STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not 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		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		8/15/24

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

Electronically Signed | 07/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 2	E 037		

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of the Emergency Preparedness Program binder and interviews with administrative staff it was determined that the facility failed to provide emergency preparedness training to all existing staff annually. This failure had the potential to affect all 141 residents who currently live in the facility. This deficient practice was evidenced by the following: On 6/26/24 at 10:00 AM, the U.S. FOIA (b) (6) provided the surveyor the requested annual education for five Certified Nursing Assistants (CNA). A review of the facility provided education for five CNAs did not include Emergency Preparedness (EP) training.	E 037	1. No residents were affected by the deficient practice. All staff who were not in compliance with the mandatory EP training were inserviced and attendance was documented with sign-in sheets. 2. All residents have the potential to be affected by the deficient practice. 3. The facility updated its training logs to include two sessions of annual emergency disaster training annually to ensure the staff have multiple opportunities to be educated and trained on the facility□s emergency disaster training.	

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E 037	Continued From page 5 On 6/28/24 at 12:45 PM, the surveyor reviewed the EP binder of the facility that was provided by the U.S. FOIA (b) (The binder did not include any staff sign in sheets for annual education. On 6/28/24 at 12:50 PM, the surveyor notified the U.S. FOIA (b) that the binder did not have the annual training. The U.S. FOIA (b) provided the surveyor a copy of two table top community based drills. A review of the drills provided included staff sign in sheets. The staff drills provided did not include all facility staff and did not include the required annual training. On 7/01/24 at 11:20 AM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) the concern that five of five CNAs reviewed and the rest of the facility staff did not have the required annual EP training. The U.S. FOIA (b) stated that they did the EP drills. The facility could not provide documented evidence that annual EP training was provided to the facility staff. The facility did not provide any additional information. A review of the facility provided policy titled, "C.N.A. In-services" with a reviewed date of 01/2024 included the following: Purpose and Policy: This facility shall provide in-service training for nurse aides to ensure their continuing competence and education. Nurse aide in-service training will be no less than 12 hours per year. The policy did not include any information on annual EP training.	E 037	4. The ADON-Training Coordinator will monitor by comparing the EP training inservice log to the current staff roster every six months. Any staff that has not attended will be identified for the next training session. On a yearly basis, the ADON/Training Coordinator will compare the EP training Log to the current staff roster to assure all staff have attended. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will review the results, identify any patterns or areas for improvement, and make recommendations to ensure ongoing compliance after a review period of four months.	

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E 037	Continued From page 6 A review of the facility's Emergency Disaster Preparedness Plan with a revised date of 01/2024 that was provided by the [US FOIA (b)(6)] included that it is the policy and responsibility of every employee of to receive training at orientation, attend in-service education routinely and when necessary follow the directives given to them by any federal, state or local authority included in the facility manual. NJAC 8:39-31.6(a)	E 037		
F 000	INITIAL COMMENTS Complaint and FRE #s: NJ#172478, #172512, #172542, #172727, #174025, #174083, #174095, #174540, and #174654. Survey Date: 7/09/2024 Census: 141 Sample: 28 sample + 3 closed records = 31 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		8/15/24

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F 583	Continued From page 7 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide full visual privacy when providing [NJ Ex Order 26] treatment, for one (1) of 28 residents, Resident #103. The deficient practice was evidenced by the following: On 6/27/24 at 10:15 AM, the surveyor observed the U.S. FOIA (b) (6)) perform a treatment to the [NJ Ex Order 26.4(b)(1)] of Resident #103.	F 583	1. Resident #103 had their privacy curtain fully closed by the [US FOIA (b)(6)] and the [US FOIA (b)(6)] was given an in-service training session on the resident□s right to privacy to reinforce the importance of maintaining full visual privacy during treatments. 2. All residents have the potential to be affected by the same deficient practice. 3. All nursing department staff were	

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F 583	Continued From page 8 The U.S. FOIA (b) (6)) was assisting the U.S. FOIA with the NJ Ex Order 26.4(b)(1) of Resident #103 during the NJ Ex Order 26 treatment. On 6/27/24 at 10:31 AM, during the NJ Ex Order 26 treatment, Resident #103 with the assistance of the U.S. FOIA was NJ Ex Order 26.4(b)(1) on the NJ Ex O facing NJ Ex Order 26.4(b)(1). The NJ Ex Orde of the resident's NJ Ex Orde was NJ Exec Order 26.4(The privacy curtain was partially pulled, around the foot of the resident's bed. The resident's bed was visible to the door of the room, which was closed. The LPN after cleansing the resident's NJ Ex Order 26.4 removed her gloves and went to the door of the room. LPN #1 fully opened the door, went to the treatment cart positioned in front of the door to get gloves from the box on top of the cart. The NJ Ex Order 26.4(b)(of the resident's NJ Ex Orde was visible to the hallway as the privacy curtain was not closed fully and the resident's door was widely open. LPN #1 retrieved the gloves from the top of the treatment cart, came back in room, put the gloves on the bedside table, next to the resident's bed and then closed the door of the resident's room. On 6/27/24 at 10:50 AM, the surveyor interviewed the U.S. FOIA after the NJ Ex Order 26 treatment about privacy for residents. The U.S. FOIA stated visual privacy should be provided and maintained for residents. The surveyor discussed the observation during the NJ Exec Order treatment. The U.S. FOIA acknowledged that she should have drawn the resident's curtain further or closed the door of the room when she went to the treatment cart to ensure that the resident was not visible from the hallway. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #103	F 583	re-educated by the Director of Social Services or his/her designee on the facility policy and residents right to physical privacy emphasizing the residents right to maintain and protect all residents privacy during medical treatments and personal hygiene activities. 4. The Assistant Director of Nursing (ADON) or ADON designee will monitor by observing five resident care in-room treatments twice per month for three months to ensure resident privacy is maintained during in-room treatments. Any non-compliance will cause immediate re-education of staff. The observations will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make recommendations for continued monitoring after a period of three months.	

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F 583	Continued From page 9	F 583		

which revealed the following:

According to the Admission Record (an admission summary), Resident #103 had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1), s[redacted] NJ Ex Order 26.4(b)(1) [redacted], and [redacted] (NJ Ex Order 26.4(b)(1)).

An Annual Minimum Data Set (MDS), an assessment tool to facilitate management of care, dated [redacted], indicated the facility assessed the resident's [redacted] using a Brief Interview for Mental Status (BIMS) test. Resident #103 scored a [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1).

On 6/27/24 at 12:41 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] the U.S. FOIA (b) (6) [redacted]), and the U.S. FOIA (b) (6) [redacted]). The surveyor notified the [redacted] and [redacted] of the concern observed during the [redacted] treatment of the resident's full visual privacy not being maintained. There was no verbal response by the facility at this time.

On 6/28/24 at 11:30 AM, the [redacted] and [redacted] met with the survey team. The [redacted] stated in-service education about resident's privacy was being provided to all staff. There was no additional information provided by the facility.

A review of the facility's Resident Rights To Privacy and Confidentiality with a reviewed date of 01/2024. Under Procedure it read, "Every nursing home resident has the right to personal privacy of not only his/her own physical body, but also of his/her personal space, including accommodations and personal care."

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F 583	Continued From page 10 A review of the facility's Resident's Rights, which was undated. Under I. Each resident shall be entitled to the following rights ...16) To have physical privacy. The resident shall be allowed, for example, to maintain the privacy of his or her body during medical treatment and personal hygiene activities, such as bathing and using the toilet, unless the resident needs assistance for his or her own safety ..." NJAC 8:39-4.1(a)12,16	F 583		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F 607		8/15/24

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F 607	Continued From page 11 employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for three (3) of five (5) newly hired licensed staff reviewed, (Staff #5, #8 and #10). This deficient practice was evidenced by the following: 1. On On 6/27/24 at 12:00 PM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: Staff #5, a U.S. FOIA (b) (6), hired NJ Ex Order 26.4, had a New Jersey Division Consumer Affairs license verification printout was dated NJ Exec Order 26.48. The verification was completed after the staff member was hired. There was no documented evidence that Staff #5's license was verified prior to the date of hire (doh). On 6/28/24 at 10:00 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding license verification. The U.S. FOIA (stated that she would check the license and print a copy and that it had to be done before orientation. The surveyor showed the U.S. FOIA (Staff #5's license verification dated after the doh. The U.S. FOIA (stated that she	F 607	1. The facility immediately verified and documented the licenses of staff members #5, #8, and #10, to ensure compliance with licensing requirements. 2. All residents have the potential to be affected by the deficient practice. 3. All department managers were re-educated on facility hiring requirements including compliance with license verifications before the date of hire by the Administrator. Department manager(s) will be accountable to verify licensures for all new hire files prior to an employee start date. 4. The BOM and/or BOM designee will monitor by randomly auditing three new hire files weekly to ensure compliance with license verification prior to an employee start date. Any non-compliance will cause immediate re-education of staff. The audit records will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee, who will make recommendations for continued monitoring after a period of four months.	

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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
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was not employed at the facility at that time. She added that the license should be verified prior to doh.

On 6/28/24 at 10:04 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding license verification. The U.S. FOIA stated that the U.S. FOIA (b) checked the license prior to doh.

On 6/28/24 at 12:06 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (6) , U.S. FOIA and U.S. FOIA (b) (6)) the concern that Staff #5's license was not verified prior to the doh. The U.S. FOIA (b) stated that he was the stand in U.S. FOIA (b) and that he missed it.

On 7/01/24 at 10:04 AM, in the presence of the survey team, U.S. FOIA and U.S. FOIA (b) (6) the U.S. FOIA (b) confirmed that the license should have been verified prior to the doh.

2. On 6/27/24 at 10:30 AM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: Staff #10, a U.S. FOIA (b) (6)), hired NJ Ex Order 26.4(b) , had a New Jersey Division Consumer Affairs license verification printout that had no date the verification was completed visible on the printout. There was no documented evidence that Staff #10's license was verified prior to the doh.

On 6/27/24 at 12:15 PM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: Staff #8, a U.S. FOIA (b) (6), hired NJ Ex Order 26.4 , had two New Jersey Division Consumer Affairs

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	315357	A. BUILDING _____ B. WING _____	C 07/09/2024

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F 607	Continued From page 13 license verification printouts that were dated [redacted] and [redacted]. The verification was completed after the staff member was hired. There was no documented evidence that Staff #8's license was verified prior to the doh. On 7/01/24 at 9:48 AM, the [redacted] provided another copy of Staff #10's printout. The printout reflected handwriting that was highlighted "printed on [redacted] print no date shown." The License verification printout did not reflect any other date that it was printed. There was no documented evidence that Staff #10's license was verified prior to the doh. A review of the facility provided policy titled, "New Hires" with a reviewed date of 01/2024, included the following: 1. All new hires shall complete the following paperwork and the paperwork will have to be reviewed by the BOM:... f. Original licenses/certification with verification by the BOM (if applicable).... A review of the facility provided policy titled, "Abuse Prevention Program" with a revised date of 02/08/2023, included the following: ...Part III-Screening... Potential hires of professional staff will have their license verified by their licensing boards prior to hire.... NJAC 8:39-43.15(a,b)	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		8/15/24

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resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon

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F 623	Continued From page 16 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and the resident's representative written notification of the reason for transfer to the hospital and also send a copy to a representative of the Office of the State U.S. FOIA (b) (6)) for two (2) of three (3) resident's (Resident #195 and #41) reviewed for hospitalization. This deficient practice was evidenced by the following: 1. A review of Resident #195's electronic medical record included the following: Resident #195's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for the three DRAMDS, reflected that the resident was transferred to the hospital. A review of Resident #195's hybrid (a combination of paper, scanned, and	F 623	1. Written notifications for the hospital transfers of Resident #195 and Resident #41 were provided to their respective representatives and copies were sent to the Long-Term Care Ombudsman Office. 2. All residents discharged/transferred to the hospital have the potential to be affected. 3. The Administrator inserviced the US FOIA (b)(6) and all facility social workers on the regulatory requirement for Emergency Transfer Notification (ETN) to the resident, the resident□s representative and the NJ Long Term Care Ombudsman□s office. 4. The Medical Records Clerk or his/her designee will monitor by auditing all acute discharges weekly to ensure ETN compliance. Any non-compliance	

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F 623	Continued From page 17 computer-generated records) medical record did not include a written notification of the reason for transfer to the resident or resident representative (RR) and a copy to the U.S. FOIA (b) for each transfer to the hospital. 2. The surveyor reviewed the hybrid medical records of Resident #41 which revealed the following: A New Jersey Universal Transfer Form (NJUTF) and nurse progress notes documented that Resident #41 was transferred to an NJ Ex Order 26.4(b)(1) [redacted] in NJ Ex Order 26.4(b)(1) According to the DRAMDS in NJ Ex Order 26.4(b)(1), Resident #41 was discharged (d/c) to an NJ Ex Order 26.4(b)(1) [redacted] with a return anticipated to the facility. There was no documentation in the hybrid medical record of Resident #41 to indicate that the facility provided written transfer notification to the resident or RR. Additionally, there was no documentation in the hybrid medical records to indicate written transfer notification was provided to the U.S. FOIA (b) (6) office. On 6/25/24 at 9:52 AM, the surveyor interviewed the U.S. FOIA (b) (6)) about written emergency transfer notifications. The U.S. FOIA stated social services department was not responsible for providing written emergency transfer notifications and did not provide notice to the U.S. FOIA (b) (6) office. The U.S. FOIA stated he was not sure who was responsible for providing the notifications. On 6/25/24 at 9:57 AM, the surveyor interviewed the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) of	F 623	discovered during audits will cause re-education of staff. The audit findings will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make recommendations for continued monitoring of ETN compliance after a period not less than four months.	

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U.S. FOIA (b) (6)) about written emergency transfer notification. The U.S. FOIA (b) (6) stated nursing was responsible for providing the written transfer notification to the resident or RR.

On 6/25/24 at 11:58 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated written emergency transfer notification was not provided by nursing. The U.S. FOIA further stated she was not sure which department was responsible for providing and would follow up to provide further information.

On 6/25/24 at 12:01 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated the medical records department was responsible for providing written emergency transfer notification to resident and/or US FOIA and the U.S. FOIA (b) (6) office.

On 6/25/24 at 12:07 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated she was not responsible for providing any written emergency transfer notification. The U.S. FOIA further explained that she would complete a monthly spreadsheet of residents that were d/c and send directly to the U.S. FOIA (b) (The U.S. FOIA stated she had no knowledge about written emergency transfer notifications and did not know who was responsible for providing.

On 6/27/24 at 12:41 PM, the survey team met with the U.S. FOIA (b) (the U.S. FOIA (b and the U.S. FOIA (b) (6) . The surveyors notified the facility of the concerns that there was no written emergency transfer notification provided to the resident/RR and no notification provided to the U.S. FOIA (b) (6) office. There was no verbal

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F 623	Continued From page 19 response by the facility at this time. On 6/28/24 at 11:30 AM, the U.S. FOIA (b) (the U.S. FOIA (b and the U.S. FOIA (b) met with the survey team. The U.S. FOIA (b) stated in-service education was provided to staff to put the process of providing emergency written transfer notifications back into place as it was not being completed. There was no additional information provided by the facility. The surveyor reviewed the facility provided policy titled "Emergency Transfer Notification" with a reviewed date of 01/2024. Under Policy it read "It is the policy of this facility to provide guidelines for the notification requirements when transferring residents to an acute care facility on an emergent basis." Under Procedure it read: "1. When a resident is temporarily transferred to an acute care facility a notice of the temporary transfer will be provided to the resident and/or RR as soon as practicable ...2. A copy of the notice will also be sent to the Ombudsman when practicable, such as a list of residents on a monthly basis ...3. The notice will contain: a. The reason for transfer; b. The effective date; c. The location to which the resident is transferred; d. Contact information ..." NJAC 8:39-5.3; 5.4	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		8/15/24

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F 641	Continued From page 20 Based on interview, record review and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for one (1) of three (3) residents, Resident #142 reviewed for closed records. This deficient practice was evidenced by the following: On 6/26/24 at 12:58 PM, the surveyor reviewed the closed medical chart for Resident #142 whose discharge MDS was coded for discharge (dc) to NJ Ex Order 26.4(b)(1). Review of Resident #142's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). Review of "A section" of the NJ Ex Order 26.4 Discharge MDS for Resident #142 revealed that section "A2105 DC Status" documented, "04. NJ Ex Order 26.4(b)(1)." The Order Summary Report (OSR) reflected a physician order dated NJ Ex Order 26.4 - dc NJ Ex Order 26.4(b)(1). The Progress Notes dated 4/27/24 at 9:30 AM that was electronically signed by U.S. FOIA (b) (6) included "resident was seen this morning in their wheelchair no signs of	F 641	1. The MDS Coordinator (MDSC) corrected the discharge status of Resident #142 in the MDS to accurately reflect the discharge to home NJ Ex Order 26.4(b)(1). 2. All residents permanently discharged have the potential to be affected by the deficient practice. 3. The facility Administrator and MDSC developed and implemented a tracking system that includes a secondary review by Nurse Unit Manager and/or social worker to assure the accuracy of MDS entries related to discharge summaries before they are finalized and submitted. 4. The Director of Social Services, Social Worker and/or Nurse Unit Managers will monitor by auditing 5 resident discharges weekly to ensure the MDS assessment accurately reflects coding the residents discharge location. The audits will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will determine the need for continued monitoring after a period not less than three months.	

