Order 26.4(b)(1) (with or without topical medications). There was no documentation on the MDS to specify what type of EX Order 26.4B1 the resident had on the EX Order 26 Review of the physician Order Summary Report (OSR) dated 10/01/22 reflected a physician's order dated 09/08/22, for a treatment to Ex.Order 26.4(b)(1) the EX Order 26.4B1 with EX Order 26.4B1 Ex.Order 26.4(b)(1) The physician OSR, dated 12/08/22 ,reflected a physician's order dated EX Order 26.4B1, for a EX Order 26.4B1 care consult for EX Order 26.4B1 of the EX Order 26.4B1 EX Order 2 The EX Order 26.4B consult dated EX Order 26.4B1 indicated that Resident #15 was seen for EX Order 26.4B1 EX Order 26.4B1. Subsequent EX Order 26.4B1 care consults dated 09/14/22, 09/28/22, 10/04/22, 10/10/22,10/18/22 ,10/25/22,11/01/22,11/08/22,11/15/22,11/22/22,11 /29/22, and 12/06/22 did not have any documentation that specified what type of EX Order 26.4B the resident had on the EX Order 26.4B1 On 12/09/22 at 10:01 AM, the surveyor interviewed the MDS Coordinator (MDSC #2) who has been employed since October and MDS Coordinator (MDSC #1) who had been employed	F 636	Date Set (MDS) will be reeducated on 12/30/22 on the accuracy of Minimum Date Set (MDS). I. Quality Assurance: a) Audits will be done by the Minimum Date Set (MDS) coordinator of all MDS submitted to ensure that section M is completed accurately. b) Audits will be done weekly x 4 weeks, monthly x 2 months, and quarterly x 2 months. c) The results of all audits will be brought to the QA committee quarterly x 3. I. Person Responsible: Director of nursing or designee, MDS coordinator	

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F 636	Continued From page 4	F 636		

in the facility for approximately one (1) year.
MDSC #1 and #2 both explained to the surveyor the process on how they obtained information to be able to score the resident's condition accurately on the MDS. They both agreed that they looked for information in the resident's medical record and interviewed residents and staff to fill out the MDS out as accurately as possible. They stated that there was a "look back window" in which information was obtained about the residents.
MDS Coordinator (MDSC #2) confirmed that she completed Resident #15's quarterly MDS on EX Order 26.4B1 and documented on the MDS that the resident had Ex.Order 26.4(b)(1) that was applied to the Ex.Order however did not know what type of EX Order 26.4B1 it was because the EX Order 26.4B1 practitioner notes did specify what type of EX Order 26.4B1 was on the EX Order. She stated that she did not see any documentation in the medical record that identified the EX Order 26.4B1 EX Order 26.4B1 as an EX Order 26.4B1 .
The MDSC#2 stated that it would be important to find out specifically what type of EX Order 26.4B1 was on the EX Order 26.4B1 as the EX Order 26.4B1 was there since 09/07/22 but did not have an explanation as to why she did not investigate the matter so that the EX Order 26.4B1 could be identified and documented accurately on the on the quarterly MDS dated 11/30/22.

The surveyor reviewed a progress note dated 12/01/22, which reflected that the MDSC #2 wrote a progress note indicating that the resident had a EX Order 26.4B1 .

On 12/12/22 at 01:16 PM, the surveyor questioned the MDSC #2 who documented that the resident had a EX Order 26.4B1

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F 636	Continued From page 5 EX Order 26.4B1 and she stated that she made a typographical error when she documented that entry. On 12/16/22 at 10:24 AM, the Regional Registered Nurse (RRN) and the Director of Nursing (DON) confirmed that there was no documentation in the medical record to specify was type of EX Order 26.4B1 was on the resident's EX Order 26.4B1 and confirmed that the MDS coordinator should have coded accurately to reflect the resident's condition. A review of the undated job description of the MDS Coordinator was to ensure that all assessments were completed and report problem areas to the Administrator, assist in determining appropriate treatment based on medical and social history of residents, demonstrate to residents and staff personnel the procedures involved in the treatment process as necessary, ensure that appropriate health professionals are involved in the assessment and that all members of the assessment team were aware of the importance of completeness and accuracy. The policy dated 09/28/22 and titled, "Minimum Data Set (MDS)-V 3.0 indicated that the MDS Registered Nurse was responsible for the completion of the section "M" of the MDS related to skin conditions. The policy also indicated that all disciplines that make entries on the MDS were responsible to sign and date the sections completed and that the signatures indicated that the section was reviewed and attest to the accuracy of the items. NJAC 8.39 - 11.1	F 636		

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		12/30/22

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F 656	Continued From page 7 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to update the resident's comprehensive care plan in a timely manner. This deficient practice was identified for 2 of 34 residents (Residents #119 and #141) reviewed for care plans and was evidenced by the following: 1. On 12/07/22 at 12:00 PM, 12/08/22 at 10:14 AM and 12/09/22 at 12:30 PM, the surveyor observed the resident seated at a table in the dayroom. The surveyor observed that Resident #119 had a EX Order 26.4B1 applied to the EX Order 26.4B1 at the time of each observation. According to the Admission Record, Resident #119 was admitted with diagnoses which included, but were not limited to, EX Order 26.4B1 EX Order 26.4B1. Review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated EX Order 26.4B1, reflected that Resident #119 was EX Order 26.4B1 required Ex.Order 26.4(b)(1) and that Resident #119 had a EX Order 26.4B1	F 656	I Immediate action a) Resident #119's care plan was updated on 12/7 22 reflecting the resident applies and removes the EX Order 26.4B1 EX Order 26.4B independently and on 12/14/22 it was further updated to reflect EX Order 26.4B1 EX Order 26.4B1 checks for integrity. b) Resident #141's care plan was updated on EX Order 26.4B1 to reflect EX Order EX Order 26.4B1 drug use. c) An audit for residents with NJ Exec. Order 26.4 was conducted on 12/14/22 to ensure all EX Order 26.4B are reflected in the resident's care plan. d) An audit for residents with EX Order 26.4B1 drugs was conducted on 12/9/22 to ensure EX Order 26.4B1 drug use is reflected in the resident's care plan. e) A Quality Assurance and Improvement Plan (QAPI) was developed on 12/9/22 for EX Order 26.4B1 drug use and presented to the Quality Assurance committee for review and implementation. II Identification of others: a. The facility respectfully submits that all patients who require NJ Exec. Order 26 have the potential to be affected.	

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F 656	Continued From page 8 EX Order 26.4 Review of the Medication Review Report dated EX Order 26.4B1, reflected an order dated EX Order 26.4B1 to don Ex.Order 26.4(b)(1) to Resident #119's monitor EX Order 26.4B1, and Ex.Order 26.4(b)(1) every shift. Review of the current Care Plan included a focus that resident "requires Ex.Order 26.4(b)(1) with ADL functions" initiated and reviewed on 12/21/21. The surveyor observed that the facility updated the Care Plan with an intervention that Resident #119 will Ex.Order 26.4(b)(1) EX Order 26.4der 26.4B1 EX Order 26.4B during day shift" on 12/07/22, approximately nineteen months after the physician ordered Resident #119's EX Order 26.4B1 EX Order 26.4 on EX Order 26.4B1. 2. During the initial tour on 12/07/22 at 11:52 AM, the surveyor observed Resident #141 seated on the side of the bed eating lunch. The resident told the surveyor his/her name and said lunch was good. On 12/08/22 at 10:22 AM and 12/09/22 at 12:02 PM, the surveyor observed Resident #141 lying in bed with eyes closed. According to the Admission Record, Resident #141 was admitted to the facility with diagnoses which included, but were not limited to, EX Order 26.4B1 Review of the Quarterly MDS dated EX Order 26.4B1	F 656	b. The facility respectfully submits that all patients who receive NJ Exec. Order 26:4.b.1 drugs have the potential to be affected. III Systemic Changes: a) The Policy and Procedure on Care planning was reviewed on 12/9/22 by the Administrator and Director of Nursing has been reviewed and found appropriate. b) All clinical staff responsible for updating any aspect of the resident's care plan were reeducated on 12/9/22 on the importance of initiating, reviewing and revising care plans to reflect the current status of all residents, including NJ Exec. Order and NJ Exec. Order 26:4.b.1 drugs. IV Quality Assurance: a) Audits will be conducted by the Director of Nursing or designee for residents with s NJ Exec. Order 2 and NJ Exec. Order 26:4.b.1 drugs to ensure that the care plans reflect the current status of the resident as well as ensuring that it is reviewed at least quarterly b) Audits will be conducted for 5 residents weekly x 4 weeks, monthly x 2 months, then quarterly x 2 quarters. c) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. V Person Responsible: Director of Nursing or designee	

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Ex.Order 26.4(b)(1) [redacted] and had diagnoses of Ex.Order 26.4(b)(1) [redacted]. The MDS further reflected that Resident #141 received an Ex.Order 26.4(b)(1) [redacted] for the last Ex.Order 26.4(b)(1) [redacted] days.

Review of the Medication Review Report dated 12/12/22, reflected an order dated 07/08/22 for Ex.Order 26.4(b)(1) [redacted]

Review of the current Care Plan reflected a focus that Resident #141 uses a EX Order 26.4B1 [redacted] medication (EX Order 26.4B1 [redacted]) to help manage target symptoms related to EX Order 26.4B1 [redacted] with an initiation date of 06/28/22 and a revised date of 12/08/22. The Care Plan further reflected the following interventions:
- Administer medications as ordered. Monitor/document for side effects and effectiveness.
- Consult with pharmacy, MD to consider dosage reduction when clinically appropriate.
- Resident #141 receives an EX Order 26.4B1 [redacted] Monitor/record/report to MD prn (as needed) side effects and adverse reactions of EX Order 26.4B1 [redacted] medications Ex.Order 26.4(b)(1) [redacted]

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F 656	Continued From page 10 not unusual to the person. - Monitor/record occurrence for target symptoms Ex.Order 26.4(b)(1) [redacted] -Offer non-pharmacological interventions as needed (activities of interest, snack, nap, walk, music of interest, calling a loved one, distraction.) Ex.Order 26.4(b)(1) [redacted] as needed. The surveyor observed that the care plan focus had an initiation date of 06/28/22, which was prior to the physician order for Ex.Order 26.4(b)(1) [redacted] dated 07/08/22. The surveyor further observed that each intervention was dated 12/07/22, approximately five months after the physician order for Ex.Order 26.4(b)(1) [redacted] dated 07/08/22. During an interview with the surveyor on 12/08/22 at 1:58 PM, the MDS Coordinator #1 stated that care plans are updated quarterly and the nurses also assist with updating the care plan. During an interview with the surveyor on 12/09/22 at 12:05 PM, Licensed Practical Nurse (LPN) #1 stated that the nurses do not complete the care plan and that the nurse manager completed the care plans. During an interview with the surveyor on 12/09/22 at 12:22 AM, the LPN/Unit Manager (LPN/UM) #1 stated that she was responsible, together with the MDS Coordinator, to update the care plans quarterly and with any change in resident status. The LPN/UM stated that it was important to update the care plan timely so that	F 656		

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F 656	Continued From page 11 everyone knows the current status of a resident. During an interview with the surveyor on 12/12/22 at 8:12 AM, the Director of Nursing stated that the care plan was updated quarterly at the care conference and with any change in resident status. It was the responsibility of the UM to oversee any resident change in condition and update the care plan within 24-48 hours of the change in status. Review of the facility's Comprehensive Care Plan policy, reviewed 08/01/22, reflected that each resident's comprehensive care plan shall be reviewed and updated by the interdisciplinary team as per the MDS 3.0 schedule: quarterly, annually, significant change in condition and if the resident's condition warrants it.	F 656		
F 658 SS=D	NJAC8:39-11.2 (e)(2) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and other pertinent facility documentation it was determined that the facility failed to a.) accurately document [redacted] in accordance with professional standards of practice for one resident who [redacted] b.)	F 658	I. Immediate Action a) Resident #37 medical record was reviewed on 12/15/22 by the Director of Nursing to determine if any harm came to the resident since the [redacted] check form initiated on [redacted] following a [redacted] was incomplete. [redacted] noted.	12/30/22

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F 658	Continued From page 12 follow physician orders for the application of EX Order 26.4B1. This deficient practice was identified for 1 of 5 residents (Resident #37) reviewed for Ex.Order 26.4(b)(1)s and 1 of 1 (Resident #15) reviewed for EX Order 26.4B1) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A.) Review of the Admission Record reflected that Resident #37 was admitted to the facility with diagnoses which included, but were not limited to, a EX Order 26.4B1	F 658	b) The Licensed Practical Nurse (LPN) #2 responsible for completing the EX Order 26.4B1 form on EX Order 26.4B1 was in serviced on the proper procedure of completing a n EX Order 26.4B1 l check form on EX Order 26.4B1 c) Resident #15 medical record was reviewed by the Director of Nursing. Medical doctor was contacted regarding the refusal of the EX Order 26.4B1 and an order was obtained to discontinue the order for EX Order 26.4B1 due to refusal on EX Order 26.4B1 A progress note was entered in the resident's electronic medical record indicating the discontinuation of the EX Orde EX Order 26.4B1 order on EX Order 26.4B1 d) The Licensed Practical Nurse (LPN)#4, The Licensed Practical Nurse (LPN)#5 and The Licensed Practical Nurse (LPN)/Unit Manager (UM)#2 were educated on 12/9/22 on importance of timely and accurately documenting any resident refusal of treatments and care. II. Identification of others: All residents receiving NJ Exec. Order 26:4.b.1 l checks and all residents with orders for NJ Exec. Order 26:4.b.1 have the potential to be affected. a) An audit was completed on 12/13/22 for all residents receiving NJ Exec. Order 26:4.b.1 checks to determine if the NJ Exec. Order 26:4.b.1 check form was completed appropriately and being followed. No other residents with NJ Exec. Order 26:4.b.1 l checks were identified. b) An audit was completed on 12/9/22 for all residents receiving NJ Exec. Order 26:4.b.1 to determine if any refusals were	

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F 658	Continued From page 13 Review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated EX Order 26.4B1 reflected that resident was EX Order 26.4B1 and had a history EX Order 26.4B1 Review of the current Care Plan reflected a focus that Resident #37 had an EX Order 26.4B1 initiated EX Order 26.4B1 with the intervention dated EX Order 26.4B1 to "continue interventions on the at-risk plan." The Care Plan further reflected a focus that Resident #37 was at EX Order 26.4B1 related to a history EX Order 26.4B1 Ex.Order 26.4(b)(1) initiated on EX Order 26.4B1 and revised on EX Order 26.4B1 with the intervention of EX Order 26.4B1 " initiated on EX Order 26.4B1 and revised on EX Order 26.4B1 Review of the Ex.Order 26.4(b)(1) report dated 09/06/22 reflected that Resident #37 sustained EX Order 26.4B1 at EX Order 26.4B1 At that time, Resident #37 was EX Order 26.4B1 on the EX Order 26.4B1 of the bed, EX Order 26.4B1 to give a proper response to what happened." The Ex.Order 26.4(b)(1) further reflected that the "Immediate Action Taken," among other things, was EX Order 26.4B1 ." On 12/14/22 at 9:05 AM, the Director of Nursing (DON) provided a blank EX Order 26.4B1 Assessment Flow Sheet (Ex.Order 26.4(b)(Flow Sheet) to the surveyor. Review of the blank Ex.Order 26.4(Flow Sheet, in the presence of the DON, reflected the following: - Instructions for the nurse to follow. The surveyor noted the instructions did not include how often the nurse would assess the resident in	F 658	encountered and properly documented. No negative findings were encountered. III. System Changes a) The facility NJ Exec. Order 26:4.b.1 check guideline was reviewed by the Administrator, Director of Nursing and found in compliance. b) The Policy and Procedure on Physicians orders which addresses refusal of treatments was reviewed by the Administrator and Director of Nursing on 12/9/22 and found in compliance. c) Re education was given to nurses by Director of Nursing or designee on 12/30/22 on proper completion of the NJ Exec. Order 26:4.b.1 l checks form. d) Re education was given to nurses by the Director of Nursing or designee on 12/30/22 on proper documentation of resident's refusal of treatments and care. IV: Quality Assurance a) Audits will be conducted by the Director of nursing or designee for all residents with NJ Exec. Order 26:4.b.1 checks and all residents with NJ Exec. Order 26:4.b.1 to ensure proper documentation weekly x 4 weeks, monthly x 2 months, then quarterly x 2 quarters. b) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. IV. Person responsible: Director of Nursing or designee	

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F 658	Continued From page 14 minutes/hours. - Columns of information for the nurse to complete with the headings of date, time, level of consciousness, pupil response, motor function, pain response, vitals, observations, and signature. The surveyor noted one column without a heading. This column included the numbers "15" "30" "1" and "4." At that time, the DON stated that the aforementioned numbers reflected the intervals of minutes and hours that the nurse would assess the resident. The nurse would assess the resident every 15 minutes times four (4), every 30 minutes times two (2), every one (1) hour times two (2) and every four (4) hours times 16, for a total of 72 hours. - The form included 24 lines where the nurse would document the aforementioned information. - The form further included an area where the nurse would document the resident's name, attending physician and room/bed number. Review of the [redacted] Flow Sheet completed by the nurses for Resident #37's [redacted] did not include the column of numbers as referenced above. The surveyor compared the blank Flow Sheet with the completed [redacted] Flow Sheet and observed the following errors: - the nurse completed six (6) [redacted] assessments every 15 minutes and - the nurse completed two (2) [redacted] assessments every two (2) hours. During an interview with the surveyor on 12/15/22 at 10:32 AM, the Licensed Practical Nurse (LPN) #2 reviewed the [redacted] Assessment Flow Sheet. She confirmed the above referenced column was missing and that the [redacted] checks were not	F 658		

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F 658	Continued From page 15 completed as scheduled. LPN #2 stated that when she started a [redacted] Flow Sheet that she will write the times in the "time" column to avoid [redacted] when the [redacted] checks should be completed. LPN #2 further stated it was important to complete the [redacted] checks as scheduled in order to report a change in resident status to the physician. During an interview with the surveyor on 12/15/22 at 11:12 AM, the LPN/Unit Manager (LPN/UM) #3 reviewed the 09/06/22 Neuro Flow Sheet. The LPN/UM #3 verified that the nurses used an incomplete form and that the nurses did not follow the designated times to complete the [redacted] checks. She stated that she expected the nurses to use the correct form and complete the [redacted] checks as indicated on the form because it was important to look for any changes in resident status. During an interview with the surveyor on 12/15/22 at 2:20 PM, the DON stated that she expected the nurses to complete the [redacted] Flow Sheet in its entirety. During a follow up interview with the surveyor on 12/16/22 at 9:13 AM, the DON stated that the directions to complete the [redacted] checks were included in the [redacted] packet according to the [redacted] Check Guidelines. Review of the facility's [redacted] Check Guidelines, revised July 2019, reflected the [redacted] checks will be performed as follows or as otherwise ordered by the Physician: A. Every 15 minutes for 1 hour, then, B. Every 30 minutes for 1 hour, then C. Every hour for 2	F 658		

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hours, then D. Every 4 hours for a combined total of 72 hours."

