STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE WEST ORANGE, NJ 07052**

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F 000	INITIAL COMMENTS Complaint #s NJ155673, 156615, 156876, 158687, 161314, 164633 STANDARD SURVEY: 4/15-4/24/2024 CENSUS: 122 SAMPLE SIZE: 24+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call light was readily accessible. The deficient practice was identified for 1 resident (Resident #5) of 24 reviewed for the reasonable accommodations of needs/preferences as evidenced by the following. On 4/15/24 at 10:35 AM and 4/16/24 at 9:10 AM, the surveyor observed the resident in bed awake, able to answer the surveyor's inquiry. The	F 558	F558 Reasonable Accommodations Needs / Preferences 1. The following corrective actions have been accomplished for the identified deficiency: - The Call bell for the identified resident #5 was repositioned and moved within accessible reach of the resident. 2. All residents have the potential to be affected by the deficient practice. 3. The following measures have been put	5/17/24

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

Electronically Signed | 05/09/2024

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F 558	Continued From page 1 surveyor asked the resident if [redacted] could reach [redacted] call light cord. The resident tried to reach for it three times and said they still could not get it. The call light cord was under the resident's right chest on both days. A review of the medical record revealed the following information. The admission record documented that Resident #5 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The recent Quarterly Minimum Data Set, an assessment tool dated [redacted], reflected that Resident #5 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating [redacted]. On 4/16/24 at 9:10 AM, the surveyor called the [redacted] to check the resident's call light cord. The [redacted] stated that it should be on top of the blanket so she could reach for it; the nurse repositioned the call bell. On 4/17/24 at 1:45 PM, the surveyor team discussed the inaccessibility of the call light cord for Resident #5 with the [redacted] and the [redacted] On 4/18/24 at 9:40 AM, the [redacted] provided a policy titled "Call Bell Audit." However, it was noted that the policy does not specifically address the call light cord being within the resident's reach.	F 558	into place to prevent the deficient practice from recurring: - All employees were in-serviced on placing the resident call bells within acceptable reach of the resident. - The Unit Manager or designee will audit 10 resident rooms daily for 1 week, weekly for 4 weeks, and monthly for 3 months to ensure the call bells are placed within accessible reach of the residents. 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 558	Continued From page 2 NJAC 8:39-27.1(a); 4.1	F 558		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly	F 640		5/17/24

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F 640	Continued From page 3 assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete and submit electronically the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for 4 of 24 residents (Resident #2, 5, 35, and #225). This deficient practice was evidenced by the following: 1. Resident #2 was observed to have a Quarterly MDS (QMDS) with an Assessment Reference Date (ARD) on [NJ Exec Order 26.4], which was due to be transmitted to CMS no later than [NJ Exec Order 26.4b] However, the QMDS was not submitted to CMS until [NJ Exec Order 2].	F 640	F640 □ Encoding/Transmitting Resident Assessments 1. The following corrective actions have been accomplished for the identified deficiency: - The identified assessments for identified residents #2, #5, #35 and #225 were reviewed by the MDS Nurse - There was NJ Exec Order 26.4b1 for identified residents #2, #5, #35 and #225 2. All residents have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - All departments were re-educated in regards to ensuring that the MDS assessments are completed timely. - MDS Nurses were re-educated on transmitting the MDS on time in accordance with the CMS RAI Manual. - The MDS Director or designee will audit 10 Resident MDS transmissions weekly for 4 weeks and monthly for 3 months to	

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F 640	Continued From page 4 2. Resident #5 was observed to have a QMDS with an ARD on [NJ Exec Order 26.4b], which was due to be transmitted to CMS no later than [NJ Exec Order 26.4b1]. However, the QMDS was not submitted to CMS until [NJ Exec Order 26.4]. 3. Resident #35 was observed to have an Entry MDS (EMDS) with an ARD on [NJ Exec Order 26.4]. The EMDS was due to be transmitted to CMS no later than [NJ Exec Order 26.4b]. However, the EMDS was not submitted to CMS until [NJ Exec Order 26.4b]. 4. Resident #225 was observed to have an Annual MDS (AMDS) with an ARD or [NJ Exec Order 26.4b] which was due to be transmitted to CMS no later than [NJ Exec Order 26.4b]. However, the AMDS was not submitted to CMS until [NJ Exec Order 26.4b1]. A review of Discharged Return Not Anticipated (DRNA), with an ARD on [NJ Exec Order 26.4b], was due to be transmitted to CMS by [NJ Exec Order 26.4b1]. The DRNA was not submitted to CMS until [NJ Exec Order 26]. A review of the undated "Final Validation Report" for Residents #2, 5, 35, and 225 by the [U.S. FOIA (b)] [redacted] revealed that "The submission date is more than 14 days after [NJ Exec Order 26.4b] on this new assessment." On 4/18/24 at 12:59 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that she started working in [U.S. FOIA (b)(6)] and added that she is not responsible for all those MDS submitted late. The only thing that she is responsible for is Res. #5. She is aware that the submissions were all late. The [NJ Exec Order 26.4b1] stated that she follows the RAI manual.	F 640	ensure transmission occurs within the appropriate time in accordance with the CMS RAI Manual. 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 640	Continued From page 5 On 4/18/24 at 1:39 PM, the survey team met with the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) . The surveyor notified the facility management of the above findings and concerns.	F 640		
F 656 SS=D	NJAC 8:39 - 11.1 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		5/17/24

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F 656	Continued From page 6 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop and implement a person-centered comprehensive care plan to meet the resident's medical needs. This deficient practice was observed for 2 of 24 residents reviewed, Residents #13 and #25 as evidenced by the following: 1. The surveyor reviewed Resident #13's electronic medical records (EMR). Resident #13 was admitted to the facility with NJ Exec Order 26.4b1 [redacted] A review of the Physician's Orders (PO) for Resident #13 revealed that the resident had an order for NJ Exec Order 26.4b1 [redacted]" The surveyor reviewed the resident's current care plans. There was no care plan developed regarding the	F 656	F656 Develop/Implement Comprehensive Care Plan 1. The following corrective actions have been accomplished for the identified deficiency: - The care plan for resident #13 was updated to include diagnosis NJ Exec Order 26.4b1 [redacted] - The care plan for resident #25 was updated to include diagnosis of NJ Exec Order 26.4b1 and identified NJ Exec Order 26.4b1 medication. 2. All residents have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - The IDCP Team were re-educated in	

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F 656	Continued From page 7 resident's PO for the [redacted] medication. On 4/22/24 at 11:44 AM, the surveyor interviewed the [redacted] who was assigned to the resident. The [redacted] stated that a care plan for the [redacted] medication should have been created 2. On 04/18/24 at 12:00 PM, the surveyor observed Resident #25 in bed. The resident stated that he/she took medications early in the morning and thought they were for his/her [redacted]. The surveyor reviewed the medical record for Resident #25. A review of the quarterly Minimum Data Sheet (MDS) (an assessment tool used to facilitate the management of care) dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, indicating the resident had an [redacted]. In addition, the section for active diagnoses included [redacted]. A review of the resident's Order Summary Report reflected a physician's order dated [redacted] for [redacted] Give one tablet by mouth one time a day every Monday for [redacted]. Give with [redacted]." A review of the resident's current Interdisciplinary Plan of Care (IDCP) had not included a plan of	F 656	regards to ensuring that residents' individualized care plans address all medical needs. - The Unit Manager or designee will audit all residents care plans once a month with the IDCP to ensure all medical needs are appropriately addressed in the individual residents care plan x 90 days 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 656	Continued From page 8 care that had been initiated for [NJ Exec Order 26.4b1]. On 4/23/24 at 9:19 AM, the survey team met with the [U.S. FOIA (b)(6)]) who stated that the Unit Managers were responsible for creating and updating the resident's care plans. In addition, the [U.S. FOIA (b)] stated that she also was responsible for inputting resident care plans. The [U.S. FOIA (b)] acknowledged that Resident #25 was actively being treated for [NJ Exec Order 26.4b1] and should have had a care plan completed. A review of the facility policy for Care Plans Comprehensive with a revised date of [NJ Exec Order 26] provided by the [U.S. FOIA (b)] reflected that "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." In addition, the facility policy reflected that "The comprehensive care plan is based on a thorough assessment that includes not limited to the MDS." "Each resident's comprehensive care plan is designed to: i. incorporate identified problem areas; ....." The policy also reflected that "Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change." And that "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: .....iv. at least quarterly."	F 656		
F 658 SS=D	NJAC 8:39-11.2(e)(1)(2)(f)(h) Services Provided Meet Professional Standards	F 658		5/17/24