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F 641	Continued From page 21 NJ Ex Order 26.4 or NJ Ex Order 26.4(b)(1) noted. Vitals taken and recorded; due medications (meds) NJ Ex Order 26.4(b)(Resident dc, left the building at 9:30 AM, with US FOIA (b)(6) . Resident has been educated on their meds and NJ Ex Order 26.4(b)(1); list of meds had been faxed to [name redacted] pharmacy." The dc Summary, with effective date NJ Ex Order 26.4 12:44 PM revealed under section NJ Exec Order 26.4b1 documented, 2. dc Status - NJ Ex Order 26.4(b)(. Ref (referred) to [name redacted] NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). On 6/27/24 at 11:28 AM, the surveyor interviewed the U.S. FOIA (b) (6)). U.S. FOIA (b) (explained, "I do remember him/her, that Resident was dc to NJ Exec Orde I made a mistake and entered their information transferred to hospital." The U.S. FOIA (b) (acknowledged that the MDS was coded inaccurately and Resident #142 went NJ Exec Orde and did not go to the hospital. On 6/28/24 at 11:28 AM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and U.S. FOIA) regarding the above concerns. The U.S. FOIA (b) stated, "she [the U.S. FOIA (b) (6 made an error in MDS." She further stated that the resident was dc home and did not go to the hospital. No further information provided.	F 641		
F 658 SS=D	NJAC 8:39-33.2(d) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		8/15/24

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F 658	Continued From page 22 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow the physician's orders for medications with parameters for two (2) of 28 residents, Residents #44 and #134, reviewed for physician orders according to standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual 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 regimes 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	F 658	1. The facility immediately reviewed and verified the medication administration records (MARs) for Resident #44 and Resident #134 to ensure their medications are administered in accordance with the physician's orders. RN #1, LPN #1 and LPN #2 were inserviced on the "Medication Administration Policy" to reinforce the importance of adhering to medication parameters as prescribed. 2. All residents have the potential to be affected by the deficient practice. 3. The facility Assistant Director of Nursing (ADON) conducted in-service training sessions for all licensed professional nursing staff on the facility medication administration policy and following physician orders. 4. The Director of Nursing (DON) or DON designee will monitor by selecting five resident MARs weekly to ensure medications are administered in accordance with the physician's orders and medication parameters to ensure compliance; any discrepancies will be corrected immediately. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who determine the need for continued	

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counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

1. The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #44 which revealed the following:

The Admission Record (AR, an admission summary) revealed that Resident #44 had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)( ), and NJ Ex Order 26.4(b)(

A Quarterly Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated NJ Ex Order 26.4(, indicated the facility assessed the resident's NJ Exec Order 26.4(using a Brief Interview Mental Status (BIMS) test. Resident #44 scored a NJ Ex out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1).

A physician's order (PO) dated NJ Ex Order 26.4(read: " NJ Ex Order 26.4(b)(1) Oral Tablet (tab) NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1)) Give 1 tab by mouth two times a day for NJ Ex Order 26.4(b)(1) hold for NJ Ex Order 26.4(b)(1) ."

A review of the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) revealed the nurses signed for NJ Ex Order 26.4(b)(1 medication (med) being administered on NJ Ex Order 26.4(at 1700 [5 PM], NJ Ex Order 26.4(at 1700, NJ Ex Order 26.4(at 0900 [9 AM], NJ Ex Order 26.4(at 0900, NJ Ex Order 26.4(at 1700, NJ Ex Order 26.4(at 1700 and NJ Ex Order 26.4(at 1700. On these entries the NJ Ex was documented to be a NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1 med should have been held per the PO.

monitoring for a period no less than three months.

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ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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 658	Continued From page 24 On 6/27/24 at 11:12 AM, the surveyor interviewed a Licensed Practice Nurse (LPN) #1 (LPN #1) assigned to care for Resident #44 about medications (meds) with parameters. The LPN stated a PO should be followed. If the [NJ Ex] results were outside the parameters of the med order, the med should be held and not administered to the resident. On 6/27/24 at 12:41 PM, the surveyor informed the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) of the concerns that the PO for the [NJ Ex Order 26.4(b)(1] med with parameters was not being followed. The facility was to follow up and provide additional information. On 6/28/24 at 11:30 AM, the [U.S. FOIA (b)] the [U.S. FOIA (b)] and the [U.S. FOIA (b)] met with the survey team. The [U.S. FOIA] acknowledged the nurses did not follow the parameters ordered by the physician for the [NJ Ex Order 26.4(b)(1] med and nurse in-service education was ongoing. 2. On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the [NJ Exec Order 26.] room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid medical record for Resident #134. Resident #134's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [NJ Ex Order 26.4(b)(1)] , NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) [NJ Ex Order 26.4(b)(1)]	F 658		

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NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) due to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) following NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and

The most recent Significant Change MDS (SCMDS) dated , reflected that the resident had a BIMS score of out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1)

A review of the OSR for and reflected a PO dated for the following: NJ Ex Order 26.4(b)(1)) oral tab give one tab orally every 12 hours (hrs) to trea NJ Ex Order 26.4(b)(1) hold if NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) oral tab give one tab by mouth one time a day for hold for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

The above orders for and were plotted in the eMAR for and were administered by nurses (checked mark), and did not follow the PO:
hold for NJ Ex Order 26.4(b)(1):
Date Time
Nurse
8 PM]
Registered Nurse#1 (RN#1)

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NJ Ex Order 26.4(b)(1) hold for NJ Ex Order 26.4(b)(1):

Date	Time	Nurse
NJ Ex Order 26.4	9 AM	NJ Ex Order 26.4(b)(1)] LPN#2
NJ Ex Order 26.4	9 PM	NJ Ex Order 26.4(b)(1)] LPN#2
NJ Ex Order 26.4	9 PM	NJ Ex Order 26.4(b)(1) LPN#2
NJ Ex Order 26.4	9 PM	NJ Ex Order 26.4(b)(1)] LPN#2
NJ Ex Order 26.4	9 PM	NJ Ex Order 26.4(b)(1) LPN#3
NJ Ex Order 26.4	9 AM	NJ Ex Order 26.4(b)(1) RN#1
NJ Ex Order 26.4	9 PM	NJ Ex Order 26.4(b)(1) LPN#2
NJ Ex Order 26.4	9 PM	NJ Ex Order 26.4(b)(1)] LPN#2

On 6/25/24 at 9:54 AM, the surveyor interviewed RN#1 who informed the surveyor that she was a regular full time per diem nurse for NJ Ex Order 26.4(b)(1) in the NJ Exec Order 26.4b1 The RN informed the surveyor that the meds with parameters like the NJ Ex meds should follow the order of the physician if needed to hold, then it should be followed. She further stated that she checked NJ Ex first prior to administering the NJ Ex meds, and documented the NJ Ex in the eMAR. The RN also stated that the checkmark in the eMAR means it was administered. The RN further stated that it was considered a med error if NJ Ex meds were administered beyond the parameters.

On that same date and time, the surveyor notified RN#1 of the above concerns and findings regarding the NJ Ex Order 2 she administered on NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 not following the

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parameters. The surveyor with another surveyor and RN#1 went to the [NJ Exec O] nursing station. RN#1 checked the eMAR and acknowledged that she was the nurse that administered the [NJ Ex] meds and it should not administered due to parameters. She further stated that she did not know why it was administered and did not follow the PO for parameters.

On 6/25/24 at 11:22 AM, the surveyor called and left a message to an agency nurse, LPN#3.

On 6/25/24 at 11:23 AM, the surveyor called and spoke to LPN#2 regarding the above concerns and findings. LPN#2 informed the surveyor that she was from an agency and had been working in the facility since [NJ Ex Order 26.4(b)(1)] as a float nurse.

On that same date and time, LPN#2 stated that meds with parameters example the [NJ Ex] meds should follow the PO for parameters. She further stated that she checked [NJ Ex] first prior to administering meds and documented the [NJ Ex] in the eMAR. LPN#2 admitted that she usually works the [NJ Ex Ord] shift.

At that time, the surveyor notified LPN#2 of the above findings regarding her administered [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(] , [NJ Ex Order 26.4] , [NJ Ex Order 26.4] , [NJ Ex Order 26.4] , [NJ Ex Order 26.4] , and [NJ Ex Order 26.4] not following the parameters. She further stated that the above meds should not be administered due to parameters. LPN#2 had no answer as to why she did not follow the PO for parameters.

On 6/25/24 at 11:38 AM, the [U.S. FOIA] provided a copy of the Med Administration Policy with a reviewed date of [NJ Exec Order 26.]. The [U.S. FOIA] stated that the policy about meds with parameters was

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incorporated in this policy (Medication Administration Policy with a reviewed date of 01/2024) and the U.S. FOIA pointed to Procedure #3: Meds must be administered in accordance with the orders, including any required time frame.

The surveyor did not receive a call back from LPN#3.

On 6/27/24 at 9:00 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) stated that she notified the physician "yesterday" about the concerns with the parameters, the physician had no new order and instructed the nurse to continue the parameters. She further stated that there was no adverse effect on the resident.

On 6/27/24 at 12:41 PM, the survey team met with the U.S. FOIA (b) the U.S. FOIA (b) and the U.S. FOIA (b) The surveyor notified the facility management of the above concerns and findings.

On 6/28/24 at 11:29 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) and the U.S. FOIA (b) The U.S. FOIA stated that one-to-one education was provided to LPN#2 regarding following the PO for parameters. The U.S. FOIA acknowledged and stated that meds were given beyond the parameters and that should have been held for both meds NJ Ex Order 2 and NJ Ex Order 26.4(b)(1)

A review of the facility provided policy titled, "Medication Administration Policy," with a reviewed date of 01/2024. Under Policy it read: "Meds shall be administered in a safe and timely manner, as prescribed."
Under Procedure it read: " ...3. Meds must be administered in accordance with the orders,

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F 658	Continued From page 29 including any required time frame ...7. The following information must be checked/verified for each resident prior to administering meds...b. Vital signs, if necessary ..." NJAC 8:39-11.2(b); 29.2(d)	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661		8/15/24

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F 661	Continued From page 30 by: Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a discharge summary was completed for two (2) of two (2) residents, Residents #13 and #142 reviewed for discharge to home, according to the facility policy and procedure . This deficient practice was evidenced by the following: 1. On 6/26/24 at 10:10 AM, the surveyor reviewed the hybrid (combination of paper and electronic) closed record of Resident #13 and revealed the following: The Admission Record (AR, or face sheet, an admission summary) showed that the resident was admitted to the facility with a diagnosis that included but was not limited to [redacted]. A review of the modified Comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] showed a brief interview for mental status (BIMS) score of [redacted] out of 15 which indicated that the resident was [redacted]. The CMDS also showed that the overall goal for the resident was	F 661	1. Resident #13 had their discharge summary completed and documented in the EMR and hard copy medical chart. Resident #142 had their discharge summary completed and documented in the EMR and hard copy medical chart. 2. All residents have the potential to be affected by the same deficient practice. 3. The MDS Coordinator (MDSC) and/or MDSC designee inserviced all Interdisciplinary team members, licensed professional nursing personnel and physicians for Resident #13 and Resident #142 on the requirements for completion and documentation of the discharge summary in the EMR and hard copy medical chart. 4. The MDS Coordinator (MDSC) and/or MDSC designee will monitor by auditing all discharge summaries weekly for no less than four months to ensure compliance. Any non-compliance discovered during audits will cause re-education of staff members or physicians. The audits will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee, who will make recommendations for continued monitoring after a period no less than four months.	

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to be discharged (DC) to the community.

Further review of the MDS revealed that the most recent DC Return Not Anticipated ARD was on [redacted] and was export-ready (which means it was completed but was not submitted to the Centers for Medicare and Medicaid Services or CMS).

The Order Summary Report (OSR) for [redacted] showed a physician's order (PO) dated [redacted] for DC NJ Ex Order 26.4(b)(1).

The Progress Notes (PN) dated [redacted] at 02:43 PM that was electronically signed by Licensed Practical Nurse #1 (LPN#1) included that patient (resident) DC to a [redacted], left in the company of the US FOIA (b)(6)).

Further review of the PN showed that the last note of the physician was on [redacted] and did not include the DC information and plan for the resident.

The DC Summary in the electronic medical records (EMR), assessment tab showed that it was "In Progress" date [redacted] and the lock date was blank. The DC Summary dated [redacted] showed the following were left blank and no documented information found:
SECTION 103. Social Services
1. Admission Status=left blank
SECTION 104. Rehab
1. Admission Status=left blank
2. Discharge Status=left blank
SECTION 105. Dietary
1. Admission Status=left blank
SECTION 106. Activities
1. Admission Status=left blank

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Further review of the DC Summary showed that there was no physician DC summary.

On 6/27/24 at 12:20 PM, the U.S. FOIA (b) (6)) with the U.S. FOIA (b) (6)) met with the surveyor. The U.S. FOIA (b) (6) notified the surveyor that the facility did not have a DC summary from the physician, and it was not the facility's practice. The U.S. FOIA (b) (6) also stated that the only requirement from the physician was to have an order for DC and the facility to document that the physician was notified of the DC of the resident. He further stated that that was the reason why there was no DC summary from the physician in the EMR and the actual paper closed chart.

On 6/27/24 at 12:41 PM, the survey team met with the U.S. FOIA (b) (6) , the U.S. FOIA (b) (6) , and the U.S. FOIA (b) The surveyor notified the facility management of the above concerns and findings. The surveyor also notified the facility management of the U.S. FOIA (b) (6) interview in the presence of the U.S. FOIA (b)

On 6/28/24 at 11:29 AM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) and the U.S. FOIA (b) (6) The U.S. FOIA (b) stated that "we have to put back the system for DC summaries, and moving forward that would be done," the DC summaries of the physician. The U.S. FOIA (b) acknowledged that the DC summary of the physician was not something new in the requirements, and should have been done.

On that same date and time, the surveyor also notified the facility management that the DC Summary that was in the Assessment tab of the

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EMR was still in progress and was not completed, where multiple areas were blank.

On 7/01/24 at 11:09 AM, the survey team met with the [redacted] and the [redacted] There was no additional information provided with regard to the above concerns.

A review of the facility's DC Policy with a reviewed date of 01/2024 by the [redacted] included that when a resident's DC is anticipated, a DC plan, summary, and instructions will be developed to assist the resident to adjust to his/her new living environment. The IDT (interdisciplinary team) will document the DC summary in the EMR.

On 7/01/24 at 11:58 AM, the survey team met with the [redacted] and [redacted] for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings.

2. On 6/26/24 at 12:58 PM, the surveyor reviewed the hybrid closed record of Resident #142 and revealed the following:

The AR showed that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) ([redacted] NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and [redacted] (NJ Ex Order 26.4(b)(1)).

A review of the DC MDS reflected BIMS score of [redacted] out of 15 which indicated that the resident was NJ Ex Order 26.4(b)(1). Further review of the MDS "section A0310F." revealed that MDS assessment was coded 10. DC assessment- return not anticipated.

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F 661	Continued From page 34 A review of OSR showed a PO dated [NJ Ex Order 26.4] for DC NJ Ex Order 26.4(b)(1) . A review of PN dated [NJ Ex Order 26.4] at 9:30 AM that was electronically signed by LPN#2 included "resident was seen this morning in their wheelchair no signs of [NJ Ex Order 26.4] or [NJ Ex Order 26.4(b)(1)] noted. Vitals taken and recorded; due medications (meds) [NJ Ex Order 26.4(b)(1)] Resident DC, left the building @ 9:30 AM, with RR. Resident has been educated on his/her meds and [NJ Ex Order 26.4(b)(1)]; list of meds had been faxed to [name redacted] pharmacy." Further review of the PN showed that the last physician note titled as "[NJ Exec Ord] was on [NJ Ex Order 26.4] and did not include the DC information and plan for the resident. Further record review did not reveal a physician DC summary for Resident #142.	F 661		
F 688 SS=D	NJAC 8:9-36.1(b) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		8/15/24

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F 688	Continued From page 35 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the medical record and other facility documentation, it was determined that the facility failed to ensure that residents with [NJ Ex Order 26.4(b)(1)] [redacted] and [NJ Ex Order 26.4] received consistent daily treatment of a [NJ Ex Order 26.4(b)(1)] to prevent [NJ Ex Order 26.4(b)(1)] or further [NJ Ex Order 26.4(b)(1)] for one (1) of two (2) residents reviewed for [NJ Ex Order 26.4] and [NJ Ex Order 26.4] (Resident #94). This deficient practice was evidenced by the following: On 6/24/24 at 10:45 AM, the surveyor observed Resident #94 seated in a wheelchair and [NJ Ex Order 26] [redacted] on their [NJ Ex Order 26.4(b)] . Resident #94 stated that he/she [NJ Ex Order 26.4(b)(1)] during the day. On 6/25/24 at 11:48 AM, the surveyor reviewed Resident #94's electronic medical record. Resident #94's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited t [NJ Ex Order 26.4(b)(1)] [redacted] (NJ Ex Order 26.4(b)(1)) and [NJ Ex Order 26.4(b)(1)]	F 688	1. The Treatment Administration Record (TAR) for Resident #94 was updated to reflect the physician's order for the [NJ Exec Orde] 2. All residents with hand splints or orthotic devices have the potential to be affected by the deficient practice. 3. The Director of Rehabilitation (DoR) re-educated all nursing staff on documentation of proper placement and documentation requirement for ordered hand splints or orthotic devices in the functional maintenance program flow sheet(s). The nurse unit manager will check documentation daily. 4. The DoR and/or DoR designee will monitor weekly by auditing five residents with hand splints and/or orthotic devices to ensure accuracy of documentation in the Functional Maintenance Program log flow sheets. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will provide recommendations for additional monitoring after a period of no less than 4 months.	

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NJ Ex Order 26.4(b)(1)

Resident #94's electronic physician order set (POS) included the following active order: "NJ Ex Order (NJ Ex Order 26.4(b)(1) Program) NJ Ex Order 26 (NJ Ex Order 26.4(b)(1)) in all planes as tolerated 3-5x/WK (week) NJ Ex Order 26.4(b)(1)). NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) after AM care and doff (to take off) before PM care daily. Further view of the order indicated POS only and did not transfer to the TAR (Treatment Administration Record) for staff signatures.

A review of Resident #94's care plan included the following focus area with an initiated date of NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) Nursing Program: NJ Ex Order 26.4(b)(1) 3-5x/week NJ Ex Order 26.4(b)(1), NJ Exec Orde NJ Exec Order 26.4 NJ Ex Order 26.4(b)(1)) on after AM care and off before PM care daily.

A review of Resident #94's NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) TAR did not have a physician's order for the NJ Ex Orde for nurses to sign as administered.