Review of the facility's Accidents: Assessment, Prevention and Interventions policy, reviewed 10/16/22, did not address Ex.Order 26.4(checks.

B.) On 12/07/22 at 9:38 AM, during the initial tour, the surveyor observed Resident #15 sitting up in a chair at the side of his/her bed fully dressed wearing EX Order 26.4B1 on EX Order 26.4B1. The surveyor observed that both residents EX Order 26.4(EX Order 26.4B1. The surveyor did not observe the resident wearing EX Order 26.4B1 The resident was interviewed at this time and stated that she always had EX Order 26.4B1 EX Order2, but that the swelling EX Order 26.4B1".

The Admission Record reflected that Resident #15 was admitted to the facility with the diagnoses which included but was not limited to: EX Order 26.4B1

The quarterly Minimum Data Set (MDS) and assessment tool utilized to facilitate the management of care, dated EX Order 26.4B1, reflected that Resident #15 was EX Order 26.4B1 and required Ex.Order 26.4(b)(1) with activities of daily living (Ex.Order 26.4(b)(1).

The surveyor reviewed the resident's physician's order dated EX Order 26.4B1 that indicated EX Order 26.4B1 EX Order 26.4B1 were to be Ex.Order 26.4 every day-shift for and to Ex.Order 26.4(b)(1) and to

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Ex.Order 26.4(b)(1) .

On 12/08/22 at 10:21 AM, the surveyor interviewed Resident #15 who stated that she did not wear any devices on EX Order 26.4B1. The surveyor observed that the resident had EX Order 26.4B1 of EX Order 26.4B1 and was wearing cotton socks. The surveyor asked the resident if she wore any devices to the EX Order 26.4B1 to decrease the EX Order 26.4B1. The resident stated, "Do you mean the EX Order 26.4B1?" She then stated that she had EX Order 26.4B1 in the drawer but that she hasn't worn them in weeks because she didn't like them. She stated that the EX Order 26.4B1 EX Order 26.4B1 caused more EX Order 26.4B1 and that it caused EX Order 26.4B1 to have EX Order 26.4B1 in other places. The resident could not provide the surveyor with a specific date when she stopped wearing the EX Order 26.4B1 .

The surveyor reviewed the Treatment Administration Record (TAR) dated 11/01/22 until 11/30/22 and 12/01/22 until 12/07/22 that reflected nursing signatures on the 07:00 AM -03:00 PM shift and 03:00PM-11:00 PM shift that EX Order 26.4B1 were being applied and removed according to the physician orders; however, the surveyor did not observe the resident wearing the EX Order 26.4B1 on 12/07/22 or 12/08/22 and the resident stated that she had not worn them in weeks. There was no documentation in the TAR from 12/01/22 until 12/07/22 that the resident had been refusing to wear the EX Order 26.4B1 .

On 12/09/22 at 8:51 AM, the surveyor interviewed a Licensed Practical Nurse (LPN#4) on EX Order 26.4B1 unit who stated treatments were

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applied by either the [redacted] nurse or the primary nurse that was assigned to the resident. She explained that the primary nurse assigned to the resident was responsible for applying assistant devices, preventative creams and/or ointments. She added that if a resident refused the treatment that she would usually go back and ask them again and provide education on importance of treatment. She stated that resident have the right to refuse and if the resident refused treatment for more than three (3) times then the physician would be notified, and nursing supervisor would be notified regarding the resident's refusal of treatment. She added that it was the responsibility of the nurse to document the refusal in the progress notes and TAR. She further added that the treatment would either be discontinued or something different could be ordered. The LPN did not have a response as to why the nurses were documenting on the TAR that they were applying EX Order 26.4B1 when the resident had been refusing to wear them.

On 12/09/22 at 9:03 AM, the surveyor interviewed LPN #5 who stated that she had been employed in the facility for approximately one (1) year. She stated that the [redacted] care nurse usually performed the treatments for any major wounds such as pressure ulcers however it was the responsibility of the primary care nurse that was assigned to the residents to apply any creams, ointments, or preventative devices. She confirmed that it was the nurse responsibility to apply and remove EX Order 26.4B1 . She stated that if a resident refused to have a treatment done such as application of EX Order 26.4B1 , then the resident would be

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educated on the importance of the application of the treatment and the nurse would document the refusal in the progress notes and on the TAR. The nurse would also be responsible to call the MD and get further orders and inform the supervisor of the resident's refusal to apply the EX Order 26.4B1 .

On 12/09/22 at 9:23 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #2) for the EX Order 26.4B1 Unit who stated that she had been employed in the facility for a month. She explained that treatment to wounds such a pressure ulcer were treated by the wound care nurse. She stated that primary care nurses assigned to the residents performed all other treatments. She stated that when a treatment was administered to a resident the nurse would sign the treatment out in the TAR. This signature on the TAR would indicate that the treatment was performed. The LPN/UM #2 further explained that if a resident refused treatment, the resident would be educated on the importance of having the treatment done and the if the resident kept refusing the nurse would notify the physician and family. She added that the nurse and doctor would try to find an alternative treatment on how to treat the resident's condition. LPN/UM #2 stated, "We would also care plan the resident's non-compliance with treatment and would have to be documented in the progress notes regarding the education that was provided to the resident and the resident refusal." The LPN/UM #2 stated that she was not notified that Resident #15 was refusing to wear the EX Order 26.4B1 EX Order 26.4B1 to his/her EX Order 26.4B1 . The LPN/UM reviewed the TAR with the surveyor and

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F 658	Continued From page 20 confirmed that the nurses were documenting that they were applying the EX Order 26.4B1 stockings. The LPN/UM #2 interviewed Resident #15 and the resident informed EX Order that he/she had been refusing to wear the Ex Order 26.4B1. The LPN/UM #2 then confirmed that there was no documentation in the medical record that indicated that the resident was refusing to wear the EX Order 26.4B1 LPN/UM #2 stated that the nurses should have been documenting on the TAR that the resident was refusing to wear the EX Order 26.4B1 and that after 3 times of refusals then the physician should have been notified and it should have been documented in the progress notes and then updated on the care plan. The surveyor reviewed the progress note dated 12/09/2022 at 11:42 that the EX Order 26.4B1 EX Order 26.4B1 for Resident #15 were discontinued due to resident refusing to wear. The note indicated that the physician was made aware and ordered for them to be discontinue. On 12/16/22 at 10:30 AM, the Director of Nursing (DON) did not have any additional information to present to the surveyor. The facility policy dated 07/01/22 and titled, "Medication Administration and Documentation Policies, Procedures and Information" indicated that the licensed nurse was responsible for: 1.) Documentation in the Electronic Medication Administration Record (EMAR) immediately following administration (i.e., refused, etc..) and identified the reason. 2.) Documents all held or refused medications on the EMAR. Uses prudent professional judgement	F 658		

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F 658	Continued From page 21 by informing physician in a timely manner when medications were held, refused, or otherwise unavailable for administration. The facility policy dated 07/21/22 and titled, "Physician Orders" indicated that it was the policy of the center to write physician orders to establish a plan of care to follow for the care of the patient. The purpose was to ensure that the plan of care was followed in accordance with the orders established by the physician and/or nurse practitioner.	F 658		
F 677 SS=D	NJAC 8:39-27.1 (a) 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 and review of the medical record and other facility documentation, it was determined that the facility failed to provide EX Order 26.4B1 to a resident that was Ex.Order 26.4(b)(1) for (one)1 of 31 residents (Residents #64). This deficient practice was evidenced by the following: According to the Admission Record, Resident #64 was admitted to the facility with the diagnoses which included but was not limited to: EX Order 26.4B1 .	F 677	I. Immediate Action a) Resident #64 care plan was reviewed and updated with the resident□s preference to have EX Order NJ Exec. Order 26:4.b.1 on 12/15/22 b) Resident #64 was approached by the Director of Nursing to have EX Order 26.4B1 inspected and EX Order 26.4B1. Director of Nursing wrote a progress note in resident□s electronic record describing resident□s refusal. c) Licensed Practical Nurse (LPN)#4, Licensed Practical Nurse (LPN)#5, Licensed Practical Nurse (LPN)/Unit	12/30/22

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F 677	Continued From page 22 The quarterly Minimum Data Set (MDS), an assessment tool used facilitate the management of a resident's care, dated 09/13/22, indicated that Resident #64 had EX Order 26.4B1 EX Order 26.4B1 with Ex.Order 26.4(b)(1) on staff for [redacted] [redacted] AM, the surveyor observed Resident #64 sitting up in a chair in the resident's room and the surveyor observed that the resident's Ex.Order 26.4(b)(1) [redacted] The resident was pleasant, however Ex.Order 26.4(b)(1) [redacted] in an interview. On 12/08/22 at 11:20 AM, the surveyor observed Resident #64 sitting up in the chair in the room,washed and dressed. The resident's [redacted] On 12/09/22 at 08:43 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #4) on the EX Order 26.4B1 Unit who stated that she had been employed in the facility for approximately (three) 3 months. She stated that residents were given showers (two) 2 to (three) 3 times a week. She stated that showers consisted of washing the resident and providing skin care. She also added that during the shower once a week, the nurse would perform a skin assessment on the day the resident was scheduled for a shower. LPN #4 explained that when the nurse performed the skin assessment that she was to document any skin issues. She stated that she was not sure who provided the nail care to the residents. She stated that if a resident asked her to file their	F 677	Manager #2 were educated on importance of documenting any refusal of care in resident□s record and care plan. II. Identification of others a) The facility respectfully submits that all residents requiring NJ Exec. Order 26:4.b.1 [redacted] are potentially affected. b) An audit was done on 12/16/22 for all residents to check for NJ Exec. Order 26:4.b.1 [redacted] and ensure all NJ Exec. Order 26:4.b.1 [redacted] refusals are properly documented. III. System Changes a) The Policy and Procedure on ADL care which included refusal of care was reviewed on 12/16/22 by the Administrator and Director of Nursing and found in compliance. b) Nursing staff was in serviced on 12/30/22 by the Director of nursing or designee on their role in ensuring that NJ Exec. O [redacted] to be provided regularly and any referrals to be documented appropriately. IV: Quality Assurance a) An audit of all residents on NJ Exec. Order 26:4.b.1 [redacted] and refusals will be conducted by the Director or designee. b) Audits will be performed weekly x 4 weeks, monthly x 2, then quarterly x 2 quarters. c) The results of all audits will be brought to the QAPI committee quarterly x 3. V Person Responsible: Director of Nursing or designee	

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nails that she would.

On 12/09/22 at 09:11 AM, the surveyor interviewed LPN #5 who stated that the Certified Nursing Assistance (CNAs) were responsible to wash and dress the residents. She explained that when a CNA performed the activities of daily living (ADLs) they were responsible to wash the residents, perform mouth care, any shaving that was needed, change protective briefs if incontinent and dress them. She stated that there was a shower schedule in which the CNAs could look at to find out who was due for a shower. She stated that skin checks were performed weekly and scheduled on the Electronic Medication Administration record (EMAR). She stated that the nurses were responsible to sign out that skin checks were done on the EMAR. She added that it would be expected that the CNA would provide nail care during the shower process.

On 12/09/22 at 09:37 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #2) who stated the residents were showered (two) 2 times a week on alternate days. She explained that the primary nurse was responsible to sign Treatment Administration Record (TAR) which indicated that the shower and the skin check were completed. She stated that the CNA was responsible to fully shower and clean the resident. She further added that the CNA was also required to perform nail care and dress the resident. She revealed that if a resident refused care, then it should be reported to the nurse and the nurse was to document the refusal in the progress notes.

On 12/09/22 at 09:47 AM, the surveyor

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interviewed Resident #64's primary care CNA #1 in the presence of the LPN/UM #2 who stated that she had been employed in the facility for 24 years. She stated that she reviewed the CNA assignment sheet daily to see what resident required a shower. She explained that when showering a resident, she would wash the resident and dress them. She stated that she had been caring for Resident #64 for a long time and the resident EX Order 26.4B1 She stated, "I just wash the resident EX Order 26.4B1." She stated that she did tell the nurses that Resident #64 EX Order 26.4B1 She stated that the resident EX Order 26.4B1 at her when she tried to EX Order 26.4B1. She also stated that the resident refused EX Order 26.4B1 . She added that the resident EX Order 26.4B1 EX Order 26.4B1 but that she did not report it to the nurse today because she was doing something with another resident. CNA #1 added that she spoke with the responsible party (RP) the other day and told him that the resident EX Order 26.4B1 . She further added that the RP indicated to CNA #1 that he was going to take Resident #64 to the EX Order 26.4B1

On 12/09/22 at 09:53 AM, the surveyor interviewed the LPN/UM #2 who accompanied the surveyor to Resident #64's room and stated that the resident should not have EX Order 26.4B1 that EX Order 26.4B1 LPN/UM #2 stated that someone should have made her aware that the resident was EX Order 26.4B1 so that she could have implemented a care plan with interventions.

On 12/09/22 at 10:48 AM, the surveyor interviewed the 1st RP listed on the resident's

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Admission Record, in the presence of the survey team by way of speaker phone, who stated that he was not made aware that his grandmother/grandfather was EX Order 26.4B1 or EX Order 26.4B1 He stated that he had visited the other day and mentioned to CNA #1 that he needed to take his grandmother/grandfather to get EX Order 26.4B1 EX Order 26.4B1 because he noticed that they were long. He further stated that it was not brought to his attention that he/she refused to have them cut. The RP added that he would like the facility to Ex.Order Resident #64's EX Order 26.4B1.

The surveyor reviewed the Progress Notes (PN) from EX Order 26.4 until surveyor inquiry of EX Order 26.4B1 and there was no documentation in the medical record that the resident had EX Order 26.4B1 or EX Order 26.4B1. There was also no documentation in the Care Plan that the resident EX Order 26.4B1 or EX Order 26.4B1.

The surveyor reviewed the Treatment Administration Records (TAR) dated EX Order 26.4B1 and there was no documentation that Resident #64 EX Order 26.4B1.