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F 658	Continued From page 9 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice by not following physician orders for 2 of the 24 residents reviewed (Residents #5 and #35). The deficient practice was evidenced by the following: 1. On 4/15/24 at 10:35 AM and 4/16/24 at 9:10 AM, the surveyor observed the resident in bed, awake, and able to respond to the surveyor's questions. The resident was not wearing a NJ Exec Order 26.4b1 on both days. A review of electronic medical record revealed the following information. The Admission Record (AR or face sheet, an admission summary) documented that Resident #5 was admitted to the facility with NJ Exec Order 26.4b1 [redacted] The recent Quarterly Minimum Data Set (QMDS), an assessment tool dated U.S. FOIA (b)(6), reflected that Resident #5 had a Brief Interview for Metal Status (BIMS) score of NJ Exe out of 15, indicating NJ Exec Order 26.4b1 [redacted]	F 658	F658 – Services Provided Meet Professional Standards 1. The following corrective actions have been accomplished for the identified deficiency: - NJ Exec Order 26.4b1 was applied as per physician orders to resident #5 and the physician's order was updated in the electronic Treatment Administration Record (eTAR) - U.S. FOIA (b)(6) were applied as per physician order to resident #35 and the order for NJ Exec Order 26.4b1 were removed. The resident was educated on the importance of NJ Exec Order 26.4b1 while in bed. The physician's order for NJ Exec Order 26.4b1 while in bed was updated in the electronic Treatment Administration Record (eTAR) - There was NJ Exec Order 26.4b1 for identified residents #2 and #35 2. All residents that require preventive measures and positioning devices have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - All Nurses and CNA's were re-educated in regards to ensuring that residents with physician orders for preventative	

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F 658	Continued From page 10 A review of the resident's Order Summary Report (OSR) reflected a Physician's Order (PO) dated [redacted] for NJ Exec Order 26.4b1 " and on [redacted] for [redacted] NJ Exec Order 26.4b1 after AM care, [redacted] before PM care." A review of the [redacted] electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) under "Unscheduled 'Other' Orders" revealed that the above-corresponding PO for U.S. FOIA (b)(6) [redacted] were not specified in either the eMAR or eTAR. On 04/17/24 at 12:11 PM, the surveyor interviewed the Certified Nurse Assistant (CNA#1), who had worked in the facility for [redacted] and stated that she was assigned to Resident #5. CNA#1 opened the resident's drawer; the surveyor observed the [redacted] inside. CNA#1 said the residents should wear the [redacted] aftercare in the morning. On 04/17/24 at 12:17 PM, the surveyor interviewed the Licensed Practical Nurse (LPN#1), who had worked in the facility for [redacted] years. The LPN#1 said the NJ Exec Order 26.4b1 should put the NJ Exec Order 26.4b1 on the resident. On 04/17/24 at 12:20 PM, the surveyor interviewed the U.S. FOIA (b)(6)) and stated that the [redacted] should put the [redacted] on the resident's after providing care. The [redacted] stated the nurse should sign in the eTAR after checking that the resident was wearing the [redacted] The [redacted] added that the order for the [redacted] was not in the eTAR and there was no specific order for how long they should be	F 658	measures and positioning devices have appropriate orders in the electronic Treatment Administration Record and that protective measures and devices are placed accordingly on the individual resident. - The Unit Mangers or designee will audit 10 Residents weekly for 4 weeks, monthly 3 month and quarterly thereafter; that utilize preventative measures or positioning devices to ensure physicians order for device Is physically in place for the individualized resident and that the physician order is placed in the electronic Treatment Administration Record(eTAR). 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 658	Continued From page 11 placed. On 04/17/24 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that Resident #5 is in the NJ Exec Order 26.4 program and needs the U.S. FOIA (b)(6). The NJ Exec Order will order the NJ Exec Order 26 and then they train nurses, including the aide, on how to apply it to the resident. They screen quarterly and revise. Resident #5 was revised on NJ Exec Order 26.4b1. The next review is scheduled in NJ Exec Order 26.4b1. She added that U.S. FOIA (b)(6) is responsible for applying the NJ Exec Order On 4/17/24 at 1:25 PM, the surveyor team discussed the above findings and concerns with U.S. FOIA (b)(6). 2. On 4/15/24 at 10:00 AM, the surveyor observed Resident #35 lying in bed awake, watching television, U.S. FOIA (b)(6), able to answer the surveyor's inquiry. Resident #35 stated that they have been in the facility for over NJ Exec Order 26.4b1. The resident stated they do not wear anything on their NJ Exec O while in bed. A review of electronic medical record revealed the following information. The AR documented that Resident #35 was admitted to the facility with diagnoses that included but were not limited to primary NJ Exec Order 26.4b1 The recent QMDS, dated U.S. FOIA (b)(6) reflected that Resident #35 had a BIMS score of NJ Exec out of 15, indicating NJ Exec Order 26.4b1. A review of the resident's OSR reflected a PO	F 658		

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F 658	Continued From page 12 dated [redacted] for "NJ Exec Order 26.4b1 [redacted]" and a PO dated NJ Exec Order 26.4b1 [redacted] while in bed every shift for protection." Further review of the NJ Exec Order 26.4b1 OSR shows no PO for NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 eMAR and eTAR under "Unscheduled 'Other' Orders" revealed that the above-corresponding PO for U.S. FOIA (b)(6) [redacted] was not specified in either the eMAR or eTAR. On 4/22/24 at 11:40 AM, the surveyor observed the resident out of bed in a wheelchair. The resident stated that they wore NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 when attending NJ Exec Order 26.4b. On 4/22/24 at 11:47 AM, CNA#2 was observed caring for the resident. She stated that she did not see any NJ Exec Order 26.4b1 in the resident's room. On 4/22/24 at 12:07 PM, the surveyor interviewed LPN #1 who stated that she was unaware that the resident had NJ Exec Order 26.4b1 [redacted] while in bed. LPN #1 stated that when the resident was attending [redacted] they wore [redacted]. On 4/22/24 at 12:10 PM, the U.S. FOIA (b)(6) stated that NJ Exec Order 26.4b1 [redacted] are ordered in bed and should be taken off during care. The surveyor asked if NJ Exec Order 26.4b1 were ordered and the [redacted] said there was no order. On 4/22/24 at 12:17 PM, the surveyor interviewed the US FOIA who stated that the she didn't order NJ Exec Order 26.4b1 and added that the resident wore NJ Exec Order 26.4b1 for protection when out of bed.	F 658		

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F 658	Continued From page 13 On 4/22/24 at 12:20 PM, the U.S. FOIA (b)(6) was observed entering the resident's room with NJ Exec Order 26.4b1 wrapped in plastic. The surveyor asked the US FOIA where the NJ Exec Order 26 came from. The US FOIA stated that they came from the laundry. On 4/22/24 at 1:05 PM, the surveyor team met with the US FOIA (b)(6) and U.S. FOIA (b)(6). The U.S. FOIA (b) stated that she thought it was understood that if the resident has a full bath while in bed, the NJ Exec Order 26.4b1 should be removed during care and a NJ Exec Orde check for for NJ Exec Order 26.4b1 should be performed. She added that NJ Exec Order 2 shouldn't have been ordered simultaneously. A review of the facility policy titled "Specialty Devices" stated under "Policy: It is the policy and procedures of this facility that residents who require preventative measures and positioning devices (i.e., foam finger spreader, etc.) will be provided with these devices in order to prevent contractures or problems associated with contractures. These measures or devices will be provided in accordance with an order from a physician, nursing, occupational therapy, and/or physical therapy."	F 658		
F 695 SS=D	NJAC 8:39 27.2(m) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		5/17/24

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F 695	Continued From page 14 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) administer NJ Exec Order 26.4b1 according to the physician's order, b.) ensure that all nurses signed the electronic Medication Administration Record (eMAR) when NJ Exec Order 26.4 was administered, and c.) ensure NJ Exec Order 26.4b1 was stored properly. This deficient practice was identified for one (1) of one (1) resident (Resident #425) reviewed for NJ Exec Order 26.4b1 according to the standard of clinical practice, and the facility's policy and procedure. 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 and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 695	F695 □ Respiratory/Tracheostomy Care and Suctioning 1. The following corrective actions have been accomplished for the identified deficiency: - The identified residents # 425 had the NJ Exec Order 26.4b1 replaced and the setting corrected to the appropriate setting as per the physician order and the nurse signed the Electronic Medical Record (eMAR). The NJ Exec Order 26.4b1 and NJ Exec Order 26.4b were placed for proper storage at bedside. - There was NJ Exec Order 26.4b1 for identified residents #425 2. All residents with respiratory treatments have potential to be affected by deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - All nurses and CNAs were in-serviced on proper procedure for respiratory tubing and cannula storage - All nurses were in-serviced to correct concentrator settings per physician orders and signing of the electronic Medical Record (eMAR) to ensure residents in need of respiratory care meet professional standards of practice. - The Unit Manager or designee will audit	

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F 695	Continued From page 15 physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 4/17/24 at 10:23 AM, the surveyor observed the U.S. FOIA (b)(6)) propell Resident #425's wheelchair into the resident's room. Inside the resident's room, the NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1) was on a NJ Exec Order 26 (NJ Exec Order 26.4b1), and the U.S. FOIA (b)(6) NJ Exec O a device that delivers extra U.S. FOIA through a was wrapped around the half side NJ Exec of the bed. The NJ Exec Order 26.4b1 of the bed had a NJ Exec Order 26.4b1 on which the NJ Exec was wrapped around. The NJ Exec O was not being used at that time and was not properly stored. At that same time, the surveyor interviewed the resident after the U.S. FO left the room. The resident informed the surveyor that he/she was a NJ Exec Order 26.4b1 resident at the facility and came from the hospital due to a NJ Exec Order 26.4b1 problem. Resident #425 stated that use was something new to the resident and was being used in the facility as needed (PRN). During an interview, the resident stated that he/she did not need the at that	F 695	5 residents with respiratory treatments weekly for 4 weeks, monthly for 3 months and quarterly thereafter; ensure appropriate concentrator settings, nurses appropriately sign the electronic Treatment Record (tMAR) and that tubing□s are stored properly. 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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time. The resident appeared to [redacted].