There was no documented evidence in Resident #94's hybrid (a combination of paper, scanned, and computer-generated records) medical record that the physician's order or care plan was being carried out.

On 6/26/24 at 9:18 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding NJ Ex Order 26 The U.S. FOIA stated that everyone could do the NJ Ex Orde and that it was documented in the computer. The U.S. FOIA stated that Resident #94 was

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currently receiving NJ Ex Order 26.4 and that NJ Ex Order 26.4 was doing the NJ Ex Orde now. She added that when the resident was not NJ Ex Order 26.4(b)(1 that nursing staff would do the NJ Ex Order and document it.

A review of Resident #94's Documentation Survey Report (CNA documentation for interventions or tasks) for NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) did not include any documentation regarding NJ Ex Order 26

On 6/26/24 at 9:23 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA stated that the U.S. FOIA (b) (6)) documented on paper when she applied the U.S. FOIA (b)

On 6/26/24 at 9:33 AM, the surveyor interviewed the U.S. FOIA (b The U.S. FOIA stated that she had a binder that she documented in for Resident #94.

On 6/26/24 at 12:09 PM, the surveyor interviewed the U.S. FOIA (b) (6)) of NJ Exec O unit regarding the process of NJ Ex Order 2 and documentation. The U.S. FOIA (b) (6) requested that the U.S. FOIA be present.

On 6/26/24 at 12:50 PM, in the presence of the U.S. FOIA (the U.S. FOIA (b) (6) stated that there was a physician order in the computer that was on the TAR and that the nurse would sign it but that it was only when resident was not on NJ Ex Order 26.4(She added that when the resident was on NJ Ex Order 26.4 the U.S. FOIA would leave the binder for the other staff to document. The surveyor requested to see the documentation.

On 6/27/24 at 10:06 AM, the U.S. FOIA provided the surveyor a copy of Resident #94's U.S. FOIA (b) documentation for the NJ Ex Order

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F 688	Continued From page 38 A review of the provided "Functional Maintenance Program Flow Record" for Resident #94's [NJ Ex Order 26.4(b)(1)] program included the following: [NJ Ex Order 26.4(b)(1)] had 18 days that the [U.S. FOIA] signed that Resident #94's [NJ Exec Ord] was [NJ Exec Order 26] and [NJ Exec Orde] by the [U.S. FOIA (b] There were 8 days that were blank. [NJ Ex Order 26.4(b)(1] had 19 days that the [U.S. FOIA] signed. There were 12 days that were blank. [NJ Ex Order 26.4(b)(1] had 20 days that the [U.S. FOIA] signed. There were 10 days that were blank. [NJ Ex Order 26.4(b)(1)] had 21 days that the [U.S. FOIA] signed. There were 9 days that were blank. [NJ Ex Order 26.4(b)(1)] had 19 days that the [U.S. FOIA] signed. There were 9 days that were blank. [NJ Ex Order 26.4(b)(1)] had 21 days that the [U.S. FOIA] signed. There were 10 days that were blank. The surveyor asked the [U.S. FOIA] about the blanks. The [U.S. FOIA] stated that he did not know how nursing documented the [NJ Ex Order] There was no documented evidence that Resident #94's [NJ Ex Orde] was applied on the days that the [U.S. FOIA] was not at the facility. On 6/27/24 at 10:13 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding the process for [NJ Ex Order]. The [U.S. FOIA] stated that the [U.S. FOIA] applied the [NJ Exec Ord] when she was working. She added that when the [U.S. FOIA] was not here that the [U.S. FOIA] or the nurse would apply the [NJ Ex Orde] and that here was a section in the TAR that they signed. The surveyor asked the [U.S. FOIA] if the [U.S. FOIA] also documented the [NJ Ex Orde] applied. The [U.S. FOIA] stated that she believed that the [U.S. FOIA] also documented in the computer but was not sure. She added that she did not think that the [U.S. FOIA] documented in a binder and that the [U.S. FOIA] only had a binder.	F 688		

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At that same time, the surveyor then showed the U.S. FOIA the forms that the U.S. FOIA provided and she confirmed that there were blanks and that the U.S. FOIA (b) were not documented on that form. The U.S. FOIA then viewed the TAR and confirmed that there was a new order placed in the TAR on NJ Exec Order 26 after surveyor inquiry, for Resident #94's NJ Ex Order The surveyor asked the U.S. FOIA what the importance of having the order in the TAR. The U.S. FOIA stated that it was to ensure that the NJ Ex Orde was applied each day and to prevent further NJ Ex Order 26.4(b)(1)

On 6/27/24 at 10:24 AM, the surveyor interviewed the U.S. FOIA regarding the binder that she documented in. The U.S. FOIA stated that she did not leave the binder for the U.S. FOIA (b) when she was not here.

There was no documented evidence that Resident #94's NJ Ex Orde was applied on the days that the U.S. FOIA was not at the facility.

On 6/27/24 at 11:18 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the process for NJ Ex Order 26.4(b) The U.S. FOIA stated that the RA documented the NJ Ex Orde in a binder. The surveyor then asked if the U.S. FO was at the facility seven days a week. The U.S. FOIA stated that the U.S. FO was not at the facility seven days a week and that the nurses documented the NJ Ex Orde in the TAR. The surveyor then asked the U.S. FOIA about the missing documentation of the NJ Ex Orde for Resident #94. The U.S. FOIA stated that she was informed after surveyor inquiry and that they failed to have the documentation.

On 6/27/24 at 01:10 PM, in the presence of the

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F 688	Continued From page 40 survey team, the surveyor notified the U.S. FOIA (b) (6) [redacted], U.S. FOIA and U.S. FOIA (b) (6) [redacted]) the concern that Resident #94 did not have any documented evidence that the NJ Ex Orde was applied on the days that the U.S. FO was not there. On 6/28/24 at 11:41 AM, in the presence of the survey team, U.S. FOIA (b) and U.S. FOIA (b) the U.S. FOIA (b) stated that the staff was inserviced on documentation for NJ Ex Order 26. The facility did not provide any additional information. A review of the facility provided policy titled, "Functional Maintenance Program" with a revised/reviewed date of 01/2024, included the following: The facility's Functional Maintenance Program (FMP) is designed to assist residents to achieve and maintain an optimal level of function. When a resident is discharged from skilled therapy to FMP, the following steps are followed: The treating therapist will initiate recommendations for FMP and notify nursing of these recommendations with appropriate instructions and training of recommendations. An FMP order will be placed in the resident's electronic chart and care planned. The care plan shall be written with nursing interventions which will give direction to the CNA's for assisting the resident in the program. CNA's shall aid the residents in performing the recommended FMP. These CNA's will be under the direction of a licensed nurse who will collaborate their activities with PT/OT (physical therapy/occupational therapy).	F 688		

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F 688	Continued From page 41 The CNA's shall document daily in the FMP log. This log will be reviewed monthly by the nursing and rehab team and monthly nursing summary will be completed to evaluate the current program. The policy did not contain any information in regards to NJ Ex Order 2 and documentation while a resident received NJ Ex Order 26.4(b)(1). N.J.A.C. 8:39-27.1(a)	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		8/15/24

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F 690	Continued From page 42 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that the NJ Ex Order 26.4(b)(1) care plan was developed according to the resident's assessment to provide appropriate treatment and services for the care of the resident who had frequent NJ Ex Orde and occasional NJ Ex Order 26.4(b)(1) according to the facility's policy and procedure, for one (1) of one (1) resident, Resident #134, reviewed for NJ Ex Order and NJ Ex Order 26.4(b)(1). This deficient practice was evidenced by the following: On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the NJ Exec Order 26 room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #134. Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that	F 690	1. Resident #134 had their care plan updated to reflect resident□s current NJ Ex Order 26.4(b)(1). 2. All residents have the potential to be affected by the same deficient practice. 3. The Director of Nursing (DON) or DON designee conducted in-service training sessions for all Registered Nurses and Licensed Practical Nurses incorporating assessment findings into individualized care plans for the proper development of incontinence care plans. MDS Coordinator (MDSC) and Nurse Unit Managers reviewed the care plan for all residents who CAA triggered for urinary incontinence and indwelling catheter to assure care plan and interventions were in place as needed. 4. The MDSC or MDSC designee will monitor by auditing 5 resident care plans monthly for non-compliance with incontinence resident care plans in conjunction with care area assessment findings. All audit results will be recorded	

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F 690	Continued From page 43 included but were not limited to [redacted]. The most recent Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had [redacted]. The SCMDS also showed that the resident was coded for frequently [redacted] and occasionally [redacted]. Also, the SCMDS revealed that the resident was not on a [redacted] and [redacted] program. Further review of the SCMDS revealed that on Section V Care Area Assessment (CAA) Summary, #6 [redacted] and [redacted] that area was triggered and was checked to proceed with Care Plan (CP). The CAA included that the [redacted] was an actual problem, and the nature of the problem: "Resident is noted more B & B ([redacted] and [redacted] accidents. Resident is assisted with [redacted] for safety." The CP's consideration was to address the problem to proceed with CP, with an overall objective to slow or minimize the decline.	F 690	and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee, who will make recommendations for continued monitoring of the corrective action after a period of no less than three (3) months.	

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A review of the personalized CP showed that there was no focus CP, goals, and interventions for NJ Ex Order 26.4(b)(1).

Further review of the medical records showed that the above SCMDS CAA for #6 was not followed to proceed with CP for NJ Ex Order

A review of the Tasks for the U.S. FOIA (b) (6)) in the electronic medical records revealed that the task description for bladder continence and bowel continence, frequency was every shift.

On 6/25/24 at 9:54 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FO stated that the resident was NJ Ex Or with some NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) at times. She further stated that Resident #134 with periods of NJ Ex Order , staff assisted the resident in NJ Ex Order 26.4(b)(1)

On 6/28/24 at 8:55 AM, the surveyor interviewed the Registered U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) informed the surveyor that Resident #134 was NJ Ex Order 26.4(b)(1) of NJ Ex Order . The U.S. FOIA (b) (6) stated that she was responsible for initiating, reviewing, and revising the CP. She added that U.S. FOIA (b) (6)) was also responsible for the resident's CP. The U.S. FOIA (b) (6) further stated that she was unsure if NJ Ex Order 26.4(b)(1) should be care planned for.

At that time, the surveyor notified the U.S. FOIA (b) (6) of the above concerns.

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On 6/28/24 at 9:13 AM, the surveyor interviewed the assigned U.S. FOIA of Resident #134. The U.S. FOIA stated that the resident was NJ Ex Or with periods of NJ Ex Order 26.4(b)(1) with periods of NJ Ex Order 26.4(b)(1) in NJ Ex Order 2 The surveyor asked the U.S. FOIA how often s NJ Ex checked on the resident for NJ Ex Order 26.4(b)(1) and what kind of care and assistance was provided to the resident. The U.S. FOIA responded that at least every two hours or more. The surveyor then asked again the U.S. FOIA (how she knew the resident should be checked for two hours or more, the U.S. FOIA responded that based on her experience as a U.S. FOIA (

On 6/28/24 at 9:20 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) stated that she was responsible for the CAA in the MDS for the "nursing side" including the NJ Ex Order 26.4(b)(1).

At that same date and time, the surveyor notified the U.S. FOIA (b) (6) about the above findings and concerns including the CAA for #6 that there was no CP. The U.S. FOIA (b) (6) stated that there should be a CP for NJ Ex Order 26.4(b)(1) and that she will check on it and get back to the surveyor.

On 6/28/24 at 10:21 AM, the U.S. FOIA (b) (6) in the presence of the survey team informed the surveyor that she did not see a CP for NJ Ex Order 26.4(b)(1) and that should have been care planned.

On 6/28/24 at 11:29 AM, the survey team met with the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)). The surveyor notified the facility management of the above findings and concerns.

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F 690	Continued From page 46 A review of the facility's Incontinence Care Policy with a reviewed/revised date of 01/2024 that was provided by the [U.S. FOIA (b)] included that the facility shall provide care for all [NJ Ex Order 26.4(b)(1)] residents. The Procedure included that the check residents at least every two hours. A review of the facility's Plan of Care and IDCP Team Meeting Policy with reviewed date of 01/2024 that was provided by the [U.S. FOIA (b)] included that the facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, and goals. Procedures: -The plan of care shall be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments and as appropriate. -the plan of care shall be documented in the facility's EMR (electronic medical record) system. Interdisciplinary Care Plan (IDCP) Team meeting: -The IDCP Team meeting shall be held after completion of the comprehensive assessment, quarterly or more frequently, as needed. On 7/01/24 at 11:58 AM, the survey team met with the [U.S. FOIA (b)] [U.S. FOIA (b)] and [U.S. FOIA (b)] for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings.	F 690		
F 712 SS=E	NJAC 8:39-11.1, 11.2 (e)(1,2), 27.1(a) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits	F 712		8/15/24

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	315357	A. BUILDING _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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F 712	Continued From page 47 §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every sixty days from NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) according to the facility's policy and procedure. This deficient practice was identified for one (1) of 28 residents, Resident #134 was reviewed for physician visits and was evidenced by the following: On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch. The surveyor reviewed the hybrid (combination of	F 712	1. Resident #134's physician conducted a face-to-face visit and entered notes from NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1). 2. All residents have the potential to be affected by the same deficient practice. 3. The Administrator (LNHA) educated Resident #134's U.S. FOIA (b) (6) on the facility policy for Physician Visits and Services and the regulatory requirement to conduct face-to-face visits and progress notes in accordance with CFR 483.30(c)(1)-(4) and NJAC 8:39-23.2(d). Any non-compliance will result in immediate re-education of the US FOIA (b)(6) by the LNHA.	

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F 712	Continued From page 48 paper and electronic) medical record for Resident #134. Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted]. The most recent Significant Change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had [redacted] There was no documented evidence that the physician visited and examined Resident #134 at least every 60 days from [redacted] through [redacted]. On 6/26/24 at 11:14 AM, the surveyor called the physician of the resident and the surveyor spoke to the [redacted] of the physician's office. The [redacted] informed the surveyor that the physician was not available and would let the physician know to call the surveyor for an	F 712	4. The Medical Records representative will monitor by auditing five medical records twice a month for a period of no less than four months to ensure compliance with timely physician visits and charting. The results of the audits will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make recommendations for continued monitoring after a period of no less than four months.	

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F 712	Continued From page 49	F 712		

interview.

On 6/26/24 at 12:03 PM, the surveyor interviewed the U.S. FOIA (b) (6)) of the Peach unit (Behavioral unit). The surveyor asked the U.S. FOIA what was the facility's protocol regarding the physician visit notes, and the U.S. FOIA responded that he would get back to the surveyor.

On that same date and time, the surveyor notified and showed to the U.S. FOIA that the resident's visits notes for dates NJ Ex Order 26.4(b) (History and NJ Ex Order 26.4(b) and NJ Ex Order 26.4 (Progress Notes) were both done by the U.S. FOIA (b) (6)), and there were no further notes found in the resident's hybrid medical records.

On 6/28/24 at 11:29 AM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), and U.S. FOIA (b) (6)). The surveyor notified the facility management of the above findings and concerns. The surveyor asked the facility management if that was the facility's policy and practice that the primary physician does not write visit notes. The U.S. FOIA (b) stated "no," and that the physician should see the resident once every 60 days, the U.S. FOIA can come in between months and do the alternating visits and notes.

A review of the facility's Physician Visits and Services Policy with a reviewed date of 01/2024 that was provided by the U.S. FOIA (b) included that the attending physician shall visit the resident at least once during the 30 days following admission and/or as required by the resident's needs. The attending physician shall visit the resident in accordance with the resident's needs, but at least once every 30 days for the first 90 days after

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F 712	Continued From page 50 admission and at least once every 60 days thereafter and as needed. On 7/01/24 at 11:58 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) and U.S. FOIA (b) for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. NJAC 8:39-23.2(d)	F 712		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency	F 728		8/15/24

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F 728	Continued From page 51 A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure a.) a non-certified Nurse Aide (NA) did not continue to work as an NA after the specified 120 days for one (1) of two (2) NAs reviewed during the Sufficient and Competent Nurse Staffing task (NA #1); and b.) there was a delineated policy and/or program in place for the hiring of non-certified NAs. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP program and completed the first 16 hours of training prior to May 11, 2023, must complete the	F 728	1. Nurse Aide (NA) #1 was terminated prior to recertification survey on [redacted NJ Ex Order 26.4(b)(1)]. 2. All residents have the potential to be affected by the same deficient practice. 3. The Administrator (LNHA) inserviced all nursing managers and facility [redacted U.S. FOIA (b) (6)] on the 120-day certification requirement of non-certified NAs as part of an educational inservice regarding facility hiring requirements. A system to track timelines and ensure compliance with the 120-day certification requirement of non-certified NAs was developed and implemented. 4. The LNHA or BOM will monitor by auditing three new hire files weekly to ensure compliance with the 120-day certification requirement of non-certified NAs. Any non-compliance will cause immediate re-education of staff. The audit results will be recorded and reported monthly to the Quality Assurance and	

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F 728	Continued From page 52 NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 6/26/24 at 9:50 AM, the surveyor randomly chose ten new hire employee files to review and requested the files from the U.S. FOIA (b) (6) [redacted] On 6/27/24 at 12:00 PM, the surveyor reviewed the facility provided file of one of the new hired employees which revealed the following: -NA #1 had a date of hire of NJ Ex Order 26.4(b) [redacted]. -NA #1 had a competency report skills test dated NJ Ex Order 26.4 [redacted]. -NA #1 was terminated on NJ Ex Order 26.4 [redacted]. The time between NA #1's date of hire and termination date was greater than NJ Exec Order 26.4(b) [redacted]. On 6/28/24 at 9:08 AM, the surveyor interviewed	F 728	Performance Improvement (QAPI) committee who will make recommendations for continued monitoring after a period of four months.	

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F 728	Continued From page 53	F 728		

the U.S. FOIA (b) (6)) regarding the process for NA employment. The U.S. FOIA (b) stated that she reviewed the skills test to see if it was within 30-60 days since they passed it. She added that they could only work at the facility for 120 days from the skills test date.