On 12/09/22 at 12:02 PM, the surveyor interviewed the Director of Nursing (DON) who stated that residents were to be showered twice a week and skin checks were to be done once a week during a shower day. The DON explained that when a CNA performed showers that they should be washing, bathing, and checking that the resident's nails were at a proper length and were clean underneath. She further added that when she had an extra CNA that she would

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assign that CNA a special assignment which could include nails, showers, passing ice out etc. The DON explained that the CNA would sign in the POC (Point of Care) that they performed the shower for the resident. She stated that the nurses would perform the skin checks on the shower days once a week. She further added that the nurses signed out that the shower and skin check were completed on the TAR. She stated that the CNA was expected to communicate to the nurse when residents refused a shower or any other care and the nurse was expected to inform the Unit Manager of the refusal. She then explained that when a nurse was informed that a resident refused any care that the nurse would document the refusal in the progress notes and on 24-hour report. She stated that if a resident refused care two (2) or three (3) times it should be care planned and anytime a resident refused care or treatment it should be documented in the progress notes. The DON stated that the RP and physician should be notified if a resident refused any treatment or care.

On 12/16/22 at 10:19 AM, in the presence of the survey team, the Regional Registered Nurse (RRN#1) stated that the Administration interviewed the 2nd responsible party who stated that his mother/father always Ex.Order 26.4(b)(1) [redacted] The DON added that when the staff recently attempted to Ex.Order 26.4(b)(1) [redacted] staff out. Both the RRN #1 and the DON stated that the CNA should have informed the nurses that the resident was refusing to shower and have Ex.Order 26.4(b)(1) and that it should have been documented in the progress notes. The RRN#1 stated that if it was

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F 677	Continued From page 27 communicated correctly then the nurse would have documented the refusals in the progress notes and that a care plan would have been formulated to indicate the Ex.Order 26.4(b)(1) refusals. The facility policy and procedure titled, "ADLs", dated 07/28/22, indicated that the policy of the center was to provide ADL care to all residents based on assessment of needs. The policy indicated that ADL care consisted of bathing, dressing, eating, transfers, toileting, bed mobility, ambulation, and grooming (shaving, nail care etc.) The policy also indicated that the CNA responsibility included that nails were inspected and care was provided as needed and that if a resident refused, that the charge nurse and social services would be notified for interventions. NJAC 8:39-27.2 (g)	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		12/30/22

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F 686	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to a.) accurately identify a [redacted] type from first identification of the EX Order 26.4B1 until 12/15/22 and b.) clarify the implementation of a diagnostic study recommended by a [redacted] care consultant. This deficient practice was identified for 1 (one) of 2 (two) residents (Resident #15) reviewed for EX Order 26.4B1 and was evidenced by the following: On 12/07/22 at 10:54 AM, during initial tour, the surveyor observed Resident #15 sitting in a chair at his/her bedside. The resident was observed with an EX Order 26.4B1 cushion on the wheelchair and an EX Order 26.4B1 mattress on the bed. The surveyor interviewed the resident at that time and Resident #15 stated that he/she had a [redacted] on the [redacted] and pointed to the EX Order 26.4B1 [redacted]) area of the [redacted]. The resident was washed and dressed and had EX Order 26.4B1 [redacted] Review of the resident medical record revealed the following: Review of the Admission Record (AR) reflected that Resident #15 was admitted to the facility with the diagnoses which included but were not limited to: EX Order 26.4B1 [redacted]. Review of the quarterly Minimum Data Set (MDS)	F 686	I Immediate Action a) Resident #15 's EX Order 26.4B1 was clarified as EX Order 26.4B1 on 12/12/22 by the [redacted] team. Care plan initiated with the [redacted] on the EX Order 26.4B1 and updated on 12/12/22 to reflect [redacted] b) Resident #15's recommendation for NJ Exec. Order 26:4.b.1 was removed from the [redacted] team's report on EX Order 26.4B1 due to Medical doctor's preference not to have the [redacted] done due to known history of [redacted] disease. Medical diagnosis record was updated to reflect EX Order 26.4B1 on EX Order 26.4B1 c) Assistant Director of Nursing #2 and Licensed Practical Nurse (LPN)/Unit Manager #2 were educated on 12/16/22 on importance of reviewing the [redacted] team reports as soon as received and address any recommendations while ensuring all [redacted] are properly identified. Also in serviced on documenting any Medical doctor's declination of [redacted] team's recommendations in the resident's record. IV. Identification of others c) The facility respectfully submits that all residents requiring [redacted] are potentially affected. d) An audit was done on 12/12/22 for all residents with [redacted] to check for proper identification of the [redacted] type, recommendations follow up and care plan updates.	

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F 686	Continued From page 29 an assessment tool utilized to facilitate the management of care, dated 11/30/22, reflected that Resident #15 was EX Order 26.4B1 and required Ex.Order 26.4(b)(1) [redacted]. Under section [redacted] Ex.Order 26.4(b)(1)" of the MDS revealed that the resident had an application Ex.Order 26.4(b)(1) [redacted] There was no documentation on the MDS that specified what type of EX Order 26.4B1 the resident had on the affected Ex.Order 26 [redacted] Review of the physician Order Summary Report (OSR) dated EX Order 26.4B1, reflected a physician's order dated EX Order 26.4B1 for a treatment to Ex.Order 26.4(b)(1) [redacted] the EX Order 26.4B1 Ex.Order 26.4(b)(1). Apply [redacted] and Ex.Order 26.4(b)(1) [redacted] The physician order did not specify what type of EX Order 26.4B1 the resident had on the EX Order 26.4B1. The physician OSR, dated EX Order 26.4B1 reflected a physician's order dated EX Order 26.4B1, for a EX Order 26.4B1 care consult for EX Order 26.4B1 of the EX Order 26.4B1 EX Order 2 [redacted] The EX Order 26.4B1 care consult dated 09/07/22, indicated that Resident #15 was seen for EX Order 26 EX Order 26.4B1 There was no documentation on the EX Order 26.4B1 consult report that accurately identified what type of EX Order 26.4B1 Resident #15 had on the EX Order 26.4B1. Subsequent EX Order 26.4B1 care consults dated 09/14/22, 09/28/22, 10/04/22, 10/10/22, 10/18/22, 10/25/22, 11/01/22, 11/08/22, 11/15/22, 11/22/22, 11/29/22, and 12/06/22, also did not have documentation that indicated what type of EX Order 26.4B1 was on the residents EX Order 26.4B1	F 686	V. System Changes I. The Policy and Procedure on Documentation: The Physician/Consultant role and Policy on Medical Administration were reviewed on 12/16/22 by the Administrator and Director of Nursing and found in compliance. II. Nurses were in serviced on 12/30/22 by the Director of nursing or designee on their role in ensuring that all NJ Exec. Order 26:4.b [redacted] are identified according to NJ Exec. Order 26:4.b.1 guidelines, care planned appropriately and any recommendations from the EX Order 26.4B1 team are followed up and documented appropriately. IV: Quality Assurance d) An audit of all residents with NJ Exec. Order 26:4.b [redacted] will be conducted by the Director or designee to ensure that all EX Order 26.4B1 are identified according to NJ Exec. Order 26:4.b.1 guidelines, care planned appropriately and any recommendations from the EX Order 26.4B1 team are followed up and documented appropriately. e) Audits will be performed weekly x 4 weeks, monthly x 2, then quarterly x 2 quarters. f) The results of all audits will be brought to the QAPI committee quarterly x 3. VI. Person Responsible: Director of Nursing or designee	

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EX Order

The EX Order 26.4B1 care consult dated EX Order 26.4B1, had recommendations from the EX Order 26.4B1 care physician for a Ex.Order 26.4(b)(1) (is a EX Order 26.4B1 to be performed to assess the resident for EX Order 26.4B1 EX Order 26.4B1 (is a EX Order 26.4B1 Ex.Order 26.4(b)(1)). Subsequent EX Order 26.4B1 consults dated 09/14/22, 09/28/22, 10/04/22, 10/10/22, 10/18/22, 10/25/22, 11/01/22, 11/08/22, 11/15/22, 11/22/22, 11/29/22, and 12/06/22 also reflected recommendation for the resident to have a EX Order 26.4B1 to assess for Ex.Order 26. The surveyor could not find any documentation in the medical record the primary care physician was notified of the recommendation for Ex.Order 26.4(b)(1) to be performed. There was no documented evidence that the Ex.Order 26.4(b)(1) was performed in the medical record.

On 12/09/22 at 10:01 AM, the surveyor interviewed the MDS Coordinator (MDSC #2) who has been employed since October and MDS Coordinator (MDSC #1) who had been employed in the facility for approximately one (1) year. MDSC #1 and #2 both explained to the surveyor the process on how they obtained information to be able to score the resident's condition accurately on the MDS. They both agreed that they looked for information in the resident's medical record and interviewed residents and staff to fill out the MDS out as accurately as possible. They stated that there was a "look back window" in which information was obtained about the residents. MDS Coordinator (MDSC #2) confirmed that she completed Resident #15's quarterly MDS on EX Order 26.4B1 and documented on

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F 686	Continued From page 31 the MDS that the resident had a Ex.Order 26.4(b)(1) that was Ex.Order 26.4(b)(1) however did not know what type of [redacted] it was because the [redacted] care practitioner notes did not specify what type of [redacted] was on the [redacted] She stated that she did not see any documentation in the medical record that identified the [redacted] as an EX Order 26.4B1 [redacted]. The MDSC #2 stated that it would be important to find out specifically what type of [redacted] was on the EX Order 26.4B1 as the [redacted] was identified on 09/07/22, but did not have an explanation as to why she did not investigate the matter so that the [redacted] could be accurately identified and documented on the on the quarterly MDS dated 11/30/22. On 12/12/22 at 11:44 AM, the surveyor interviewed the Assistant Director of Nursing Infection Preventionist (ADON/ICP #2) who stated that he would assist the [redacted] care consultant with [redacted] rounds. ADON/ICP #2 stated that if a recommendation was made by the [redacted] care physician, then the [redacted] nurse or unit manager would notify the primary care physician regarding any recommendations. He stated that the primary care physician would either agree with the recommendations or not agree with the recommendations and that it would be the responsibility of the [redacted] nurse or the unit manager to write the primary care physician responses to the recommendations in the progress notes. He stated that it would be important to document the physician responses to the recommendations so that team was made aware of his decision. He also added that there should have been documentation in the [redacted] care consults what type of [redacted] the resident	F 686		

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had because it could be caused by Ex.Order 26.4(b)(1) [redacted]. He added that depending on what type of [redacted] it was, a treatment plan would have been developed to treat that specific [redacted].

On 12/12/22 at 11:54 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #2) for the EX Order 26.4B1 [redacted] unit who stated that the [redacted] nurse that accompanied the [redacted] care practitioner weekly for [redacted] rounds was usually responsible to call the primary care physician regarding any recommendations that the [redacted] care practitioner had. If the primary care physician agreed with the recommendations, the [redacted] care practitioner would write the orders for the recommendations in the physician orders. If the primary care physician was not in agreement with the recommendations, then the [redacted] care nurse should have documented the conversation she had with the physician in the progress notes. The LPN/UM #2 confirmed that there was no documentation in Resident #15's medical record that indicated that the primary care physician was notified of the [redacted] care practitioners' recommendations for Ex.Order 26.4(b)(1) and confirmed that there was no documentation that specified what type of [redacted] Resident #15 had on the EX Order 26.4B1. The LPN/UM #2 stated that there was documentation in the medical record that the [redacted] was related to EX Order 26.4B1 however, it was not related to Ex.Order 26.4(b)(1) and was related to EX Order 26.4B1 [redacted]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 33 On 12/12/22 at 12:10 PM, the surveyor interviewed the EX Order 26.4B1 care consult practitioner who stated that she was familiar with Resident #15 and saw the resident one time per week. She stated that she evaluated the resident's EX Order 26.4B1, performed measurements of the EX Order 26.4B1 would ask the resident general health questions, and assured that there was Ex.Order 26.4(b)(1) in the EX Order 26.4B1 She stated, "I believe the primary care physician did not want Ex.Order 26.4(b)(1) done therefore, the Ex.Order 26.4(b)(1) r was not completed." The surveyor questioned the EX Order 26.4B1 nurse practitioner regarding why there was no documentation on the EX Order 26.4B1 care notes for the recommendations to perform Ex.Order 26.4(b)(1) to rule out Ex.Order 26.4 and she stated that the electronic medical record was EX Order 26.4B1 and that's why the recommendation for the Ex.Order 26.4(b)(1) kept showing up on the EX Order 26.4B1 care sheets. The EX Order 26.4B1 care practitioner did not have a response as to why there was no documentation that she had a conversation regarding the Ex.Order 26.4(b)(1) recommendation to rule out Ex.Order 26.4 with the primary care physician. She further stated that the resident was Ex.Order 26.4(b)(1) and that she did not think that the family wanted any further interventions or tests done but did not have any documentation to include specific dates when she spoke with the family. The EX Order 26.4B1 care practitioner also did not have a response as to why there was no documentation on the EX Order 26.4B1 care consults as to what specific type of EX Order 26.4B1 was on the resident's EX Order 26.4B1 EX Order 2 The surveyor reviewed the progress notes dated 12/01/22 at 09:07 AM, that was written by the MDSC #2 who documented that the resident had a EX Order 26.4B1 .	F 686		

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	315225	A. BUILDING _____ B. WING _____	12/16/2022

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F 686	Continued From page 34 On 12/12/22 01:16 PM, the surveyor interviewed the MDSC #2 who stated that she made a typographical error when she documented on 12/1/22, that the resident had a EX Order 26.4B1 EX Order 26.4B1 On 12/16/22 at 10:24 AM, the surveyor interviewed the Regional Registered Nurse and the Director of Nursing in the presence of the survey team and both confirmed that there was no documentation in the medical record to accurately specify what type of EX Order 26.4B1 was on Resident #15's EX Order 26.4B1. It was also confirmed that when the staff informed the physician of the recommendations from the EX Order 26.4B1 care practitioner for the resident to have a Ex.Order 26.4(b)(1) on 9/14/22 to rule out EX Order 26, that it should have been documented in the progress notes. They both confirmed that the primary care physician should have also documented the diagnoses of EX Order 26 in the resident's medical record. On 12/16/22 at 11:07 AM, the surveyor conducted a telephone interview with the primary care physician in the presence of the survey team, and he stated that he already knew that Resident #15 had a diagnoses of EX Order 26 and therefore, he was not in agreement with the resident having Ex.Order 26.4(b)(1) done. He confirmed that the documentation should have been completed in the resident's medical record that Resident #15 had the diagnosis of EX Order 26 He also confirmed that there should have been documentation in the resident's medical record to accurately specify what type of EX Order 26.4B1 the resident had and stated that he would speak to	F 686		

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F 686	Continued From page 35 the [EX Order 26.4B3] care consult physician regarding this issue with documentation. He further stated, "I agree and we will try to do better." The facility policy dated 07/05/22 and titled, "Documentation: The Physicians/Consultant Role." The policy indicated that the center was to establish guidelines for documentation expected of all primary care physicians and consultant physicians. The policy indicated that the attending physician should provide timely medical orders based on an appropriate patient assessment and provide documentation required to explain medical decisions, that promotes effective care, and allows nursing facility to comply with relevant legal and regulatory requirements. The facility policy dated 07/05/22 and titled, "Medical Administration" indicated that the center was to establish guidelines for documentation expected of all primary care physicians and Consultant physicians. The policy indicated that the attending physician should, at each visit: - Provide a legible note in a timely manner for placement in the chart and over time, these progress notes should address relevant information about specific ongoings, active, potential problems, including reasons for changing or maintaining treatments or medications and plan to address relevant medical issues. -Properly define and describe patient symptoms and problems, clarify, and verify diagnoses, relate diagnoses to patient problems and help establish a realistic prognoses and care goals. -Provide documentation required to explain medical decisions, that promotes effective care	F 686		

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F 686	Continued From page 36 and allows nursing to comply with legal and regulatory compliance. NJ: 8:39-27.1(a)	F 686		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (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	F 758		12/30/22

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F 758	Continued From page 37 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to adequately monitor the EX Order 26.4B1 for the use of EX Order 26.4B1 medications Ex.Order 26.4(b) for 2 of 5 residents (Resident #86 and #115) reviewed for Ex.Order 26.4(b)(1) This deficient practice was evidenced by the following: 1. On 12/08/22 at 11:29 AM, the surveyor observed Resident #86 seated in a wheelchair in the dayroom while an activity was being held. On 12/08/22 at 12:23 PM, the surveyor reviewed Resident #86's electronic medical record (eMR). A review of the Admission Record face sheet (an admission summary) reflected that the resident	F 758	I Immediate Action a) Resident #86 orders for NJ Exec. Order 26:4.b.1 and EX Order 26.4B drug side effect monitoring were placed on 12/11/22 b) Resident #115 orders for NJ Exec. Order 26:4.b.1 and EX Order 26.4B drug side effect monitoring were placed on 12/11/22 c) Unit managers and ADON were in serviced on 12/11/22 on EX Order 26.4B1 drug management, including proper monitoring of NJ Exec. Order 26:4.b.1, monthly documentation of NJ Exec. Order 26:4.b.1 and care plan for EX Order 26.4B drug use. II Identification of others a) The facility respectfully submits that all residents receiving EX Order 26.4B1 drugs are potentially affected. b) An audit for residents with EX Order 26.4B1 drugs was conducted on 12/9/22 to ensure all residents receiving	