On 4/18/24 at 10:07 AM, the surveyor asked the assigned Licensed Practical Nurse #1 (LPN#1) to go with the surveyor inside the resident's room. In the room, both the surveyor and the [redacted] observed Resident #425 seated in a regular chair, the [redacted] was ongoing with the [redacted] attached to the [redacted] while the other end of the [redacted] was wrapped around the [redacted] of the bed directly touching the [redacted] The resident appeared to be in [redacted].

On that same date and time, the surveyor asked LPN#1 to check the [redacted] at which the [redacted] was running. The [redacted] checked the [redacted] and informed the surveyor that the resident order for [redacted] was at [redacted] The [redacted] confirmed that the [redacted] was at [redacted] The [redacted] stated that the [redacted] should have been placed inside a plastic bag when not in use for infection control. She further stated that she would remove the [redacted] and change it with a new one. The surveyor observed that [redacted] detached the [redacted] and turned off the [redacted].

At that same time, the [redacted] assessed the resident and the resident was stable.

The surveyor reviewed the medical record for Resident #425.

The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included [redacted]

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NJ Exec Order 26.4b1 [redacted]).

A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, showed the admission MDS was in progress (not completed) for an ARD (assessment reference date) of [redacted].

A review of the individualized person-centered Care Plan (CP) initiated on [redacted] for a focus on NJ Exec Order 26.4b1) related to [redacted] had an intervention that included but was not limited to patient is on [redacted] at [redacted] PRN.

Further review of the CP did not include NJ Ex Order 26.4b1 on how to store the [redacted] and supplies when not in use.

The Social Service Admission/Readmission Evaluation with an effective date of [redacted] revealed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] which indicated that the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1.

A review of the Order Summary Report included a physician's order (PO) dated [redacted] for [redacted] at [redacted] NJ Exec Order 26.4b1 [redacted]

The above order for [redacted] was transcribed into the eMAR for [redacted]. Upon review of the [redacted] eMAR showed that there was no

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documentation that the nurses signed that the [redacted] as administered.

A review of the [redacted] in the electronic medical record (eMR) revealed the following dates that the resident had [redacted]

[redacted] Summary:

Date Time Sats Nurse

[redacted]

Further review of the eMR revealed that on dates [redacted] the eMAR should have been signed by nurses indicated the PRN [redacted] was administered.

On 4/18/24 at 10:17 AM, LPN#1 informed the surveyor that the order for [redacted] and not [redacted] The [redacted] asked the surveyor to go again with LPN#1 to the resident's room and check that it was on [redacted] now.

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In the resident's room both the surveyor and the [redacted] observed that the [redacted] was below [redacted] and there was a yellow light on. LPN#1 stated that she had to replace the [redacted] because the yellow light meant that there was a problem with the [redacted] LPN#1 acknowledged that it was probably broken.

At this time, the surveyor notified LPN#1 of the surveyor's observation on [redacted] that it was at [redacted] and wrapped around the [redacted].

On 4/18/24 at 01:39 PM, the survey team met with the [redacted]. The surveyor notified the facility management of the above findings and concerns regarding [redacted] observations, orders not followed, and nurses not signing the eMAR when [redacted] was administered as evident in the [redacted] records in the [redacted] ([redacted] x the resident was on [redacted]

On 4/19/24 at 10:10 AM, the surveyor interviewed the [redacted] who worked on [redacted] at the 7 AM to 3 PM shift. The [redacted] informed the surveyor that Resident #425 was [redacted] with some [redacted] and was on [redacted] The [redacted] stated that if the nurse administered the PRN [redacted], the nurse should document and sign the eMAR.

At that same time, the surveyor notified the [redacted] of the above findings and concerns. The surveyor asked the [redacted] why the resident's [redacted] during the observation was at [redacted] wrapped around the [redacted], not properly stored when not in use, and the eMAR was not signed. The [redacted] had no response.

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F 695	Continued From page 20 On 4/19/24 at 10:19 AM, the surveyor called and left a message to LPN#2. On 4/19/24 at 12:01 PM, the surveyor interviewed the U.S. FOIA (b)(6) The U.S. FOIA (b)(6) informed the surveyor that she was responsible for in-service/education regarding infection control including NJ Exec Order 26.4b1 care and use of U.S. FOIA (b)(6) supplies on how to properly store when not in use. The NJ Exec Order 26.4b stated that it was an expectation that the nursing staff store NJ Exec and NJ Exec supplies like NJ Exec Order and NJ Exec Order 26 inside a plastic bag when not in use and change it once a week for infection control because bacteria can accumulate in the NJ Exec Order and NJ Exec Orde when exposed to resident's environment. On that same date and time, the surveyor notified the U.S. FOIA (b)(6) of the above findings and concerns regarding NJ Exec NJ Exec wrapped around the NJ Exec Order 26.4b on two observations. The U.S. FOIA (b)(6) stated that it was not appropriate that the NJ Exec NJ Exec was not stored when not in use and that was not the facility's practice. On 4/19/24 at 12:11 PM, the surveyor interviewed LPN#3 via phone conference. LPN#3 informed the surveyor that she remembered Resident #425 with an NJ Exec O and the US FOIA (thought the order for was NJ Exec Order 26.4b1. The US FOIA (stated that if the order was PRN for NJ Exec O, then the PRN NJ Exec should have been signed. The US FOIA (further stated that she was unable to remember why the PRN NJ Exec O in the NJ Exec Or eMAR was not signed but it should have been signed. A review of the facility's Respiratory Tubing Storage Policy with an updated date of 9/2023	F 695		

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F 695	Continued From page 21 that was provided by the U.S. FOIA (b)(6) included that it was the policy and procedure of the facility to ensure the sanitation of all O2 accessories for residents' care. The procedure included but was not limited to when the mask or n/c is not in use, it will be stored in the bag. A review of the facility's Oxygen Administration Policy with an updated date of 12/2023 that was provided by the U.S. FOIA (b)(6)r included that it was the policy and procedure of the facility to provide [redacted] to residents in compliance with their physician order. On 4/19/24 at 12:25 PM, the surveyor met with the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated that the facility management acknowledged the concerns and that the facility would continue to monitor the NJ Exce[redacted]. NJAC 8:39-11.2(b); 19.4(a); 27.1(a)	F 695		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per	F 711		5/17/24

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F 711	Continued From page 22 physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents' current medical regimen was appropriate. This deficient practice was observed for 6 of 24 residents (Resident #12, #16, #22, #111, #13, and #62) reviewed and occurred over several months. This deficient practice was evidenced by the following: 1. A review of the hybrid medical record for Resident #12 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Exec Order 26.4b1 [redacted]. The monthly physician's orders were not in the chart and there was no electronic signature. 2. A review of the hybrid medical record for Resident #16 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for NJ Exec Order 26.4b1 [redacted]. The monthly physician's orders were not in the chart and there was no electronic signature. 3. A review of the hybrid medical record for Resident #22 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for U.S. FOIA (b)(6) and NJ Exec Order 26.4b1. The monthly physician's orders were not in the chart and there was no electronic	F 711	F711 Physician Visits □ Review/Notes/ Orders 1. The following corrective actions have been accomplished for the identified deficiency: - Physician Orders for were signed for residents identified #12 for the months of NJ Exec Order 26.4b1 [redacted] resident #16 for the months of NJ Exec Order 26.4b1 [redacted] resident #22 for the months of NJ Exec Order 26.4b1 [redacted], resident #111 for the months of NJ Exec Order 26.4b1 [redacted], resident #13 for the months of NJ Exec Order 26.4b1 [redacted], and resident #62 for the months of NJ Exec Order 26.4 [redacted] - There was NJ Exec Order 26.4b1 for residents identified #12, #16, #22, #111, #13 and # 62 2. All residents with Physician Orders have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - Meeting was held with all Physicians at the facility and all Physicians were re-educated on signing all physician orders by the 5th of each month. If the attending physician is unable to sign their monthly physician orders in a timely manner, the Medical Director will be informed and will follow up as needed.	