On 6/28/24 at 10:06 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the process for NA employment. The U.S. FOIA stated that they would make sure that the NA's skill test was within 120 days. She added that if they do not pass the test within 120 days then the NA would be removed from the schedule.

On 6/28/24 at 10:09 AM, the surveyor asked the U.S. FOIA (b) (6)) for the facility's policy process for NA employment.

On 6/28/24 at 12:06 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (U.S. FOIA and U.S. FOIA (b) (6)) the concern that NA#1 worked at the facility for more than 120 days after their date of hire and their skills test.

On 7/01/24 at 10:18 AM, in the presence of the survey team, the U.S. FOIA (b) stated that the only policy for NA's was the Nurse Aide Orientation policy that was provided at an earlier time.

On 7/01/24 at 11:11 AM, in the presence of the survey team, U.S. FOIA and the U.S. FOIA (b) (the U.S. FOIA (b) stated that NA #1 was no longer employed at the facility.

The facility did not provide any additional information.

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F 728	Continued From page 54 A review of the facility provided policy titled, "Nurse Aide Orientation" with a reviewed date of 01/2024, included the following: Purpose and Policy: This facility is committed to ensuring newly hired Nurse Aides (NA) have the knowledge, skills and abilities to have their own assignment to function effectively in this facility. This facility has established a NA orientation program to help them fully utilize their capabilities. Procedures: 1. Newly hired NA's will take part in the facility general orientation program on the first day of employment which covers the policies of the facility. 2. All newly hired NA's will shadow a C.N.A. and undergo a competency evaluation covering core competencies which include, but not limited to: a. Bed bath b. Bed making occupied/unoccupied ... p. Ambulation with assistance. 3. The NA will be given an assignment after they have successfully demonstrated competency in the above skills. The policy did not include information regarding the requirement of becoming certified within 120 days or the NA hiring process. N.J.A.C. 8:39-43.1	F 728		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		8/15/24

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F 732	Continued From page 55 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report was posted and in a prominent place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the	F 732	1. The facility immediately posted the Nurses Staffing Information in the front lobby near the reception desk for the three separate nursing shifts on 07/11/2024. 2. All residents have the potential to be affected by the same deficient practice.	

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F 732	Continued From page 56 following: On 6/24/24 at 9:00 AM and 6/25/24 at 8:55 AM, the surveyor entered the facility and observed that there was no Nursing Home Resident Care Staffing Report (NHRCSR) posted in the entrance area. On 6/25/24 at 9:37 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the posting of the NHRCSR. The U.S. FOIA (b) (6) stated that the NHRCSR was usually posted on the wall behind her. The surveyor observed three sheet protectors that did not have any documents in them hanging on the wall. The U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6)) would post them and that the last time she saw them posted was last week. On 6/25/24 at 9:44 AM, the surveyor interviewed the U.S. FO regarding the posting of the NHRCSR. The U.S. FO stated that she posted it daily and would try to post them by 9:30 or 10 am and that the night U.S. FOIA (b) (6) would discard them. On that same date and time, the surveyor notified the U.S. FO that the NHRCSR was not posted for the last two days. The U.S. FO stated that she was off yesterday. She added that she was having an issue with connection to the printer but could send it to admissions to print. The surveyor asked the U.S. FO who would post the NHRCSR in her absence. The U.S. FO stated that a colleague should print them out and the U.S. FOIA (b) (6)) or U.S. FOIA (b) (6)) would post it. On 6/27/24 at 01:08 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (6)	F 732	3. The Administrator (LNHA) provided inservice education to the U.S. FOIA (b) (6) , U.S. FOIA (b) (6) and U.S. FOIA (b) (6) regarding their responsibility to ensure mandatory posting of the daily nurses staffing information reports for all three shifts prominently and, the LNHA purchased and mounted three separate clear placards to ensure compliance for displaying the daily nurse staffing reports at the facility front desk. 4. The Business Office Manager and/or LNHA will monitor by observing daily nurse staffing shift reports weekly for three months to ensure compliance with the updated policy. Any non-compliance will cause immediate posting of the nursing staffing shift reports. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee, who determine the need for continued monitoring after a period of no less than three months.	

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U.S. FOIA (b) and U.S. FOIA (b) (6)) the concern that 24-hour staffing report was not posted and in a prominent place within the facility readily accessible to the residents and the visitors.

On 6/28/24 at 11:56 AM, in the presence of the survey team, U.S. FOIA (b) and U.S. FOIA (b) the U.S. FOIA (b) stated that the U.S. FOIA was off. The U.S. FOIA (b) stated that he would post it if it was not posted and that staff were inserviced.

The facility did not provide any additional information.

A review of the facility provided policy titled, "Posting Nurses Staffing Information" with a revised/reviewed date of Jan 2024 included the following:
1. The required information that needs to be posted includes:
Facility name
Current date
Resident Census
Total number of staff and actual hours worked per shift for: Registered Nurses; Licensed Nurses; Certified Nurse Aides
2. The facility needs to post nurse staffing information in a prominent place where it is accessible to residents and visitors.
3. The data should be clear, readable, up to date and current.
4. When listing the total number of staff and actual hours worked, the facility is required to reflect staff absences on each shift ...

A review of the facility provided policy titled, "Facility Staffing Policy" with a revised/reviewed date of Jan 2024 included the following:
8. The facility is responsible for posting nurse

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	315357	A. BUILDING _____ B. WING _____	C 07/09/2024

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ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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 732	Continued From page 58 staffing as well as have it available upon request and retain it per regulatory requirements. N.J.A.C. 8:39-41.2 (a)(b)(c)	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of 28 residents reviewed. (Resident #67).	F 757	1. Resident #67 medication orders were reviewed and consulted with the prescribing physicians to clarify indication of use for medication ([redacted]). Resident #67 had an appointment schedule with [redacted] and orders were discontinued by the [redacted]	8/15/24

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F 757	Continued From page 59 The deficient practice was evidenced by the following: On 6/24/24 at 11:17 AM, the surveyor observed Resident #67 lying in bed. The resident agreed to speak with the surveyor. During the brief interview, the surveyor asked the resident if they can [redacted] themselves. The resident stated, no, the nurses aides come to assist them and [redacted] if needed. The surveyor reviewed Resident #67's electronic medical record (EMR) which revealed the following. Resident #67's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]). The Medicare 5-day Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify cognitive condition, score of [redacted] out of 15, which indicated that Resident #67 had [redacted] Further review of the resident's Medicare 5-day MDS dated [redacted] revealed under section H the resident was described as always [redacted] A review of the resident's MDS Care Area	F 757	2. The facility identified 3 residents on this medication having the potential to be affected by the deficient practice. 3. In-service for nurses conducted by Assistant Director of Nursing (ADON) or ADON designee on prevention of administering unnecessary medication. Unit manager to review Consultant Pharmacist recommendations upon admission and monthly for mentions of medication usage outside of the approved indication and consult with prescribing physician. LNHA met with consultant Pharmacist regarding commenting in monthly reports on any medication being used for unapproved use. 4. Director of Nursing (DON) or DON designee will review 5 resident consultant pharmacist reviews weekly x 4 months to assure that consultant pharmacist reports are properly followed up on and documented on. Any discrepancies or non-compliance will be reported to the resident□s physician immediately for corrective action. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement committee to review the findings and make recommendations for continued monitoring or necessary adjustments after the initial four-month period.	

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Assessment (CAA) (triggered responses to items coded on the MDS specific to a resident's possible problems) revealed that the resident needed assistance for [redacted] and was always [redacted] It also revealed the analysis of findings that the resident had a [redacted] condition of [redacted] and was on routine [redacted].

The resident's medication orders in the EMR included the following order:
[redacted]) (used to treat [redacted] who have symptoms of an [redacted], which is also known as [redacted] or [redacted] give one capsule by mouth one time a day for [redacted], with a start date of [redacted].

Further review of Resident #67's AR did not reveal a diagnosis of [redacted] but did reveal a diagnosis of [redacted] in a Physician's progress note dated [redacted] that was created on [redacted].

The surveyor reviewed the manufacturer package insert for [redacted] The section labeled Indications and Usage reflected, [redacted] is an [redacted] indicated for treatment of the signs and symptoms of [redacted]

On 6/25/24 at 10:15 AM, the [redacted]) provided the survey team the pharmacy consultant recommendations binder which included reports from [redacted] through [redacted].

On that same date and time, the surveyor

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reviewed the recommendations and did not observe any mention of [NJ Ex Order 26.4(b)(1)] use for Resident #67.

On 6/25/24 at 01:20 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] for the unit where Resident #67 resides. The surveyor asked the [U.S. FOIA (b) (6)] about the change in BIMS recently. The [U.S. FO] stated that the recent BIMS was done by the [U.S. FOIA (b) (6)] and that Resident #67 "has [NJ Ex] days" and may be an [NJ Ex Order 26.4b1] on another week and can vary how they answer questions.

On 6/27/24 at 10:10 AM, The surveyor interviewed the [U.S. FOIA (b) (6)]) by telephone. The surveyor asked the [U.S. FO] if they would normally comment on the use of [NJ Ex Order 26.4(b)(1)] for an unapproved use. the [U.S. FO] stated, "sometimes." The [U.S. FO] had nothing further to add that was pertinent to this resident's use of [NJ Ex Order 26.4(b)(1)]

On 6/27/24 at 12:42 PM, the surveyor requested, from the [U.S. FOIA (b) (6)] in the presence of the survey team, any further documentation regarding the use and effectiveness of [NJ Ex Order 26.4(b)(1)] in Resident #67.

On 6/28/24 at 10:20 AM, the [U.S. FOIA (b)] provided several Physician progress notes (PN) for Resident #67. Two of the notes, dated [NJ Ex Order 26.4] and [NJ Ex Order 26.4] were observed as being late entries, created [NJ Ex Order 26.4], after survey entrance and surveyor inquiry, one note dated [NJ Ex Order 26.4(b)] and one note dated [NJ Ex Order 26.4(b)] observed as a late entry created [NJ Ex Order 26.4(b)]. The note dated [NJ Ex Order 26.4(b)] revealed documentation by the attending physician that the resident has an [NJ Ex Order 26.4(b)(1)]

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F 757	Continued From page 62 NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) and it is managed with NJ Ex Order 26.4 (NJ Ex Order 26.4(b)(1)). Further review of the above documentation by nursing in the MDS and the Physician's PN showed that there were NJ Ex Order 26.4(b)(1) with regard to resident's NJ Ex Order 26.4(b)(1) condition. Furthermore, there were no documentation regarding use of NJ Ex Order 26.4(b)(1) outside the manufacturer's approved indication or the benefit versus the risk in relation to the effectiveness. On 7/01/24 at 11:59 AM, the survey team met with the U.S. FOIA (b) (6), the U.S. FOIA (b) and the U.S. FOIA (b) (6) . The surveyor discussed the concern with the documentation with the facility administrative team regarding the inconsistency in the documentation. No further documentation was provided regarding Resident #67. N.J.A.C. 8:39-11.2(b)	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation on 6/26/24,	F 759	1. Resident #34 medication orders were reviewed and to ensure accuracy, including specifying the dosage for NJ Ex Order 26.4 Consulted with the prescribing physicians to clarify and update order.	8/15/24

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F 759	Continued From page 63 the surveyor observed four (4) nurses administer medications to six (6) residents. There were 25 opportunities for error, and three (3) errors were observed which calculated to a medication administration error rate of 12%. This deficient practice was identified for two (2) of six (6) residents, (Resident #34 and Resident #132), that were administered medications by two (2) of four (4) nurses that were observed. The deficient practice was evidenced by the following: 1. On 6/26/24 at 8:31 AM, during the medication (med) administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN #1) preparing to administer medications (meds) to Resident #34. The surveyor observed the resident's Electronic Medication Administration Record (eMAR) which reflected an order for NJ Ex Order 26 oral capsule (NJ Ex Order 26.4(b)(1)), give one (1) capsule by mouth two (2) times a day for NJ Ex Order 26.4(b)(1) The order did not reflect a strength or dosage. The surveyor observed LPN #1 prepare one (1) tablet of NJ Ex Order 26.4(b)((NJ Ex Order 26.4(b)(1)) NJ Ex O). The surveyor asked LPN #1 how they knew that was the correct dose. LPN #1 stated that those were the only ones they use there. The Surveyor continued to observe LPN #1 administer meds to Resident #34. LPN #1 returned to the med cart to electronically sign the eMAR for the meds that were administered. The surveyor observed LPN #1 electronically sign by checking the box for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). The surveyor did not observe LPN #1 prepare or	F 759	Orders corrected to reflect correct dosage for NJ Ex Order 26.4 LPN#1 was in-serviced on medication administration highlighting areas with errors for resident #34. LPN#2 was in-serviced on medication administration highlighting areas with errors for resident #132. 2. All residents have the potential to be affected by the same deficient practice. 3. The Assistant Director of Nursing (ADON) or ADON designee provided inservice education to nursing personnel on proper medication administration. The nurse will review EMAR prior to medication administration of each assigned resident to capture any medication without strength or dosage and to inform unit manager immediately to notify MD. 4. The Director of Nursing (DON) or DON designee will monitor by auditing five resident medical records weekly during nurse medication observations for missing strength and dosages on medication. The Director of Nursing and/or designee will complete five medication pass observations per month to assure the nurse is following proper medication administration technique. Any observed non-compliance will cause corrective action by immediate re-education of the nurse. The audit and observation results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make recommendations for continued	

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F 759	Continued From page 64 administer this med to resident #34. The surveyor asked LPN #1 why they were signing for that med. LPN #1 stated that they gave the [NJ Ex Order 26.4(b)(1)] earlier, prior to the surveyor observation. The surveyor asked LPN #1 if they always sign for meds at times other than when they were administered. LPN #1 stated, no they do not. The surveyor asked LPN #1 if this was the only med that they administered earlier and signed after administering meds to another resident. LPN #1 responded, "yes." 2. On 6/26/24 at 8:56 AM, during the med administration observation, the surveyor observed LPN #2 preparing to administer meds to Resident #132. The surveyor observed LPN #2 place the resident's oral meds in a plastic dose cup on top of the med cart and prepare a container of [NJ Ex Order 26.4(b)] (NJ Ex Order 26.4(b)(1)), [NJ Ex Order 26.] (NJ Ex Order 26.4(b)(1)) and a cup of water. The surveyor then observed LPN #2 take the [NJ Ex Order 26.4(b)(1] [NJ Ex Order 26.] and water to the resident who was in the day room (a common area often used for recreation) while leaving the dose cup of other oral meds on top of the med cart unattended in the hallway. The surveyor asked LPN #2 if meds should be left on the med cart unattended. The [US FOIA] responded, "no, but I wanted the resident to finish the [NJ Ex Order 26.4(b)] first." On 6/26/24 and 10:58 AM, the U.S. FOIA (b) (6))provided the facility's Policy and Procedure for Med Administration. The surveyor reviewed the policy. The policy reflected an effective date of 11/2010 and a reviewed date of 01/2024. The policy reflected on page 1 item 6, "The individual administering meds must check the label to verify the right med, right dosage, right time and right method (route) of	F 759	monitoring after a period of no less than four (4) months.	

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administration before giving the med.". The policy reflected on page 2 item 12, "The nurse administering the med must electronically sign, date and time the resident's eMAR by selecting 'Y' (yes) after giving each med. The nurse will then select the 'Save' button to finalize the administration of given meds before moving on to the next resident.". The policy reflected on page 2 item 11, " ...No meds are kept on top of the cart.".

The surveyor reviewed the med information sheet for [redacted] capsules [redacted]). The information reflected that [redacted] capsules are available in multiple strengths, including [redacted] and [redacted]. The information also reflected that the daily dose can be from [redacted] to [redacted] per day.

On 6/27/24 at 10:10 AM, the surveyor interviewed the [redacted]) by phone and asked if they perform Med Pass observations. The [redacted] responded "yes." The [redacted] stated that she was aware of the med pass observation results and was usually aware of what was happening in the facility. The surveyor asked the [redacted] if the order for [redacted] was appropriate and if LPN #1 signed meds appropriately. The [redacted] responded that the provider pharmacy should have addressed the incorrect [redacted] order. The [redacted] offered no further information pertinent to the med pass observation.

On 6/27/24 at 12:42 PM, the surveyor, in the presence of the survey team, discussed the Med Pass Observation concerns with the [redacted] the [redacted] and the [redacted]. No further information was provided to the surveyor.

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F 759	Continued From page 66 N.J.A.C 8:39-29.2 (d)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in one (1) of five (5) medication carts inspected and two (2) of two (2) medication storage rooms inspected on three (3)	F 761	1. All items not properly labeled or stored were discarded or disposed. 2. All residents have the potential to be affected by the same deficient practice. 3. The Assistant Director of Nursing	8/15/24

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F 761	Continued From page 67 of four (4) units. This deficient practice was evidenced by the following: On 6/27/24 at 10:35 AM, the surveyor inspected the Pink Unit Medication (med) Room. The surveyor accessed the med refrigerator located in the med room. The surveyor observed an unlabeled amber plastic vial in the refrigerator. Upon inspection of the amber vial, the surveyor observed an unlabeled vial of Retacrit (a med used to increase red blood cell production) located inside. The surveyor opened an under counter drawer in the med room and observed a Novolin R Flex Pen (a self-contained device used to administer insulin, a med used to treat high blood sugar) with a pharmacy label and dispensed date of 4/06/24. At that same time, the surveyor interviewed the U.S. FOIA (b) (6)) who was present on the unit if they thought the medications (meds) were stored properly. The U.S. FOIA (b) stated that the insulin pen should have been in the refrigerator and the Retacrit should have had a label identifying who it was prescribed to. The surveyor then inspected a room labeled "Pharmacy Room" on the Pink Unit. The surveyor observed the med refrigerator which contained vaccines. The surveyor also observed a temperature log on the outside of the refrigerator that reflected documentation of the refrigerator temperature once per day. The surveyor observed a bag of medical supplies that contained individually wrapped tubes labeled BD Viral transport tubes. The wrapper reflected an expiration date of 6/08/24. The surveyor asked the U.S. FOIA (b) to check the expiration date. The	F 761	(ADON) or ADON designee provided inservice education to nursing personnel on proper storage and labeling of medication and including the appropriate accessory, cautionary instructions and expiration date when applicable. The assigned nurse will check their medication carts during their shift to ensure all medications are properly labeled and dated with expiration date if applicable. Unit managers will inspect the medication rooms and medication refrigerators on their units daily to ensure all items are stored appropriately, and labeled and temperatures are recorded. 4. The Director of Nursing (DON) or DON designee will monitor by inspecting all medication carts, refrigerator temperatures and medication rooms weekly x 3 months. Any discrepancies or non-compliance will cause immediate re-education. The inspection results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make recommendations for continued monitoring after a period of no less than four (4) months.	