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F 758	Continued From page 38 was admitted to the facility with diagnoses which included but were not limited to EX Order 26.4B1 [redacted] A review of Resident #86's annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Order 26.4B1 which indicated that Resident #86 had EX Order 26.4B1 [redacted]. A further review of the MDS, indicated that the resident received EX Order 26.4B1 medications on EX out of the last EX days during the look-back period. A review of the electronic Medication Administration Record (eMAR) revealed the following order: EX Order 26.4B1 [redacted] The eMAR did not include an order to monitor Ex.Order 26.4(b)(1) to record the number of Ex.Order 26.4(b)(1) [redacted] that occur each day to monitor the use of EX Order 26.4B1 medications. A review of the Ex.Order 26.4(b)(1) Follow up note dated EX Order 26.4B1 included the following: Pt seen for medication follow up EX Order 26.4B1 [redacted] Further review of the electronic Medical Record (eMR) revealed that Resident #86 had EX Order	F 758	EX Order 26.4B1 drugs have an order for NJ Exec. Order 26:4.b.1 [redacted] monitoring and also an order for side effect monitoring, also to ensure that EX Order 26.4B1 drug use is reflected in the resident's care plan. All negative findings were corrected. III System Changes a) The Policy and Procedure on Documentation: Managing/Documenting Resident NJ Exec. Order 26:4.b.1 s was reviewed on 12/9/22 by the Administrator and Director of Nursing and found in compliance. b) A Quality Assurance and Improvement Plan (QAPI) was developed on 12/9/22 for EX Order 26.4B1 drug use and presented to the Quality Assurance committee for review and implementation c) Nurses were in serviced by the Director of nursing or designee on 12/30/22 on EX Order 26.4B1 drug management, including proper monitoring of NJ Exec. Order 26:4.b.1, monthly documentation of NJ Exec. Order 26:4.b.1 and care plan for NJ Exec. Order 26 drug use. IV: Quality Assurance a) An audit of residents with EX Order 26.4B1 drugs will be conducted by the Director or designee to ensure that all residents receiving EX Order 26.4B1 drug have proper monitoring of NJ Exec. Order 26:4.b.1, monthly documentation of NJ Exec. Order 26:4.b.1 and care plan for NJ Exec. Order 26:4.b.1 use b) Audits will be performed on 5 residents weekly x 4 weeks, monthly x 2, then quarterly x 2 quarters.	

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F 758	Continued From page 39 EX Order 26.4B1 Notes ( ), a monthly summary of Ex.Order 26.4(b)(1), one dated and the other dated Ex.Order 26.4(b)(1) dated included the following: EX Order 26.4B1 [redacted] The diagnosis of EX Order 26.4B1 was not an indication for the EX Order 26.4B1 medication prescribed for Resident #86. The facility did not monitor the appropriate EX Order 26.4B1 for the medication listed. There was no documented evidence that the facility had a for any other months. On 12/09/22 at 9:04 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #3 regarding the EX Order 26.4B1 monitoring for Resident #86. LPN #3 stated that he was from an agency and that he worked at the facility on and off for the last two years and that he had been at the facility for the last two weeks. He stated that he did not see EX Order 26.4B1 monitoring in the eMAR. He stated that he was not familiar with EX Order 26.4B1 at this facility but that at other facilities he would document it. The surveyor then asked what the purpose of EX Order 26.4B1 and LPN #3 stated that for a particular diagnosis they would monitor for the signs and symptoms of EX Order 26.4B1 and document the EX Order 26.4B1 related to	F 758	c) The results of all audits will be brought to the QAPI committee quarterly x 3. V Person Responsible: Director of Nursing or designee	

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the medications for the EX Order 26.4B1 to review. The surveyor then asked what the Ex.Order 26.4(b) for Resident #86 and LPN #3 stated that he did not know of any EX Order 26.4B1 and added that he was not familiar with Resident #86.

On 12/09/22 at 11:32 AM, the surveyor interviewed the LPN unit manager of the third floor (LPN/UM #3) regarding Resident #86's Ex.Order 26.4(b)(1) and the EX Order 26.4B1 monitoring. LPN/UM #3 stated that Resident #86 could be EX Order 26.4B1 and had EX Order 26.4B1 awareness and that the resident received the medication EX Order 26.4B1. The surveyor then asked the LPN/UM #3 if there were any additional EX Order's besides for the two dated EX Order 26.4B1 and EX Order 26.4B1. LPN/UM #3 confirmed that there were none prior to EX Order 26.4B1 and none after EX Order 26.4B1

On 12/15/22 at 10:13 AM, the surveyor interviewed the Director of Nursing (DON) regarding the EX Order 26.4B1 monitoring of Resident #86. The DON stated that there should have been other monthly Ex.Order 26.4 done. She then stated that the Ex.Order 26.4 done were not filled out appropriately. The DON stated that EX Order 26.4B1 is not the indication for EX Order 26.4B1 to her knowledge. She added that the resident was not being monitored appropriately.

2. On 12/08/22 at 10:02 AM, the surveyor observed Resident #115 in bed watching television.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included but were

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F 758	Continued From page 41 not limited to EX Order 26.4B1 [redacted] A review of Resident #115's quarterly MDS, dated EX Order 26.4B1 [redacted], reflected that the resident had a BIMS score of EX Order 26.4B1 [redacted] which indicated that Resident #115 was EX Order 26.4B1. A further review of the MDS, indicated that the resident received EX Order 26.4B1 [redacted] medications on [redacted] out of the last [redacted] days during the look-back period. A review of the eMAR revealed the following orders: EX Order 26.4B1 [redacted] The eMAR did not include a separate order to monitor EX Order 26.4B1 [redacted] to record the number of Ex.Order 26.4(b)(1) EX Order 26.4B1 [redacted] that occur each day to monitor the use of EX Order 26.4B1 [redacted] medications. A review of the EX Order 26.4B1 [redacted] Follow up note dated EX Order 26.4B1 [redacted] included the following: Diagnosis: EX Order 26.4B1 [redacted]	F 758		

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F 758	Continued From page 42 EX Order 26.4B1 [redacted] A review of the order summary indicated that Resident #86 had received EX Order 26.4B1 EX Order 26.4B1 medications since they were initially ordered on EX Order 26.4B1 Further review of the eMR revealed that Resident #115 had one Ex.Orde, a monthly summary of EX Order 26.4 EX Order 26.4B1 that were monitored, dated EX Order 26.4B1 There was not any other EX Order 26.4 in the eMR. The EX Orde dated EX Order 26.4B1 included the following: A. 1st EX Order 26.4B1 [redacted] B. 2nd EX Order 26.4B1 [redacted] The EX Order 26.4B1 medication and the EX Order 26.4B	F 758		

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F 758	Continued From page 43 EX Order 26.4B1 to monitor for the medication was not listed on the Ex.Order 26 The diagnosis of EX Order 26.4B1 EX Order 26.4B1 was not indicated on the EX Orde for the EX Order 26.4B1 medication prescribed for Resident #115. The facility did not monitor the appropriate EX Order 26.4B1 for the EX Order 26.4B1 medication. There was no documented evidence that the facility had a EX Orde for any other months. On 12/09/22 at 9:04 AM, the surveyor interviewed LPN #3 regarding the Ex.Order 26.4(b)(1) for Resident #115. LPN #3 stated that he was from an agency and that he worked at the facility on and off for the last two years and that he had been at the facility for the last two weeks. He stated that he did not see behavior monitoring in the eMAR. He stated that he was not familiar with target behaviors at this facility but that at other facilities he would document it. The surveyor then asked what the purpose of target behaviors were. LPN #3 stated that for a particular diagnosis they would monitor for the signs and symptoms of EX Order 26.4B1 and document the behaviors related to the medications for the EX Order 26.4B1 to review. The surveyor then asked what the EX Order 26.4B1 that were to be monitored for Resident #115. LPN #3 stated that he did not know of any EX Order 26.4B1 and added that he was not familiar with Resident #115. On 12/09/22 at 09:21 AM, the surveyor interviewed LPN/UM #3 regarding Resident #115's EX Order 26.4B1 and the EX Order 26.4B1 monitoring. LPN/UM #3 stated that the facility would document a EX Order 26.4B1 note if the resident had a EX Order 26.4B1. She added that for residents that do have EX Order 26.4B1, some may have an order in	F 758		

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F 758	Continued From page 44	F 758		

the eMAR for the Ex.Order 26.4(b)(1) r monitoring. The surveyor then asked if a resident was on a EX Order 26.4B1 medication if they would have Ex.Order 26.4(b)(1) monitoring. The LPN/UM #3 stated that the monitoring would be a monthly summary under the assessment tab in the eMR. She added that she would print out the eMAR and go through the medications, see if a gradual dose reduction (GDR) was done and when the physician last visited them. She then stated that she would count out how many EX Order 26.4B1 were documented in the progress notes. She stated that everyone on EX Order 26.4B1 meds should have a monthly EX Order 26.4B1 note and have a Ex.Order 26.4(to monitor and the EX Order 26.4B1 should be in the resident's care plan. The surveyor then asked what the purpose was for Ex.Order 26.4(b)(1) monitoring and EX Order 26.4B1. The LPN/UM #3 stated that it was to see if the resident needed an adjustment in medication dose, to see if the medication was working, or to see if they needed a GDR. The surveyor then asked if Resident #115 was on any EX Order 26.4B1 medications. The LPN/UM #3 stated that the resident was on EX Order 26.4B1 and EX Order 26.4B1 The surveyor then asked what the Ex.Order 26.4(b)(1) were for Resident #115. She stated that the resident preferred to be in his/her room by themselves. She added that the resident was EX Order 26.4B1 and that "you can see it when he/she is EX Order 26.4B1." The surveyor then asked if Resident #115's Ex.Order 26.4(b)(1) to be monitored were on the resident's care plan. The LPN/UM #3 stated that Resident #115's care plan did not have the EX Order 26.4B1 and that they should be on the care plan. The surveyor then asked the LPN/UM #3 if there were any Ex.Order 26 beside for the Ex.Order dated 09/30/22. The LPN/UM #3 confirmed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 45 that there were no other monthly [Ex.Order 26] and that there should have been [Ex.Order 26] done monthly. On 12/09/22 at 11:30 AM, the surveyor asked the LPN/UM #3 if the medication of [EX Order 26.4B1] should have been included on the [Ex.Order 2] dated [EX Order 26.4B1] and she confirmed that it should have been included. On 12/09/22 at 11:43 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Consultant Preventionist (ADON/ICP) #2 regarding the facility's [Ex.Order 26.4(b)(1)] The ADON/ICP #2 stated that he started at the facility in July and that he was not "very informed" on the policy at the facility for [EX Order 26.4B1] medications and [Ex.Order 26.4(b)(1)] monitoring. The surveyor asked the ADON/ICP #2 what his expectation would be if someone was on a [EX Order 26.4B1] medication. He stated that they would have [Ex.Order 26.4(b)(1)] monitoring and that if the resident had [EX Order 26.4B1], it would be documented in the eMR. He added that there were different ways to document it and that it could be an order in the eMAR or a [EX Order 26.4B1] note in the electronic progress notes. The surveyor then asked if a monthly summary of the [EX Order 26.4B1] should be done. The ADON/ICP #2 stated that he was not familiar if a monthly summary should be done. The ADON/ICP #2 stated that a [Ex.Order 26.4(b)(1)] was specific to the resident and what [Ex.Order 26.4(b)(1)]s were to be monitored. He added the reason to monitor [Ex.Order 26.4] was to see if the medication was effective or not effective. On 12/15/22 at 10:07 AM, the surveyor interviewed the DON regarding [Ex.Order 26.4(b)(1)]	F 758		

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	315225	A. BUILDING _____ B. WING _____	12/16/2022

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F 758	Continued From page 46 monitoring. The DON stated that the resident should have had a monthly [Ex.Order] while on the [EX Order 26.4B1] medication. She confirmed that the medication [EX Order 26.4B1] should have been included on the [Ex.Order 2] that was done. The DON stated that the [Ex.Order] did not list the appropriate [EX Order 26.4B1] and that it looked like the nurse did the assessment based on diagnosis and not [EX Order 26.4B1]. She added that the [Ex.Order] was not filled out in its entirety. The DON then confirmed that an order for [Ex.Order 26.4(b)(1)] r monitoring in the eMAR was ordered and started after surveyor inquiry. The surveyor then asked if Resident #115's [Ex.Order 26.4(b)(1)] were on the resident's care plan. The DON confirmed that the resident's care plan did not have the [Ex.Order 26.4(b)(1)] on the care plan and that they should have been included in the care plan. On 12/16/22 at 9:49 AM, in the presence of the survey team, the surveyor interviewed Regional Registered Nurse (RRN) #1 regarding the [Ex.Order 26.4(b)(1)] for Resident #86 and Resident #115. The RRN #1 confirmed that the [Ex.Order 26.4(b)(1)] was incomplete and that it was not done monthly and that it should have been done monthly. A review of the facility provided policy titled, "Managing/Documenting Resident Behaviors" with a review date of 8/1/22, included the following: Policy: It is the policy of this facility to monitor resident's behavior and document behaviors in the medical record. Purpose: To provide a method of addressing resident behaviors, documenting behaviors.	F 758		

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F 758	Continued From page 47 Procedure: Registered Nurse 1. Assess resident for behaviors, how behaviors have been managed in the past, what triggers the behaviors, and what pharmacological interventions have been successful. 2. All residents with known behaviors or history of behaviors should have a behavior care plan. 3. Will initiate behavior care plan and psychoactive medications for anyone on psych medications. Licensed Nurse 4. Documents episodically in medical record to include where possible, cause or trigger all interventions attempted, disruption to others and duration of episode. 5. Documents on episodic behavior note summarizing type of behavior, diagnoses, medications, other interventions. 6. A monthly cycle note should also summarize behavior or no behaviors is residents not on any medications but may have had a history of behaviors ....Nurse manager/designee 8. Review psych consult and psychology notes and updates behavior and psych care plan accordingly. Updates diagnoses according to psychiatrist findings. Certified nursing Assistant 10. Notifies nurse of any behaviors noted on tour of duty. A review of the facility provided policy, titled "Antipsychotic Medication Use" with a revised date of 10/22/22 included the following: Under Policy Statement Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review Under Policy Interpretation and Implementation 1. Resident will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and	F 758		

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F 758	Continued From page 48 effective. 2. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 3. The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. The policy did not address behavior monitoring. N.J.A.C. 8:39-27.1 (a)	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record, and other facility documentation, it was determined that the facility failed to verify and accurately transcribe readmission medications. The deficient practice was identified for 1 of 5 residents (Resident #80) reviewed for unnecessary medications and was evidenced by the following: According to the Admission Record, Resident #80 was admitted with diagnoses that included, but were not limited to, EX Order 26.4B1 EX Order 26.4B1 . Review of Resident #80's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated	F 760	I Immediate Action a) Resident #80 medical record was reviewed by the Director of Nursing on 12/15/22 to determine if any harm came to the resident due to the transcription error of the NJ Exec. Order 26:4.b.1 No change in condition noted. b) A medication error report was completed on 8/11/22 and 11/8/22. c) Nurses responsible for the medication errors were in serviced by the Director of Nursing on 8/11/22 and 11/8/22. II Identification of others c) The facility respectfully submits that all residents newly admitted and receiving medications, including NJ Exec. Order 26:4.b.1	12/30/22