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F 711	Continued From page 23 signature. 4. A review of the hybrid medical record for Resident #111 revealed there were no monthly orders signed by the Physician for the months of [redacted]. 5. A review of the hybrid medical record for Resident # 13 revealed there were no monthly orders signed by the Physician for the months of [redacted] 6. A review of the hybrid medical record for Resident # 62 revealed there were no monthly orders signed by the Physician for the months of [redacted]. On 4/22/24 at 11:25 AM, the surveyor interviewed License Practical Nurse (LPN) #1, who was also the [redacted] Units and has been working in the facility for [redacted]. The [redacted] stated, "The primary physicians come in every 1-2 weeks or monthly." The [redacted]), who was also present stated, "The doctors have started signing orders in the Electronic Health Records (EHR) since last year, they used to come in and sign on paper but now they come in to sign orders in EHR." On 4/22/24 at 11:44 AM , the surveyor interviewed LPN # 2, who stated that the Physicians should be signing the residents' orders monthly in the electronic health record.	F 711	- The Unit Clerk or designee will review 10 resident charts on a monthly basis to ensure the physicians are signing the Physician Orders monthly x 90 days 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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	315066	A. BUILDING _____ B. WING _____	C 04/24/2024

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F 711	Continued From page 24 On 4/22/24 at 1:05 PM, the survey team met with the U.S. FOIA (b)(6) [redacted], regarding missing physician monthly orders review and signature from U.S. FOIA (b)(6) [redacted] The administration acknowledged that the physicians should be coming in monthly to sign orders. On 4/23/24 at 9:00 AM, the [redacted] provided the facility policy and procedure for Physician Orders dated 12/23. The Physician Orders policy reflected, "All verbal or written orders must be signed by the prescriber monthly."	F 711		
F 755 SS=E	NJAC 8:39-23.2(b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		5/17/24

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F 755	Continued From page 25 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring that manufacturer's specifications were followed for the administration time and sequence of a medication NJ Exec Order 26.4b1 [redacted] until surveyor inquiry. This occurred for one (1) of 11 residents, (Resident #25), reviewed for medication management. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching,	F 755	F755 □ Pharmacy Srvcs/ Procedures/Pharmacist/Records 1. The following corrective actions have been accomplished for the identified deficiency: - Physician was notified and assessed resident in regard to the deficient practice for the identified resident #25 in regards to the medication [redacted] and the medication order was changed so that the medication would not be given at the same time as the identified medications of NJ Exec Order 26.4b1 [redacted]. - There was NJ Exec Order 26.4b1 for identified resident #25 2. All residents receiving medications with manufacturer specifications have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring:	

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F 755	Continued From page 26 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: On 4/18/24 at 12:00 PM, the surveyor observed Resident #25 in bed. The resident stated that he/she took medications early in the morning and thought they were for his/her NJ Exec Order 26.4b1 [redacted]. The resident added that she received his/her early morning medications all together. The surveyor reviewed the medical record for Resident #25. A review of the quarterly Minimum Data Sheet (MDS) (an assessment tool used to facilitate the management of care) dated NJ Exec Order [redacted], reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec [redacted] out of 15, indicating the resident had an NJ Exec Order 26.4b1. In addition, the section for active diagnoses included NJ Exec Order 26.4b1	F 755	- All nurses were in-serviced on ensuring medications are given according to manufacturer recommendations and nursing standards of practice. - The Unit Manager, Pharmacy Consultant or designee will conduct a medication pass with review of the electronic Medical Record (eMAR) to ensure medications are administered according to standard of practice to all nurses quarterly. 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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NJ Exec Order 26.4b1

A review of the resident's Order Summary Report reflected a physician's order (PO) dated NJ Exec Order 26.4 for 'NJ Exec Order 26.4b1), Give NJ Exec Order 26.4b1 one time a day every NJ Exec Order 26.4b for NJ Exec Order 26.4b1. Give with NJ Exec Order 26.4b1 "

A review of the April electronic medication administration record (EMAR) revealed the above PO for NJ Exec Order 26.4b1 had a time of administration every NJ Exec Order 26.4b1

Further review of the EMAR revealed that there was a PO dated NJ Exec Order 26 for NJ Exec Order 26.4b1 that had a time of administration of NJ Exec Order 26.4b and was administered every day at that time. In addition, there was a PO dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1) that had a time of administration of 6:00 AM.

On 4/18/24 at 1:30 PM, the surveyor interviewed the US FOIA via the telephone. The US FOIA acknowledged that NJ Exec Order 26.4b1 had specific instructions for administration and should be administered as the first medication in the morning with no other medications for at least 30 minutes and that a recommendation should be made regarding these instructions. The US FOIA acknowledged that the NJ Exec Order 26.4b1 instructions for administration were not being followed because the NJ Exec Order 26.4b1 had a time of administration of 6 AM.

On 4/18/24 at 1:38 PM, the surveyor team met

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F 755	Continued From page 28	F 755		

with the NJ Exec Order 26.4b1 [redacted]. The [redacted] acknowledged that [redacted] had specific administration instructions that it was the first medication to be administered in the morning with no other medications. The [redacted] also stated that she thought there would have been a recommendation from the [redacted] and then the nurses would have to change the medication times. The [redacted] acknowledged that the nurses were to follow cautionary warnings. The [redacted] added that she would have to check.

On 4/22/24 at 7:18 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] via telephone. The [redacted] stated that she had worked the 7 PM to 7 AM shift and was responsible for administering the early morning medications to Resident #25. The [redacted] was unsure which medications she had administered and had to check the EMAR. The [redacted] then stated that she had checked the EMAR and had administered all three of the resident's medications at the same time that morning because they were timed together. The [redacted] could not speak to the cautionary warning.

On 4/22/24 at 11:50 AM, the surveyor interviewed the owner of the US FOIA (b)(6) [redacted] who acknowledged the [redacted] manufacturer's administration instructions. The [redacted] also stated that the cautionary warning was on the [redacted] package. The [redacted] added that the [redacted] time of 6 AM would have to be changed and that the [redacted] could be administered without regard to meals so the 6:30 AM time should also be changed.

A review of the [redacted] packaging labeled for

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F 755	Continued From page 29 Resident #25 that was in the medication cart reflected a cautionary warning on a red colored sticker 'NJ Exec Order 26.4b1 [redacted] On 4/22/24 at 1:02 PM, the survey team met with the U.S. FOIA (b)(6) The [redacted] acknowledged that the nurses should have been aware of the instructions for [redacted] as per the PO. The [redacted] also acknowledged the administration times on the EMAR for the resident's early morning medications had administration times that were not able to follow the specific instructions for [redacted] administration and should have been changed. A review of the facility policy for Medication Administration revised 10/2023 provided by the [redacted] reflected for accuracy "Right Drug-Compare the pharmacy label/package to the EMAR ..." and "Right Time-Medications are scheduled to avoid drug/food interactions and per manufacturer recommendations." In addition, for medication administration general instructions included "Cautionary warnings followed." A review of the manufacturer's specifications reflected "Take [redacted] first thing in the morning, at least 30 minutes before you eat or drink anything or take any other medicine." The specifications also reflected, "Take with a full glass (6 to 8 ounces) of plain water. Do not use coffee, tea, soda, juice or mineral water. Do not eat or drink anything other than plain water." In addition, "For at least 30 minutes after taking [redacted] Do not lie down or recline. Do not take any other medicine including vitamins, calcium or antacids."	F 755		

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F 755	Continued From page 30	F 755		
F 756 SS=E	NJAC 8:39-11.2(b), 29.2 (a)(d), 29.4(b)(3) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756		5/17/24

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F 756	Continued From page 31 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interviews, record review and a review of pertinent facility documents, it was determined that the facility failed to ensure that the U.S. FOIA (b)(6)) identified and reported irregularities to the physician and the facility regarding a.) a rationale for the length of therapy for a medication (NJ Exec Order 26.4b1) from NJ Exec Order 26.4b1 until surveyor inquiry, b.) the appropriate documentation of vital sign parameters for a medication NJ Exec Order 26.4b1 as ordered by the physician according to standards of clinical practice and facility practice, c.) a rationale for the continued off-label use of a medication NJ Exec Order 26.4b1) from NJ Exec Order 26.4b until surveyor inquiry and d.) following a cautionary warning for a medication (NJ Exec Order 26.4b1) from NJ Exec Order 26.4b1 until surveyor inquiry. The deficient practices were identified for three (3) of 11 residents, (Resident #72, #103 and #25) reviewed for medication management. The deficient practice was evidenced by the following: 1. On 4/17/24 at 10:20 AM, the surveyor	F 756	756 - Drug Regimen Review 1. The following corrective actions have been accomplished for the identified deficiency: - The US FOIA (b)(6) conducted a drug regimen review for identified Resident #72, Physician was made aware of irregularities of documentation for the medication NJ Exec Order 26.4b1 tablet and the hold parameters for U.S. FOIA (b)(6) as well as the need for documentation about indication of continued use of the medication U.S. FOIA (b)(6). Resident had NJ Exe noted. - The US FOIA (b)(6) conducted a drug regimen review for identified resident #103 for the medication use of NJ Exec Order 26.4 with the use of NJ Exec Order 26.4b1, Physician was made aware and NJ Exec Ord NJ Exec Order 26.4b was removed prior to resident discharge on NJ Exec Order 26.4b1. Resident had NJ Exec Order 26.4b1 noted. - The US FOIA (b)(6) conducted a drug regimen review for identified resident #25 for the medication NJ Exec Order 26.4b1 being administered at the same time as the medications NJ Exec Order 26.4b1 Physician was made aware and residents medication times were changed to ensure medications were given according to manufacturer instructions. Resident had	