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U.S. FOIA (b) agreed that the tubes were expired.

The surveyor inspected the High Side med cart on the Blue Unit. The surveyor observed one (1) foil package of Ipratropium/Albuterol nebulizer solution (an inhaled med used to treat asthma) that contained 1 vial and was not dated when it was opened. The surveyor asked the med nurse assigned to the med cart if there was a date on the opened package or box and what were there any manufacturer instructions after opening. The med nurse stated there was no date and the package reflected instructions to dispose one (1) week after opening.

On 6/27/24 at 12:42 PM the surveyor, in the presence of the survey team, discussed the Med Storage and Labeling concerns with the U.S. FOIA (b) (6), the U.S. FOIA (b) (6), and the U.S. FOIA (b) (6). The facility did not provide requested policy for Med Storage. The facility did not provide any further pertinent information regarding med storage and labeling.

A review of the facility's Medication Administration Policy that was provided by the U.S. FOIA (b) reflected on page 2 item 8, "The expiration date on the med label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container.". On page 2 item 9, "Med and Treatment carts are checked by 11-7 nurse for any discontinued or expired meds."

The surveyor reviewed the CDC (Centers for Disease Control and Prevention) guidelines for vaccine storage which reflected for "Monitoring Vaccine Temperatures, To ensure the safety of vaccines, the storage unit minimum and

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F 761	Continued From page 69 maximum temperatures should be checked and recorded at the start of each workday. If using that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday)." The surveyor reviewed the manufacturer packaging and labeling for Ipratropium/Albuterol nebulizer solution. The product packaging and labeling reflected under Storage Conditions: Once removed from the foil pouch, the individual vials should be used within one week. The surveyor reviewed the manufacturer information sheet for Novolin R Flex Pen. The manufacturer information sheet reflected under 16.2 Table 2: Storage Conditions and Expiration Dates for Novolin R. Single patient use Flex Pen, storage at room temperature either in use (opened) or not in use (unopened) is 28 days. NJAC 8:39-29.4(d)(g)	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		8/15/24

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professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 71 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: COMPLAINT: NJ#172727 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete, available, and readily accessible medical records. This deficient practice was identified for three (3) of the 31 residents reviewed (Residents #86, #134, and #196). This deficient practice was evidenced by the following: 1. On 6/24/24 at 9:15 AM, during an interview with the surveyor, regarding the process for reportable, the U.S. FOIA (b) (6) stated that when an incident occurred, he was supposed to be notified with the U.S. FOIA (b) (6)) immediately. We also notify the physician, family, state agency and the ombudsman's office for a reportable. The U.S. FOIA (b) also stated that determining the cognitive level such as the BIMS (Brief Interview for Mental Status) score, when a resident was not NJ Ex Order 2	F 842	1. The facility immediately reviewed and updated the medical records for Residents #86, #134, and #196 to ensure they are complete and readily accessible. This includes ensuring all physician and APN notes, incident reports, and investigative summaries are accurately documented and filed in the residents' medical records. 2. All residents have the potential to be affected by the same deficient practice. 3. The Administrator (LNHA) updated the facility Medical Records policy with detailed guidelines on timely documentation of responsible staff documentation, physician and APN visits, and proper documentation of incident reports/ investigations with timelines in documentation and record keeping. The Assistant Director of Nursing (ADON) and/or ADON designee conducted educational in-service training on the	

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F 842	Continued From page 72 NJ Ex Order 26.4 that needs to be investigated and depending on what was learned will depend on if it should be a reportable or not. All staff that sees an abuse, incident or accident must report to the nurse, or supervisor. Multiple parties investigate such as the U.S. FOIA (b) (6)), the Social Services, the U.S. FOIA (and U.S. FOIA (b) "we are all in the process for the investigation." Sometimes the U.S. FO and U.S. FOIA (b) (6)) will gather information and we review those. Any questions remained unanswered, we follow up and seek, we have the initial investigation and follow-up with the aid, family member etc. At that time, the U.S. FOIA (b) stated that the initial investigation consisted of resident statements, witnesses, assessments, skin checks, neuro checks, pain assessment, range of motion, review of the CCTV (closed circuit television; video surveillance) of the common areas, courtyard outside, nursing station and day room. "I don't know how far back it [CCTV] goes. At that time, the U.S. FOIA (b) stated that the Summary and conclusion were done within five days of the incident/accident/ abuse. At that time the surveyor submitted the requests for the Investigative File for Resident #196 and #86. A review of the reportable event record/report (FRE; Facility Reported Event) reflected that it was called in on NJ Ex Order 26.4 at 9:47 PM, with an event date of NJ Ex Order 26.4 at 9:15 PM. The incident was reported as an allegation of NJ Ex Order 26.4(b)(1) . The event was description included but was not	F 842	updated policy and procedure for RNs, LPNs, CNAs to assure compliance. 4. The LNHA and/or LNHA designee will conduct monthly audits of staff documentation, physician and APN visits, and proper documentation of incident report investigations with timelines in documentation and recordkeeping by randomly selecting five resident records from the list of monthly incident reports to ensure compliance with the updated policy. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make the determination for continued monitoring after a period of not less than four months.	

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limited to the following:
Resident #196 was walking down the hallway by Resident # 86, then was [redacted] Resident #196 [redacted] without [redacted] Staff in the area immediately [redacted] both residents preventing [redacted] to Resident #86, who sustained [redacted] from the incident.

Resident #196's diagnoses included [redacted]) The resident had a BIMS score of [redacted] which indicated the resident was [redacted]

Resident #86 diagnoses included [redacted]). Review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care dated [redacted], reflected BIMS score of [redacted] out of 15 which indicated the resident had [redacted]

A review of the facility's investigative folder included the following under Summary and Conclusion:
The investigation summary included review of staff statements, CCTV.
"The CCTV feedback showed Resident #86 walking towards the nurses' station speaking with an aide, then Resident #86 began to walk away from the nurses' station at around 9:15 PM, Resident #196 was walking in the same direction. Resident #86 did not address Resident #196, nor was anything spoken in between both residents. Resident #196 [redacted] Resident #86 and [redacted] at [redacted]

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NJ Ex Order 26.4(b). Resident #196 provided no NJ Ex Order 26.4 to staff or residents about NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) The staff that were actively monitoring the hallway, acted immediately to ensure NJ Ex Order 26.4(b)(1) of resident and no NJ Ex Order 26.4(b)(was witnessed by either resident. Resident #86 did not NJ Ex O nor did he NJ Ex Order 26.4(b)(1) from this accident; signed by the U.S. FOIA (b)

A review of the nursing progress notes (PN) for Resident #196 included the following:

Incident #1
On NJ Ex Order 26. at 18:27 [6:27 PM], the nurse documented that Resident #186 had a NJ Ex Order 2 with another patient. Resident #186 became NJ Ex Order 26.4 after being told that he/she had to wait until 7:30 PM which was the next scheduled of the NJ Ex Order 26.4(b)(1). The resident went to the hallway and NJ Ex Order 26.4(b)(1) and then went to his/her room and NJ Ex Order 26.4(b)(1)

Incident #2
On NJ Ex Order 26. at 21:10 [9:10 PM], the nurse documented that Resident #196 asked the aid for a NJ Ex Order 26.4(b)(1). The aid stated that she would in a few minutes when she completed her tasks. Resident #196 did not want to wait, and NJ Ex Order 26.4(b)(, and NJ Ex Order 26.4(b)(1) that had food and drinks on it and NJ Ex Order 26.4(b)(1) in the day room.

Incident #3 (associated with the FRE)
On NJ Ex Order 26. at 21:41 [9:41] the nurse documented that after the resident NJ Ex Order 26.4(b)(1) the nursing supervisors were called in to the unit. In front of both supervisors and this nurse, the patient NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b) the nurses station NJ Exec Order 26.4b) and

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NJ Ex Order 26.4(b)(1) .
The US FOIA (b)(6) was made aware of the situation and ordered to have the resident sent out for NJ Ex Order 26.4(b)(1) evaluation. NJ Ex O was called and NJ Ex Orde arrived but refused to NJ Ex Order 26.4(b) the resident because the resident NJ Ex Order 26.4(b)(1) in the NJ Ex Order 26.4(b)(1) and they felt it would be a NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) was contacted and at this time we are waiting for another NJ Ex Order 26.4(b)(1) to arrive. Patient NJ Ex Order 26.4 to have NJ Ex vital signs taken at this time."

The surveyor reviewed the facility provided investigative folder, the hybrid (combination of paper and electronic) medical records and staff statements. The medical records did not show evidence that the resident was NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) or monitored for NJ Ex Order 2.

On 6/25/24 at 12:18 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) stated that the nurse on duty for incident #1 was a good nurse.

At that time, the surveyor and the U.S. FOIA (b) (6 reviewed Resident #186's electronic Medical Record together. The U.S. FOIA (b) (6 confirmed that the record did not show how the NJ Ex Order 2 on NJ Ex Order 26.4 at 9:15 PM was prevented when there were two incidents on the same day that began at 6:27 PM followed by 9:41 PM.

At that time the surveyor discussed the concern and the U.S. FOIA (b) (6 stated that he would investigate the matter and inform his supervisors.

On 6/26/24 at 9:43 PM, during a meeting with the U.S. FOIA (b U.S. FOIA (b) (6, the U.S. FOIA (b provided three new signed statements that addressed what was done

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in between incidents.

At that time, the U.S. FOIA (b) and the U.S. FOIA (b) (6) acknowledged that the statements were collected yesterday (6/25/24) and was not part of the original investigative summary folder.

At that time, the surveyor asked the U.S. FOIA (b) (6) how long should the statements be gathered, for the root cause analysis that was required to arrive at the result of the NJ Ex Order 26.4(b)(1) investigation.

At that time, the U.S. FOIA (b) stated "no excuse" why it was not immediately done.

On 6/26/24 at 12:03 PM, in the presence of the surveyors, the U.S. FO and the U.S. FOIA (b) confirmed the statements were obtained yesterday (6/25/24) only to show that there was a NJ Ex Order 26.4(b)(1) of what the nurses described as NJ Ex Order 26.4(b)(1).

A review of the provided policy and procedure for the Abuse Prevention Program, dated/revised on 02/08/23, under Part VII Investigation, subsection Procedure included the following: The results of the investigation are reported within five days of the incident.

Reference
§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken

2. On 6/24/24 at 11:39 AM, the surveyor observed

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Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch.

The surveyor reviewed the hybrid medical record for Resident #134.

Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted].

The most recent Significant Change Minimum Data Set (SCMDS) dated [redacted], reflected a BIMS score of [redacted] out of 15, which indicated the resident had [redacted].

A review of the hybrid medical records reflected there was no documented evidence that the physician visited and examined Resident #134 at least every 60 days from [redacted] through [redacted].

The [redacted] had a printed documented History and [redacted] dated [redacted] and a Progress Note (PN) dated [redacted] that was in the paper chart of the resident.

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Further review of the resident's hybrid medical records showed that there were no other PN from the physician and the [U.S. FOIA] except for the [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4] of the [U.S. FOIA (b)].

On 6/26/24 at 12:03 PM, the surveyor interviewed the U.S. FOIA (b) (6)) of the Peach unit (Behavioral unit). The surveyor asked the [U.S. FOIA] what was the facility's protocol regarding the physician visit notes, and the [U.S. FO] responded that he would get back to the surveyor.

On that same date and time, the surveyor notified and showed to the [U.S. FOIA] that the resident's visits noted for dates [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4] were both done by the [U.S. FOIA (b)] and there were no further notes found in the resident's hybrid medical records.

At that same time, the surveyor asked the [U.S. FOIA] if physician and [U.S. FOIA] notes should be available and easily accessible as part of the resident's medical records, and the [U.S. FOIA] responded "yes."

On 6/27/24 at 12:41 PM, the survey team met with the [U.S. FOIA (b)] U.S. FOIA (b) (6)), and [U.S. FOIA (b)] The surveyor notified the facility management of the above findings and concerns.

On 6/28/24 at 8:59 AM, the surveyor reviewed the paper chart of Resident #134 in the [NJ Ex Order 2] unit nursing station. There were a total of 12 PN (not previously seen in the chart) and revealed the following:

Service Date	Created and Electronically signed	Provider
[NJ Ex Order 26.4] [NJ Ex Order 26.4]	[NJ Ex Order 26.4] [NJ Ex Order 26.4] at 01:20 PM at 04:31 PM	[U.S. FOIA] [U.S. FOIA]

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F 842	Continued From page 79 NJ Ex Order 26.4 at 01:29 PM NJ Ex Order 26.4 at 07:29 AM NJ Ex Order 26.4 at 05:34 AM NJ Ex Order 26.4 at 07:27 AM NJ Ex Order 26.4 at 05:40 AM NJ Ex Order 26.4 at 05:39 AM NJ Ex Order 26.4 at 05:32 AM NJ Ex Order 26.4 at 05:34 AM NJ Ex Order 26.4 at 01:53 PM NJ Ex Order 26.4 at 01:39 AM On 6/28/24 at 11:29 AM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) The U.S. FOIA stated and acknowledged that the above PN was not on the "physical chart" of the resident not until the surveyor's inquiry. She further stated that the facility management spoke to the U.S. FOIA about the visit notes and that was why all PNs were in the chart now. The facility management acknowledged that the visit notes of the U.S. FOIA should have been completed on time and readily accessible to the resident's medical records. On 7/01/24 at 11:58 AM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (b) for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings. NJAC 8:39-35.2 (d)(6)	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		8/15/24

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions 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.

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F 880	Continued From page 81 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices to prevent and control the spread of infection: a) improper storage of a NJ Ex Order 26.4(b)(1) for one (1) of two (2) residents (Resident #103), reviewed for NJ Ex Order 26 care, b) performing hand hygiene during a NJ Ex Order 26 treatment observation by one (1) of one (1) nurse (U.S. FOIA (b) (6)), and c) doffing (taking off) of Personal Protective Equipment (PPE) when exiting an NJ Ex Order 26.4(b)(1) room during a NJ Ex Order 26 treatment by one (1) of one (1) nurse.	F 880	1. The floor nurse immediately stored Resident #103s NJ Ex Order 26.4(b)(1) below the NJ Ex Order 26.4(b)(1) in a NJ Ex Order 26.4(b)(1) The US FOIA (b)(6) was immediately inserviced on proper policies and procedures for hand hygiene and donning/doffing PPE. 2. All residents have the potential to be affected by the same deficient practices. 3. The facility Infection Preventionist Nurse and ADON of Education conducted comprehensive training sessions for all relevant staff on infection control policies and procedures focusing on the proper storage of urinary drainage bags, correct	

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F 880	Continued From page 82 This deficient practice was evidence by the following: 1. On 6/24/24 at 10:49 AM, the surveyor observed Resident #103 with their face only visible from behind the privacy curtain drawn. Resident #103 greeted the surveyor and for the surveyor to approach their bedside. Resident #103 was observed lying in bed, [redacted] and [redacted]. The surveyor observed the resident's [redacted] was open, their [redacted] were [redacted], and the resident had a [redacted]. The resident's [redacted] was connected to a [redacted], which was resting on top of the resident's mattress at the foot of their bed. The [redacted] was not [redacted] and [redacted] was [redacted] from the [redacted] into the [redacted]. Resident #103 stated staff was helping them, were to return and could not say how much time had passed. The resident was [redacted] for the surveyor to follow up with nursing staff. The surveyor did not observe any staff or cart near the resident's room. On 6/24/24 at 10:50 AM, the surveyor approached the [redacted]) who was seated at the nurses' station. The [redacted] accompanied the surveyor to Resident #103's room. Resident #103's [redacted] remained open, and their [redacted] on the foot of the resident's mattress. The [redacted] stated that [redacted]) provided [redacted] care to the resident and was to let [redacted] know when [redacted] was done, to provide [redacted] treatment to the resident's [redacted]. The [redacted] stated [redacted] would do the resident's [redacted] and	F 880	hand hygiene techniques and proper procedures for donning and doffing PPE. 4. The Director of Nursing (DON) or DON designee will monitor by conducting weekly audits of infection control practices to assure staff compliance with proper hand hygiene, PPE usage, and urinary catheter care during resident care treatments to assure compliance with facility policy. The audits will be recorded and reported monthly to the Quality Assurance and Performance Improvement committee who will provide recommendations for continued monitoring for a period no less than three months.	

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assist resident.

On 6/24/24 at 10:58 AM, the surveyor interviewed the U.S. FOIA who was assigned to Resident #103. The U.S. FOIA had been in another room assisting a resident. The surveyor discussed with the U.S. FOIA the observation of Resident #103 in bed. The U.S. FOIA stated NJ Ex O pulled the privacy curtain prior to exiting room and stated that NJ Ex O informed the U.S. FOIA that the resident was ready for their NJ Ex Order 26 to be changed. The U.S. FOIA stated she did not realize NJ Ex O left the resident's NJ Ex Order 26.4(b)(1) on the foot of the mattress and acknowledged it should not have been left there. The U.S. FOIA stated the NJ Ex Order 26.4(b)(1) should be in a NJ Ex Order 26.4(b)(1) hanging on the side of the resident's bedframe.