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F 760	Continued From page 49 EX Order 26.4B1 included the resident had a Brief Interview for Mental Status of EX Order which indicated that the resident was EX Order 26.4B1. Further review of the MDS revealed the resident received Ex.Order 26.4(b)(1) medication for the last Ex.Order 26.4(b)(1) Review of the EX Order 26.4B1) indicated to continue all current medications as prescribed, which included EX Order 26.4B1. The benefits outweigh the risk. Review of the Progress Notes (PN) revealed a EX Order 26.4B1 nursing progress note that Resident #80 was readmitted to the facility and that medications and treatments were confirmed by the APN [advanced practice nurse]. Review of Resident #80's EX Order 26.4B1 "After Visit Summary" report (hospital discharge instructions) reflected under the "Medication List" medication order for EX Order 26.4B1) (EX Ord EX Order 26.4B1) EX Order 26.4B1) and to administer EX Order 26.4B1 daily. [for a total of EX Ord EX Order 26.4B1 Review of the Order Summary Report, order date range EX Order 26.4B1, revealed a 08/11/22 physician order (po) for EX Order 26.4B1 and to administer EX Order 26.4B1. [for a total of EX Order 26.4B1 daily]. Review of the EX Order 26.4B1 and EX Order 26.4B1 Medication Administration Records (MAR) revealed the aforementioned order with the administration times of 9:00 AM, 1:00 PM and 5 PM. Further review of the MARs revealed that Resident #80 received EX Order 26.4B1 daily	F 760	are potentially affected. d) An audit for residents newly admitted or readmitted and receiving medications including NJ Exec. Order 26:4.b.1 was conducted to ensure medication reconciliation is done by 2 different nurses and accurate. Task completed 12/15/22, no other errors found. III System Changes d) The Policy and Procedure on Physicians Orders was reviewed on 12/15/22 by the Administrator and Director of Nursing and found in compliance. e) Nurses were in serviced on 12/30/22 by the Director of nursing or designee on medication reconciliation process for all residents newly admitted and readmitted to ensure all orders are carried out correctly. The checks will be done by 2 different nurses and all negative findings to be corrected immediately and reported to the Director of Nursing. IV: Quality Assurance a) An audit of residents newly admitted or readmitted receiving medications including NJ Exec. Order 26:4.b.1 will be conducted by the Director or designee to ensure that all orders are carried out correctly. b) Audits will be performed on 5 residents weekly x 4 weeks, monthly x 2, then quarterly x 2 quarters. c) The results of all audits will be brought to the QAPI committee quarterly	

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F 760	Continued From page 50 for the following dates: -08/12/22, 08/15/22, 08/16/22, 08/17/22, 08/18/22, 08/19/22, 08/20/22, 08/21/22, 08/22/22, 08/23/22, 08/24/22, 08/25/22, 08/26/22, 08/27/22, 08/28/22, 08/29/22, 08/30/22, 08/31/22, 09/01/22, 09/02/22, 09/03/22, 09/04/22, 09/05/22, 09/06/22, 09/07/22, 09/08/22, 09/09/22, 09/10/22, 09/11/22, 09/12/22, 09/13/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, 09/18/22, and 09/19/22. Review of Resident #80's 11/04/22 "After Visit Summary" report reflected under the "Medication List" section, a po for EX Order 26.4B1 and to administer EX Order 26.4B daily. Review of the Order Summary Report, for active orders as of EX Order 26.4B1 revealed a EX Order 26.4B1 po for EX Order 26.4B1 and to administer Ex.Order 26.4 day. [for a total of Ex Order 26.4B1 daily]. Review of the EX Order 26.4B1 revealed the aforementioned order with the administration times of 9:00 AM, 1:00 PM and 5 PM. Further review of the MARs revealed that Resident #80 received EX Order 26.4B1 During an interview with the surveyor on 12/09/22 at 11:48 AM, LPN #1 stated the admitting nurse would review the packet from hospital, which included the discharge instruction and medication list. LPN #1 added that if there was a change in dosage of a medication, she would inform the physician of the previous dosage and the dosage recommended from	F 760	x 3. V Person Responsible: Director of Nursing or designee	

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F 760	Continued From page 51	F 760		

hospital in order to make sure the correct dose was ordered and administered.

During an interview with the surveyor on 12/09/22 at 12:01 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #3 stated the admitting nurse would review the hospital record, verify the medication list with the physician and then input any orders into the Electronic Medical Record (EMR). LPN/UM #3 added that the nurse should review the resident's previous medication list, the hospital discharge medication list, and clarify any dosage discrepancy with the physician to make sure the resident was receiving the correct dosage.

During an interview with the surveyor on 12/09/22 at 12:20 PM, the Director of Nursing (DON), stated that the nurse should reconcile the resident's previous medication orders and hospital discharge medication list with the physician.

Review of the [redacted] "Medication Error Report Form" indicated the incident type was [redacted]." The "Resident was ordered [redacted] due to transcription error."

Review of the 11/08/22 "Medication Error Report Form" indicated the incident type was [redacted] he "Resident was to receive [redacted] Resident receive[d] [redacted]."

Review of the facility's "Physician's Orders" policy, last reviewed on [redacted], indicated that

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F 760	Continued From page 52 "all orders upon admission/readmission must be reconciled with the discharge medication list/discharge record, transcribed appropriately and verified with the physician."	F 760		
F 812 SS=E	NJAC 8:39-27.1(a), 29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent	F 812	I. Immediate Attention The following were completed on 12/7/22 a) Stack of 18 inch sheet pans were rewashed and allowed to dry without nesting to prevent bacterial growth and	12/30/22

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F 812	Continued From page 53 foodborne illness. This deficient practice was evidenced by the following: On 12/07/22 at 10:54 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the kitchen tour: 1. A stack of 18-inch sheet pans was stored on a multi-tiered cart. The surveyor observed the top sheet pans were wetnesting. When interviewed, the FSD stated the sheet pan should not have been stacked while wet. 2. In the dry storage room, an opened, undated container of beef base wrapped in plastic was stored on a shelf. When interviewed, the FSD stated the container should have been dated when opened. 3. In the dry storage room, a dented can with no labeled was stored on a shelf alongside undented cans. When interviewed, the surveyor observed the FSD remove the dented can from the rack and placed it on the shelve designated for the dented cans. The FSD stated the can should not have been on the rack and should have been placed in the designated dented can area. 4. A stack of uncovered coffee filters was stored directly on top of the juice dispenser machine. When interviewed, the FSD stated the stacks of coffee filters should be stored in a plastic bag. 5. In the walk-in freezer, two packages of crab flake were stored on the top rack under the freezer fans. The surveyor observed the packages of crab flake covered with ice build-up.	F 812	then put away b) Opened undated container of beef base wrapped in plastic was discarded c) Dented can removed from dry storage and placed in dented can section for disposal d) Stack of uncovered coffee filters were discarded e) 2 packages of crab flake with ice built up were discarded f) Fully thawed vanilla shakes were immediately dated appropriately The following were completed on 12/15/22 a) Dented can removed from dry storage and placed in dented can section for disposal b) Kitchen staff immediately in serviced on checking and documenting temperatures of food items on the tray line II. Identification of others All residents have the potential to be affected. a) The Certified Dietary Manager (CDM)/ Food service director performed an audit of all areas identified with issues and no additional findings were noted. Completion date 12/7/22 and 12/15/22 III. Systemic Changes a) The Policy and Procedure for Wet nesting was reviewed on 12/15/22 by the Administrator and CDM/Food service director and found to be in compliance. b) The Policy and Procedure for Label, Storage and Dating was reviewed on	

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F 812	Continued From page 54 When interviewed, the FSD stated the freezer fan leaked from time to time. 6. In the walk-in refrigerator, the surveyor observed multiple trays stored on a multitiered cart. The first tray contained 23 fully thawed undated/unlabeled vanilla health shakes. The survyeor observed a ripped piece of cardboard, dated 12/07 and 12/14. A second tray contained seven fully thawed undated/unlabeled vanilla health shakes. A third tray contained 42 fully thawed undated/unlabeled vanilla health shakes. The surveyor observed a ripped piece of card, dated 12/07 and 12/10. When interviewed, the FSD confirmed the surveyor's findings and stated the health shakes should have been dated as soon as they were pulled from the freezer. On 12/15/22 11:30 AM, the surveyor, in the presence of the FSD, observed the following during the second kitchen tour: 7. In the dry storage room, a dented can of spaghetti sauce was stored on a shelf alongside undented cans. When interviewed, the surveyor observed the FSD remove the dented can from the rack and place it on the shelve designated for the dented cans. 8. The surveyor observed dietary staff actively plating residents' lunch meal plates and requested to review the facility's "Service Line Checklist," form (a form that documents the tray line food temperatures) for the 12/15/22 lunch meal service. The FSD provided the surveyor with a Service Line Checklist dated 12/14/22. When questioned about the 12/14/22 date, the FSD responded that the staff must have written	F 812	12/15/22 by the Administrator and CDM and found to be in compliance. c) The Policy and Procedure for Dented cans was reviewed on 12/15/22 by the Administrator and CDM and found to be in compliance. d) The Policy and Procedure for Food temperatures was reviewed on 12/15/22 by the Administrator and CDM and found to be in compliance. e) All kitchen staff were reeducated on 12/30/22 by the Certified Dietary Manager on the following topics. a. Dating and Labeling of Food Items procedure b. Receivable and Storing procedures c. Sanitizing Surfaces procedures d. Checking food temperatures on tray line procedure e. Dented Can procedure f. Wet nesting policy IV. Quality Assurance a) Audits will be conducted by the Certified Dietary Manager (CDM) of all areas of the kitchen including but not limited to dating, labeling and storage of food and kitchen supplies, receivables and storage of food items, sanitizing food services, dented cans, wet nesting, checking food temperatures on the tray line b) Audits will be done by the Certified Dietary Manager (CDM)/supervisor weekly x 4 weeks, monthly x 2 months, quarterly x 2 quarters. c) The results of all audits will be	

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F 812	Continued From page 55 the wrong date on the sheet and confirmed that the provided 12/14/22 Service Line Sheet was for the 12/15/22 lunch meal service. Review of Service Line Checklist, dated 12/14/22, revealed that the following tray line food items' temperatures were not documented: -beef goulash with brown sauce -mashed potatoes -beef gravy. When interviewed, the FSD stated that everything [food] on the tray line should have a temperature documented on the Service Line Checklist form. Review of the facility's "Policy for Wet nesting," with the approval dated of 11/23/22, indicated that all pots and pans must be "put on shelve side way for airdry for at least 10 minutes or and until it is completely dried." Review of the facility's "Policy for Label and dating," with the approval dated of 11/23/22, indicated that leftover food should be clearly labeled and dated. The policy further indicated that "Health shakes will be put out of freezer and labeled to expire for 14 days after thawing." Review of the facility's "Policy for dented cans," with the approval dated of 11/23/22, revealed that "All dented and rusted cans must be put at a designated area to be returned." Review of the facility's "Policy for food temperatures," with a approval dated in March of 2022, revealed that "The temperatures will be taken and recorded for all items at all meals."	F 812	brought to the Quality Assurance committee quarterly x 3quarters. V. Person Responsible: Certified Dietary Manager (CDM)/Food service director or designee	

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F 812	Continued From page 56	F 812		
F 814 SS=D	NJAC 8:38-17.2 (g) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff and the public by failing to keep the garbage compacter area free of garbage and debris and failed to have the doors to the trash compactor closed for 1 of 1 trash compactor. This deficient practice was evidenced by the following: On 12/07/22 at 10:54 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and requested to see the outside garbage receptacle area. The surveyor observed a trash compactor (TC) on a cement pad. The surveyor further observed that both the left-side and right-side doors of the TC open exposing multiple trash bags inside. The surveyor further observed that the outside garbage receptacle area was littered with leaves, debris, used gloves, cans, cardboard boxes, milk and juice cartons. When interviewed at that time, the FSD stated that everyone was responsible for cleaning the garbage receptacle area and the lids and doors of the TC should be closed when not in use.	F 814	I Immediate Attention Following items were completed on 12/7/22 a) garbage compacter area was cleaned and cleared of garbage and debris b) the doors to the trash compactor were immediately closed II Identification of others All residents have the potential to be affected. III Systemic Changes a) The Policy and Procedure for garbage and dumpster pick up was reviewed on 12/7/22 by the Administrator, CDM/Food service director and Environmental services director and found to be in compliance. b) In services done for all environmental, kitchen and maintenance staff on keeping the garbage and dumpster area clean and trash compactor doors closed at all times. VI. Quality Assurance a) Audits of the garbage and dumpster area will be conducted by the Administrator or designee weekly x 4 weeks, monthly x 2 months, quarterly x 2	12/30/22

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F 814	Continued From page 57 A reviewed the facility's "Policy for garbage and dumpster pick up," with an approved date of 11/23/22, indicated that the "Dumpster is provided and kept outside / area is kept cleaned at all time[s] and compactor is kept closed at all time[s]." The policy further instructed to clean around in case any garbage fell on the ground and to close dumpter['s] doors.	F 814	quarters. b) The results of all audits will be brought to the Quality Assurance committee quarterly x 3 quarters. VII. Person Responsible: Administrator or designee	
F 838 SS=C	NJAC 8:39-19.7 Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to	F 838		12/30/22

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F 838	Continued From page 58 provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documentation, it was determined that the	F 838	I. Immediate Action a) The Facility Assessment was revised	

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F 838	Continued From page 59 facility failed to ensure that the Facility Assessment included the resources required to establish policies and procedures for the management of an active COVID-19 (a potentially deadly virus) outbreak. This deficient practice was identified by the following. Reference F880, F886 On 12/07/22 at 9:30 AM during the entrance conference, both the Administrator and the Director of Nursing (DON) stated that the facility was in an active outbreak of COVID-19 and confirmed that there were no active cases of COVID-19, or persons under investigation (PUI) for signs and symptoms of COVID-19. At that time, the DON stated that those staff who were not up to date with their COVID-19 vaccinations (unvaccinated, exempt employees) were tested twice weekly and both residents and staff were tested once weekly. On 12/12/22 at 11:14 AM, the surveyor interviewed Infection Control Practitioner (ICP #1) in the presence of the survey team. ICP #1 stated that on EX Order 26.4B1, Resident #107 was EX Order 26.4B1 at the Ex.Order 26.4(b)(1). ICP #1 stated that the resident was a [redacted] and all residents who went out to smoke with the resident prior to Ex.Order 26.4(b)(1)n were tested once for EX Order 26.4B1 ICP #1 further stated that no staff were tested as she had determined that based on the process used for EX Order 26.4B1 supervision, staff did not have close contact with the resident, and staff were up to date with both their EX Order 26.4B1 vaccinations and boosters.	F 838	by the Administrator on 12/15/22 to include the resources required to establish policies and procedures for the management of an active COVID-19 outbreak. Category of Infectious Diseases was revised to include care of the resident with COVID-19. II. Identification of Others: All residents have the potential to be affected. III. System Changes: a) The Policy and Procedure titled Facility Assessment was reviewed on 12/15/22 and found in compliance. b) The facility Administrator or designee reviewed the facility assessment on 12/30/22 to ensure all areas are still up to date and made the necessary corrections/revisions if needed. IV. Quality Assurance a) Audits of the Facility Assessment will be done by the Regional nurse to ensure the assessment contains Category of Infectious Diseases to include care of the resident with COVID-19 b) Audits will be done weekly x 4 weeks, monthly x 2 months and Quarterly x 2 quarters. c) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. V. Person Responsible: Administrator or designee	

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F 838	Continued From page 60 ICP #1 further stated that CNA #4 Ex.Order 26.4(b)(1) [redacted] and the residents that she cared for were tested one time in response to their exposure. ICP #1 stated that she tested all residents who were not up to date with their Covid vaccinations on 11/14/22, 11/16/22, 11/21/22, 11/29/22 and 12/1/22. ICP #2 stated that further testing for COVID-19 should have been completed on 12/5/22, but she had other stuff that she was assigned to do and was unable to complete the required testing. On 12/12/22 at 12:35 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that she would have expected that all smokers would have been tested twice weekly with results documented on a log during outbreak through 12/05/22. The DON stated that while symptom monitoring was conducted once every shift, she would not know if somebody was positive for COVID-19 if the residents were not tested and testing was not documented as required. The DON stated that no residents should have been excluded during outbreak testing. The DON further stated that outbreak testing should have begun immediately and should not have been delayed until 11/14/22, as there was a concern for spread of infection. On 12/13/22 at 8:57 AM, the DON provided the surveyor with a copy of the facility Resident and Staff Outbreak Line List (a table that contains key information about each case in an outbreak) which revealed that Resident #107 who was admitted to the facility in EX Order 26.4B1 had a EX Order 26.4B1 [redacted] episode and was sent to the Ex.Order 26.4(b)(1) [redacted] where he/she EX Order 26.4B1 [redacted]	F 838		

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EX Order 26.4B1 The resident returned to the facility on EX Order 26.4B1 and was placed on Ex.Order 26.4(b)(1) through [redacted]

Further review of the line list confirmed that CNA #4 developed Ex.Order 26.4(b)(1) after being exposed to a sick family member who tested positive for COVID-19. CNA #4 then Ex.Order 26.4(b)(1) [redacted] on 11/29/22 and remained home under Ex.Order 26.4(b)(1) through 12/4/22.

On 12/13/22 at 9:58 AM, the surveyor interviewed the Administrator in the presence of the survey team, who stated that the residents were vaccinated for Covid, asymptomatic, tested twice for Covid, and were all negative. The Administrator further stated that because everyone was vaccinated and we tested the smokers who were asymptomatic, there was not a need for more testing.