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F 756	Continued From page 32 observed Resident #72 laying on the bed with eyes closed and there was one NJ Exec Order 26.4b1 inside the room. The surveyor reviewed the medical record of Resident #72. Resident #72's Admission Record (AR; or face sheet, an admission summary) reflected that the resident had diagnoses that included but were not limited to unspecified NJ Exec Order 26.4b1 and that doesn't have a known cause). The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an ARD (assessment reference date) of NJ Exec Order 26.4b1, included in NJ Exec Order 26.4b1 a BIMS (brief interview for mental status) score of which indicated that the resident's NJ Exec Order 26.4b1 was The qMDS showed that the resident was on an NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 Order Summary Report (OSR) included a physician's order (PO) with a start date o NJ Exec Order 26.4b1 A review of the resident's Pharmacy Review (or MRR) by CP#1, located in a binder which was	F 756	NJ Exec Order 26.4b1 noted. 2. All residents that receive medications have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - The Consultant Pharmacist Group has in-serviced their US FOIA (b)(6) on documenting and reporting any irregularities to the attending physician and the director of nursing - All Nurses were re-educated on understanding of proper medication administration - Pharmacy consultants will conduct a monthly audit of all residents' medication to ensure residents are receiving their medications according to their recommendations and cautionaries and will report their findings monthly to the Director of Nursing and Medical Director. 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 756	Continued From page 33 provided by the U.S. FOIA (b)(6), revealed the last MRR date was on NJ Exec Order 26.4b. The report did not identify the irregularities regarding the absence of documentation of the resident's and in the eMAR for U.S. FOIA (b)(6). Further review of the U.S. FOIA (b)(6) OSR showed that there was PO with a start date of for NJ Exec Order 26.4b1 The above order for NJ Exec Order 26.4b1 was transcribed into the eMAR from NJ Exec Order 26.4b1 through A review of the resident's Progress Notes (PN) showed that there was no physician's documentation about indications of continued use of NJ Exec Order 26.4b1 The US FOIA (b)(6) Reports for and revealed that the med NJ Exec Order 26.4b1 was not identified in the MRR for any irregularities. On 4/17/24 at 10:28 AM, the surveyor interviewed the U.S. FOIA (b)(6)) in the nursing station. The informed the surveyor that she was the assigned nurse of Resident #72. The stated that residents with NJ Exec Order 26.4b1 with parameters for and should be obtained before administering meds and document the and in the eMAR according to the facility's practice. She further stated that the and can be seen also in the NJ Exec Order 26.4b1 section of the electronic medical record (eMR).	F 756		

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F 756	Continued From page 34 On that same date and time, the surveyor asked the [U.S. FO] if the nurse should follow the PO for [NJ Exec Order 26.4b1] for the resident about the [NJ Exec Order 26.4b1] and she responded "Yes." The surveyor then asked the [ ] again, why the resident's [U.S. FOIA (b)(6)] eMAR did not have documentation of the resident's [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] for the [NJ Exec Order 26.4b1] order. The [ ] stated she did not know why it was not documented. Later on, the [U.S. FOIA] acknowledged there should be documentation of [NJ Exec Order 26.4b] [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1] eMAR. The [NJ Exec] stated that she would fix the eMAR in order for nurses to document the required [NJ Exec Order 26.4b1] She indicated that when the order was entered, there was a dropdown that should have been checked to include supplemental documentation of [NJ Exec Order 26.4b1] She further stated that was the reason why the [NJ Exec Order 26.4b1] were not documented [NJ Exec Order 26.4b] as supposed to be. On 4/17/24 at 10:39 AM, the surveyor interviewed the [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] stated that per facility protocol, [U.S. FOIA (b)(6)] parameters should have been documented in the eMAR. She further stated that the [US FOIA] comes to the facility once a month to do MRR and it was her responsibility as a [U.S. FOIA] to act upon the [US FOIA (b)] review and recommendations. On 4/17/24 at 01:36 PM, the survey team met with the [U.S. FOIA (b)(6)]. The surveyor notified the facility management of the above findings and concerns for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1].	F 756		

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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 756	Continued From page 35 On 4/18/24 at 9:09 AM, the surveyor called CP#2 in the presence of the survey team. CP#2 informed the surveyor that she was the [US FOIA] that went to the facility monthly until [NJ Exec Order 26.4b1] and now it was CP#1. CP#2 stated that CP#1 was unavailable and that CP#2 would answer surveyors' inquiries on behalf of CP#1. CP#2 informed the surveyor that it was her responsibility as [US FOIA] to identify irregularities with meds and notify the physician and the facility, and this included the meds with parameters and justification of continued use of meds. At that same time, the surveyor notified CP#2 of the above findings and concerns. The surveyor asked CP#2 why the CPs did not identify the irregularities with [NJ Exec Order 26.4b1] without indications for continued use of med from the physician and [NJ Exec Orde] and the [NJ Exec Order 26.4b1] parameters. CP#2 did not respond. On 4/18/24 at 11:01 AM, the survey team met with the U.S. FOIA (b)(6) [redacted] The U.S. FOIA (b)(6) did not provide additional information and responses for the above concerns and findings. A review of the facility's Medication Administration Policy that was provided by the [U.S. FOIA (b)] with a reviewed date of [NJ Exec Order 26.4b] included that it is the policy and procedure of the facility to provide the nursing staff with an understanding of proper med administration. On 4/19/24 at 12:25 PM, the surveyor met with the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated that there was no additional information.	F 756		

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	315066	A. BUILDING _____ B. WING _____	C 04/24/2024

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2. On 4/15/24 at 10:40 AM the surveyor attempted to interview Resident #103. The resident was in a wheelchair watching television. The resident NJ Exec Order 26.4b1 by the surveyor. The surveyor was NJ Exec Order 26.4b1 due to the resident's NJ Exec Order 26.4b1 status.

The surveyor reviewed the electronic medical record (EMR) for Resident #103. A review of the NJ Exec Order 26.4b quarterly Minimum Data Sheet (MDS) ,an assessment tool used to facilitate the management of care, reflected the resident was unable to complete a brief interview for mental status (BIMS) due to NJ Exec Order 26.4b1. The MDS NJ Exec Order 26.4b1 also reflected use of an NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and was not on any NJ Exec Order 26.4 or NJ Exec Order 26.4b program. A review of the resident's active diagnoses included, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 .

The surveyor reviewed the resident's medications in the EMR. The EMR reflected an order for NJ Exec Order 26.4b1, also known as NJ Exec Order 26.4b1) with an initial date of NJ Exec Order 26.4b1 that coincides with a readmission from the hospital.

On 4/17/24 at11:09 AM the surveyor interviewed the U.S. FO who was assigned to the resident. The U.S. FO stated that the resident is scheduled to be discharged home soon and will have the NJ Exec Order 26.4b removed.

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The surveyor reviewed the manufacturer package insert for [NJ Exec Order 26.4b1]. The section labeled Indications and Usage did not indications for off-label use.

A further review of the EMR, including the physician's progress notes, had not revealed any documentation of [NJ Exec Order 26.4b1] or the use of [NJ Exec Order 26.4b1] with or without a [NJ Exec Order 26.4b1].

On 4/17/24 at 12:15 PM, the surveyor reviewed the [US FOIA] reports from [NJ Exec Order 26.4b1] to present for Resident #103. Review of the [US FOIA] notes had not revealed any recommendation directed to the facility or physician requesting clarification or additional documentation regarding the rationale for use of [redacted] with or without a [NJ Exec Order 26.4b1] or in an approved indication for use or off-label use.

On 4/18/24 at 9:09 AM, the surveyor interviewed CP#2 by telephone in the presence of the survey team. The CP #2 stated she comes to the facility once a month and was doing the medication reviews until [NJ Exec Order 26.4b1]. CP#1 now did the reviews. However, she could speak to the facility issues. The CP#2 stated she reviewed records for appropriate diagnosis and indications and was familiar with the medication [NJ Exec Order 26.4b1]. The CP#2 stated she would not necessarily comment on off label or unapproved use depending on what the physician was using it for. The CP#2 stated that there are studies where [NJ Exec Order 26.4b1] is used in an unapproved manor effectively. She also stated other studies reviewed use of the medication when weaning off a [NJ Exec Order 26.4b1] to facilitate [NJ Exec Order 26.4b1]. She stated this was a "common use."