On 6/24/24 at 11:15 AM, the surveyor interviewed the NJ Ex Ord about the observation of the resident's NJ Ex Order 26.4(b)(1). The NJ Ex Ord stated the resident's NJ Ex Order 26.4(b)(1) was supposed to be hanging by gravity NJ Ex Order the resident's NJ Ex Order 26.4(b)(1). The NJ Ex Ord further explained that the NJ Ex Order 26.4(b)(1) was placed on the mattress at the foot of the bed because the resident was going to be NJ Ex Order 26.4(b)(1) of the bed with a NJ Ex Order 26.4(b)(1)). She acknowledged that the NJ Ex Order 26.4(b)(1) should not have been placed on the mattress and it should have been moved at the time of the resident being NJ Ex Order 26.4(b)(1) of bed.

On 6/24/24 at 11:20 AM, the surveyor interviewed the U.S. FOIA (b) (6)) about the observation of Resident #103's NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated the NJ Ex Order 26 should be hanging by gravity. She further explained that while a

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resident was in bed, the NJ Ex Order 26.4(b)(1) should be hanging by gravity from the bed frame positioned NJ Ex Order 26.4(b)(1) the resident's NJ Ex Order 26.4(b)(1) as to allow the NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated the NJ Ex Order 26.4(b)(1) should not have been on the foot of the resident's mattress even if the resident was NJ Ex Order 26.4(b)(1) of bed.

On 6/27/24 at 12:41 PM, the surveyor informed the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) of the above concerns. There was no verbal response from the facility at this time.

On 6/28/24 at 11:30 AM, the U.S. FOIA (b) (the U.S. FOIA (b and the U.S. FOIA (b) met with the survey team. The U.S. FOIA (b) acknowledged the NJ Ex Order 26.4(b)(1) should not have been on the resident's mattress and provided staff with in-service education for NJ Ex Order 26.4(b)(1).

The surveyor reviewed the facility policy titled, "Catheter Care, Urinary" with a reviewed date of 01/2024. Under catheter care it read, " ...3. The urinary drainage bag must always be positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder ..."

2. On 6/27/24 at 10:15 AM, the surveyor observed the U.S. FOIA perform a NJ Ex Order 26.4(b)(1) treatment for Resident #103. The U.S. FOIA informed the surveyor that Resident #103 was on NJ Ex Orde which required providers and staff to don (put on) gown and gloves when performing NJ Ex Order 26.4(b)(1) t resident care activities, such as NJ Ex Order 26.4(b)(1). The surveyor observed signage at door which indicated the resident was on NJ Ex Order 26.4(b)(1). The U.S. FOIA and U.S. FOIA (who was to assist the U.S. FOIA

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with the NJ Ex Order 26.4(b)(1) of the resident during the NJ Ex Order 26 treatment, donned gown, and gloves prior to entering the resident's room.

The U.S. FOIA took germicidal disposable wipes and cleaned the bedside table by the resident's bed. The U.S. FOIA disposed the used wipe in the garbage bin, removed her gloves, and disposed it in the garbage bin. The U.S. FOIA went to the bathroom sink to wash her hands. She turned on the faucet, applied soap to her hands first, then wet her hands with the running water, lathered her hands for 22 seconds, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet.

On 6/27/24 at 10:27 AM, after the U.S. FOIA set up a field with the NJ Ex Order 26 treatment supplies on the resident's bedside table, the surveyor observed the U.S. FOIA wash her hands at the sink. She turned on the faucet, applied soap to her hands first, then wet her hands with water from the sink, lathered her hands for 21 seconds, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet.

The U.S. FOIA applied new gloves, removed the NJ Ex Order 26 covering the resident's NJ Ex Order 26.4(b)(1) and removed the NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1). She disposed of the NJ Ex Order 26.4(b)(1) in the plastic garbage bag attached to the bedside table. She did not remove her gloves, opened two NJ Ex Order 26 removing the tops and placed the NJ Ex Or back on the supply field of the bedside table. The U.S. FOIA removed her gloves, did not wash her hands, and applied new gloves. She then picked up the two NJ Ex Order 26.4(b)(1), applied the

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[redacted] to [redacted], and [redacted].

On 6/27/24 at 10:31 AM, the [redacted] removed her gloves, did not wash her hands, opened the door of the room, and retrieved gloves from the top of the treatment cart outside doorway of the room. She returned to the room, placed the gloves on the supply field on the bedside table and then closed the room door.

The [redacted] washed her hands at the sink. She turned on the faucet, applied soap to her hands first, then wet her hands with water from the sink, lathered her hands for 24 seconds, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet.

The [redacted] applied new gloves, then applied the [redacted] and [redacted] to the [redacted]. The [redacted] with gloves retrieved a marker, wrote the date and time on the [redacted] on the bedside table. She lifted her PPE gown with one hand and with the other hand placed the marker into her jacket pocket. She removed her gloves, did not wash her hands, and applied new gloves.

On 6/27/24 at 10:37 AM, the [redacted] cleaned the supply field and disposed items in the plastic garbage bag. She tied off plastic garbage bag, removed gloves, and stated to the surveyor "I'm going to throw this out in the soiled utility room". The surveyor observed the [redacted] wearing a PPE gown and holding the plastic garbage bag walk out of the room and down the hallway of the unit.

On 6/27/24 at 10:39 AM, the surveyor observed from the doorway of the resident's room, the [redacted]

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walking back toward the room with the PPE gown balled up in her right hand. She stated to the surveyor "I'm not supposed to walk in the hallway with this [showing PPE gown in hand]" and explained that there was a red bin in the room to throw the gown away before exiting room. She threw the gown away in the red bin of the room.

On 6/27/24 at 10:50 AM, the surveyor interviewed the U.S. FOIA after the NJ Ex Order 2 treatment about hand hygiene. She stated the steps for hand hygiene were to open the faucet, apply soap to hands, then wet hands, scrub hands, dry hands with paper towel, and then when hand are dried use another paper towel to turn off the faucet. The U.S. FOIA replied to surveyor when asked about the sequence of applying soap prior to wetting hands, that it was the appropriate sequence and to not get the soap dispenser wet with water.

The surveyor asked the U.S. FOIA about hand hygiene when changing gloves. The U.S. FOIA stated when changing or removing gloves hand hygiene should be performed. The surveyor discussed observations during the NJ Ex Order 26.4(b)(1) when hand hygiene was not performed. NJ Ex Or replied she was trying to save time and get the NJ Ex Order 2 done.

The surveyor discussed observation of wearing PPE gown in the hallway. The U.S. FOIA stated she should not have been in the hallway wearing the used PPE gown and it should have been thrown out in the red bin of the room prior to exiting room.

On 6/27/24 at 11:03 AM, the surveyor interviewed the U.S. FOIA (b) (6) about the NJ Ex Order 26.4(b)(1) observation. The U.S. FOIA (b) (6) demonstrated hand

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hygiene and stated hands should be wet first prior to applying soap. U.S. FOIA (b) (6) stated that when changing gloves hand hygiene should be performed and PPE gowns should not be worn in the hallway.

On 6/27/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b) (6) about the NJ Ex Order 26 observation. The U.S. stated the steps of hand hygiene were to turn on the water faucet, wet hands, apply soap, scrub hands at least 20-30 seconds, rinse, dry hands with paper towel, and use another paper towel to turn off faucet. U.S. stated when changing gloves hand hygiene was to be performed. U.S. stated applying soap then wetting hands was not the appropriate sequence and hand hygiene should have been performed when the nurse changed her gloves. The U.S. continued that PPE should be disposed of prior to exiting the room and not worn in the hallway. The U.S. stated she would provide in-service education to the U.S. FOIA

On 6/27/24 at 12:41 PM, the surveyor informed the U.S. FOIA (b) (the U.S. FOIA (and the U.S. FOIA (b) (of the above concerns observed during the NJ Ex Order 26.4(b)(1). There was no verbal response by the facility at this time.

On 6/28/24 at 11:30 AM, the U.S. FOIA (b) (the U.S. FOIA (and the U.S. FOIA (b) met with the survey team. The U.S. FOIA (b) stated NJ Ex Order 26.4(b)(1) and hand hygiene competency was completed with the U.S. FOI and in-service education was being provided to all nursing staff. There was no additional information provided by the facility.

A review of the facility's policy titled "Handwashing/Hand Hygiene" with a reviewed

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F 880	Continued From page 89 date of 6/28/2024, under "Guidelines: Hand hygiene will be performed by staff as follows" it read: " ...On entering and leaving an isolation room ...Before and after contact with wounds ...Before gloving and after gloves are removed ..." Under Hand Washing Procedure it read, "Turn on water and adjust temperature ...wet hands and wrist thoroughly ...apply soap to hands ...Rub hands briskly, pay attention to areas between the fingers, for at least 20 seconds ..." A review of the facility's policy titled "Infection Control- Standard Precautions, EBP and Transmissions Based Precautions" with last reviewed/revised date of 3/22/24, documented that CDC (Centers for Disease Control and Prevention) guidelines were the primary resource for determining the type of precaution and duration of isolation. The policy did not further address doffing of PPE when exiting EBP rooms. N.J.A.C. 8:39-19.4	F 880		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882		8/15/24

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F 882	Continued From page 90 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to ensure have an [redacted]) dedicated solely to the infection prevention and control program (IPCP) who worked at least part-time and had completed specialized training in infection control and prevention for one (1) of two (2) staff. According to the NJ Executive Directive 21-012 (revised 12/22/22) included "The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022 Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time [redacted] While the requirement is to have at least a part-time [redacted] the [redacted] must meet the needs of the facility. The [redacted] must physically work onsite and cannot be an off-site consultant or work at a separate location. [redacted]'s role is critical to mitigating infectious diseases through an effective infection	F 882	1. The facility confirmed and documented the current [redacted], hired on [redacted], is dedicated solely to the infection prevention and control program (IPCP) on a full-time basis. 2. All residents have the potential to be affected by the same deficient practice. 3. The facility developed and implemented a policy for maintaining oversight during any future employment vacancies of the Infection Control Program Coordinator (ICPC) position. The facility identified currently employed alternate nurses who have completed infection prevention and control training who can be temporarily reassigned to the IP role on a full-time basis in case of a gap in coverage. 4. The Director of Nursing will assure the ICPC role is filled on a full time basis and will be responsible for reassigning nurses when/if a gap in the full time ICPC coverage arises. The Director of Nursing (DON) or DON designee will report the completion of the corrective action to the Quality Assurance and Performance Improvement (QAPI) committee who will	

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F 882	Continued From page 91 prevention and control program. [redacted] specialized training is required and available. On 6/24/24 at 10:04 AM, during entrance conference, the U.S. FOIA (b) (6) [redacted] informed the [redacted] the current [redacted] was full-time and started working in the facility at the [redacted] The [redacted] requested the [redacted] for the [redacted] timeline since the last recertification survey. On 6/28/24 at 10:05 AM, the surveyor interviewed the [redacted] about the [redacted] timeline. The [redacted] stated he started working in the facility in [redacted] and at the time there was no [redacted] The [redacted] stated there were ongoing attempts to recruit and hire without success. The [redacted] acknowledged they did not have an [redacted] in the facility from [redacted] until the current [redacted] started working in [redacted]. The surveyor asked the [redacted] who was responsible for overseeing the IPCP in the facility during the time there was no [redacted] The [redacted] replied that the U.S. FOIA (b) (6)) was responsible for the IPCP and that he assisted with the reporting of data to outside agencies such as the New Jersey Department of Health. A review of the timeline provided by the [redacted] revealed the previous [redacted] last day of employment at the facility was [redacted]. The current [redacted] began working on [redacted] at the facility. On 6/28/24 at 11:30 AM, the surveyor informed the [redacted] and U.S. FOIA (b) (6) [redacted] of the concern that there was no [redacted] working at the facility from [redacted] until when the current [redacted] was hired in [redacted]. Additionally, the full-time [redacted] was responsible for the [redacted] role which was to be at least a part-time	F 882	monitor for any identified gaps in the ICPC position and provide recommendations for continued monitoring for a period not less than three months.	

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position.

On 7/01/24 at 9:46 AM, the U.S. FOIA (b) interviewed the U.S. FOIA (b) regarding the facility's Quality Assurance and Performance Improvement (QAPI) plan. The U.S. FOIA (b) asked about two (2) of three (3) QAPI meeting quarters there was no IP present. The U.S. FOIA (b) stated there was no on-site U.S. FOIA (b) at the time. The U.S. FOIA (b) asked how infection reports were being communicated for QAPI meetings. The U.S. FOIA (b) replied that statistics data for NJ Ex Order 26.4(b)(1) were reviewed and he could not further explain what other infection control reports were reviewed.

On 7/01/24 at 11:09 AM, the U.S. FOIA (b) U.S. FOIA (b) and U.S. FOIA (b) met with the survey team. There was no additional information provided by the facility.

The surveyor reviewed the facility's policy titled "Infection Prevention and Control Program" with an effective date of 9/12/2017. Under Policy it read, " ...7. The Infection Prevention and Control Program shall be conducted in accordance with all applicable federal and state rules and regulations, accrediting body standards, as well as nationally recognized infection prevention and control practices and guidelines ...9. There shall be a collaboration between the Infection Preventionist and all departments to identify any HAI (Hospital Acquired Infection) trends or patterns that may occur, as well as identification of opportunities to improve outcomes in the reduction and control of infections ..."

The surveyor reviewed the facility's policy titled "Surveillance Plan" with an effective date of 9/15/2017 read under Procedure, "1. The Infection Preventionist(s) shall have overall responsibility for the Surveillance Plan..."

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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 882	Continued From page 93 The qualifications and job responsibilities of the Infection Preventionist were outlined in the Infection Preventionist Job Description. The position summary read "The Infection Disease Preventionist is an RN (Registered Nurse), with a BSN (Bachelor of Science in Nursing) preferred, that performs all nursing functions related to Infectious Disease prevention. These include but are not limited to surveillance, data collection, assessment, teaching, and policy development." NJAC 8:39-19.1(b)	F 882		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		8/15/24

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F 883	Continued From page 94 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that a.) each resident was offered NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1), b.) education was provided regarding the benefits and potential side effects of the NJ Ex Order 26.4(b)(1) c.) resident or	F 883	1. The facility provided education to Resident #134 and, verified the NJ Ex Order 26.4(b)(1) status of Resident #134 with the resident's representative for NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). 2. All residents have the potential to be	

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Continued From page 95

representative has the opportunity to refuse [redacted] unless the [redacted] was medically contraindicated or the resident had been [redacted] This deficient practice was identified for one (1) of five (5) residents, Resident #134, reviewed for unnecessary medications.

This deficient practice was evidenced by the following:

On 6/24/24 at 11:39 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room (also known as the dining area) with other five residents for early lunch.

The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #134.

Resident #134's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted]), [redacted] ([redacted]) [redacted], [redacted] ([redacted]) [redacted], [redacted] ([redacted], [redacted] ([redacted]) and [redacted] ([redacted]) [redacted], [redacted] ([redacted]), [redacted] ([redacted]) [redacted], [redacted], and [redacted].

The most recent Significant Change Minimum

F 883

affected by the same deficient practice.

3. The Infection Prevention Nursing (IPN) or IPN designee conducted mandatory in-service training for all nursing staff on the revised immunization policies, emphasizing the importance of documenting offers, education, consents, and refusals of immunizations.

4. The Infection Prevention Nurse (IPN) or IPN designee will monitor the immunization status of 10% of the resident population weekly for three months. This will ensure that offers, education, consents, and refusals of immunizations are properly documented. Immunization compliance will be a standing agenda item in the monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing monitoring and continuous improvement. The results of the audits will be recorded and reported monthly to the QAPI committee, which will review the findings, identify any trends or areas for improvement, and make recommendations for continued monitoring after a period of not less than three months.

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Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated [NJ Ex Order 26.4(b)] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had [NJ Ex Order 26.4(b)(1)] [redacted]. The SCMDS revealed that the resident did not receive the [NJ Ex Order 26.4(b)] and NJ Ex Order 26.4(b)(1) because it was offered and declined.

A review of the Immunization tab in the electronic medical record (EMR) showed that there was no documentation about the [NJ Ex Order 26.4(b)] and NJ Ex Order 26.4(b)(1). There was no documented evidence that the [NJ Ex Order 26.4(b)(1)] were offered and declined.

The Miscellaneous tab in the EMR revealed a hospital records with a printed date of [NJ Ex Order 26.4(b)] that showed:
NJ Ex Order 26.4(b)(1) this season?-refused
NJ Ex Order 26.4(b)(1) ever?-unsure

A review of the personalized care plan (CP) showed that there was no focus CP, goals, or interventions about the [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)] status of the resident.

Further review of the hybrid medical records showed that there was no documentation from the facility that the [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)] [redacted] were offered and declined. There was no documentation that the education was provided to the representative about the benefits and potential side effects of the [NJ Ex Order 26.4(b)(] Also, there was no documentation that the representative was provided an opportunity to refuse the [NJ Ex Order 26.4(b)] and no documentation that the [NJ Ex Order 26.4(b)] were contraindicated and previously

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received.

On 6/26/24 at 10:46 AM, the surveyor interviewed the U.S. FOIA (b) (6) of the Peach unit (Behavioral unit). The surveyor asked the U.S. FOIA regarding the NJ Ex Order 26.4(b)(1) and where it was documented that the resident received or declined NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that it should be documented in the EMR in the NJ Ex Order 26.4(b)(1) tab.

At that same time, the surveyor showed the U.S. FOIA the NJ Ex Order 26.4(b)(1) tab of the resident wherein there were no NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) documented except for NJ Ex Order 26.4(b)(1)) test results and NJ Ex Order 26.4(b)(1). The U.S. FOIA then stated that he would get back to the surveyor and he would ask the U.S. FOIA (b) (6)

On 6/26/24 at 12:03 PM, the U.S. FOIA informed the surveyor in the presence of the survey team that the resident's representative (RR) told him (U.S. FOIA (b that the resident was "probably" NJ Ex Order 26.4(b)(1) at the previous facility. The U.S. FOIA stated that he called the RR today to verify the resident's NJ Ex Order 26.4(b)(1) status.