On 12/15/22 at 9:55 AM, the surveyor notified the Administrator that a copy of the facility assessment was needed for review.

On 12/15/22 at 10:42 AM, the surveyor reviewed the Facility Assessment titled, "Facility Wide Assessment Tool." The date of the Assessment was January 2022. Further review of the document revealed that Quality Assurance Performance Improvement (QAPI) Committee Reviews of the document were conducted in January 2022, April 2022, July 2022 and October 2022. Further review of the documented revealed the following: Riverfront Rehab can provide care for residents, that may develop the following common diseases, conditions, physical and

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F 838	Continued From page 62	F 838		

cognitive disabilities, or combinations of conditions that may require complex medical care and management. For all admissions accepted, the center coordinates services to ensure all required equipment, treatments, and training/skills, necessary to care for the specific diagnosis/conditions of each new admission is coordinated and ready on the day of admission ... A review of the Category of Infectious Diseases failed to include care of the resident with COVID-19.

On 12/15/22 at 10:42 AM, the surveyor interviewed the Administrator who stated that COVID-19 should have been included in the Facility Assessment. The Administrator stated that the Facility Assessment served as a guide for the building and the whole team. The Administrator stated that the facility did have policies related to COVID-19 and that the Facility Assessment did not cover everything. The Administrator stated that staff roles and responsibilities related to COVID-19 should have been included within the Facility Assessment. The Administrator maintained that COVID-19 may have been inadvertently removed from the Facility Assessment when he last updated the document, and he was unable to provide the surveyor with documentation to support the explanation for the omission when requested.

Review of the facility policy, "Annual Facility Assessment" (reviewed 06/16/22) revealed the following: It is the policy of this facility to conduct and document facility wide assessments to determine the resources necessary to care for our residents competently during both day-to-day operations and emergencies to ensure that

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F 838	Continued From page 63 quality of care and quality of life are maintained. The facility assessment must address or include: The care required by the resident population considering the types of diseases, conditions, physical and cognitive abilities, overall acuity, and other pertinent facts that are present within a population. Responsibility: Administrator Procedure: Responsible for ensuring that the facility assessment is completed no less than annually and whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.	F 838		
F 880 SS=F	NJAC 8:39-19.1 (a) (b) 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,	F 880		12/30/22

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F 880	Continued From page 64 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 65 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent documents, it was determined that the facility who had been in an active COVID-19 outbreak since 11/18/22, failed to: a) follow the facility policy and conduct complete and thorough contact tracing to prevent the spread of COVID-19 (a potentially, deadly virus) and b) implement measures to prevent the growth of EX Order 26.4B1 and other waterborne pathogens in the facility's water systems. This deficient practice was identified for 1 (one) of 1 (one) sampled EX Order 26.4B1 resident (Resident #107) and a review of 1 (one) of 1(one) EX Order 26.4B1 staff member (Certified Nursing Assistant (CNA) #4) and was evidenced by the following: Reference: Contact Tracing for COVID-19 Centers for Disease Control: https://www.cdc.gov/coronavirus/2019-ncov/php/	F 880	I. Immediate Action 1. a)Resident #107 recovered from EX Order 26.4B1 had been EX Order 26.4B1 since readmission to the facility on EX Order 26.4B1 No other residents were identified with EX Order 26.4B1 after resident #107 EX Order 26.4B1. b)CNA #4 was isolated at home immediately starting date NJ Exec. Order 26:4.b.1 and recovered from NJ Exec. Order 26:4 after 10 days. No other residents or staff were identified with NJ Exec. Order 26:4.b.1 after CNA#4 tested NJ Exec. Order 26:4.b. a) Unit managers and Infection Preventionist were in serviced on 12/13/22 by the Director of Nursing on proper procedure for Contact tracing when a NJ Exec. Order 26:4.b.1 case is identified. 2. Water testing for EX Order 26.4B1 a) Facility Administrator ordered a test kit for water testing for EX Order 26.4B1 on EX Order 26.4B1. II. Identification of Others: a) The facility respectfully submits that	

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F 880	Continued From page 66 contact-tracing/contact-tracing-plan/contact-tracing.html. Reference F886 a) On 12/07/22 at 9:30 AM, during the entrance conference, both the Director of Nursing (DON) and Administrator confirmed that the facility was in a COVID-19 Outbreak and indicated that there were no residents who required transmission based precautions (TBP, infection control precautions for residents known or suspected to be infected) or who were considered persons under investigation (PUI) for COVID-19 who were monitored for signs and symptoms of COVID-19 under TBP. On 12/12/22 at 11:24 AM, the surveyor interviewed the Infection Control Preventionist (ICP #1) who stated that on 11/11/22, Resident #107 was NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1 where he/she was diagnosed with EX Order 26.4B1 ICP #1 stated that since the resident was NJ Exec. Order 26:4.b.1 immediately for NJ Exec. Order 26:4.b.1 the resident's unsampled room mate and transferred the resident to the NJ Exec. Order 26:4.b for observation where the resident continued to test EX Order 26.4B1 on day NJ Exec. Order 26:4.b.1. ICP #1 stated that since Resident #107 was a EX Order 26.4B1 she then tested all EX Order 26.4B1 who may have went out to EX Order 26.4B1 with the resident on EX Order 26.4B1 ICP #1 stated that she did not conduct contact tracing or testing with the Activity Aides	F 880	all residents can potentially be affected by this deficient practice regarding COVID 19 contact tracing and water testing for Legionella. III. Systemic Changes 1. a) The Policy and Procedure titled Contact Tracing Policy COVID 19 Pandemic" was reviewed on 12/13/22 by the Director of Nursing and Infection Preventionist and found to be in compliance. b) A Quality Assurance Performance Improvement (QAPI) was completed for Contact tracing on 12/13/22 and presented to the Quality Assurance committee for review and implementation. c) Contact tracing forms for employee and resident was revised on 12/13/22 d) Education was provided to all nurses on 12/30/22 on Contact tracing procedure and new contact tracing form by the Director of Nursing or designee and Infection Preventionist. 2.a) The Policy and Procedure titled Water Management Plan was reviewed on 12/15/22 by the Administrator and Maintenance Director. No revisions done. b) Education was provided to the Maintenance staff responsible for the water testing on 12/30/22 to ensure all guidelines are followed. c) Water testing kit was ordered on 12/15/22, received and water was tested for Legionella IV. Quality Assurance	

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F 880	Continued From page 67 (AA) who supervised the residents during EX Order 26.4B1 sessions as they were all up to date with their EX Order 26.4B1 vaccinations. ICP #1 further stated that she assumed that the AA remained inside while masked behind the door while the residents EX Order 26.4B1 outdoors and did not have prolonged exposure to Resident #107. Review of the facility's EX Order 26.4B1 Break Record Sheet revealed the Resident #107 last attended EX Order 26.4B1 Break on 11/9/22 at 8:45 AM. ICP #1 further stated that an employee, a Certified Nursing Assistant (CNA #4), tested NJ Exec. Order 26:4.b.1 on 11/29/22. ICP #1 explained that CNA #4 worked the 11-7 shift on 11/28/22, and called ICP #1 that morning to inform her that she was NJ Exec. Order 26:4.b.1 and was recently exposed to a family member who tested NJ Exec. Order 26:4.b.1. CNA #4 informed ICP #1 that she tested herself with a home test kit which was NJ Exec. Order 26:4.b.1. ICP #1 stated that she directed CNA #4 to have a PCR EX Order 26.4B1) test completed at urgent care. ICP #1 confirmed that CNA #4 subsequently tested NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 testing on 11/29/22. ICP #1 provided the surveyor with the Contact Tracing-Employee form which indicated that CNA #4 who was NJ Exec. Order 26:4.b.1 with her NJ Exec. Order 26:4.b.1 tested NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 test on 11/29/22, was "symptomatic", with no signs or symptoms checked off in the spaces provided on the form, and last worked 11-7 shift on 11/28/22. The remainder of the form was not filled in and failed to include a designated area to document any residents or staff members who may have been in close contact with CNA #4 prior to testing	F 880	1a)Audits on Contact tracing will be performed by the Director of Nursing or designee for 5 residents weekly x 4 weeks, monthly x 2 and quarterly x 2 to ensure all nurses have been observed. b) The results of all audits will be brought to the QAA meeting quarterly x 3 quarters. 2a) Audits on water testing will be done by the Administrator or designee to ensure water testing for Legionella guidelines are followed. 2b) Audits will be performed weekly x 4 weeks, monthly x 2 weeks and then Quarterly x 2 quarters. 2d) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. DPOC ADDITIONAL ACTION/INTERVENTIONS: " The facility will develop and implement an infection sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection. All nursing leaders will be educated on how to use the tool " The Infection Preventionist Will complete the CDC □ s Infection Preventionist training in order to help facilitate enhanced compliance with infection control and prevention. " The charge nurse for each shift will document all resident and staff infections on the facility □ s shared infection tracking log. Compliance and review of the infection control log will be completed	

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F 880	Continued From page 68 NJ Exec. Order 26:4.b for NJ Exec. Order 26:4.b.1. ICP #1 noted that was the only documentation that she completed regarding CNA #4's EX Order 26.4B1 ICP #1 further stated that CNA #4 denied being near any staff for a 15 minute period. ICP #1 stated that she did not ask CNA #4 who she may have shared her meal time with. ICP #1 stated that when CNA #4 texted her on 11/29/22, with her signs and symptoms which included NJ Exec. Orde [redacted] she acknowledged that she did not document the information on the Contact Tracing form in the space provided as she, "Was playing catch up." ICP #1 stated that she just did testing in response to the interview that she had with CNA #4 and did not document the interview on the form or elsewhere. ICP #1 confirmed that she did not complete any additional contact tracing with other staff or residents in response to CNA #4 or Resident #107's NJ Exec. Order 26:4.b.1 EX Order 26.4B1. ICP #1 also failed to complete a NJ Exec. Order 26:4.b.1 [redacted] Assessment form as outlined within the facility policy. Review of Resident #107's Admission Record (an admission summary) revealed that the resident was readmitted to the facility with diagnoses which included but were not limited to: EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted] and need for NJ Exec. Order 26:4.b.1 [redacted] with care. Review of Resident #107's quarterly Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of EX Ord [redacted] out of EX Ord [redacted], which indicated that the resident was EX Order 26.4B1 Review of the functional	F 880	by the Infection Preventionist daily " The facility will complete QAPI/RCA regarding this deficient practice " The facility will complete the directed training modules 1.Nursing Home Infection Preventionist Training Course Module 1 Infection Prevention & Control Program https : / /www. train. org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist 2.CDC COVTD-19 Prevention Messages for Front Line Long-Term Care Staff : Keep COVID-19 Out ! https : / / youtu. be/ 7 srwrF9MGdw Provide the training to: Frontline staff 3.CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff : Closely Monitor Residents https : / / youtube/ IZbTINj v6x¿ Provide the training to: Frontline staff 4.Nursing Home Infection Preventionist Training Course Module 5 Outbreaks https : / /www. train. org/cdctrain/course/10818 Provide the training to: Topline staff and infection preventionist 5.Nursing Home Infection Preventionist Training Course Module 4 Infection Surveillance https : / /www. train . org/cdctrain/course/10818 02/ Provide the training to: Topline staff and infection preventionist only 6.Nursing Home Infection Preventionist Training Course Module 6¿ □ Principles of Standard Precautions https : / /www.	

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F 880	Continued From page 69 status portion of the MDS revealed that the resident was NJ Exec. Order 26:4.b.1 and required r NJ Exec. Order 26 for bed mobility, transfer, both walking in room and in the corridor, dressing, eating or personal hygiene. Further review of the MDS indicated that the resident had a NJ Exec. Order 26:4.b.1 On 12/15/22 at 9:58 AM, the surveyor observed Resident #107 NJ Exec. Order 26:4.b.1 within his/her room and the resident wore a surgical mask that hung from the EX Order 26.4B1 by a single loop and did not cover the resident's mouth and nose. When interviewed, the resident stated that he/she usually EX Order 26.4B1 times per day. The resident reportedly walked down the hall to the exit, waited in line, and went out to EX Order 26.4B1. The resident did not immediately recall being NJ Exec. Order 26:4.b.1 when questioned. At 10:03 AM, Resident #107 was observed seated alone in a chair at the end of the hall with a NJ Exec. Order 26:4.b.1 positioned in front of him/her. The resident wore a surgical mask. At 10:04 AM, the surveyor interviewed CNA #3 who stated that Resident #107 was NJ Exec. Order 26:4.b.1 with care and mainly just went out to or sat in a chair at the end of the hallway. On 12/12/22 at 2:12 PM, in a later interview with ICP #1, she confirmed that she had not completed Contact Tracing with the Activity Aides who supervised Resident #107 during EX Order 26.4B1 observation prior to the resident's NJ Exec. Order 26:4.b.1 and she did not know for sure without asking them if they went outside to supervise the residents during EX Order 26.4B1 break, "which left room	F 880	train . org/main/course/10818 04/ Provide the training to: All staff including topline staff and infection preventionist 7.Nursing Home Infection preventionist Training Course Module 6B Principles of Transmission Based Precautions https : / /www . train. org/main/course/10818 05/ Provide the training to: All staff including topline staff and infection preventionist Monitoring : " The Infection Preventionist and Director of Nursing , and other nursing leadership will conduct rounds throughout the facility to ensure all staff is exercising appropriate use of PPE, to ensure infection control procedures are being followed by staff, and to ensure that testing and contact tracing requirements are implemented, as necessary . " The Infection Preventionist and Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the State survey agency in order to obtain further assistance to control infection. Such monitoring will continue until the facility is free of infection for at least four weeks . V. Person Responsible: Director of Nursing or designee, Administrator or designee, Infection Preventionist	

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F 880	Continued From page 70 for error" with possible exposure to [NJ Exec. Order 26:4.b.1]. ICP #1 further stated that she was from out of state and had begun working at the facility on [EX Order 26.4B1], as a new Infection Preventionist. ICP #1 stated that she was getting used to how they did things in New Jersey and was still learning the role as ICP. ICP #1 stated that after surveyor inquiry she realized that,"maybe she should have documented her interview with CNA #4 as part of the Contact Tracing and that was something that she needed to start doing." ICP #1 stated that the DON trained her on how to do the ICP role. On 12/12/22 at 12:35 PM, the surveyor interviewed the DON in the presence of the survey team, who stated that when ICP #1 completed Contact Tracing, she should have ensured that the Contact Tracing forms were completed and included information about both the residents and the staff that CNA #4 worked with. The DON stated that CNA #4's signs and symptoms should have been documented on the form in the space provided. The DON stated that ICP #1 also should have documented whether CNA #4 shared a meal break with another staff member and documented the outcome on the Contact Tracing form, though the form did not provide a designated field for this information. The DON stated that the Contact Tracing form was created for a reason and in order to do proper Contact Tracing, the form should have been completed in its entirety. On 12/13/22 at 9:43 AM, the surveyor interviewed the Administrator who stated that the Contact Tracing form was developed under previous ownership and remained in effect since	F 880		

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F 880	Continued From page 71	F 880		

the current company took over on 07/01/22. When the surveyor asked if ICP #1 received training on how to complete the Contact Tracing form, the DON who was present stated that "we covered everything" in town hall meetings and all staff were in-serviced. ICN #1 who was present at that time, acknowledged that she should have completed all required fields on the Contact Tracing form.

On 12/16/22 at 9:55 AM, Regional Registered Nurse (RRN #1) provided the surveyor with Employee Education Attendance Record with Topic of In-Service: [redacted] Contact Tracing and Testing that was presented by ICP #1 and was dated 12/13/22, which was noted to have been conducted via discussion with participation in discussion and verbalization of content with facility nursing staff.

On 12/16/22 at 9:47 AM, the surveyor interviewed RRN #1 in the presence of the survey team, who stated that the smokers who were potentially exposed to Resident #107 prior to the resident being diagnosed with [redacted] were not subject to Contact Tracing and should have been. RRN #1 acknowledged that the Contact Tracing Forms that were utilized by ICN #1 failed to contain a 48 hour look back period to identify close contacts to help prevent the [redacted]

b) On 12/15/22 at 12:00 PM, the surveyor interviewed the facility's Maintenance Director (MD) who stated that he served in the position for nearly five years. The MD stated that the local municipality provided the facility with a annual waters quality report. The MD provided the

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F 880	Continued From page 72	F 880		

surveyor with Annual Water Quality Report from 2018 and 2020, and was unable to provide the surveyor with a current report to reflect the municipality's findings of the facility's water supply. The MD confirmed that neither Annual Water Quality Report indicated that the water supply was tested for the presence of Legionella.

The MD further stated that in his ten years of experience in working in long-term care, testing for Legionella had never come up before, and he has never had to test for it. The MD further stated that the facility's water supply should be tested because if there were pathogens in the water, he would want to know about it.

On 12/15/22 at 1:20 PM, the Administrator showed the surveyor a text message on his cell phone and stated that the photo depicted an alleged Legionella water test kit result that was obtained by his Regional Maintenance Director in October 2022. The Administrator stated that the results of the testing were not documented and he was unable to validate that the test results pertained to the facility's water supply. The Administrator confirmed that the facility did not have a purchase order or a contract in place for water testing. The Administrator further stated that all of this was new to him and he would implement measures to test the facility's water supply for the presence of pathogens such as Legionella, going forward.

On 12/16/22 at 9:55 AM, the RRN #1 provided the surveyor with a QAPI Action Plan related to Contact Tracing dated 12/13/22, which revealed the following: Concern: It was noted that the facility does not always follow Contact tracing

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F 880	Continued From page 73 and testing guidelines, especially in regard to documentation Review of the Root Cause Analysis revealed the following: 1. Facility staff, IP (Infection Preventionist) or designee not always compliant with consistently documenting contact tracing and COVID testing 2. Facility staff, IP or designee inconsistent with filling out the contact tracing form in its entirety 3. Facility staff, IP designee requiring re education on importance of timely and appropriate contact tracing procedure/COVID testing procedure and documentation as per guidelines and facility policy 4. Facility staff, IP or designee requiring consistent oversight to ensure compliance with contact tracing, COVID testing procedure and documentation Review of the facility's undated, "Water Management Plan" revealed the following: Identify Areas Subject to Legionella: Ice machines, Water coolers, HVAC-PTAC units, Eyewash systems, Hot water holding tanks, Faucet Aerators/Shower heads Control Measures & Corrective Action included a cleaning and inspection schedule of all aforementioned areas subject to Legionella. The Water Management Plan failed to identify a process for water testing to detect the presence of pathogens within the facility's water supply. Review of the facility policy, "Contact Tracing Policy COVID 19 Pandemic" (Revised 09/30/22) revealed the following:	F 880		

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F 880	Continued From page 74 Purpose: The facility is committed to following all State and Federal guidance and regulations to prevent the spread of COVID-19. For a new onset of a positive COVID case for a resident or staff member the Infection Preventionist will document all contacts and conduct contact tracing for the 48 h prior to the positive test result utilizing facility Contact Tracing procedure. For any COVID positive patient, the COVID Risk Assessment form and Contact Tracing form (patient) must be filled out. For any COVID positive staff, the Contact Tracing form (employee) must be filled out. The Infection Preventionist will keep a Contact Tracing form/log for all positive cases (patients and employees). Any patient identified as close contact with a COVID positive patient will have to be tested immediately (rapid antigen test) Any employee identified as close contact with a COVID positive patient ill have to be tested immediately (rapid antigen test) Any employee identified as a close contact with a COVID positive patient will have to be tested immediately (rapid antigen test).	F 880		
F 886 SS=F	NJAC 8:29-19.2(a) 19.4 (a) (d) (f) (g); 27.1 (a) COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6)	F 886		12/30/22

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F 886	Continued From page 75 §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing	F 886		

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F 886	Continued From page 76 was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent documents, it was determined that the facility failed to: a) conduct immediate, comprehensive resident and staff COVID-19 (a potentially, deadly virus) testing upon the identification of a single positive resident or staff member in accordance with the facility policy b) ensure that comprehensive COVID-19 testing was completed and accurately documented during a COVID-19 outbreak that began on [redacted], in accordance with current Federal, State and Centers for Disease Control guidelines. This deficient practice was identified for 1 (one)	F 886	I Immediate Action a)Resident #107 [redacted] on [redacted], had been [redacted] since readmission to the facility on [redacted] No other residents were identified with [redacted] after resident #107 [redacted]. b)CNA #4 was isolated at home immediately starting date [redacted] and recovered from [redacted] after 10 days. No other residents or staff were identified with [redacted] after CNA#4 tested [redacted] c)Unit managers and Infection	

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F 886	Continued From page 77 of 1 (one) NJ Exec. Order 26:4.b.1 resident (Resident #107), 1 (one) of 1 (one) NJ Exec. Order 26:4.b.1 staff members (Certified Nursing Assistant (CNA #4) on 3 (three) of 3 (three) nursing units, and was evidenced by the following: Reference: Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements (Ref: QSO-20-38-NH) Revised 09/23/22 Centers for Disease Control and Prevention: COVID-19 Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (updated 09/23/22) According to QSO-20-38-NH (revised 09/23/22), Interim Final Rule: Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad based (e.g. facility-wide testing). If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If the facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area (s) of the facility)...	F 886	Preventionist were in serviced on 12/13/22 by the Director of Nursing on proper procedure for COVID 19 testing as per CDC guidelines, NJDOH requirements, CMS requirements and facility policy when a COVID positive case is identified. II Identification of others a) The facility respectfully submits that all residents can potentially be affected. III Systemic Changes a) The Policy and Procedure on COVID 19 testing was reviewed on 12/13/22 by the Administrator and the Director of Nursing and revised to reflect the CDC testing guidance from 9/23/22. b) A Quality Assurance Performance Improvement (QAPI) was completed for COVID 19 testing on 12/13/22 and presented to the Quality Assurance committee for review and implementation Additional training was provided to the Infection preventionist by the Director of Nursing and Regional Nurse on her responsibilities for tracking, contact tracing and testing for COVID 19 when a positive case is identified. c) Education was provided to nurses on 12/30/22 by the Director of Nursing on COVID 19 testing guidelines and procedure. I. Quality Assurance a) Audits will be performed by the Director of Nursing or designee for COVID 19 testing compliance with guidelines and facility policy.	

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F 886	Continued From page 78 Documentation of Testing: Facilities must demonstrate compliance with the testing requirements. To do so, the facilities should do the following: For symptomatic residents and staff, document the date(s) and time (s) of the identification of signs and symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results. Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests (see section "Testing of Staff and Residents During an Outbreak Investigation")... According to the CDC's, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (09/23/22): Perform testing for all residents and HCP (health care providers) identified as close contacts or on the affected unit (s) if using broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), and day 3 (three), and day 5 (five).	F 886	b) This audit will be performed on 5 residents weekly x 4 weeks, monthly x 2 weeks then quarterly x 2 quarters. c) The results of all Audits will be brought to QAPI meeting quarterly x 3 quarters. II. Person Responsible: Director of Nursing or designee	

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F 886	Continued From page 79 ...If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. ... Refer to F 880 On 12/07/22 at 9:30 AM during the Entrance Conference, that was attended by both the Director of Nursing (DON) and Administrator, it was confirmed that the facility was in an active COVID-19 Outbreak and the facility tested the unvaccinated, exempt staff twice weekly and once weekly testing was performed for residents and staff. At that time, it was confirmed that there were no positive cases of COVID-19 in the building, and the census was [redacted] On 12/12/22 at 10:00 AM, during an interview with Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP #2), it was revealed that the facility experienced an Outbreak of COVID-19 after CNA #4 tested [redacted], date not immediately specified. ADON/ICP #2 further stated that the testing that was completed was based on the Contact Tracing that was completed by ICP #1 and anyone else who may not have been up-to-date with their vaccinations. ADON/ICP #2 stated that staff members who were not up to date were tested twice weekly due to high community rates of COVID-19. He further stated that only staff who were not up to date or were identified as having been a close contact (within six feet distance for fifteen minutes total in a twenty-four hour period due to an exposure to someone who tested positive for COVID-19). ADON/ICP #2 further stated that ICP #1 did all of the testing.	F 886		

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F 886	Continued From page 80 On 12/12/22 at 11:24, AM the surveyor interviewed ICP #1 in the presence of the survey team, who stated that in response to Resident #107's EX Order 26.4B1 diagnosis that was reported to the facility from the NJ Exec. Order 26:4.b.1 facility on EX Order 26.4B1, ICP #1 tested the resident's unsampled roommate immediately prior to transferring the resident to the NJ Exec. unit (NJ Exec. Order 26:4.b.), then tested the resident on day five and day ten and all testing yielded EX Order 26.4B1. ICP #1 stated that since Resident #107 was a EX Order 26.4B1 she asked the Activity Aides which smokers went out to EX Order 26.4B1 with Resident #107 during that time. ICP #1 maintained that all EX Order 26.4B1 who went out to EX Order 26.4B1 on EX Order 26.4B1, were EX Order 26.4B1 only once with EX Order 26.4B1. ICP #1 further stated that no staff were tested as they were all up to date with their vaccinations and boosters. ICP #1 further stated that CNA #4 tested NJ Exec. Order 26:4.b for NJ Exec. Order 26:4.b.1 via an NJ Exec. Order 26:4.b.1 on 11/28/22, after she had just worked the 11 (eleven) to 7 (seven) shift. She stated that CNA #4 was referred to urgent care where she tested NJ Exec. Order 26:4.b.1 on 11/29/22 with NJ Exec. Orde diagnostic test) testing. ICP #1 maintained that she only tested the residents that CNA #4 cared for in the previous 48 hours prior to testing NJ Exec. Order 26:4.b for NJ Exec. Order 26:4.b.1. ICP #1 further stated that she did not test any staff who worked with CNA #4 as they were not determined to have been close contacts. ICP #1 stated right now, she tested the residents who were exposed to CNA #4 and were not up to date with their vaccinations based on Local Health Department (LHD) recommendations. The surveyor requested to	F 886		

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F 886	Continued From page 81 view all guidance provided by the LHD at that time and ICP #1 was unable to provide the guidance that she referenced. ICP #1 stated that the testing was conducted based on staff interview, which she failed to document. At that time, the surveyor requested to view all Contact Tracing and COVID-19 testing that was obtained in response to the current outbreak. ICP #1 stated that the information was in her office. ICP #1 provided the surveyor with Resident testing logs that were dated 11/14/22, 11/16/22, 11/29/22, and 12/1/22. The surveyor noted that the Resident Testing Log dated 12/01/22 was largely incomplete. On the first page of the logs, there were 13 resident names listed and only the first resident on the list had the following information filled in: date of testing, time (7-3), result (Neg) and the testers signature, ICP #1. There was no documented evidence to indicate that the remaining 12 residents on the page were tested. On page two and three of the log only the date was filled in for the first of 13 residents on the list and none of the aforementioned information was filled in on the log for any of the residents. On the last page of the log, seven resident names were listed and only the date was filled in for the first resident listed and no other information was documented on the log to indicate that any of the residents had been tested. ICP #1 stated that on 12/01/22, she conducted rapid testing and went through the roster to determine which residents were up to date and tested the residents who were not up to date with their vaccinations. When the surveyor questioned why the log was not filled in ICP #1 stated that she only listed the names of each resident, so that she knew who she had to see.	F 886		

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F 886	Continued From page 82	F 886		

The surveyor asked how anyone would know that the residents were tested if the testing were not documented? ICP #1 stated that if she were off, the facility would have to call her to find out if the residents were tested because she did not document the results of testing for each resident on the testing log as required. ICP #1 further stated, "I intended to fill it in later, because it is just me, this is my process." ICP #1 clarified that she tested all residents independently. ICP #1 stated, "If it was not documented, it was not done." ICP #1 further stated that she tried to fill it in later that same day. ICP #1 confirmed that she, "delayed completing the form since 12/01/22, because there was always something going on and she tried to find a way to get organized."

ICP #1 further stated that while in outbreak, she tested residents twice weekly in the beginning. ICP #1 stated that when she learned that Resident #107 tested NJ Exec. Order 26:4.b.1, she confirmed that she was working that day. ICP #1 stated that Resident #107's roommate was EX Order 26.4B EX Order 26.4B1. ICP #1 attempted to look through piles of papers on her desk for the remainder of testing that was completed on EX Order 26.4B1 and handed the surveyor an undated piece of paper which was titled, EX Order 26.4B1 and listed nine residents all of which had the word (NEG) listed next to each name. ICP #1 stated that the Unit Managers had obtained testing for their perspective units and she agreed to furnish the documentation for EX Order 26.4B1.

On 12/12/22 at 12:01 PM, in a later interview with ICP #1, she stated that she only tested the smokers once and did not have any guidance to support the decision to stop testing, as it was

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something that she had come up with. ICP #1 stated that on 11/11/22 when the Unit Managers helped her conduct testing, she did not transcribe the information onto a Resident Testing Log. ICP #1 explained that on 11/11/22, the Unit Managers helped me to test smokers. ICP #1 further explained that all of the EX Order 26.4B1 EX Order 26.4B1 to Resident #107 EX Order 26.4B1 regardless of vaccination status.

On 12/12/22 at 12:35 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that she completed Infection Prevention training. She stated that twice weekly testing was required to continue for 28 days for outbreak testing and close contacts. The DON stated at this point, it does not matter if the resident was up to date with vaccinations or not. She stated, "Everyone should be tested." The DON stated that ICP #1 should have maintained all COVID-19 testing on the logs. She stated that ICP #2 assisted ICP #1 with the Infection Control task as, "ICP #1 gets overwhelmed." The DON further stated that she would have expected that ICP #1 would have tested all smokers during outbreak testing which should have been completed on 12/05/22.

On 12/12/22 at 1:04 PM, ICP #1 presented the surveyor with Nursing Progress Notes that were dated 11/11/22, which were documented by the EX Order 26.4B1 Unit Manager and revealed that she tested eight residents using a rapid test and all eight residents were EX Order 26.4B1, and tested NJ Exec. Order 26:4.b.1. At that time, ICP #1 also provided the surveyor with "COVID Testing" that was completed by the EX Order 26.4B1 Unit Manager and there were eight resident's names

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F 886	Continued From page 84 highlighted, and four of the eight highlighted residents had the notation, "wasn't out" next to their names. ICP #1 further stated, in addition to the testing conducted by the EX Order 26.4B1 Unit Managers, she conducted testing of all residents who were not up to date with their vaccinations on 11/14/22, 11/16/22, 11/21/22, 11/29/22 and 12/1/22. The surveyor reviewed the logs and questioned why on 11/29/22, only six residents were tested. ICP #1 confirmed that those residents were not up to date and were tested in response to exposure to CNA #4. ICP #1 explained, "Further testing should have been completed on 12/05/22, but I had other stuff I was assigned to do." ICP #1 stated that she would have to check to determine when she was required to cease outbreak testing. ICP #1 further who stated that she looked at the CDC website today after surveyor inquiry because the facility did not have a policy related to post-exposure testing. ICP #1 stated that according to the Outbreak policy, testing should have happened for everyone on 11/11/22, when Resident #107 EX Order 26.4B1 ICP #1 stated, "Maybe, I should have tested them the first day (11/11/22), then in 48 hours, and in another 48 hours in accordance with CDC guidelines. ICP #1 stated that according to the facility Outbreak Policy, testing should have happened for everyone on 11/11/22, the guidance directed to test everyone who was not up to date or unvaccinated, and was not current. ICP #1 stated we used to test everyone under the prior ownership. ICP #1 stated that under this company, I was only taught to test residents who	F 886		

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F 886	Continued From page 85	F 886		

were not up to date or who were unvaccinated. ICP #1 explained that for employees, we mandated that they all have to be up to date and none of them were tested during outbreak because only two staff members were not up to date who were exempt. ICP #1 stated that, "The risk of delayed testing was that it could spread throughout the facility and puts other residents at risk for contracting [NJ Exec. Order 26:4.b.1]." ICP #1 further stated, "I test on Monday and Thursday, but that does not always happen." She maintained that testing should have continued and been done on 12/05/22, 12/08/22, and 12/12/22. ICP #1 stated that she had not obtained the testing as described, (last test date was 12/01/22) and did not tell anyone that she needed help with the testing because everyone has been really busy around here." ICP #1 stated that, "Testing was the most important part of identification of new COVID cases during an outbreak." ICP #1 stated that no residents were tested in response to CNA #4 testing NJ Exec. Order 26:4.b.1. The surveyor reviewed the testing log completed for 12/1/22 and determined that only three of the ten residents that CNA #4 cared for on her assignment were tested on that date.

ICP #1 further stated that the Activity Staff who supervised Resident #107 while [EX Order 26.4B1] should have been interviewed for Contact Tracing purposes and tested as they too could have been exposed to [NJ Exec. Order 26:4.b.1]

On 12/14/22 at 8:57 AM, the DON presented the surveyor with the Root Cause Analysis dated 12/13/22, related to Testing and Contact Tracing. The surveyor noted that the Testing Log for 12/01/22 was now completely filled in and asked

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the DON to explain the rationale for this. The DON stated that, "ICP #1 filled in the Resident Testing last night, because it was not filled in yesterday when you viewed it."

On 12/13/22 at 9:43 AM, the DON stated that, "Broad based testing (testing the whole facility) would have been done if someone tested positive out of the group of smokers that we tested, because we would have had to do Contact Tracing with that person who tested positive."

On 12/13/22 at 9:58 AM, ICP #1 stated that she only tested three of the ten residents on CNA #4's assignment as those were the residents with whom she would have had over 15 minutes of direct contact with based on their level of care. ICP #1 stated that one of the (unsampled) residents that were tested required CNA #4 to provide 1:1 observation on 11/26/22, and that resident was tested on 12/01/22 and was negative. Review of CNA #4's Assignment Sheets failed to indicate that CNA #4 was assigned to a 1:1 as described by ICP #1. ICP #1 further explained that she only tested those residents that CNA #4 indicated she was in close contact with. ICP #1 confirmed that she did not document the conversation that she had with CNA #4 in order to validate the explanation. ICP #1 stated that after surveyor inquiry, she will document all such data in the medical record going forward, even if asymptomatic and negative.

ICP #1 further stated, she was testing twice weekly, and should have tested once more after 12/01/22, on 12/05/22. ICP #1 stated that, "The residents were not done (tested) because I

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F 886	Continued From page 87 honestly did not get to it." The DON who was present stated that while she provided oversight to ICP #1, she was not aware that testing did not occur as required. ICP #1 stated that weekly testing on Monday and Thursday should have been completed for two rounds of testing and again on 12/08/22. The Administrator who was present stated, "The residents were [NJ Exec. Order 26:4.b.1] and [EX Order 26.4B1], we tested twice, and they were all [NJ Exec. Order 26:4.b.1], and signs and symptoms were monitored and that was part of the logic." The Administrator further stated, "Because everyone was [NJ Exec. Order 26:4.b.1] we tested the smokers who were [EX Order 26.4B1], there was not a need for more testing." On 12/16/22 at 9:47 AM, the Registered Regional Nurse (RRN #1) stated, We did a root cause analysis to see what we did and what we could do better. RRN #1 stated that Resident #107 was [EX Order 26.4B1] and kept to themselves. The smokers were tested, but a second round of testing was required and was not completed. RRN #1 stated that we only did the initial testing with the smokers and subsequent testing in the policy at that time, indicated that testing should have occurred twice weekly for two weeks. RRN #1 stated that after review of the current CDC guidance dated 09/23/22, it was identified that testing should have occurred on day one, three and five. RRN #1 agreed that the smokers were not subject to contact tracing and should have been. RRN #1 stated that going forward, Contact Tracing would be performed prior to testing. Review of the QAPI (Quality Assurance Performance Improvement) Action Plan provided by the Regional Registered Nurse (RRN) #1 on	F 886		

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F 886	Continued From page 88 12/16/22 and implemented on 12/13/22, revealed the following: Concern: It was noted that the facility does not always follow Contact Tracing and Testing guidelines, especially in regard to documentation. Root Cause Analysis: ...IP, or designee requiring consistent oversight to ensure compliance with Contact tracing, COVID testing, procedure and documentation... Review of the facility policy, COVID-19 Management (revised 10/12/22) revealed the following: Testing Summary: Testing Trigger: Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts. Staff: Test all staff regardless of vaccination status, that had a higher-risk exposure with a COVID 19 positive individual Residents: Test all residents, regardless of vaccination status, that had close contact with a COVID 19 positive individual Trigger: Newly identified COVID 19 positive staff or resident a facility that is unable to identify close contacts. Staff: Test all staff, regardless of vaccination status, facility wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor or other specific area (s) of the facility). Residents: Test all residents, regardless of vaccination status, facility wide or at a group level (e.g., unit, floor or other specific area (s) of the facility). Review of the facility policy titled, "Smoking" (reviewed 10/25/22) revealed the following:	F 886		

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F 886	Continued From page 89 Residents will be observed by staff while smoking, 6-10 feet away, identify any unsafe behavior such as smoking cigarette down to the filter, incorrect placement of smoking apron, allowing ash to accumulate before disposing in ashtray, hording [sic.] of cigarettes, etc. Staff will wear a mask at all times. NJAC 8:39-19.4 (a) (f)	F 886		

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
315225 Y1	A. Building B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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 F0636	Correction	ID Prefix F0656	Correction	ID Prefix F0658	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
ID Prefix F0677	Correction	ID Prefix F0686	Correction	ID Prefix F0758	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
ID Prefix F0760	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.45(f)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
ID Prefix F0838	Correction	ID Prefix F0880	Correction	ID Prefix F0886	Correction
Reg. # 483.70(e)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80 (h)(1)-(6)	Completed
LSC	12/30/2022	LSC	12/30/2022	LSC	12/30/2022
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?
12/16/2022	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060415	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTH	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

(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 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shifts. The facility was deficient in CNA staffing for residents on 13 of 14 day shifts. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for 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	S 560	I. Immediate Action 1. The facility respectfully submits that staff to resident ratios were reviewed on 12/28/22 to ensure compliance with New Jersey new minimal staffing requirements dated 1/28/21. 2. Staffing coordinator was immediately re in-serviced on staffing ratio requirements. II. Identification of Others: i. The facility respectfully submits that all residents may be affected by this practice. III. System Changes	12/30/22

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

Electronically Signed | 12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 11/20/22-11/26/22 and 11/27/22-12/03/22, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: -11/20/22 had 13 CNAs for 152 residents on the day shift, required 19 CNAs. -11/21/22 had 14 CNAs for 152 residents on the day shift, required 19 CNAs. -11/22/22 had 17 CNAs for 152 residents on the day shift, required 19 CNAs. -11/23/22 had 16 CNAs for 152 residents on the day shift, required 19 CNAs. -11/24/22 had 16 CNAs for 153 residents on the	S 560	1. Policy and Procedure for Minimal Staffing was reviewed and revised on 12/30/22 by Administrator and DNS to include staffing ratio of C.N.A.s of 1:8 for day shift, 1:10 for evening shift and 1:14 for the night shift. 2. Director of Nursing and Administrator will review open positions and applications plus results of any interviews weekly to look for opportunities to hire. 3. The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, reaching out to agencies for supplemental staff, setting up booths at nursing schools utilization of all possible avenues to increase staffing in the facility. IV. Quality Assurance 1a) Audits will be completed by the Staffing coordinator to ensure that daily staffing complies with new staffing ratios. 1b) Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters. 1c) All negative findings will be brought to the Director of nursing/Administrator□s attention immediately to ensure compliance with the required staffing ratios. 1d)The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. V. VI. Responsibility 1. Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVER FRONT REHABILITATION AND HEALTH	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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S 560	Continued From page 2 day shift, required 19 CNAs. -11/25/22 has 16 CNAs for 153 residents on the day shift, required 19 CNAs. -11/26/22 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. -11/27/22 had 13 CNAs for 151 residents on the day shift, required 19 CNAs. -11/28/22 had 12 CNAs for 151 residents on the day shift, required 19 CNAs. -11/29/22 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. -11/30/22 had 18 CNAs for 151 residents on the day shift, required 19 CNAs. -12/01/22 had 15 CNAs for 152 residents on the day shift, required 19 CNAs. -12/03/22 had 16 CNAs for 152 residents on the day shift, required 19 CNAs. During an interview with the surveyor on 12/15/22 at 12:27 PM, the Director of Nursing and the Infection Control Preventionist stated they were the staffing coordinators at that time and were aware of the staffing ratios.	S 560	2. LPN/IP 3. Administrator	
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify	S 830		12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 830	Continued From page 3 for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.) This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to obtain a Criminal Background (CB) check prior to the date of hire for new employees. This deficient practice was identified for 1 of 5 newly hired employees reviewed and was evidenced by the following: A review of the five randomly selected newly hired employee files included the following: A Licensed Practical Nurse (LPN), who was hired on [redacted], had a CB ordered on 11/4/22 and reported on 11/07/22. On 12/13/22 at 11:53 AM, the surveyor interviewed the Director of Human Resources (DHR) regarding a newly hired employee's CB. The DHR stated that when someone is hired a background check would be done before they start orientation. She added that the date of hire is the orientation date. On 12/13/22 at 1:08 PM, the surveyor requested the time card for the first two weeks of work for the LPN.	S 830	I Immediate Action a) The facility respectfully submits that the background check completed for the Licensed Practical Nurse on 11/4/22 came back without negative results. b) The Human resources staff was in serviced on 12/15/22 on proper procedure of performing a background check prior to hire. II Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III System Changes 1. Policy and Procedure for Hiring was reviewed on 12/15/22 by Administrator and Director of Nursing and found to be in compliance. 2. An audit was conducted by the Administrator and Director of Nursing on 12/15/22 on all new hired employees to ensure all had background checks prior to their hire dates. No negative findings. IV Quality Assurance a) Audits will be completed by the Director	

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S 830	Continued From page 4 A review of the LPN's time card indicated the LPN worked on 10/31/22, 11/01/22, 11/02/22, 11/03/22, 11/04/22 and 11/07/22. On 12/15/22 at 9:50 AM, the surveyor interviewed the DHR regarding the reason why the LPN did not have a CB done prior to the date of hire. The DHR stated that the staff should have had a CB. The DHR stated that she had started at the facility on [redacted] and that when she noticed that a CB was not done for the LPN she ordered the CB on 11/4/22. She added that she was the interim person at that time. On 12/15/22 at 10:22 AM, the surveyor interviewed the Director of Nursing (DON) regarding when a CB should be done. The DON stated that she expected that a CB would be done prior to date of hire/orientation. A review of the facility provided policy titled, "Hiring" with a reviewed date of 05/22/22, included the following: Under Policy Interpretation and Implementation 8.The following steps will be followed when accepting applications from outside the facility: ... f. The HR Director will extend an offer of employment to the chosen applicant. Such offer will contain any relevant contingencies or disclaimers; g. The HR Director will then conduct any applicable investigations and determine whether the applicant is legally eligible to work in the United States; and h. An offer of employment may be revoked and employment may be terminated if an investigation reveals that an applicant made misrepresentations about or failed to disclose	S 830	of Nursing or designee to ensure that all new hired staff have background checks completed prior to hire date. b) Audits will be done on all new hired staff weekly x 4 weeks, monthly x 2 months and quarterly x 2 quarters. c) The results of all audits will be brought to the QAPI committee quarterly x 3 quarters. V Responsibility : Director of Nursing or designee, Administrator or designee	

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S 830	Continued From page 5 any fact which might indicate that the applicant is not qualified for the position in question ... 10. Where appropriate, background investigations may be conducted on persons making application for employment with this facility and on current employees.	S 830		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060415		2/9/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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 12/30/2022	ID Prefix S0830 Reg. # 8:39-9.3(b) LSC	Correction Completed 12/30/2022	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	
12/16/2022	☐ 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
	315225	A. BUILDING **01** B. WING _____	**12/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	**5101 NORTH PARK DRIVE** **PENNSAUKEN, NJ 08109**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/09/22. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/09/22 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 Riverfront Rehabilitation and Healthcare Center, a three-story building that was built in 1982. It is composed of Type II protected construction. The facility is divided into eight smoke zones. The generator does approximately 50% of the building as per the Maintenance Director. The current occupied beds are 157 of 182.	K 000		
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	K 200		1/30/23

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

Electronically Signed | 12/30/2022

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 200	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 157 residents. Findings include: Observations of the facility's fire doors on 12/09/22 from 11:00 AM to 1:30 PM, revealed the door lacked the required inspection tags required to be placed on the doors after completed inspections. The Maintenance Director was present at the time of observation and confirmed the doors were not inspected. The Maintenance Director advised that he did not know that the fire doors had to be inspected annually by a qualified person who had knowledge of the fire doors and how they operate. Use NJAC 8:39-31.1(c), 31.2(e)	K 200	Immediate Corrective Action The facility fire door assemblies will be inspected by a qualified person by 1/30/23. Method to Assess Others All facility fire door assemblies were accounted for. No Residents were affected by this practice. All residents have the potential to be affected by this practice. Systematic Process Maintenance Department has been educated on fire safety and the need for all fire doors to be inspected. The Maintenance Department will continue to perform annual inspections of the facility fire door assemblies as part of the facility□s life safety program. Quality Assurance Maintenance Director/Designee will do Quarterly audits x4 after that to ensure	

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K 200	Continued From page 2	K 200	that door inspection is completed annually. Maintenance Director will present audits to quarterly QAPI meeting x4 Quarters.	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress for one of three stairway exit doors on the [redacted] floor. The stairway exit door was missing a self-closing device in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.2.2.2.7. This deficient practice had the potential to affect 17 residents. Findings include: Observation on 12/09/22 at 1:06 PM, revealed that the stairway door was missing a self-closing device. At the time of the observation, the	K 223	Immediate Corrective Action The facility fire door assemblies will be inspected by a qualified person by 1/30/23. Method to Assess Others All facility fire door assemblies were accounted for. No Residents were affected by this practice.	1/30/23

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K 223	Continued From page 3 Maintenance Director verified the self-closing device was missing from the stairway door. NJAC 8:39-31.2(e)	K 223	All residents have the potential to be affected by this practice. Systematic Process Maintenance Department has been educated on fire safety and the need for all fire doors to be inspected. The Maintenance Department will continue to perform annual inspections of the facility fire door assemblies as part of the facility's life safety program. Quality Assurance Maintenance Director/Designee will do Quarterly audits x4 after that to ensure that door inspection is completed annually. Maintenance Director will present audits to quarterly QAPI meeting x4 Quarters.	
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced	K 311		1/30/23

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K 311	Continued From page 4 by: Based on observation and interview, the facility failed to maintain the means of egress for one of three stairway exit doors on the [redacted] floor. The stairway exit door was missing a label that indicated the fire rating of the door in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.3.1.1. This deficient practice had the potential to affect 17 residents. Findings include: Observation on 12/09/22 at 1:06 PM, revealed the stairway exit door located on the [redacted] floor, was missing the label indicating the fire rating of the door. At the time of the observation, the Maintenance Director verified the label was missing from the stairway door. NJAC 8:39-31.1 (c) NJAC 8:39-31.2 (e)	K 311	Immediate Corrective Action Stairway exit doors will be labeled with the fire rating attached to it. Method to Assess Others No Residents were affected by this practice. All residents have the potential to be affected by this practice. All other stairwell doors Have been inspected to ensure the presence of a fire rated label. Systematic Process Maintenance Department has been educated on fire safety and the need for all fire doors to be fire rated and labeled on the door. The Maintenance Director will continue to perform annual inspections of the facility stairwell doors to ensure the presence of a fire rated label as part of the facility's life safety program. Quality Assurance Maintenance Director will do monthly audits x4 after that to ensure all fire doors have been rated appropriately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING **01** B. WING _____	**12/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	**5101 NORTH PARK DRIVE** **PENNSAUKEN, NJ 08109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 5	K 311	Maintenance Director will present audits to quarterly QAPI meeting x2 Quarters	
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 observation, interview, and document review, the facility failed to ensure smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. This had the potential to affect all 157 residents. Findings include: Observation of the facility smoke detectors on 12/09/22 from 12:30 PM to 3:00 PM, revealed smoke detectors located in the corridors and other concealed areas throughout the building. Review of the facility fire alarm "Inspection and Testing Form" dated 07/26/22, provided by the Director of Maintenance, revealed no documented reference to a smoke detection sensitivity test. During an interview on 12/09/22 at 3:15 PM, the Director of Maintenance verified that the fire	K 345	Immediate Corrective Action Sensitivity testing was performed by a 3rd party vendor. Method to Assess Others All facility smoke detectors were accounted for. No Residents were affected by this practice. All residents have the potential to be affected by this practice. Systematic Process Maintenance Department has been educated on fire safety and the need for sensitivity testing for all smoke detectors	1/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING **01** B. WING _____	**12/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	**5101 NORTH PARK DRIVE** **PENNSAUKEN, NJ 08109**

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K 345	Continued From page 6 alarm sensitivity testing was not completed on the fire alarm system. NJAC 8:39-31.2(e)	K 345	throughout the building. The Maintenance Director will continue to coordinate on an ongoing basis with a third-party fire alarm system vendor to perform biennial smoke detector sensitivity testing as part of the facility's life safety program. Quality Assurance Maintenance Director/Designee will do bi-annual audits x4 after that to ensure sensitivity testing is completed Biennially. Maintenance Director will present audits to quarterly QAPI meeting x4 Quarters.	

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
315225 Y1	A. Building 01 - COOPER RIVER WEST B. Wing Y2	2/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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 K0200	01/30/2023	LSC K0223	01/30/2023	LSC K0311	01/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0345	01/30/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/16/2022	☐ YES ☐ NO