The CP#2 provided no further information

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F 756	Continued From page 38 regarding irregularities for use of [NJ Exec Order 26.4b1] for an off-label use with or without a [NJ Exec Order 26.4b] On 4/18/24 at 11:06 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] The [U.S. FOIA (b)] stated she had a discussion with the CP#2 and thought there were studies for an off-label indication. The [U.S. FOIA (b)] stated that the medication was started at the hospital. The [U.S. FOIA (b)] agreed that a continued off-label use of a medication without supportive documentation from the physician would be considered an irregularity. 3. On 4/18/24 at 12:00 PM, the surveyor observed Resident #25 in bed. The resident stated that he/she took medications early in the morning and thought they were for his/her [NJ Exec Order 26.4b1] The resident added that she received his/her early morning medications all together. The surveyor reviewed the medical record for Resident #25. A review of the quarterly Minimum Data Sheet (MDS) (an assessment tool used to facilitate the management of care) dated [NJ Exec Order 26], reflected the resident had a brief interview for mental status (BIMS) score of [NJ Exec] out of 15, indicating the resident had an [NJ Exec Order 26.4b1]. In addition, the section for active diagnoses included [NJ Exec Order 26.4b1]	F 756		

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F 756	Continued From page 39 [redacted] without current [redacted]. A review of the resident's Order Summary Report reflected a physician's order (PO) dated [redacted] for [redacted] before [redacted] A review of the [redacted] electronic medication administration record (EMAR) revealed the above corresponding PO for [redacted] with a time of administration every Monday at 6:30 AM. Further review of the EMAR revealed that there was a PO dated [redacted]) that had a time of administration of 6:30 AM and was administered every day at that time. The same time of administration as [redacted]. In addition, the EMAR revealed that there was a PO dated [redacted] that had a time of administration of 6:00 AM. The administration time was before the administration of [redacted]. A review of the [redacted] reports from [redacted] revealed that there was no recommendation made regarding [redacted] for Resident #25. On 4/18/24 at 1:30 PM, the surveyor interviewed the CP#2 via the telephone. The CP#2 acknowledged that [redacted] had specific instructions for administration and should be	F 756		

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administered as the first medication in the morning with no other medications for at [redacted] and that a recommendation should be made regarding these instructions. The CP#2 stated that she had been the [redacted] who was completing the reports a while ago but recently another CP#1 had been doing the reports so she could not speak for anyone else. CP#2 stated that CP#1 was unavailable for interview.

On 4/18/24 at 1:38 PM, the survey team met with the [redacted]). The [redacted] acknowledged that [redacted] had specific administration instructions that it was the first medication to be administered in the morning with no other medications. The [redacted] also stated that she thought there would have been a recommendation from the [redacted] and then the nurses would have to change the medication times on the EMAR. The [redacted] added that she would have to check.

On 4/22/24 at 11:50 AM, the surveyor interviewed the owner of the [redacted]) who stated that there was a recommendation made on [redacted] regarding the [redacted] instructions for administration. The [redacted] provided a copy of the CP's Nursing Summary Report dated [redacted] The report had not been initialed by a facility staff member or had a completed date by the facility. The recommendation reflected [redacted] must be given as the first med of the day and given alone. Schedule all other meds at least 30 minutes after the administration of [redacted] ([redacted]"

On 4/23/24 at 9:19 AM, the survey team met with the [redacted] who stated that the [redacted] had shown her

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F 756	Continued From page 41 the [US FOIA] report with the [NJ Exec Order 26.4b1] recommendation dated [NJ Exec Order 26] but that according to her portal the facility had not received that recommendation. On 4/23/24 at 10:06 AM, the surveyor, in the presence of another surveyor, interviewed the [redacted] and [U.S. FOIA (b)]. The [U.S. FOIA (b)] stated that when she received the computerized [US FOIA] report, she would print it out and give the report to the corresponding U.S. FOIA (b)(6) The [NJ Exec Orc] added that the [redacted] would complete the [US FOIA] report and give back the report initialed and dated. The [U.S. FOIA (b)] then explained that she had a new employee who ran the report in [NJ Exec Order 26.4b1] and that the facility had not received the whole report. The [U.S. FOIA (b)] also stated that the next month when the [US FOIA] had reviewed the EMAR and saw that the timing of the [redacted] was not acted upon then the [US FOIA] should have repeated the comment regarding [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)] acknowledged that there was no other recommendation made by the [US FOIA] regarding [U.S. FOIA (b)(6)] for Resident #25. The surveyor requested a Policy and Procedure for the US FOIA (b)(6) reports. There was no policy and procedure provided. NJAC 8:39-29.3(a)(1)	F 756		
F 757 SS=E	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	F 757		5/17/24

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F 757	Continued From page 42 §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 by failing to document on the effectiveness, appropriate indication, or benefit vs risk statement for an unapproved use for one (1) of eleven (11) residents reviewed for medication management (Resident #103). The deficient practice was evidenced by the following: On 4/15/24 at 10:40 AM the surveyor attempted to interview Resident #103. The resident was in a wheelchair watching television. The resident was NJ Ex Order 26.4b1 basic questions posed by the surveyor. The surveyor was NJ Exec Order 26.4b1 [redacted] due to the resident's U.S. FOIA (b)(6) The surveyor reviewed the electronic medical record (EMR) for Resident #103. A review of the	F 757	F757- Drug Regimen is Free from unnecessary Drugs 1. The following corrective actions have been accomplished for the identified deficiency: - Physician was notified in regard to the deficient practice for the identified resident #103 in regards to the medication U.S. FOIA (b)(6) and NJ Exec Order 26.4b1 was removed prior to discharged home. - There was NJ Exec Order 26.4b1 for identified resident #103. 2. All residents utilizing the medication Flomax have potential to be affected by deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - All nurses were in-serviced on ensuring medications are with a proper indication and physicians to be notified to document justification if required.	

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F 757	Continued From page 43 quarterly Minimum Data Sheet (MDS) (an assessment tool used to facilitate the management of care) dated [redacted] reflected the resident was [redacted] a brief interview for mental status (BIMS) test due to [redacted] The MDS section H also reflected use of a NJ Exec Order 26.4b1 [redacted] nd was not on any toileting or weaning program. A review of the resident's active diagnoses included, NJ Exec Order 26.4b1 [redacted]. The surveyor reviewed the resident's medications in the EMR. The EMR reflected an order for NJ Exec Order 26.4b1 also known a NJ Exec Order 26.4b1 [redacted]) with an initial date of [redacted] that coincides with a readmission from the hospital. On 4/17/24 at11:09 AM the surveyor interviewed the NJ Exec Order 26.4b1 [redacted]) who was assigned to the resident. The [redacted] stated that the resident is scheduled to be discharged home soon and will have the [redacted] removed. The surveyor reviewed the manufacturer package insert for NJ Exec Order 26.4b1. The section labeled Indications and Usage reflected, [redacted] is an NJ Exec Order 26.4b1 [redacted] A review of the EMR, specifically the physician's progress notes for the dates of [redacted] through [redacted] inclusive, did not reveal any notation of	F 757	-All residents utilizing the medication Flomax were reviewed for proper indication of use - The Unit Manager or designee will audit all residents utilizing the medication Flomax weekly for 4 weeks, then monthly for 3 monthly and then quarterly thereafter; to ensure proper indication is documented and/or physician justification is documented. 4. The DON or designee will review any findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 757	Continued From page 44 [redacted], or use of [redacted] with or without a [redacted] until [redacted] in a discharge note after it was brought to the facility's attention by the surveyor. A further review of the EMR, specifically the physician's progress notes entered and signed by the [redacted] for the dates of [redacted] inclusive, did not reflect any use of [redacted]. The surveyor reviewed the resident's care plan (a summary of a resident's health conditions, specific care needs and current treatments). The care plan reflected that the resident had [redacted], an [redacted] and [redacted] On 4/18/24 at11:06 AM the surveyor interviewed the [redacted]. The [redacted] stated that she was aware of the resident receiving [redacted] and that the medication was started at the hospital. The [redacted] agreed that the physician should document about continued unapproved use of [redacted] in the resident's chart and that she had contacted the physician and asked him to provide documentation.	F 757		
F 761 SS=D	N.J.A.C. 8:39-11.2(b) 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.	F 761		5/17/24

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F 761	Continued From page 45 §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 relevant document review, 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 three (3) medication carts and one (1) one of two (2) medication storage rooms inspected on two (2) of two (2) units. This deficient practice was evidenced by the following: On 4/16/24 at 10:56 AM the surveyor in the presence of another surveyor and the Licensed Practical Nurse (LPN#1) assigned to the medication cart inspected the medication cart identified as the northwest cart. The surveyor observed one (1) brown package containing one (1) vial of latanoprost eye drops (a medication used to treat glaucoma). The brown	F 761	F761 □ Label / Store Drugs and Biologicals 1. The following corrective actions have been accomplished for the identified deficiency: - Latanoprost eye drop vial that was identified as opened but not dated was discarded. - Flucticasone/salmeterol discus 500/50 that was identified as opened but not dated was discarded. - Flucticasone/salmeterol discus 250/50 that was identified as dated 2/23/24 was discarded. - The blister pack was moved and the lock box containing the controlled substances was immediately locked. - Temperature log for the identified refrigerator in the Northwest medication	