On that same date and time, the surveyor then asked the U.S. FOIA what was the facility's protocol and policy with regard to offering NJ Ex Order 26.4(b to the resident. The U.S. FOIA stated that it was the facility's policy and protocol to offer NJ Ex Order 26.4(b including NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) to all residents upon admission, and quarterly. The U.S. FOIA was not able to provide and show documentation that the NJ Ex Order 26.4(b were offered from admission and the most recent quarterly MDS.

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At that same time, the [NJ Ex Orde] further stated that he was still waiting for RN/Unit Manager #1 (RN/UM#1) from the [NJ Exec O] unit if the [NJ Ex Order 26.4(b] were offered prior to transferring the resident to the [NJ Exec Order] unit.

On 6/27/24 at 8:14 AM, the surveyor interviewed the [U.S. FO] in the [NJ Exec Orde] unit. The [U.S. FO] informed the surveyor that [NJ Ex O] started working in the facility end of [NJ Ex Order 26.4(b)(1)] and there was no [U.S.] at that time she started as an [U.S. FOA] and unsure when the last [U.S.] worked in the facility. The [U.S. FO] stated that [NJ Ex O] was responsible for tracking the [NJ Ex Order 26.4(b)(1)] records of staff and residents. She further stated that she gathered information from the records of the resident. The [U.S. FO] also stated that when the resident comes in for admission, the [U.S. FOIA (b) (6)] will page or notify the [U.S. FO] of the admission Monday through Friday "when I'm here," the [U.S. FO] check the records for [NJ Ex Order 26.4(b)(1)] of new admit and document it in the [NJ Ex Order 26.4(b)(1)] tab of EMR.

On that same date and time, the [U.S. FO] informed the surveyor that as per facility policy and protocol, [NJ Ex Order 26.4(b)(1)] was being offered during [NJ Ex Order 26.4(b)(1)]. The [U.S. FO] acknowledged that [NJ Ex] was from [NJ Exec Order 26] through [NJ Exec Order 2] She further stated that the facility offers [NJ Ex Order 26.4(b)(1)] if the resident has not received the [NJ Ex Order 26.4(b)] The [U.S. FO] also stated that the consent should be gathered from the resident or RR, and documented in the [NJ Ex Order 26.4(b)(1)] tab and IDT (Interdisciplinary) notes in the EMR.

At that time, the surveyor asked the [U.S. FO] if there was a form the facility used to offer, consent, and decline the [NJ Ex Order 26.4(b)(] and the [U.S. FO] responded that there was no form. The surveyor then notified the

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U.S. FO of the above findings and concerns. The U.S. FO stated that the information regarding the resident's NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) should have been documented and it should have been offered.

Furthermore, the surveyor asked the U.S. FO if NJ Ex O was responsible for tracking NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) records. The U.S. FO said "yes," but the NJ Ex Order 26.4(b)(1) tracking was for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(and there were none for NJ Ex Order 26.4(b)(1) The surveyor asked the U.S. FO why the NJ Exec Order 26.4b1 was not being tracked, and the U.S. FO did not respond. The surveyor then asked for the tracking log for the NJ Ex Order 26.4(b)(1) of the residents in the facility and she stated that she would get back to the surveyor.

On 6/27/24 at 8:25 AM, the surveyor observed Resident #134 seated in a wheelchair in the Therapy room with other residents, and RN/UM#2. RN/UM#2 was the U.S. FO in the NJ Ex Order 2 Unit.

At that time, the surveyor interviewed RN/UM#2 when she left the NJ Exec Order 26.4 room when another nurse stepped in to watch the room. RN/UM#2 informed the surveyor that it was the responsibility of the admitting nurse to check, verify, and document in the NJ Ex Order 26.4(b)(1) tab in the EMR the NJ Ex Order 26.4(b)(1) of the resident including NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) She stated that the admitting nurse would check the hospital records for NJ Ex Order 26.4(b)(1) if there was none in the record, the nurse would have to ask the resident or RR for the history of NJ Ex Order 26.4(b)(1) She further stated that if the resident or RR did not have or was unsure, the facility's responsibility was to offer the NJ Ex Order 26.4(b and document the

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information and the refusal in the NJ Ex Order 26.4(b)(1) tab and IDT notes in the EMR. The surveyor asked if there was a consent form for the NJ Ex Order 26.4(b)(1) and RN/UM#2 stated "yes, there's a form on paper." The surveyor then asked RN/UM#2 to provide a copy of the consent form and she stated that she would get back to the surveyor.

At that same time, the surveyor notified RN/UM#2 of the above findings and concerns. RN/UM#2 stated that she was unaware that the RR was called by U.S. FOIA "yesterday," to verify the NJ Ex Order 26.4(b)(1) status of the resident. She further stated that she thought this was done before and was documented in the IDT notes, she also stated that she would verify it with the U.S. FOIA (b

On 6/27/24 at 8:32 AM, RN/UM#2 informed the surveyor that there was no consent form for the refusal of NJ Ex Order 26.4(b)(1)

On 6/27/24 at 9:01 AM, the U.S. FO in the presence of the survey team informed and showed to the surveyor the copy of NJ Exec Order 26.4b1 log dated NJ Ex Order 26.4, and U.S. FO stated the NJ Exec O forms was where the NJ Ex Order 26.4(b)(1) status of their residents was being tracked. The U.S. FO showed that NJ Ex Order 26.4(b) and NJ Ex Order 26. were being tracked but not the NJ Ex Order 26.4(b)(1).

At that same time, the surveyor asked the U.S. FO if she should track the NJ Ex Order 26.4(b)(1) status of their residents, and the U.S. FO responded that she should track them as well. She further stated that if she needed the list of residents with their NJ Ex Order 26.4(b)(1) she could just print it from EMR. The surveyor then asked how she

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would know who needed to offer and who was due for NJ Ex Order 26.4(b)(1), the U.S. FO did not respond. The U.S. FO also stated that she would get back to the surveyor to provide a copy of the IDT notes that the NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) were offered and declined for Resident #134.

A review of the provided NJ Exec log revealed that Resident #134 was on the list, but the NJ Ex Order 26.4(b) log was blank (no information if it was offered and declined).

On 6/27/24 at 12:25 PM, the U.S. FOIA (b) (6) in the presence of the U.S. FOIA provided a copy of the hospital records when the resident was admitted to the facility that included the following the NJ Ex Order 26.4(b)(1) for the season was refused and the NJ Ex Order 26.4(b)(1) was unsure. The surveyor then asked the facility management if that was from the hospital, should the facility offer the NJ Ex Order 26.4(b)(1) because it was NJ Ex Order 26.4(b)(1) when the resident was admitted to the facility, and also offer the NJ Ex Order 26.4(b)(1) since the hospital records showed it was unsure if the resident received the NJ Ex Order 26.4(

At that same time, the U.S. FOIA stated that the facility was waiting for the RR to respond regarding the NJ Ex Order 26.4(b)(1) status of the resident at this time. The surveyor then asked, if should there be documentation that NJ Ex Order 26.4(b were offered and declined on admission. The U.S. FOIA stated that he was aware that there was no documentation that the NJ Ex Order 26.4(b were offered in the medical records which was why the facility was trying to get the email correspondences from the RR.

On 6/27/24 at 12:41 PM, the survey team met

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with the U.S. FOIA (b) (6) , U.S. FOIA (b) (6)), and U.S. FOIA (b) (6)). The surveyor notified the facility management of the above findings and concerns.

A review of the facility's NJ Ex Order 26.4(b)(1) Policy and Procedure with a reviewed/revised date of 01/2024 that was provided by the U.S. FOIA (b) included that NJ Ex Order 26.4(b)(1) is the primary method for preventing NJ Ex Order 26.4(b) and its severe complications. Therefore, NJ Ex Order 26.4(b)(1) against NJ Ex Order 26.4(b) will be offered to residents of this facility.
Procedure:
-All persons, upon admission to long-term care programs, shall be assessed for recent and past flu vaccinations.
-The influenza vaccine shall be offered to all residents annually during flu season. Education shall be provided regarding the risks vs benefits of the vaccine. The resident or resident's representative may refuse immunization.
-Those residents who are admitted during the winter months after completion of the program's vaccination program, will be offered the vaccine at the time of their admission.
-The facility shall document the provision or did not receive the vaccine due to medical contraindications, previous vaccination, or refusal of the flu vaccine for each resident.

A review of the facility's Pneumococcal Vaccination Policy and Procedure with a reviewed date of 01/2024 that was provided by the U.S. FOIA (b) included that in order to prevent the spread of infectious diseases and decrease the morbidity and mortality associated with pneumococcal pneumonia, the facility will offer pneumococcal

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F 883	Continued From page 103 vaccinations to residents as per the following procedures. Administration of pneumococcal vaccines will be made in accordance with current CDC (Centers for Disease Control and Prevention) recommendations. CDC recommends pneumococcal vaccination for 65 years old and older, adults 19 through 64 years old with certain underlying medical conditions or other risk factors which include but were not limited to chronic heart disease (including congestive heart failure and cardiomyopathies). On 7/01/24 at 11:58 AM, the survey team met with the [redacted] and [redacted] for an Exit Conference. No additional information was provided by the facility management, and the facility did not refute findings.	F 883		
F 921 SS=E	NJAC 8:39-19.4 (a,4)(d)(h)(i) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and sanitary environment. This deficient practice was identified in behavioral unit for four (4) of six (6) residents rooms, one (1) of one (1) shower room, and one (1) of two (2) unit rooms. This deficient practice was evidenced by the following:	F 921	1. The ceiling tiles, smoke detector, and air vent cover were replaced and all other identified areas, including air vents, windows, bathroom fixtures and floors in rooms 321, 317, 416, and 420, as well as the Eyewash Station and Motor Access Room were immediately cleaned. 2. All residents have the potential to be affected by the same deficient practice.	8/15/24

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	315357	A. BUILDING _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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F 921	Continued From page 104 On 6/25/24 at 10:08 AM through 10:49 AM, the surveyor conducted a NJ Exec Order 26.4b1) tour with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) the presence of a second surveyor. The following was observed during the tour: 1. At 10:08 AM, the surveyor entered into Room 321 and observed a gray-black colored substance on the air vent cover on the ceiling of the room. The U.S. FOIA (b) stated, "the gray/black substance was an accumulation of dust." The U.S. FOIA (b) was unable to state when the air vent was last cleaned. The surveyor observed one ceiling tile near the window area with a large circular, brownish colored stain in the middle of the tile. The U.S. FOIA (b) responded that it was probably due to condensation, and he was unsure when that had happened. The U.S. FOIA (b) (6) stated, "the tile should not be there." The surveyor entered the bathroom and observed a laundry bin with one piece of black colored clothing inside of it. The U.S. FOIA (b) (6) stated, "the clothing was probably from other resident who was transferred to another room last Friday." The U.S. FOIA (b) (6) acknowledged that the room and the dirty clothing should have been cleaned immediately after the resident was moved to another room. 2. At 10:15 AM, the surveyor entered into Room 317 and observed dry debris hanging from the upper area of the window. The U.S. FOIA (b) (6) confirmed that it was dust. The U.S. FOIA (b) and U.S. FOIA (b) (6) acknowledged that the window should have been cleaned. 3. At 10:21 AM, the surveyor entered into the	F 921	3. All housekeeping, maintenance staff and unit managers were inserviced by the Assistant Director of Nursing and/or Infection Preventionist on environmental policies, emphasizing infection control and safety protocols for proper storage. A rounding schedule and log was updated to reflect the identified deficient areas for cleanliness and safety issues in resident rooms and common areas. 4. The Administrator (LNHA) or LNHA designee will monitor by inspecting 1 resident room, 1 shower room and 1 motor room in each of the four separate nursing units once weekly for 3 months to ensure compliance. Inspections will focus on cleanliness, functionality, and safety. Any non-compliance or deficiencies identified during these inspections will be addressed immediately. The inspection results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will review the inspection findings, identify any trends or areas for improvement and make recommendations for continued monitoring after a period not less than three months.	

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F 921	Continued From page 105	F 921		

bathroom of Room 416 and observed two toilet paper holders with brownish discoloration. The [redacted] acknowledged it was rust and stated it should not be like that. The surveyor observed a white "hat" [a plastic container for urine collection] on the floor. The [redacted] stated, "it was a urine collection container, and it should not be on the floor for infection control. It was used to measure the resident's urine output. The [redacted] further explained that there was currently no resident in the room and the resident was transferred to the hospital yesterday.

4. At 10:27 AM, the [redacted] opened the unlocked door of the Motor Access Room and informed the surveyors that it was an electrical room. The surveyor observed a brown colored, dried-up substance on the floor. There was a blanket on the floor with brownish discoloration. The [redacted] acknowledged that the room door should have been locked.

5. At 10:30 AM, the surveyor entered into Room 420 and observed that the smoke detector on the ceiling. The smoke detector was detached and hanging from the ceiling. The [redacted] stated, "it should have been fixed and attached to the ceiling."

6. At 10:43 AM, the surveyor entered the room labeled the "Eyewash Station." Inside the room there were three shower stalls on the right side. The surveyor observed in the second shower stall, a square shaped opening on the right wall of the shower where there was a knob to control the water. The [redacted] acknowledged that the part to close the opening was missing.

The surveyor observed an air vent on the ceiling

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F 921	Continued From page 106	F 921		

which had no cover. The [U.S. FOIA (b) (6)] stated that it should have been covered and acknowledged that there was an accumulation of dust, and it should have been cleaned.

On 6/27/24 at 8:53 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated that the housekeeping staff were supposed to clean the resident rooms and hallway daily. The [U.S. FOIA] stated he was responsible to make daily rounds on the units to ensure that housekeeping staff were completing their responsibilities. He further stated that he did not have any logs or documentation to account for the cleaning of vents and windows, or for his daily rounds.

On 6/27/24 at 12:41 PM, the survey team met with the [U.S. FOIA (b) (6)], and [U.S. FOIA (b) (6)]. The surveyors notified the facility management of the above concerns and findings regarding the resident rooms, bathrooms, shower room, and motor access room.

On 6/28/24 at 11:29 AM, the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] met with the survey team. The [U.S. FOIA (b) (6)] stated in-service was provided to housekeeping staff regarding environmental concerns and high dusting issues. The [U.S. FOIA (b) (6)] stated that the valve in the middle shower stall was temporarily covered and closed until a new cover was received. The [U.S. FOIA (b) (6)] further explained the air vent cover in the shower room was replaced and the smoke detector was properly mounted to ceiling.

A review of the facility provided "Facility Environment" policy with a revised date January 2024, included:
Policy: It is the policy of this facility to provide a

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F 921	Continued From page 107 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Procedure: 1. The facility shall provide a safe, clean, comfortable and homelike environment, allowing the resident to use their personal belongings to the extent possible. 2. Housekeeping and maintenance shall maintain a sanitary, orderly and comfortable environment. NJAC 8:39-31.4 (a)(b)(f)	F 921		

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H 000	Initials Comments A Recertification Survey was conducted and it was determined that the faciilty was not in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures And Standards Applicable To All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical records and other facility documentation, it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer Form (UTF) as part of the medical record for one (1) of three (3) residents reviewed for hospitalizations (Resident #195). This deficient practice was evidenced by the following: Reference: New Jersey Administrative Code 8:43 E General Licensure Procedures and Standards: Section 8:43E-13.4 - Mandatory use of Universal	H5790	1. For resident #195 the facility conducted a thorough search for the missing Universal Transfer Form (UTF) including reviewing all thinned records and off-site storage. The original was unable to be located. 2. All residents have the potential to be affected by the same deficient practice. 3. The Director of Nursing and/or Assistant Director of Nursing in-serviced all nursing and medical records staff on the UTF policy and procedures,	8/15/24

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

Electronically Signed | 07/22/24

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H5790	Continued From page 1 Transfer Form (a) A licensed healthcare facility or program shall use the UTF, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. 1. Emergency departments are exempt from mandatory use of the UTF, but shall follow hospital procedures regarding documentation. (b) A licensed healthcare facility or program shall complete all sections of the UTF, to the best of the licensed healthcare facility or program's ability. 1. The UTF is not complete if medication information is not attached. (c) A licensed healthcare facility or program shall send a completed, paper copy of the UTF with a patient when a patient is transferred. (d) A licensed healthcare facility or program shall retain a completed copy of the UTF sent with a patient when a patient is transferred as part of the patient's medical record. 1. A review of Resident #195's electronic medical record included the following: Resident #195's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for the three DRAMDS, reflected that the resident was transferred to the hospital. A review of Resident #195's hybrid (a combination of paper, scanned, and computer-generated records) medical record did not include a copy of the UTF for Resident #195's two of the three transfers to the hospital.	H5790	emphasizing the importance of retaining copies of UTF□S in the chart immediately upon transfer to the hospital. 4. The Medical Records Clerk (MRC) and/or MRC designee will conduct weekly audits reviewing a random sample of 10% of the total discharges in the facility each week to ensure UTFs are in the medical record following all hospital transfers. The MRC will record and report the results monthly to the Quality Assurance and Performance Improvement (QAPI) committee who will make recommendations for continued monitoring after a period of not less than three months.	