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F 761	Continued From page 46 packaging was labeled with a dispensing pharmacy label which reflected a dispensing date of 3/29/24. There was no date when the vial was opened observed on the packaging or on the vial. The surveyor observed one (1) package containing Fluticasone/salmeterol discus 500/50 (a medication used to treat asthma and chronic obstructive pulmonary disease). The packaging was labeled with a dispensing pharmacy label which reflected a dispensing date of 4/11/24. The medication device which is used to administer the medication was observed to have an automatic dosage counter that reflects the number of doses used/remaining. The counter reflected fifty-five (55) out of sixty (60) uses. There was no date when the medication was opened observed on the packaging or on the medication device. The surveyor observed one (1) package containing Fluticasone/salmeterol discus 250/50 that reflected a date when opened of 2/23/24. The surveyor observed that the medication cart contained a separate lockable box that contained controlled substances. The surveyor observed that the box was not locked by lifting the lid without the use of a key. The surveyor observed on closing the lid that it was blocked from fully closing by excess medication packages outside the box. The surveyor discussed the above areas of concern with LPN#1. LPN #1 agreed that the latanoprost and fluticasone/salmeterol should have a date when opened, the fluticasone/salmeterol dated 2/23/24 was opened more than 30 days, and that the lock box containing controlled substances should always	F 761	room was reviewed 2. All residents that receive medications have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - All Nurses were re-educated on properly labeling and dating of medications and discarding medications as per the manufacturer. - All Nurses were re-educated on ensuring the lock box containing the controlled substances are clear of any blister packs and able to be appropriately closed and locked. - All Nurses were re-educated on properly documenting the refrigerator temperature in the medication room twice daily -The Unit Manager, Pharmacy Consultant or designee will audit medication carts for proper labeling and discarding of medications as well as the lock box being appropriately locked while conducting Medication pass on all Nurses quarterly - Unit Manager or designee will audit medication room refrigerator temperature logs weekly x 4 weeks, monthly for 3 months, and then quarterly thereafter. 4. The Director of Nursing or designee will review findings monthly and the findings will be reported to the QAPI committee quarterly to determine the frequency of these audits.	

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STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE WEST ORANGE, NJ 07052**

(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 761	Continued From page 47 be locked when not in use. The surveyor in the presence of another surveyor entered the northwest medication room with assistance from a nurse. The surveyor observed a locked refrigerator with a temperature log on the door that reflected documentation of refrigerator temperatures twice a day. The surveyor observed that the temperature log had blank spaces for the dates of 4/12/24 AM, 4/12/24 PM and 4/13/24 AM. The surveyor reviewed the manufacturer package insert for latanoprost. The section labeled storage reflects: Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks. The surveyor reviewed the manufacturer package insert for fluticasone/salmeterol. The section labeled 16 How Supplied/Storage reflects: The device should be discarded 1 month after removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads "0"), whichever comes first. On 4/16/24 at 1:33 PM, the surveyor in the presence of the survey team discussed the concerns with the U.S. FOIA (b)(6) [redacted] The U.S. FOIA (b) stated that she had removed the medications of concern the previous day and educated the staff. On 4/17/24 at 1:15 PM the U.S. FOIA (b) provided to the surveyor a policy for medication storage. The policy reflects on line nine (9) All controlled drugs are stored under double-lock and key.	F 761		

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F 761	Continued From page 48 NJAC 8:39-29.4(g)(h), 8:39-29.7(c)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 4/18/24 at 9:52 AM, in the presence of the U.S. FOIA (b)(6)), the surveyor observed the	F 812	F812 - Food Procurement, Store/Prepare/Serve-Sanitary 1. The following corrective actions have been accomplished for the identified deficiency: - The 2 identified dented cans were immediately removed from rotation. - The oven knobs, oven handle and convection oven handle were immediately cleaned. 2. All residents have the potential to be affected by the deficient practice. 3. The following measures have been put	5/13/24

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F 812	Continued From page 49 following: 1. In the food preparation area, the surveyor observed seven of seven oven knobs and the oven handle soiled with a brown colored substance, which was able to be lifted with the tip of a pen. In the food preparation area, the surveyor also observed 1 of 2 handles of the convection oven soiled with a brown colored substance, which was also able to be lifted with the tip of a pen. The [redacted] stated that these areas should be cleaned. 2. In the dry storage room, the surveyor observed the following cans with dents, which were in rotation for use: - A number 10 sized can of butterscotch pudding which had a ½ inch dent on the upper lip of the can, - A number 10 sized can of tapioca pudding which had a 1 inch dent to the upper lip of the can, The [redacted] stated that the cans on this shelf are in rotation for use and that there should not be any dents in them. On 4/18/24 at 1:50 PM, the surveyor discussed the above concerns with the U.S. FOIA (b)(6) [redacted]	F 812	into place to prevent the deficient practice from recurring: - All dietary staff members were re-educated on properly storing food in a manner to prevent foodborne illness -ie; separating dented cans to appropriate location and not be placed in rotation. - All dietary staff members were re-educated on properly maintaining the kitchen environment in a sanitary manner to prevent contamination from foreign substances; i.e. oven handles and oven knobs cannot be soiled as well as convection oven handles. - Food service Director or designee will audit for soiled oven knobs, oven handles or convection oven handles, daily for 90 days. - Food Service Director or designee will audit that dented cans are removed from rotation and placed in the proper location weekly for 90 days. 4. The Food Service Director or designee will review findings monthly with the Administrator and the findings will be reported to the QAPI committee quarterly to determine the frequency of these audits.	
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/17/24

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F 880	Continued From page 50 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 51 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to establish appropriate infection control practices for environmental cleaning for 1 of 24 residents (Resident #5). This deficient practice was evidenced by the following: On 04/15/24 at 10:40 AM, the first day during rounds in Resident #5 room, the surveyor noticed a splash of a creamy substance on the right-side wall near the metal pole, extending from the	F 880	F880- Infection Prevention and Control 1. The following corrective actions have been accomplished for the identified deficiency: - The substance noted on the wall in the room for resident #5 was immediately cleaned and sanitized. 2. All residents have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice	

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F 880	Continued From page 52 resident's bedside table to the electrical outlet. The [U.S. FOIA (b)(6)]) stated that it looked like a [NJ Exec Order 26.4b1] on that wall and added that she would ask housekeeping to clean it. On 4/17/24 at 1:25 PM, the surveyor team met with the [U.S. FOIA (b)(6)] about the concern regarding the splash of creamy milk-like substance on the wall. The [U.S. FOIA (b)(6)] stated it was already clean and did not provide further information. NJAC 8:39-19.1(a)	F 880	from recurring: - All staff were re-educated to report any area noted as unclean to housekeeping so the area can immediately be cleaned and sanitized. -Director of Environmental Services or designee will conduct environmental rounds weekly for 4 weeks, monthly for 3 months and then quarterly thereafter. 4. The Director of Environmental Services or designee will review findings monthly with the Administrator and the findings will be reported to the QAPI committee quarterly to determine the frequency of these audits.	

New Jersey Department of Health

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	060714	A. BUILDING: _____ B. WING _____	C 04/24/2024

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STRATFORD MANOR REHABILITATION AND C	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint# NJ156615; NJ156876; NJ158687; NJ164633 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the minimum direct care staff-to-resident ratios mandated by the State of New Jersey. Reference: NJ State requirement, Chapter 112, An Act Concerning Staffing Requirements for Nursing Homes and Supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	S560 - Mandatory Access to Care 1.What corrective actions(s) will be accomplished for those residents affected by the deficient practice? -The staffing coordinator was educated on the minimum direct care staff to resident ratios as mandated by the state of New Jersey. -There was no negative outcome for residents on the identified dates due to the deficient staffing ratio 2. All residents have the potential to be affected by the deficient Practice. 3. The following measures have been put into place to ensure the deficient practice from recurring:	5/9/24

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

Electronically Signed | 05/09/24

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff-to-resident ratios: 1. one certified nurse aide to every eight (8) residents for the day shift. 2. one direct care staff member to every ten (10) residents for the evening shift provided that no fewer than half of all staff members shall be certified nurse aides and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties and 3. 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 certified nurse aide and perform certified nurse aide duties. b. Upon any expansion of the resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	-The facility has posted job openings on job sites to promote CNA openings. -The facility has contracted with staffing agencies to assist with our staffing needs. -The staffing coordinator will offer staff the ability to pick up more shifts for overtime, incentive bonuses are being offered. -The facility is partnered with a CNA school to recruit new graduates. -The administrator/designee will review the daily staffing sheets weekly for 4 weeks and monthly for 3 months and quarterly thereafter. 4. The Staffing Coordinator/designee will review any findings of these audits monthly with the Administrator and the findings will be presented quarterly to the QAPI committee to determine frequency of future audits.	

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S 560	Continued From page 2 (2) If the application of the ratios listed in subsection A of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next highest whole number when the resulting ratio carried to the hundredth the place is fifty one hundredths or higher. 4. All computations shall be based on the midnight census for the day the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels at any time beyond the established minimum ... A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports for thirteen (13) weeks of staffing for five (5) distinct periods received from facility administration during the 4/24/2024 Standard survey revealed deficient staffing ratios as evidenced by the following: 1. For the three weeks of Complaint staffing from 7/24/22 to 8/13/22, the facility was deficient in CNA staffing for residents on 16 of 21-day shifts as follows: - 7/24/22 had 14 CNAs for 120 residents on the day shift, which required at least 15 CNAs. - 7/26/22 had 14 CNAs for 120 residents on the	S 560		

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S 560	Continued From page 3 day shift, which required at least 15 CNAs. - 7/27/22 had 14 CNAs for 120 residents on the day shift, which required at least 15 CNAs. - 7/28/22 had 14 CNAs for 125 residents on the day shift, which required at least 16 CNAs. - 7/29/22 had 14 CNAs for 123 residents on the day shift, which required at least 15 CNAs. - 7/30/22 had 14 CNAs for 123 residents on the day shift, which required at least 15 CNAs. -7/31/22 had 11 CNAs for 123 residents on the day shift, which required at least 15 CNAs. - 8/02/22 had 14 CNAs for 122 residents on the day shift, which required at least 15 CNAs. - 8/04/22 had 13 CNAs for 122 residents on the day shift, which required at least 15 CNAs. - 8/05/22 had 13 CNAs for 122 residents on the day shift, which required at least 15 CNAs. - 8/06/22 had 11 CNAs for 122 residents on the day shift, which required at least 15 CNAs. - 8/07/22 had 13 CNAs for 124 residents on the day shift, which required at least 15 CNAs. - 8/08/22 had 13 CNAs for 124 residents on the day shift, which required at least 15 CNAs. - 8/09/22 had 13 CNAs for 123 residents on the day shift, which required at least 15 CNAs. - 8/11/22 had 13 CNAs for 123 residents on the day shift, which required at least 15 CNAs. - 8/13/22 had 13 CNAs for 123 residents on the day shift, which required at least 15 CNAs. 2. For the two weeks of Complaint staffing from 10/02/2022 to 10/15/2022, the facility was deficient in CNA staffing for residents on 4 of 14-day shifts as follows: - 10/02/22 had 14 CNAs for 122 residents on the day shift, which required at least 15 CNAs. -10/08/22 had 13 CNAs for 119 residents on the day shift, which required at least 15 CNAs.	S 560		

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S 560	Continued From page 4 -10/09/22 had 14 CNAs for 119 residents on the day shift, which required at least 15 CNAs. -10/10/22 had 14 CNAs for 118 residents on the day shift, which required at least 15 CNAs. 3. For the week of Complaint staffing from 10/30/2022 to 11/05/2022, the facility was deficient in CNA staffing for residents on 3 of 7-day shifts as follows: -10/30/22 had 13 CNAs for 122 residents on the day shift, which required at least 15 CNAs. -11/03/22 had 13 CNAs for 124 residents on the day shift, which required at least 15 CNAs. -11/05/22 had 14 CNAs for 122 residents on the day shift, which required at least 15 CNAs. 4. For the five weeks of Complaint staffing from 04/23/2023 to 05/27/2023, the facility was deficient in CNA staffing for residents on 5 of 35 days as follows: - 4/23/23 had 14 CNAs for 125 residents on the day shift, which required at least 16 CNAs. - 4/24/23 had 14 CNAs for 124 residents on the day shift, which required at least 15 CNAs. - 4/30/23 had 14 CNAs for 127 residents on the day shift, which required at least 16 CNAs. - 5/13/23 had 14 CNAs for 124 residents on the day shift, which required at least 15 CNAs. - 5/20/23 had 14 CNAs for 121 residents on the day shift, which required at least 15 CNAs. 5. For the two weeks of staffing before the survey from 03/31/2024 to 04/13/2024, the facility was deficient in CNA staffing for residents on 4 of 14-day shifts as follows:	S 560		

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S 560	Continued From page 5 - 3/31/24 had 13 CNAs for 125 residents on the day shift, which required at least 16 CNAs. - 4/06/24 had 13 CNAs for 123 residents on the day shift, which required at least 15 CNAs. - 4/07/24 had 13 CNAs for 122 residents on the day shift, which required at least 15 CNAs. - 4/08/24 had 14 CNAs for 122 residents on the day shift, which required at least 15 CNAs. On 4/24/24, at 12:17 PM, the survey team discussed with the Licensed Nursing Home Administrator and Director of Nursing that some of the shifts fell below the state-required minimum staffing ratios.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315066 Y1	A. Building B. Wing Y2	5/31/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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 F0558	Correction	ID Prefix F0640	Correction	ID Prefix F0656	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	05/17/2024	LSC	05/17/2024	LSC	05/17/2024
ID Prefix F0658	Correction	ID Prefix F0695	Correction	ID Prefix F0711	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.30(b)(1)-(3)	Completed
LSC	05/17/2024	LSC	05/17/2024	LSC	05/17/2024
ID Prefix F0755	Correction	ID Prefix F0756	Correction	ID Prefix F0757	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	05/17/2024	LSC	05/17/2024	LSC	05/17/2024
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	05/17/2024	LSC	05/13/2024	LSC	05/17/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/24/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060714 Y1	A. Building B. Wing Y2	5/31/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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 05/09/2024	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 4/24/2024	☐ 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
	315066	A. BUILDING **01** B. WING _____	**04/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE** **WEST ORANGE, NJ 07052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 04/24/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 04/24/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Stratford Manor Rehabilitation and Care Center is a one-story building built in the 1970's and is composed of Type II protected construction. The facility is divided into nine - smoke zones. The generator does approximately 100 % of the building per the Maintenance Director. The current occupied beds are 110 of 132.	K 000		
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	K 353		5/9/24

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

Electronically Signed | 05/09/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING **01** B. WING _____	**04/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE** **WEST ORANGE, NJ 07052**

(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 1 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 by: Based on observation and interview, the facility failed to ensure the automatic sprinkler system's gauges were calibrated or replaced in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (2011 Edition) section 13.2.4.2. This deficient practice had the potential to affect all 110 residents who resided at the facility. Findings include: An observation on 04/24/24 at 12:21 PM revealed the two gauges on the automatic sprinkler system were last replaced on 08/22/17 as noted on the gauges. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the automatic sprinkler system gauges were not calibrated or replaced. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	K353 - Sprinkler System- Mainteance & Testing 1. The following corrective actions have been accomplished for the identified deficiency: -Our licensed sprinkler contractor was contacted and the gauges were appropriately replaced. 2. All residents have potential to be affected by deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: -The licensed sprinkler contractor will replace or calibrate the gauges every 5 years as per NFPA 25 requirements. -The Maintenance Director will audit the sprinkler gauges monthly for 3 months and annually thereafter to ensure the gauges are replaced or calibrated as per the NFPA 25 requirements. 4.The Director of Facilities will ensure that the licensed sprinkler company will replace or calibrate the gauges every 5 years as per NFPA 25 standard for Inspection, Testing and Maintenance of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING **01** B. WING _____	**04/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE** **WEST ORANGE, NJ 07052**

(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 2	K 353	Water Based Fire Protection Systems is being followed and will alert the Administrator of any non- compliance. The Administrator will review the findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the laundry dryers' wiring was installed correctly in accordance with NFPA 70 National Electrical Code (2011 Edition) Section 406.7. This deficient practice had the potential to affect all 110 residents who resided at the facility. Findings include: An observation on 04/24/24 at 12:17 PM revealed two commercial dryers were plugged into wall outlets using non-metallic sheath wiring.	K 511	K511 - Utilities- Gas and Electric 1. The following corrective actions have been accomplished for the identified deficiency: - Licensed electrical contractor, was contacted and rewired the dryers to be compliant with NFPA70 National Electrical Code. 2. All residents that receive medications have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice	5/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. BUILDING **01** B. WING _____	**04/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	**787 NORTHFIELD AVE** **WEST ORANGE, NJ 07052**

(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 511	Continued From page 3 The U.S. FOIA (b)(6) was present at the time of observation and confirmed the commercial dryers' cords were non-metallic sheath wiring. NJAC 8:39-31.2(e) NFPA 70	K 511	from recurring: -The US FOIA (b)(6) was re-educated on NFPA70 National Electrical Code in relation to deficient practice. -The Maintenance Director will audit the wires behind the dryers monthly for 3 months and annually thereafter to ensure the wires are compliant with the NFPA70 National Electrical Code. 4. The Maintenance Director will alert the Administrator of any non- compliance in relation to the dryers with NFPA 70 National Electrical Code. The Administrator will review the findings of these audits monthly and then present them quarterly with the QAPI committee to determine the frequency of future audits.	

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
315066 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/31/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD MANOR REHABILITATION AND CARE CENTER	787 NORTHFIELD AVE WEST ORANGE, NJ 07052

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 Reg. # NFPA 101 LSC K0353	Correction Completed 05/09/2024	ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 05/09/2024	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 4/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			