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H5790	Continued From page 2 On 6/26/24 at 12:26 PM, the surveyor interviewed the Registered Nurse (RN) regarding the UTF. The RN stated that the nurse would fill out the UTF and keep a copy in the medical record. The RN reviewed Resident #195's hybrid medical record and confirmed that the most recent and one other UTF was not in the resident's medical record. The RN stated that usually the UTF would be in the medical chart. He added that the charts had been thinned recently. The surveyor asked the RN if the most recent UTF should remain in the medical chart. The RN confirmed that the most recent UTF should still be in the medical record. On 6/26/24 at 12:38 PM, the RN called medical records and was told that the thinned documents were in the filing cabinet drawer on the unit. The RN looked through the drawer and did not locate the two UTFs. On 6/26/24 at 12:40 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) of the green unit, regarding the UTF. The UM/LPN stated that the UTF was usually on the chart. The UM/LPN confirmed that two of the UTFs were not in the medical chart. She added that there should be a copy on the medical chart. On 6/27/24 at 11:17 AM, the surveyor interviewed the Director of Nursing (DON) regarding the UTF. The DON stated that there should be a copy of the UTF in the chart. On 6/27/24 at 01:08 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON and Vice President of Operations (VPoO) the concern that a copy of the UTF was not in the medical	H5790		

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H5790	Continued From page 3 record for Resident #195 for two transfers to the hospital. On 6/28/24 at 11:39 AM, in the presence of the survey team, LNHA and DON, the VPoO stated that the staff were inserviced on UTF and retained copy in the medical record. The DON stated that the nurse found one of the UTFs but that the other one was still missing. The facility did not provide any additional information. The facility did not provide a policy for UTF.	H5790		
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:	S 560		8/15/24

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S 560	Continued From page 4 REPEAT DEFICIENCY Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed	S 560	1. The facility adjusted staffing schedules to ensure compliance with the minimum staffing ratios via use of temporary agency staff to fill immediate gaps and needs in the nursing schedule. 2. All residents have the potential to be affected by the same deficient practice. 3. The facility Administrator (LNHA) developed and implemented a staffing-to-census grid aligned with N.J.S.A. 30:13-18 mandatory nursing staffing requirements and, in-serviced and educated the Staffing Coordinator (SC), Director of Nursing (DON) and Assistant Director of Nursing (ADON) delineating all RN, LPN and CN.A mandatory staffing requirements for variability in census conditions in accordance with N.J.S.A. 30:13-18. In addition to use of temporary staffing agency use to meet staffing needs, the facility has increased hiring efforts by advertising open positions and utilizing a recruiter to fill open positions. 4. The LNHA and Director of Nursing will monitor compliance by auditing posted staffing schedules daily to ensure adherence to N.J.S.A. 30:13-18. Any non-compliance will be addressed immediately to fill gaps in nurse staffing, including stopping admissions on days when minimum staffing requirements are not met until compliance is achieved. An audit DON or DON designee of staffing compliance comparing actual staffing to required staffing will be conducted daily, and results will be recorded. The audit results will be recorded and reported	

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S 560	Continued From page 5 by the facility for the 2 weeks of staffing from 06/09/2024 to 06/22/20243, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -06/09/24 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -06/10/24 had 10 CNAs for 144 residents on the day shift, required at least 18 CNAs. -06/11/24 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. -06/12/24 had 15 CNAs for 143 residents on the day shift, required at least 18 CNAs. -06/13/24 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -06/14/24 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -06/15/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -06/16/24 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -06/17/24 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -06/19/24 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. -06/20/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. -06/21/24 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. On 6/25/24 at 9:44 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding the required minimum direct care staff to resident ratios. The SC confirmed that she was aware of the ratios. The surveyor asked the SC if the facility was meeting the ratios. The SC stated that as far as she knew the facility was meeting the ratio. She added that sometimes when there was one to one observation needed then they might	S 560	monthly to the Quality Assurance and Performance Improvement (QAPI) committee, who will review the findings, identify trends or areas for improvement, and make recommendations for continued monitoring after a period of not less than three months.	

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S 560	Continued From page 6 not. On 6/27/24 at 11:14 AM, the surveyor interviewed the Director of Nursing (DON) regarding the required minimum direct care staff to resident ratios. The DON confirmed that she was aware of the ratios. The surveyor asked the DON if the facility was meeting the ratios. The DON stated that sometimes if there was a callouts that the facility may not meet the ratio. On 7/01/24 at 10:04 AM, in the presence of another surveyor, the Licensed Nursing Home Administrator stated that he was aware of staffing issues. A review of the facility provided policy titled, "Facility Staffing Policy" with a revised/reviewed date of Jan 2024 included the following: 1. The facility shall assess the resident population to determine the level of sufficient staff needed ... 4. The facility shall provide a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care; ... 7. The facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system. The policy did not include any information on the required minimum direct care staff to resident ratios.	S 560		
S2905	8:39-43.1(a)(2) Certification of Nurse Aides (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a	S2905		8/15/24

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ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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S2905	Continued From page 7 licensed long-term care facility in New Jersey: 2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation and interview with facility staff, it was determined that the facility failed to ensure that a.) two (2) of two (2) non-certified Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility, reviewed during the Sufficient and Competent Nurse Staffing task (NA #1 and NA #2); and b.) there was a delineated policy and/or program in place for the hiring of non-certified NAs. . This deficient practice was evidenced by: On 6/26/24 at 9:50 AM, the surveyor randomly chose ten new hire employee files to review and requested the files from the Licensed Nursing Home Administrator (LNHA). On 6/27/24 at 12:00 PM, the surveyor reviewed the facility provided file of two of the new hired employees which revealed the following: -NA #1 had a date of hire of [redacted]. -NA #1 had a competency report skills test dated [redacted]. -NA #1 was terminated on [redacted].	S2905	1. All NA personal files were reviewed and any outstanding NA enrollment program paperwork was placed in the NA employee file. 2. All residents have the potential to be affected by the same deficient practice. 3. The Administrator (LNHA) provided inservice education to the Director of Nursing (DON), Assistant Director of Nursing and Business Office Manager (BOM) on the process of hiring NAs which includes documentation of enrollment in a NA program. The DON will review each NA nursing employee file prior to the employee start date to ensure compliance. 4. The LNHA or BOM will monitor by auditing 100% of all new NA employee files weekly to ensure compliance with their documented enrollment in a NA program. Any non-compliance will cause immediate suspension of NA until enrollment program information is obtained. The audit records will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306000	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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
S2905	Continued From page 8 -There was no documented evidence in the file that NA #2 was enrolled in a NA program when hired. -NA #2 had a date of hire of [NJ Ex Order 26.4b1]. -NA #2 had a competency report skills test dated [NJ Exec Order 26.4b1] -NA #2 was employed currently at the facility. -There was no documented evidence in the file that NA #2 was enrolled in a NA program when hired. On 6/28/24 at 9:08 AM, the surveyor interviewed the Business Office Manger (BOM) regarding the process for NA employment. The BOM stated that she reviewed the skills test to see if it was within 30-60 days since they passed it. She added that they could only work at the facility for 120 days from the skills test date. The BOM stated that they would bring letters that they were enrolled in school and it would all be in their employee file. On 6/28/24 at 10:06 AM, the surveyor interviewed the Director of Nursing (DON) regarding the process for NA employment. The DON stated that they would make sure that the NA's skill test was within 120 days. She added that if they do not pass the test within 120 days then the NA would be removed from the schedule. On 6/28/24 at 10:09 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for the facility's policy for the process of NA employment. On 6/28/24 at 10:15 AM, the surveyor interviewed NA #2 regarding her NA program. NA #2 stated that she finished her NA program in [NJ Exec Order 26.4b1]. NA #1 no longer was employed at the facility. The surveyor could not interview NA #1 regarding their	S2905	reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee, who will make recommendations for continued monitoring after a period of four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306000	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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
S2905	Continued From page 9 NA program. On 6/28/24 at 12:06 PM, in the presence of the survey team, the surveyor told the LNHA, DON and Vice President of Operations (VPoO) the concern that NA #1 and NA #2 were not enrolled in an approved nurse aide training course during their employment with the facility and that there was no verification of the course enrollment in their employee file. On 7/01/24 at 11:11 AM, in the presence of the survey team, DON and the VPoO, the LNHA stated that NA #1 was no longer employed at the facility and NA #2 was getting the school information. The VPoO stated that enrollment in school should have been verified when hired. The facility did not provide any additional information. A review of the facility provided policy titled, "Nurse Aide Orientation" with a reviewed date of 1/2024, included the following: Purpose and Policy: This facility is committed to ensuring newly hired Nurse Aides (NA) have the knowledge, skills and abilities to have their own assignment to function effectively in this facility. This facility has established a NA orientation program to help them fully utilize their capabilities. Procedures: 1. Newly hired NA's will take part in the facility general orientation program on the first day of employment which covers the policies of the facility. 2. All newly hired NA's will shadow a C.N.A. and undergo a competency evaluation covering core competencies which include, but not limited to: a. Bed bath b. Bed making occupied/unoccupied ...	S2905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306000	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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
S2905	Continued From page 10 p. Ambulation with assistance. 3. The NA will be given an assignment after they have successfully demonstrated competency in the above skills. The policy did not include information regarding verification of NA program or hiring requirements for NA.	S2905		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
315357	A. Building B. Wing	8/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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 E0037 Reg. # 483.73(d)(1) LSC	Correction Completed 08/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315357 Y1	A. Building B. Wing Y2	8/27/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0583	Correction	ID Prefix F0607	Correction	ID Prefix F0623	Correction
Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed
LSC	08/15/2024	LSC	08/15/2024	LSC	08/15/2024
ID Prefix F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0661	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed
LSC	08/15/2024	LSC	08/15/2024	LSC	08/15/2024
ID Prefix F0688	Correction	ID Prefix F0690	Correction	ID Prefix F0712	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.30(c)(1)-(4)	Completed
LSC	08/15/2024	LSC	08/15/2024	LSC	08/15/2024
ID Prefix F0728	Correction	ID Prefix F0732	Correction	ID Prefix F0757	Correction
Reg. # 483.35(d)(1)-(3)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	08/15/2024	LSC	08/15/2024	LSC	08/15/2024
ID Prefix F0759	Correction	ID Prefix F0761	Correction	ID Prefix F0842	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	08/15/2024	LSC	08/15/2024	LSC	08/15/2024

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

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
315357 Y1	A. Building B. Wing Y2	8/27/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix F0882	Correction	ID Prefix F0883	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	08/15/2024	LSC	08/15/2024	LSC	08/15/2024
ID Prefix F0921	Correction				
Reg. # 483.90(i)	Completed				
LSC	08/15/2024				

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/9/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
306000		8/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 08/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
306000	A. Building B. Wing	8/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/15/2024	ID Prefix S2905 Reg. # 8:39-43.1(a)(2) LSC	Correction Completed 08/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/8/24 and 7/9/24, Alaris Health at Cedar Grove was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Alaris Health at Cedar Grove is a one-story building with a partial basement approximately 85,000 square feet in size, no residents are allowed in the basement. The facility has 2-elevator devices that are for staff only. The facility currently utilizes an exterior 32 KW diesel generator that produces enough power to do approximately 35% of the facility. The construction is Type I protected (222). The basement has signs indicating is could be used as a fallout shelter. The building was built in January 1959. The facility is divided into 9 smoke zones. The facility is divided into 4-wings: Peach, Blue, Green, and Pink.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		8/15/24

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

Electronically Signed | 07/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

(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 324	Continued From page 1 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation on 7/09/24, in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6) , and U.S. FOIA (b) (6)), it was determined that the facility failed to provide the required instructional signage, above the Class K portable fire extinguisher, to ensure all portable fire extinguishers were ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition. The deficient practice could affect 144 of 144 residents residing in the facility and was evidenced by the following: At approximately 11:28 AM, during the kitchen tour, the surveyor observed one K-type fire extinguisher that did not have the required	K 324	1. The facility installed the required instructional placard above the Class K portable fire extinguisher, indicating: "Warning in case of appliance fire, use this Class K extinguisher only after fixed suppression system has been activated." 2. All residents have the potential to be affected by the same deficient practice. 3. The Administrator (LNHA) updated and revised the facility fire safety policy to include required display of instructional signage above all Class K fire extinguishers and, the Plant Operations Director (POD) conducted a training session for all kitchen and maintenance staff on the importance the instructional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

(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 324	Continued From page 2 instructional placard indicating: "Warning in case of appliance fire, use this extinguisher only after fixed suppression system has been activated." The POD was interviewed at the time of the observation and stated that he was unaware of this requirement. The [redacted] was informed of the finding at the Life Safety Code exit conference on 7/09/24. NJAC 8:39-31.2(e) NFPA 10 2010 edition 5.5.5.3(a)	K 324	signage placement on the procedural use of Class K fire extinguishers. 4. The facility POD and/or POD designee will monitor the corrective action by observing all Class K fire safety signage requirements twice a month for three months to ensure compliance. The observations will be recorded and reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee who will determine the need for continued compliance after a period of three months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		8/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

(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 353	Continued From page 3 by: Based on observation on 7/09/24, in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), a). it was determined that the facility failed to have five (5) of five (5) private fire hydrants inspected annually according to NFPA 25. b). it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice could affect 144 residents residing at the facility and was evidenced by the following: a) At approximately 11:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The reports did not indicate any annual inspection of the (5) five private fire hydrants on the facility's property as required by NFPA 25. The U.S. FOIA (b) (6) U.S. FOIA and U.S. FOIA (b) (6) all indicated that the annual fire hydrant inspection requirement was not performed, and no further documentation was provided. b). At 10:30 AM. the surveyor, U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (b) observed that the fire sprinkler head in the physical therapy room was missing the escutcheon plate, leaving approximately a 1/2 inch gap around the drop ceiling tile into the space above.	K 353	1. The facility completed the annual inspection of all five (5) private fire hydrants on the facility's property in accordance with NFPA 25 requirements. ON 7/10/24, the facility installed an appropriate escutcheon plate for the fire sprinkler head in the physical therapy room to ensure a smoke-resistant and fire-rated ceiling. 2. All residents have the potential to be affected by the same deficient practice. 3. The facility Administrator (LNHA) inserviced the U.S. FOIA (b) (6) on the requirement for annual inspection of all private fire hydrants and on identifying missing escutcheon plates to ensure ceiling is smoke resistant and fire rated. The Plant Operations Director inspected all other sprinkler heads in the building to assure they had a proper escutcheon plate. The facility Administrator (LNHA) and Plant Operations Director (POD) reviewed and updated the facility's fire safety policy to include specific procedures for advanced scheduling of the annual inspection of private fire hydrants and, the inspection of properly fitted escutcheon plates. 4. The POD and/or POD designee will monitor the corrective action by adding the private fire hydrants as a Life Safety Code inspection agenda item in the Quality Assurance and Performance Improvement (QAPI) committee and,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

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K 353	Continued From page 4 The [redacted] and [redacted] all agreed that the escutcheon plate was missing and a gap of approximately 1/2 inch was observed. The [redacted] was informed of the findings at the Life Safety Code conference on 7/09/24. NFPA 25 NJAC 8:39-31.2(e)	K 353	inspect two common rooms and two resident rooms by rounding weekly for three months to ensure fire sprinkler heads have the appropriate escutcheon plate fitting. The inspections will be recorded and reported monthly to the QAPI committee who will monitor the monthly inspection results and determine the need for continued monitoring after a period of not less than three months.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation on 7/09/24, in the presence of the [redacted], it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection.	K 374	1. The facility repaired the set of smoke barrier doors outside resident rooms 316 and 317 on 7/10/2024 by reattaching the wooden astrical properly to eliminate any gaps to ensure they meet the required standards. 2. All residents have the potential to be	8/15/24

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	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

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ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

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K 374	Continued From page 5 This deficient practice was identified for one (1) of nine (9) smoke barrier door sets observed, and had the potential to affect 35 residents residing in the facility and was evidenced by the following: At 12:28 PM, the surveyor observed, that the set of smoke barrier doors in the blue wing outside resident rooms 316 and 317, when released from the electro-magnetic hold open device. The doors closed properly, but when the double doors met, a gap was observed approximately 1/4" to 1/2" due to the wooden astrical that was installed on the door. The wooden astrical was not attached to the lower section of the door, compromising the integrity of the smoke door requirements. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA all confirmed the findings above during the observation. The U.S. FOIA (b) (6) was informed of the findings during the Life Safety Code survey exit conference on 7/09/24. NJAC 8:39-31.1(c), 31.2(e)	K 374	affected by the same deficient practice. 3. The U.S. FOIA and his team received education on the revised smoke barrier inspection policy to ensure proper understanding and implementation of the new inspection frequency. The facility Plant Operations Director (POD) revised the facility's monthly smoke barrier door inspections by increasing the number of inspections from once monthly to twice monthly to assure smoke barrier doors are in compliance with NFPA 101, 2012 Edition, Section 19.3.7.6, 19.3.7.8, and 19.3.7.9. 4. The POD and/or POD designee will visually inspect all smoke doors twice monthly for compliance. Any non-conforming doors will be corrected immediately. The results of these inspections will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the inspection results, identify any trends or areas for improvement, and make recommendations to ensure ongoing compliance. This will continue for a period of not less than three months.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the	K 911		8/15/24

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	315357	A. BUILDING **01** B. WING _____	**07/09/2024**

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ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE** **CEDAR GROVE, NJ 07009**

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K 911	Continued From page 6 applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 7/09/24, in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6) , U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that one (1) of five (5) electrical outlets located next to a water source was equipped with a Ground Fault Circuit Interrupter (GFCI) protection as per NFPA 99. This deficient practice had the potential to affect eight (8) of 144 residents residing in the facility and was evidenced by the following: At 12:02 PM, the surveyor and the U.S. FOIA (b) (6) U.S. FOIA (b) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) observed in the Physical Therapy room that a Hydrocollator was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations. The U.S. FOIA confirmed the finding at the time of observation. The U.S. FOIA (b) (6) was informed of the finding at the Life Safety Code exit conference on 7/09/24. NJAC 8:39 -31.2 (e) NFPA 99	K 911	1. On 07/10/2024 the facility replaced the standard duplex wall outlet in the Physical Therapy room, where the Hydrocollator is plugged in, with a Ground Fault Circuit Interrupter (GFCI) outlet. 2. All residents have the potential to be affected by the deficient practice. 3. The facility U.S. FOIA (b) (6)) and his staff have been instructed by the Administrator on the code requirements regarding GFCI outlets. Training sessions were conducted by the POD with maintenance personnel. The facility Plant Operations Director audited all electrical outlets in the building to assure that any located next to a water source were properly equipped with GFCI protection. 4. The facility Plant Operations Director (POD) will conduct inspections of GFCI outlets next to water sources twice a month for three months to ensure they are properly equipped with GFCI protective outlets. The audit results will be recorded and reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the results, identify any trends or areas for improvement, and make recommendations to ensure ongoing	

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K 911	Continued From page 7	K 911	compliance. This will continue for a period of not less than three months.	

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
315357 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/27/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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 K0324	08/15/2024	LSC K0353	08/15/2024	LSC K0374	08/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	08/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
7/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO