STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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F 000	INITIAL COMMENTS A Recertification and Complain Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ157239, NJ156747, NJ151575, NJ165553, NJ164172, NJ160197, NJ154487 Survey Dates: 07/23/23 - 07/26/23 Survey Census: 141 Sample Size: 35 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(	F 567		8/18/23

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

Electronically Signed | 08/18/2023

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F 567	Continued From page 1 l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the timely availability of personal resident funds for one (Resident (R)21) of three residents reviewed for access to personal funds out of a total sample of 35 residents. The facility's banking hours were limited to Monday through Friday and residents did not have access to their money on weekends or on the same day if requested outside of the posted banking hours. Findings include: The facility's banking hours, posted in the hallway across from the nurse's station on each unit,	F 567	1. Corrective action for deficient practice: (a) banking hours and days were extended to include saturdays and Sundays at the receptionist desk. (b) posted signs for banking was changed as follows: "Money is available from 8:00AM to 4:00PM Monday through Sunday. If you need money outside of this, please contact the Nurse supervisor or the receptionist. 2. Residents with potentials to be affected by deficient practice:	

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F 567	Continued From page 2 indicated the facility's banking hours were Monday through Friday from 9:00 AM to 4:00 PM. R21's "Admission Record," dated NJ ex order 26.4b1 and found in the electronic medical record (EMR) under the "Profile" tab, revealed R21 was NJ ex order 26.4b1 on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 R21's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, indicated a "Brief Interview for Mental Status (BIMS)" score of NJ ex out of 15 indicating R21 NJ ex order 26.4b1 During an interview with R21 on 07/24/23 at 9:54 AM, she stated, "If you need money you can go downstairs [to the Administrator to request it] and then it takes a while [to receive the money]. Last time I requested money I had to wait a week. We can only get money Monday through Friday. If you want money to spend on a weekend you have to [request it] on Friday. During an interview with the Regional Business Office Manager (BOM) on 07/26/23 at 11:51 AM, she indicated there was not a BOM working in the facility but that the BOM position was a regional position, and she was responsible for managing several facilities. She indicated she was the BOM who was in charge of the facility, but day to day money management was handled by the facility's Administrator. She stated the residents' personal funds cash was kept in the Administrator's office but that when funds were requested by a resident the money was expected to be available the same day, including on weekends.	F 567	(a) All residents who maintain PNA account with facility can potentially be affected by the deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a) residents are educated during residents' council meeting on availability of residents' funds and the new hours/days by Activity director on 8/15/23 (b) staff are educated about the availability of funds and new hours/dates by business office manager on 9/15/23. (c)Facility will maintain sufficient cash in the petty cash to avoid delay in giving out money to residents 4. How to monitor corrective action: (a) Business office manager to monitor availability of sufficient fund, once daily for 1 week; once weekly for 3 weeks; and once monthly for 3 months. (b) Activity director to sample residents about availability of funds during residents council meetings; once monthly for 3 months. (c)Administrator to randomly audit residents for ease and availability of getting their money once monthly. 5. Results of the monitoring will be presented to monthly QAPI committee	

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F 567	Continued From page 3 During an interview with the Administrator on 07/26/23 at 12:08 PM, he confirmed the cash used for resident fund requests was kept in his office and stated, "This is the advice we give. If they [residents] want money on the weekend, they need to let us know on Friday. If they [residents] have to have it [money] on the weekend they have to let me know on Friday."	F 567	meeting for review and revision as deemed appropriate.	
F 578 SS=D	NJAC 8:39-4.1(a)10 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		8/18/23

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F 578	Continued From page 4 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the NJ Exec Order 26.4b1 [redacted] was complete and code status (to resuscitate or not) orders were in place for one of six residents (Resident (R) 55) reviewed for advanced directives out of a total sample of 35 residents. This failure had the potential to negatively affect the dignity, designated wishes, and physical status of the resident in case of cardiac or respiratory arrest. Findings include: Review of R55's profile, located on the "Profile" tab of the electronic medical record (EMR), revealed an admission date of NJ ex order 26.4b1 with a diagnosis of NJ ex order 26.4b1 [redacted]	F 578	1. Corrective action for deficient practice: (a) NJ ex order 26.4b was completed for resident 55 on NJ ex order 26.4b1 - Advanced directive - NJ ex order 26.4b (a) Full house audit was completed on all residents by social worker on 8/15/23 2. Residents with potentials to be affected by deficient practice: (a) Full house audit of POLST & (b) Full house audit of Advanced Directive being conducted by Social Worker 3. Systemic change to make sure deficient practice does not recur: (a) Social Worker educated completion of POLST and Advanced Directive by Administrator	

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F 578	Continued From page 5 NJ ex order 26.4b1 [redacted] Review of R55's significant change "Minimum Data Set (MDS)" with an assessment reference date (ARD) of [redacted] revealed R55's had a "Brief Interview for Mental Status (BIMS)" score of [redacted], indicating R55 was NJ ex order 26.4b1 [redacted] Review of R55's NJ ex order 26.4b1 [redacted] form, located under the "Miscellaneous" tab of the EMR, revealed the following selections: under medical interventions when the person is NJ ex order 26.4b1 [redacted]" was initially selected and then crossed out and "defined trial period" was selected and dated [redacted] (the form was otherwise undated). Further review revealed, under if the person has no pulse/is not breathing, "NJ Exec Order 26.4b1 [redacted] were selected. The document revealed R55's daughter and a second surrogate decision were identified. The signatures section was blank, there were no representative signatures indicating they reviewed the form with a practitioner. There was no practitioner signature. Review of R55's EMR "Orders" tab lacked documentation of a code status for R55. During an interview with the Social Services Assistant (SSA) 07/26/23 at 2:18 PM, confirmed paperwork for the [redacted] had not been signed and R55 did not have a code status order. The	F 578	(b) All licensed staff will be educated on completion of POLST and Advanced Directives by Social Worker 4. How to monitor corrective action: (a) Audit to be completed on all new admissions by Admission Director (b) Audit/monitoring to be completed weekly for 6 weeks, then monthly for 2 months by Social service Director 5. Results of the monitoring will be presented monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 578	Continued From page 6 SSA stated she spoke with the daughter yesterday and confirmed the [NJ Exec Order] status and it was now documented in R55's medical record that the resident is [NJ Exec Order]. The POLST and advanced care planning policies were requested, and none were provided. NJAC 8:39-4.1(a)4 NJAC 8:39-9.6(a)(b) NJAC 8:39-35.2(d)14	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		8/18/23

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F 583	Continued From page 7 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to provide privacy during personal care for one (Resident (R)43) of 35 sampled residents. Findings include: Review of R43's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R43 was NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1 Review of R43's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of NJ ex order 26.4b1 and located under the "MDS" tab of the EMR, revealed R43 scored a NJ Exec out of 15 on her "Brief Interview for Mental Status (BIMS)," which indicated R43 NJ ex order 26.4b1 It was recorded, R43 NJ ex order 26.4b1 During an observation on 07/23/23 at 11:11 AM, the door to R43 and R65's room was observed to be open. The privacy curtain was pulled to the	F 583	1. Corrective action for deficient practice: (a) Resident # 43 was NJ ex order 26.4b1 2. Residents with potentials to be affected by deficient practice: (a) All residents that reside in the facility have the potential to be affected by the deficient practice. 3. Corrective actions to ensure deficient practice does not recur: (a) The facility educator provided CNA 1: 1:1 in service on the facility policy and procedures on resident rights for personal privacy and confidentiality on 7/25/23. (b) DON/designee in serviced all License nurses on the facilities policy and procedures on residents' rights for personal privacy and confidentiality when providing care. 4. How to monitor corrective measures	

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F 583	Continued From page 8 end of the right side of R43's bed, and the resident was not seen from the hallway. The surveyor knocked on the door, heard someone say, "come in," and then entered the room. Certified Nurse Aide (CNA) 1 was standing on the right side of R43's bed providing personal care and helping R43 dress. CNA1 pulled R43's top off, NJ Exec Order 26.4b1. The privacy curtain between R43 and R65's bed was fully open. R65 was in her bed, with a full view of R43, and was watching CNA1 provide care to R43. During an interview on 07/25/23 at 10:16 AM, CNA1 stated the purpose of closing the privacy curtain was to provide privacy to residents during care. CNA1 stated she had made a mistake by not pulling the privacy curtain closed. CNA1 stated she did not always close the door to a resident's room during care because some residents did not like their door to be closed. During an interview on 07/25/23 at 10:44 AM, Unit Manager (UM) 1 stated it was her expectation that staff closed the privacy curtains while providing resident care. Review of the facility's undated policy titled, "Residents Rights Acknowledgment," revealed, " . . . The resident has a right to personal privacy . . . Personal privacy includes . . . personal care . . . " NJAC 8:39-4.1(a)16	F 583	(a) DON/designee will perform random observations on the units during routine rounds to assure the privacy curtains are closed during direct care. The audit will be completed daily x 5, weekly x 4, bi-weekly x 4 and monthly x3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		8/18/23

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F 584	Continued From page 9 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 584	1. Corrective action for the deficient	

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F 584	Continued From page 10 failed to ensure a clean and sanitary environment for five of 35 sampled residents (Resident (R) 43, R83, R95, R20, and R61) and one (Cherry Blossom) of two treatment carts located on the second floor. Findings include: 1. During an observation on 07/23/23 at 11:11 AM, R43's room was observed. The bed frame and overbed table frame were noted to have a buildup of dirt and debris. The wall behind the head of the bed was noted to have gouges. The floor was noted to be sticky. 2. During an observation on 07/23/23 at 1:56 PM, R83's room was observed. The overbed table frame and the bed frame were noted to have a buildup of dirt and debris. The floor around the perimeter of the bed was noted to be sticky. 3. During an observation on 07/23/23 at 2:43 PM, R95's room was observed. The overbed table frame, bed frame, and the front of the bedside table were noted to have a buildup of dirt and debris. The paint was chipping from the frame of the overbed table. The front of the television was noted to have splatters of an unknown substance. 4. During an observation on 07/23/23 at 6:05 PM, R20's room was observed. The overbed table frame and bed frame were noted to have a buildup of dirt and debris. The three-drawer bedside table had missing handles on the first and third drawers. Numerous splatters were observed on the wall behind the head of the bed, and the floor was sticky. 5. During an observation on 07/23/23 at 6:47 PM,	F 584	practice: - Resident 20 was NJ ex order 26.4b1 [redacted] on [redacted] NJ ex order 26.4b - Two missing drawer handles on the night stand belonging to bed 'A' were replaced (a) Affected residents rooms; (43, 83, 95, 20 and 61), day rooms, med and treatment carts were properly cleaned and sanitized by House keeping. (b) All surfaces, furniture, equipment and appliances identified to have build up dirt and debris were cleaned and sanitized by house keeping. (c) All defects on the wall (hole and chippings), sticky floors were corrected. (d) Over head bed tables were cleaned; oxygen concentrator and under bed was cleaned by house keeping. (e) Hole in the wall was fixed by Maintenance staff 2. Residents with potentials to be affected by deficient practice: (a) House keeping staff will be re-educated on proper cleaning procedures for walls, floors, equipment, furniture, med and treatment carts by Regional director of environmental services	

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F 584	Continued From page 11 R61's room was observed. The bed frame and overbed table were noted to have a heavy buildup of dirt and debris. There was a large buildup of dirt and debris under the bed. NJ ex order 26.4b1 [redacted] was observed to have splatters, stains, and a buildup of debris on the front of the machine. The floor was sticky, and there was a hole in the wall behind the door where the doorknob came in contact with the wall. During an interview on 07/23/23 at 12:01 PM Housekeeper (HSK) 1 stated she cleaned the rooms five days per week. HSK1 stated each day she swept, mopped, cleaned the overbed table, dusted, and cleaned the sink and toilet. HSK1 stated she cleaned the bed frames and overbed table frames daily. 6. During an observation and interview on 07/26/23 at 10:11 AM, the treatment cart for Cherry Blossom was noted to have dried spills down both sides of the cart. The top had numerous dried splatters of some substance, and the platform was observed to have a heavy buildup of dust and debris. Licensed Practical Nurse (LPN) 2 stated the treatment carts were cleaned every two weeks by the housekeeping department. 7. During an observation and interview on 07/26/23 at 10:30 AM through 10:50 AM, the Administrator, Housekeeping Director (HSKD), and Regional Director of EVS (RDEVS) toured Hibiscus Highway on the second Floor and the following were noted: At 10:33 AM, the HSKD stated R61's room was scheduled for a "complete clean." The HSKD stated the debris and stains on the NJ ex order 26.4	F 584	(b) Cleaning schedules for rooms, walls, floors, equipment furniture and carts will be House keeping director. 3. Systemic change to make sure deficient practice does not recur: (a)Maintenance staff were educated on preventative and corrective maintenance schedule and logs by Regional Director of Environmental Services. (b)Housekeeping staff were educate on room and equipment/furniture cleaning. (c)All staff were educate on Maintenance log completion and notifying housekeeping. 4. How to monitor corrective action: (a) House keeping director to conduct audit of sample rooms, hallways, carts, equipment and furniture once daily for thirty days, once weekly for four weeks and once monthly for 2 months. (b) RDEVS to conduct weekly audit for 4 months. (c) IDT rounding of management staff led by the administrator to be conducted once weekly. 5. Results of the audits will be presented	

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F 584	Continued From page 12 NJ ex order 26.4b1 should have been cleaned during the daily cleaning. The HSKD, Administrator and RDEVS stated the hole in the wall was not the responsibility of the housekeeping department but should have been reported and fixed. At 10:36 AM, the HSKD stated R83's room needed some work and needed to be cleaned. At 10:38 AM, the HSKD stated he did not know why the paint was chipping on R95's overbed table frame. He stated it might be the chemicals that were used to clean it. The RDEVS confirmed there were splatters on the front of the television, and it needed to be cleaned. The RDEVS stated the floor was sticky, but that could be due to the chemicals that were used to clean with. The HSKD confirmed the room and equipment needed to be cleaned thoroughly. At 10:40 AM, R43's room was toured. The HSKD confirmed the bed and overbed table needed to be cleaned. At 10:42 AM, R20's room was toured. The HSKD confirmed the bed frame and overbed table frame needed to be cleaned, the splatters on the wall should be cleaned if possible, and the drawer handles on the bedside table repaired. At 10:44 AM, the HSKD confirmed the treatment cart for Cherry Blossom was dirty and needed to be cleaned. The HSKD stated it was the responsibility of the housekeeping department to clean bed frames, overbed tables, the outside of the treatment carts, the general environment, and the oxygen concentrators. The HSKD, Administrator, and Regional Director of EVS confirmed the housekeeping concerns.	F 584	to Monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 584	Continued From page 13 During an observation, interview, and record review on 07/26/23 at 10:45 AM, the RDEVS stated there was a list of rooms located at the nurses' station that were designated for high priority room cleaning, indicating they were to be cleaned first with special attention. Taped to the wall at the nurses' station was a form titled, "Hi Priority Room Cleaning," dated 07/2023. R83 and R20's room were listed on the form as high priority for cleaning. NJAC 8:39-4.1(a)11 NJAC 8:39-31.8(e)	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		8/18/23

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F 623	Continued From page 14	F 623		

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 15 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 27) reviewed for hospitalization out of a total sample of 35	F 623	1 Corrective action/s for deficient practice: - Written notice of discharge was sent to	

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F 623	Continued From page 16 residents and their resident representative were provided with a written transfer notice that stated the reason for transfer, the place of transfer, the name and contact information of the Ombudsman, and information concerning the right to appeal the transfer if desired. This failure had the potential to affect the resident and their Resident Representative (RR) by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: Review of R27's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R27 was NJ ex order 26.4b1 [redacted] with diagnoses that included NJ ex order 26.4b1 [redacted]. Review of R27's "Health Status Note," dated NJ ex order 26.4b1 [redacted] at 3:44 PM and located under the "Progress Notes" tab of the EMR, revealed, " . . . At 7:26 AM, patient was standing by the elevator pressing its button when all of a sudden I saw patient NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Ex [redacted] of the nurses station. Patient was NJ Exec [redacted] and NJ Exec Order 26.4b1 [redacted]. NJ Exec Order 26.4b1 noted. NJ Exec Order 26.4b1 [redacted]. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]. Patient NJ Exec Order 26.4b1 [redacted] . . . At 8:32 AM, pick up by EMT [emergency medical technician] Personnel . . . Did transfer hand over to . . . nurse at [hospital name withheld]. House nurse notified. [Family member] called and notified . . . " Review of R27's "Summary for Providers," dated NJ ex order 26.4b1 [redacted] and located under the "Progress Notes"	F 623	resident's representative - Policy was updated to include written transfer notification to be given to residents or representative. - (a) Resident # 27 NJ ex order 26.4b1 [redacted] and was no longer active during the time of the Department of Health Annual Survey. (b) A full house audit of all resident files completed with bed hold policy in place effective 7/27/23 2. Residents with potentials to be affected by deficient practice: (a) All residents that reside in the facility have the potential to be affected by the same deficient practice. Systemic change to ensure deficient practice does not recur: - DON or designee to educate all licensed nurses and Social service staff that "written notice to residents or representative is required for transfers" (a)The DON or designee in-service all licensed nurses on facility policy and procedures on transfers/discharge. (b)Director of Social Services was in-service on the process of notifying resident and the residents' representative	

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F 623	Continued From page 17 tab of the EMR, revealed documentation of R27's vital signs, medical history, a summary of the events that occurred on [NJ ex order 26.4b1] and the physician's order to send R27 to [NJ ex order 26.4b1] [redacted] The form did not include written notice to R27 or his representative of the reason for the transfer; the place of transfer; appeal rights; or the name, address, and telephone number of the Ombudsman. Review of R27's entire EMR and hard chart revealed no documentation R27 or his representative had been provided a written transfer notice that contained the required information, included the effective date of the transfer, place of transfer, the reason for transfer, the Ombudsman's contact information, and notice of the right to appeal the transfer if desired. During an interview on 07/25/23 at 3:12 PM, Licensed Practical Nurse (LPN) 1 stated that if a resident needed to be transferred to the hospital, the physician was called, orders were placed, documents from the medical record were prepared, vital signs were obtained, and the ambulance was called to pick the resident up. LPN1 stated a universal transfer form was completed listing all the resident's pertinent medical information and the name and contact number of the resident's representative. When asked if a transfer notice, containing all the required information, was provided to the resident and their representative, LPN1 stated he had no knowledge of that information being provided. LPN1 confirmed he did not provide the transfer notice information to R27 or his representative. LPN1 stated he notified R27's family member via telephone of the transfer, and that was all he did. LPN1 stated he did not know the facility's policy	F 623	at the time of transfer. 4. How to monitor corrective action/s: (a)Social Services/Designee will monitor all hospital transfers weekly X 4 weeks, bi-weekly X 4 weeks, then monthlyX3 for appropriate documentation and evidence of the notice of transfer has been given. (b)DON/Designee will conduct spot audits weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 623	Continued From page 18 on providing the required transfer notice to the resident or representative. During an interview on 07/25/23 at 4:24 PM, Unit Manager (UM) 1 stated if a resident was able to understand at the time of discharge, the facility explained to them where they were going during an emergency transfer. UM1 stated staff would call the physician and the family before the resident left the facility and give report to the hospital where the resident was going. UM1 confirmed the facility did not provide written transfer notices when a resident was transferred to the hospital. As of NJ ex order 26.4b1, R27 had NJ ex order 26.4b1 [redacted] Review of the facility's policy titled, " Transfer and Discharge (Including AMA [Against Medical Advice]," revised 09/2022, revealed, " . . . Provide transfer notice as soon as practicable to resident and representative . . . " The policy did not address what information would be provided in the transfer notice to the resident or representative. NJAC 8:39-4.1(a)31,32	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625		8/18/23

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F 625	Continued From page 19 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide one of three residents (Resident (R) 27) reviewed for hospitalization out of a total sample of 35 residents and their representative written notice of the facility's bed-hold policy when the resident was transferred to the hospital. This failure created the potential for residents and/or responsible parties to not have the information needed to safeguard their return to the facility. Findings include: Review of R27's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R27 was admitted to the	F 625	1. Corrective action for deficient practice: (a)Resident # 27 has a NJ ex order 26.4b1 [redacted] (b)A full house audit of all resident files completed with bed hold policy was started on 7/27/23 2. Residents with potentials to be affected by deficient practice: (a)All residents that reside in the facility have the potential to be affected by the same deficient practice. 3. Systemic change to make sure	

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F 625	Continued From page 20 facility on NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1 Review of R27's "Health Status Note," dated NJ ex order 26.4b1 at 3:44 PM and located under the "Progress Notes" tab of the EMR, revealed, " . . . At 7:26 AM, patient was standing by the elevator pressing its button when all of a sudden I saw NJ ex order 26.4b1 of the nurses station. Patient NJ ex order 26.4b1 NJ ex order 26.4b1 . At 8:32 AM, pick up by EMT [emergency medical technician] Personnel . . . Did transfer hand over to . . . nurse at [hospital name withheld]. House nurse notified. [Family member] called and notified . . . " Review of R27's entire EMR and hard chart revealed no documentation R27 or his representative had been provided a written notice of the facility's bed-hold policy at the time of transfer. During an interview on 07/25/23 at 3:12 PM, Licensed Practical Nurse (LPN) 1 confirmed he did not know a resident and their representative had to be provided written notice regarding the facility's bed-hold policy if the resident was sent to the hospital. LPN1 confirmed he did not provide such information when he sent R27 to the hospital. During an interview on 07/25/23 at 4:24 PM, Unit Manager (UM) 1 confirmed she had no knowledge of the requirement to provide written notice of the facility's bed-hold policy at the time	F 625	deficient practice does not recur: (a)The facility has created a written notice to be used as a guide for all hospital transfers. The DON or designee in-service all licensed nurses on completing the written notice and provide a copy to the resident during the transfer. (b)Director of Social Services was in-service on the process of providing the residents with the written bed hold policy to the resident and the residents' representative at the time of transfer. 4. How to monitor corrective action: (a)Social Services/Designee will monitor all hospital transfers weekly X 4 weeks, bi-weekly X 4 weeks, then monthlyX3 for appropriate documentation and evidence of the notice of transfer has been given. (b)DON/Designee will conduct spot audit on all acutes with notification of bed hold policy weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 625	Continued From page 21 of transfer. As of NJ ex order 26.4b1 at 4:00 PM, R27 had NJ ex order 26.4b1 [redacted] Review of the facility's policy titled, "Transfer and Discharge (Including AMA [Against Medical Advice]," revised 09/2022, revealed, " . . . Provide a notice of the resident's bed hold policy to the resident and representative at time of transfer, if possible, but no later than 24 hours of the transfer . . . " NJAC 8:39-4.1(a)31 NJAC 8:39-5.3(b)	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate "Minimum Data Set (MDS)" assessments for one of 35 sampled residents (Resident (R) 119). Failure to code the MDS correctly can lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: Review of R119's "Admission Record," located under the "Profile" tab of the EMR, revealed R119 was admitted to the facility on NJ Exec Order 26.4 with diagnoses that included NJ ex order 26.4b1 [redacted]	F 641	1. Corrective action for deficient practice: (a)Resident #119 MDS was corrected by Regional MDS coordinator on NJ ex order 26.4 upon being told it was wrongly coded by surveyors. 2. Residents with potentials to be affected by deficient practice: (a)All residents that reside in the facility have the potential to be affected by the same deficient practice. 3. Systemic change to make sure	8/18/23

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F 641	Continued From page 22 Review of R119's "Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen," dated NJ ex order 26.4b1 and located under the "Misc (Miscellaneous)" tab of the electronic medical record (EMR), revealed R119 had a NJ ex order 26.4b1 NJ ex order 26.4b1 It was recorded a 'NJ ex order 26.4b1 was requested for R119. The form recorded, " . . . For an individual with a NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 is primary or more progressed than the NJ Exec Order 26.4b1, a referral to the DMHAS [Division of Mental Health and Addiction Services] for the PASRR Level II evaluation and determination is required prior to NF [nursing facility] admission . . . " Review of R119's "PASRR Level II Determination Notification," dated NJ ex order 26.4b1 and located under the "Misc" tab of the EMR, revealed R119 was to NJ ex order 26.4b1 Review of R119's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, revealed R119 was coded as NJ ex order 26.4b1. During an interview on 07/25/23 at 3:54 PM, the Social Services Director (SSD) confirmed R119	F 641	deficient practice does not recur: (a)MDS Coordinator(s) were in-serviced on correct coding of assessments By Regional Nurse/Quality assurance nurse. (b)ADON/Designee will check all current facility residents' assessments for accuracy on diagnoses and MDS coding that reflect residents' needs and status. 4. How to monitor corrective action: (a)MDS Coordinator/Designee will conduct audit for all residents to ensure proper coding for incontinence, diagnosis and diagnosis; MDS Coordinator will place MDS modifications if any incorrect coding identified; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly. (b)DON/Designee will conduct spot audits on MDS' coding; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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	315204	A. BUILDING _____ B. WING _____	C 07/26/2023

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F 641	Continued From page 23 did have a NJ Exec Order 26.4b1 [redacted] The SSD stated a Level II determination had been completed, and the information was in the EMR. The SSD stated the recommendations from the Level II determination were to be incorporated into R119's plan of care. During an interview on 07/26/23 at 9:09 AM, the Regional MDS Coordinator (RMDSC) confirmed the MDS was coded incorrectly for R119. Review of the RAI Manual, dated October 2019, indicated, "The RAI process has multiple regulatory requirements. Federal regulation . . . require that the assessment accurately reflects the resident's status . . . A1500: Preadmission Screening and Resident Review (PASRR) . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions . . . A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions . . . Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . . ." NJAC 8:39-11.2(e)1	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		8/18/23

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F 644	Continued From page 24 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to refer one (Resident (R) 57) of ten sampled residents reviewed for Preadmission Screening and Resident Review (PASRR) out of a total sample of 35 residents for a NJ Exec Order 26.4b1 resident review after the resident experienced a NJ Exec Order 26.4b1 in status assessment related to NJ Exec Order 26.4b1. This had the potential to cause R57 to not receive necessary NJ Exec Order 26.4b1 services. Findings include: Review of R57's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed R57 NJ ex order 26.4b1 [redacted] Review of R57's "Preadmission Screening and Resident Review NJ ex order 26.4b1 [redacted] and located under the "Misc (Miscellaneous)" tab of the EMR, revealed R57 NJ ex order 26.4b1 [redacted]	F 644	1. Corrective action for deficient practice: (a)Resident 57 level 1 NJ ex order 26.4b1 [redacted] by social worker. 2. Residents with potentials to be affected by deficient practice: (a)All residents can potentially be affected by deficient practice (b)Full house audit was completed by social worker 3. Systemic change to make sure deficient practice does not recur: (a)Social service staff were educated by DON/designee on completion of PASRR. (b)All potential residents will have their PASRR completed prior to admission to the facility - All resident with change in mental health status after admission will have PASRR completed for them	

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F 644	Continued From page 25 in NJ Exec Order 26.4b1 related to a NJ Exec Order 26.4b1 . Review of R57's "Diagnoses," listed under the "Med Diag (Medical Diagnoses)" tab of the EMR, revealed R57 was NJ ex order 26.4b1 " on NJ ex order 26.4b1 and with having NJ ex order 26.4b1 NJ ex order 26.4b1 both during her stay at the facility. Review of R57's entire EMR and hard chart revealed no documentation a NJ Exec Order 26.4b1 screening had been completed after receiving the NJ ex order 26.4b1 or that R57 had been referred for a NJ Exec Order 2 resident review. On NJ ex order 26.4b1 at 4:03 PM, the Social Services Director (SSD) confirmed the addition of the NJ Exec Order 26.4b1 diagnoses for R57 were a NJ Exec Order 26.4b1 for the resident and a NJ Exec Order 26.4b1 and NJ Exec Order 2 resident review should have been completed at that time.	F 644	4. How to monitor corrective action: (a)Social Services/Designee will conduct an audit for 5 charts a week to ensure that PASRR has diagnosis or evidence of major mental illness for appropriate resident; weekly for 4 weeks, bi-weekly for 4 weeks and then monthly. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	
F 645 SS=D	NJAC 8:39-11.2(i) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		8/18/23

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F 645	Continued From page 26	F 645		

authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

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F 645	Continued From page 27 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure two of ten residents (Resident (R) 43 and R95) reviewed for Pre-Admission Screening and Resident Review (PASRR) out of a total sample of 35 residents had accurate screenings and/or were referred for a Level II review as required following a NJ Exec Order 26.4b1. This had the potential to cause delay in receiving necessary NJ Exec Order 26.4b1 services for R43 and R95. Finding include: 1. Review of R43's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R43 was admitted to the facility on NJ Exec Order 26.4b with diagnoses that included NJ Exec Order 26.4b1	F 645	1. Corrective action for deficient practice: (a) Residents 43 and resident 95's NJ Exec Order 2 were referred to the NJ Exec. Order 26:4.b.1 on NJ Exec Order 26 for completion of NJ Exec Order 26 evaluation. 2. Residents with potentials to be affected by deficient practice: (a)All residents in the facility could potentially be affected by the deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)Social services staff to be educated on completion of PASRR	

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F 645	Continued From page 28 Review of R43's NJ ex order 26.4b1 NJ Exec Order 26.4b1," dated NJ ex order 26.4b1 and located under the "Misc (Miscellaneous)" tab of the EMR, revealed documentation R43 NJ ex order 26.4b1 and NJ ex order 26.4b1 Review of R43's "NJ Exec Order 26.4b1 dated NJ ex order 26.4b1 and located under the "Misc" tab of the EMR, revealed documentation R43 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1. It was documented R43's current location was a NJ ex order 26.4b1 or unit. It was documented R43 had a NJ ex order 26.4b1, and a NJ ex order 26.4b1 The form recorded, " . . . NJ ex order 26.4b1 Applies only to INITIAL NF [nursing facility] admission . . . NOT . . . NF readmission . . . " Review of R43's entire EMR and hard chart revealed no documentation a NJ Exec Order 26 resident review had been completed for R43. On 07/25/23 at 3:54 PM, the Social Services Director (SSD) confirmed that neither of the NJ Exec Or completed for R43 were correct. The SSD confirmed that with the NJ ex order 26.4b1 screening,	F 645	(b)Admission staff to be educated to request for PASRR from hospital where applicable before admission 4. How to monitor corrective action: (a)Social worker/designee will conduct an audit of 5 charts a week for residents that reside in the facility for positive level 1 and level 11, weekly for 4 weeks, bi-weekly for 4 weeks and then monthly. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 645	Continued From page 29	F 645		

it should have been coded R43 did have a NJ ex order 26.4b1 the 30-day Exempted Hospital Discharge request did not apply because R43 had already been admitted to the nursing facility. The SSD confirmed R43's screenings had been completed by people outside the facility but they should have been checked for accuracy by the facility. The SSD confirmed R43 should have had a NJ Exec Order 26 resident review.

2. Review of R95's "Admission Record," located under the "Profile" tab of the EMR, revealed R95 was NJ ex order 26.4b1 on NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1.

Review of R95's NJ Exec Order 26.4b1 dated NJ ex order 26.4b1 and located under the "Misc" tab of the EMR, revealed R95 was determined to have a diagnosis of NJ ex order 26.4b1, NJ ex order 26.4b1 that NJ ex order 26.4b1 It was recorded R95 had a "NJ ex order 26.4b1 Only." The form documented that for a "NJ Exec Order 26.4b1," a referral to Division of Mental Health and Addiction Services (DMHAS) was required. There was no documentation that any exceptions or exclusions had been requested.

Review of R95's entire EMR and hard chart revealed no documentation that the referral to DMHAS had been completed.

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F 645	Continued From page 30 On [NJ ex order 26.4b1] at 4:07 PM, the SSD reviewed R95's [NJ Exec Order 26.4b1] and confirmed a referral should have been made for a [NJ Exec Order 2] review. The SSD reviewed the EMR and R95's paper file and confirmed she could not find any information showing the referral had been made as required. Review of the facility's policy titled, "PASSR Policy and Procedure," reviewed 11/2022, revealed, " . . . The Preadmission screening and Resident Review ensures that individuals are placed in the most appropriate setting for their needs . . . If the Level I is positive for serious mental illness then a copy of the Level I must be faxed to the Division of Mental Health and Addiction Services . . . for a Level II Evaluation and Determination . . . "	F 645		
F 657 SS=D	NJAC 8:39-11.2(i) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		8/18/23

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F 657	Continued From page 31 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and policy review, the facility failed to ensure notification was provided for and care plan meetings were conducted routinely for one (Residents (R) R36) of a total sample of 35 residents. Findings include: R36's "Admission Record," dated NJ ex order 26.4b1 and found in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 [redacted] 36 was her own responsible party (RP). R36's quarterly "Minimum Data Set" assessment with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" assessment score of NJ ex [redacted] out of 15 indicating R36 NJ ex order 26.4b1 . Review of R36's comprehensive care plan indicated the plan of care was most recently revised with the resident's quarterly "MDS"	F 657	F657 Care Plan Timing and Revision 1. Corrective action for deficient practice: (a) Resident #36 was reassessed with NJ Ex [redacted]. Resident #36 was invited and attended the quarterly IDCP team meeting with revision to CP on NJ Exec Order 2[redacted] 2. Residents with potentials to be affected by deficient practice: (a) All residents that reside in the facility have the potential to be affected by the same deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a) All current residents due for a care plan meeting for their annual, quarterly, or significant changes were invited to attend with supporting documentation in the EMR	

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F 657	Continued From page 32 assessment dated [NJ Exec Order 26.4b].	F 657	on&.	

R36's "Interdisciplinary Team (IDT) Notes," dated [NJ Exec Order 26.4b] and found under the "Notes" tab in the EMR, indicated a quarterly care planning meeting was held on that date with the resident present. There was no additional documentation in the resident's record to indicate a care planning meeting had been conducted with the resident since that date.

Comprehensive review of R36's EMR indicated nothing to show the resident had been invited to a care planning meeting since [NJ Exec Order 26.4b]

During an interview with R36 on 07/23/23 at 1:59 PM, she indicated she was her own RP and stated she did not recall having been invited to a care planning meeting with the Inter-Disciplinary Team (IDT) at any time recently. She indicated she would participate if invited.

During an interview with the Social Services Assistant (SS) on 07/25/23 at 7:47 PM, she indicated she was in charge of scheduling care planning meetings for residents. She stated if a care planning meeting had been held recently, documentation of the invitation to the meeting as well as notes from the meeting itself would be found in the progress notes in the EMR.

During an interview with the Regional Clinical Director (RCD) on 07/26/23 at 1:20 PM, she confirmed she was unable to locate any documentation to show R36 had been invited to a care planning meeting since [NJ Exec Order 26.4], or that a care planning meeting had been held by the IDT for the resident since that date. The RCD stated her expectation was care planning meetings were

(b) Social Service were in-service on Comprehensive Care Plan and following policy and procedures to
ensure notification are provided to the resident and the resident□s representative on a routine
basis and in a timely manner.

4. How to monitor corrective action:

(a) Social Services/Designee will conduct an audit for all residents that reside in the facility to
ensure that notification and documentation with invitation to the care plan meeting is noted in the
EMR. The audit will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X3.

(b) DON/Designee will conduct spot audits on proper completion of comprehensive care plan audits will be
conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly x3.

5. Results of the audits will be presented to the monthly QAPI meeting for review and revision as
deemed appropriate.

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F 657	Continued From page 33 to be conducted for residents at least quarterly and R36 should have been invited to the meeting and in attendance if she chose to be. The facility's "Residents Rights Policy," revised September 2022, read, in pertinent part, " ....The resident has the right to participate in the development and implementation of his or her person-centered plan of care .....and has the right to request meetings ...and has the right to participate the establishment of expected goals and outcomes of care." NJAC 8:39-4.1(a)3	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide three residents (Resident (R)28, R88, and R36) who were unable to carry out activities of daily living (ADLs) the necessary services to maintain [NJ Exec Order 26.4b], and [NJ Exec Order 26.4b1] out of a total sample of 35. Findings include: 1. Review of an undated "Face Sheet," found in the "Profile" tab of the electronic medical record (EMR), revealed R28 was admitted to the facility on [NJ ex order 26.4b1] with diagnoses including	F 677	1. Corrective actions for deficient practice: (a) Resident # 28, Resident #88, Resident #36 were reassessed with [NJ Exec Order 26.4b1] [redacted] noted. (b) Resident 28 was cleaned, provided clean clothing on [NJ ex order 26.4b]. (c) Resident 88 was showered and given clean, dry clothes, linens were changed and bed cleaned on [NJ ex order 26.4b] (d) Resident 36 was showered on [NJ ex order 26.4b] (e) A full audit was conducted to ensure all	8/18/23

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F 677	Continued From page 34 NJ ex order 26.4b1 [redacted] R28's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 assessed R28 as NJ ex order 26.4b1 with a "Brief Interview for Mental Status (BIMS)" score of eight of a possible NJ ex points. R28 was NJ ex order 26.4b1 and required NJ ex order 26.4b1 [redacted] On 07/23/23 at 10:30 AM, R28 was observed in her room, on her bed, and calling out for assistance in NJ Exec Order 26. Her privacy curtain was partially opened and when approached she pointed NJ Exec Order 26.4b1 with NJ Exec Or and NJ Exec Order 26.4b1 [redacted]. Her bedside table was cluttered including a breakfast tray not yet picked up. R28's call light was not accessible as she yelled out to be changed in NJ Exec Order 26. The call light was found on the floor behind the bed. The Unit Manager/Licensed Practical Nurse (UM1) was working the other end of the hall but stopped to locate a Certified Nurse Aid (CNA) to assist R28, and stated, "there is only one CNA on this floor today with more than 50 people to get up." A follow-up visit an hour later confirmed R28 had been changed and her demeanor was much improved. 2. Review of an undated "Face Sheet," found in the "Profile" tab of the EMR, revealed R88 was admitted to the facility on NJ ex order 26.4b1 with NJ ex order 26.4b1 [redacted]	F 677	residents have had a recent shower per facility policy on 7/26/23 with results recorded on the ADLs sheets. No adverse effects 2. Residents with potentials to be affected bu deficient practice: (a) All residents residing in the facility have the potential to be affected by this deficient practice. 3. Systemic change to ensure deficient practice does not recur: (a) All License nursing staff and Certified Nursing Assistance we re-educated on the facility's policy and procedure for ADL□s to include the routine master shower schedule with supporting documentation. (b) All Licensed nursing staff and CNAs were reeducated on 'Care for the incontinent' 4. How to monitor corrective action/s (a) Unit Manager/Designee will conduct an audit for all residents that reside in the facility to ensure showers are completed based on the master shower schedule and the documentation is reflected on the ADL sheets. The audit will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X3. (b) DON or designee will perform random shower audit weekly x 4 weeks, bi-weekly x 2 weeks, and then	

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F 677	Continued From page 35 R88's quarterly "MDS" assessment with an ARD of NJ ex order 26.4b1 assessed R88 with NJ ex order 26.4b1 with a "BIMS" score of NJ ex of a possible 15 points. R88 was NJ ex order 26.4b1 R88 NJ ex order 26.4b1 Observation on 07/25/23 at 9:30 AM revealed R88 was dressed and (R28's roommate) lying on her bed with a NJ Exec Order 26.4b1 present. When asked, R88 nodded to indicate she was NJ Exec Order 26.4b1 and pulled her shirt up to reveal a NJ Exec Order 26.4b1. The call light was initiated by R88 on request. After 10 minutes this writer looked to see if staff were in the hallway to respond to the call light. The LPN3 assigned to care for the residents on R28's and R88's hallway was located in Dayroom 2 on her cell phone. LPN3 was advised that R88 required assistance with her NJ Exec Order 26. LPN3 entered R88's room four minutes later. When LPN3 entered the room, R88 was exiting the bathroom with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 LPN3 instructed R88 to go back in the bathroom to put on a NJ Exec Order 26. but did not offer assistance or NJ Exec Order 26.4b1. CNA3 was passing in the hallway and stopped to assist R88 with her NJ Exec Order 26 and clean clothes. CNA 3 was assigned to the other end of the hall, and not specifically to R28 and R88. CNA3 stated she was nearby and came to help R88. CNA3 stated everybody had to pitch in when "we are short staffed" and she worked both halls and was familiar with R28 and R88. Observation on 07/26/23 at 9:45 AM revealed R88 and R28 were in their room. R88 was lying on top of her bed and was asked if she was going to a 10 o'clock activity in the dayroom. She said	F 677	monthly X3. Any adverse findings will be immediately addressed. (c) DON or designee to randomly monitor residents for incontinent supply availability and incontinent care weekly x 4, bi-weekly x 4 and then monthly x3 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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no and pointed to NJ Exec Order 26.4b1 so she didn't want to leave her room.

On 07/26/23 at 11:30 AM the Interim Director of Nursing (iDON) was interviewed regarding the ADL concerns for R28 and R88. She stated, "R88 NJ Exec Order 26.4b1 because she [iDON] was just in there ..." When advised that one of the two women in that room had been found (by this writer) with NJ Exec Order 26.4b1 each day of the survey, the iDON stated, " ...well, she's a NJ Exec Order 26.4b1 ..." When pushed further for an interview the iDON stated " ...I am only interim while the new DON get her licensure issues worked out ..." when asked about staffing she stated, yes, she was a nurse but, no, she had not worked the floor to assist with the staffing shortages.

3. R36's "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile" tab, revealed she was NJ ex order 26.4b1 on NJ ex order 26.4b1 with NJ ex order 26.4b1 .

R36's quarterly "MDS" assessment, with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "BIMS" assessment score of NJ ex o out of 15,indicating R36 was NJ Exec Order 26.4b1 The "MDS" assessment indicated R36 NJ ex order 26.4b1

Review of R36's "Activities of Daily Living Care Plan," dated NJ ex order 26.4b1 and found in the EMR under the "Care Plan" tab, indicated the resident NJ ex order 26.4b1 . Interventions included maintain consistent schedule with daily routine and provide assistance with ADLs as needed.

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R36's undated "Daily Rhythm of Life Document," found in the ADL book at the nurses station, indicated the resident's preference was to bathe on the day shift (7 AM to 3 PM) on Mondays and Fridays.

R36's "Stop and Watch Forms" (staff documentation of resident bathing), dated NJ ex order 26.4b1 and found in the ADL book at the nurses station, indicated R36 received baths/showers on NJ ex order 26.4b1 [redacted]. There was no documentation in the resident's record to indicate R36 refused to shower/bathe during the referenced time frame.

During an interview with R36 on 07/23/23 at 2:03 PM, she stated she had not received a shower in "who knows how long." She further stated, "There is no staff, and if no staff ...no shower. That's the way it is."R36 was observed to be unkempt during the interview and her hair appeared oily.

During an interview with the Interim Director of Nursing (iDON) on 07/25/23 at 3:48 PM, she indicated her expectation was residents receive baths/showers at least twice weekly/per their preference and that all shower/bath documentation was kept at the nurses' stations in ADL books. She indicated refusals to bathe/shower were expected to be documented in each resident's progress notes in the EMR. The iDON indicated residents were scheduled for bathing by room number and the schedule was also kept in the ADL books at the nurses' stations.

A review of an undated facility policy titled "ADL Care" revealed "Policy: It is the policy of this

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F 677	Continued From page 38 facility to provide ADL care to residents requiring such assistance to ensure all ADL needs are met on a daily basis ...each residents physical functioning will be assessed ...the level of ADL assistance required will be included on the residents care plan ...a variety of approaches will be utilized in assisting residents with dementia ..." NJAC 8:39-27.2(g)(h)(i)	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to provide a consistent program of preferred and planned activities for four (Residents (R)21, R43, R88, and R97) of seven residents reviewed for activities out of a total sample of 42 residents. Activities were not provided routinely for residents per their assessed preferences due to a lack of both nurse and activities staffing. In addition, activities posted on the activities schedule on the facility's third floor were not provided per the posted schedule.	F 679	1. Corrective action for deficient practice: (a) Activities calendar was updated 7/28/23 to include residents' preferences, independent pursuits, 1:1 or group activities. (g)Recreation director will ensure there is available activities staff for any scheduled activities for each unit (b)Residents 21, 43, 88 and 97's care plans will be updated to reflect activities of interest and need. (c)All residents will be provided with activities: individualized and in a group	8/18/23

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F 679	Continued From page 39 Findings include: The facility's Third Floor Activity Calendar, posted in the hallway across from the nurses' station, indicated the following scheduled activities during the survey period: Sunday 07/23/23 10:30 AM "Anagrams" and 2:15 PM "Would You Rather," Monday 07/24/23 10:15 AM "Move to the Groove," 10:30 AM "Karaoke Fun," 2:15 PM "BINGO," and 2:15 PM "Balloon Volleyball," and Tuesday 07/25/23 10:15 AM "Tone Up Tuesday," 10:30 AM "Balloon Volleyball," 2:15 PM "Afternoon Movie," and 4:00 PM "Room Visits/Sensory Stimulation." 1. R21's "Admission Record," dated NJ ex order 26.4b1 and found in the electronic medical record (EMR) under the "Profile Tab, revealed R21 was NJ ex order 26.4b1 on NJ ex order 26.4b1 with NJ ex order 26.4b1 R21's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, indicated a "Brief Interview for Mental Status (BIMS)" score of NJ ex out of 15, indicating R21 was NJ ex order 26.4b1. This "MDS" assessment indicated R21 NJ ex order 26.4b1 R21's "Activities Care Plan," dated NJ ex order 26.4b1 and found in the EMR under the "Care Plan" tab, indicated the resident engaged in group activities when not pursuing self-directed leisure. The resident's preferred activities were listed as reading, socializing, Resident Council, menu planning, video chatting, going outside when the weather was nice, crossword puzzles, parties,	F 679	setting whichever is appropriate. (d)Director will ensure that all residents attend activities and attendance is documented (e)Rcreation director to ensure available staff are on time to carry out activity programs (f)Recreation director to ensure that staff will be on unit 15 - 30 minutes before start of activities. 2. Residents with potentials to be affected by deficient practice: (a)All residents could potentially be affected by deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)Educate CNA staff to have residents ready for activities in timely fashion by activities director (b)educate activities staff to ensure that all residents activities need are meet, individually and collectively by activities director. 4. How to monitor corrective action: (a)The recreation dirctor to conduct random audit of 10 residents daily for 4 weeks, 4 weeks, and then monthly. (b)recreation director to audit residents' participation log, daily for 4 weeks, weekly for 4 weeks and then monthly. 5. Results of the monitoring will be presented to monthly QAPI committee	

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F 679	Continued From page 40 socials, and bingo. Interventions included: Provide with activity calendar monthly and Staff provide independent leisure materials of choice. R21's "Life Enrichment Evaluation," dated [NJ ex order 26.4b1] and found in the EMR under the "Evaluations" tab, indicated it was "Very Important" for the resident to: do things with groups of people, listen to music she liked, do her favorite activities, and go outside to get fresh air when the weather is good and "Somewhat Important" for the resident to: have books, newspapers, and magazines to read, be around animals such as pets, and keep up with the news. Preferred activity pursuits on the assessment included games, crafts, sports, talking/conversing, walking/wheeling outdoors, music, reading/audio books, writing, baking/cooking, trips/shopping, TV viewing, watching movies, groups/club organizations, and parties/social events. The resident's indicated preferred activity setting was "Day/Activity Room." R21's Activity Participation Logs were not able to be located anywhere in the resident's record or in the Activity Logbook kept by the facility's Interim Activities Director. R21 was observed lying in her bed or in her wheelchair on [NJ ex order 26.4b1] at 10:59 AM, on [NJ ex order 26.4b1] at 9:51 AM, 12:01 PM, and 3:49 PM, and on [NJ ex order 26.4b1] at 9:33 AM, 10:25 AM, 10:46 AM, and 12:03 PM. R21 was not engaged in any scheduled activities during the observations. The resident's television set was on during all the observations. None of the scheduled activities listed on the published and posted third floor Activity Calendar, with the exception of the [NJ Exec Order 26.4b] 10:30 AM	F 679	meeting for review and revision as deemed appropriate.	

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"Balloon Volleyball" Activity, were observed to be offered on the facility's third floor. Observation of the [redacted] "Balloon Volleyball" activity revealed three residents invited and participating in the activity, which was conducted at 11:15 AM rather than 10:30 AM since the Activities Assistant assigned to the third floor on that date had working hours of 11:00 AM until 7:00 PM. One of the residents observed attending the activity slept through the entire activity and no attempt was made by the activity assistant to awake and involve the resident in the activity.

During an interview with R21 on 07/23/23 at 10:59 AM, she stated she was [redacted] on that day to attend any activities because there was not enough (nursing) staff. She stated, "Only one aide and two nurses (are working today) so they told her can't get me up. I have to stay in bed today. This happens frequently."

During an interview with R21 on 07/24/23 at 9:51 AM, she stated, "They [the facility] don't have anything [activities] on the weekends. Every weekend is like that. They [activities staff] will put something on the calendar but none of it happens. They don't have enough people. A lot of people stay in bed [instead of attending activities]."

During an interview with R21 on 07/24/23 at 12:01 PM, she indicated none of the scheduled activities (per the posted activity calendar) had happened that morning. She stated she had been up out of bed and would have attended activities if they had been offered that morning.

During an interview with R21 on 07/24/23 at 3:49

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PM, she stated BINGO had been on the activity calendar for that afternoon at 2:30 PM, but the activity had not happened. She stated, "They did not do [the scheduled] balloon volleyball at 2:15 [PM], either. No one has been here to invite me to anything."

During an interview with R21 on 07/25/23 at 10:31 AM, the resident indicated she would have liked to attend the morning's scheduled activities ("Tone-Up" and "Balloon Volleyball"), however she was still in bed since nursing staff had not been in to get her up into her wheelchair yet that morning and so was unable to attend. She stated she had not been asked if she would like to participate in activities yet that morning, and stated she did not want to stay in bed but would rather get up and attend activities.

During an interview with the Interim Activities Director (iAD) on 07/25/23 at 1:44 PM, she indicated she had been the interim director of activities since [redacted] and stated activities were scheduled to begin every morning at 10:30 AM. She stated different activities were scheduled each day. She stated morning activities were scheduled between 10:30 AM and 11:00 AM and then afternoon activities were scheduled between 2:15 PM and 3:00 PM. The last activity in the morning is 10:30 to 11:00 and then afternoon 2:15 until 3:00. The iAD stated her expectation was activities were to be offered based on the calendar for each unit on the weekend as well as during the week. She stated activity participation logs were kept for each resident to document attendance at activities.

During a follow-up interview with the iAD on 07/25/23 at 2:41 PM, she stated she had not

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been able to find activity participation logs for any of the residents residing on the facility's third or fourth floor, including R21, from [redacted] through [redacted]. She indicated her expectation was the Activity Aides would invite residents to activities, conduct the activities, and then document resident attendance at the activities. The iAD stated each floor had a different activities calendar each month, but some activities were provided jointly for the third and fourth floors. She stated if a joint activity was to occur, it was conducted in the Lounge on the third floor. The iAD confirmed BINGO had not been offered at all per the schedule on 07/24/23 and stated it was supposed to have been offered on the third floor on that day.

During an interview with the iAD and Activity Assistant (AA) AA1 on 07/25/23 at 2:58 PM, AA 1 indicated he frequently worked on the third floor, was familiar with residents on the unit, and stated R21 enjoyed activities like reading, word searches, and BINGO. He stated his work hours were 11:00 AM to 7:00 PM and indicated morning activities were not offered on the floor he was working on each shift until after his arrival at 11:00 AM. The iAD confirmed morning activities were not being provided on the floor AA 1 was working on each shift since he did not arrive at work until after the scheduled morning activities were to be offered.

During an interview with the Regional Activities Director (RAD) on 07/25/23 at 3:19 PM, she stated it was her expectation the activities calendar be followed for each floor. She stated, "If it is on the calendar, it should be happening. Unless there is an emergency." She further stated resident attendance at all activities was

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expected to be recorded in the Activity Attendance Log. She stated activities staff was expected to be in the building and on the unit inviting residents to activities 15 to 30 minutes prior to the beginning of each activity to encourage residents to attend.

2. Review of R43's "Admission Record," located under the "Profile" tab of the EMR, revealed R43 was admitted to the facility on [NJ ex order 26.4b1] with diagnoses that included [NJ ex order 26.4b1] [redacted]

Review of R43's annual "MDS" with an ARD of [NJ ex order 26.4b1] and located under the "MDS" tab of the EMR, revealed R43 scored a [NJ ex orde] out of 15 on the "BIMS" which indicated R43 was [NJ ex order 26.4b1] [redacted] It was recorded it was very important to R43 to listen to music she liked, be around animals such as pets, do things with groups of people, do favorite activities, and go outside to get fresh air when the weather is good. It was also recorded R43 [NJ ex order 26.4b1] [redacted].

Review of R43's "Care Plan," revised [NJ Exec Order 26.4b] and located under the "Care Plan" tab of the EMR, revealed, " . . . attends all activities and is assisted as necessary . . . "

Review of the facility's "Activity Calendar," dated 07/23/23 and provided by the Activities Director, revealed the following activities were scheduled for R43's floor:
10:00 AM - Rise and Shine Café
10:30 AM - Anagrams
2:15 PM - Karaoke

During an observation and interview on 07/23/23

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at 11:11 AM, Certified Nurse Aide (CNA) was observed providing personal care for R43. CNA1 confirmed R43 had not been out of bed to attend the activities at 10:00 AM and 10:30 AM.

During a continuous observation on 07/23/23 from 1:39 PM through 2:30 PM, R43 was observed in her bed. R43's television was not on, and there was no music playing. Staff did not enter her room during that time, and R43 did not attend the Karaoke activity.

Review of R43's "Record of Record of One-to-One Activities and Resident Participation Record," dated 07/23/23 and provided by the Activities Director (AD), documented R43 had independent activity pursuits and watched television on 07/23/23.

Review of the facility's "Activity Calendar," dated 07/24/23 and provided by the Activities Director, revealed the following activities were scheduled for R43's floor:
10:15 AM - Move to the Groove
10:30 AM - Guess Who?
2:15 PM - Balloon Volleyball

During observations on 07/24/23 at 10:15 AM, 10:30 AM, and 2:15 PM, R43 was observed in her bed. R43 did not attend the scheduled activities for the day, and there was no television or music playing in her room.

Review of R43's "Record of Record of One-to-One Activities and Resident Participation Record," dated 07/24/23 and provided by the Activities Director (AD), documented R43 had independent activity pursuits and watched television on 07/24/23.

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During an interview on 07/25/23 at 10:08 AM, CNA1 confirmed R43 liked to attend most activities but she had been the only aide on R43's floor on 07/23/23 and she did not have time to get R43 up to attend the activities.

During an interview on 07/25/23 at 5:11 PM, Unit Manager (UM) 1 was asked why R43 was not taken to activities on 07/23/23 and 07/24/23. UM1 confirmed there was not enough staff to get R43 up to get her to activities.

3. Review of an undated "Face Sheet," found in the "Profile" tab of the EMR, revealed R88 was admitted to the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 R88's quarterly" MDS" assessment with an "ARD" of NJ ex order 26.4b1 assessed R88 with moderate cognitive impairment with a "BIMS" score of NJ ex of a possible 15 points. R88 was NJ ex order 26.4b1 She NJ ex order 26.4b1 .

Observations of R88 on 07/23/23 at 2:30 PM revealed she was in her room sitting on the bed. She did not have anything to occupy or entertain her. R88 stated, " .. NJ Exec Order 26.4b1 R88 was NJ ex order 26.4b1 with some encouragement and NJ Exec Order She enjoys trying to help others.

4. Review of an undated "Face Sheet," found in the "Profile" tab of the EMR, revealed R97 was

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NJ ex order 26.4b1 on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1

R97's MDS assessment with an ARD of NJ ex order 26.4b1 assessed R97 as cognitively intact with a BIMS score of NJ ex of a possible 15 points. R97 was NJ ex order 26.4b1 and NJ ex order 26.4b1 97 was able to self-direct his activities but the thing he planned his day around was NJ Exec Order 26.4. He stated that" ... other than NJ Exec Order 26.4b1 .."

A group meeting was conducted with six NJ Exec Order 26.4b1 residents on 07/24/23 at 11:00 AM.
The group agreed that staffing is their primary issue, and it interferes with their ability to enjoy activities, or go outside on nice days, or just get the care they need, especially on night shift. The activity calendar was reviewed, and the group stated they rarely followed the calendar and there was little to do to occupy their interests. The residents from the third floor stated there are activities scheduled every day at 10:00 AM, and activity staff don't even arrive until 11:00 AM. The group identified activities as a concern in the group meeting in May and were told there would be more outdoor activities, and new board games and puzzles were to be provided for resident use. They were told that the group could choose a special meal at least monthly, but they haven't received any follow up about any of those things

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F 679	Continued From page 48 NJAC 8:39-7.3(a)	F 679		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interviews and job description review, the facility failed to have a qualified Activities Director to oversee the activities department for all 141 current residents in the facility. This failure resulted in all residents not being provided with resident specific activities. Findings include: During an interview on 07/26/23 at 7:27 PM, the Administrator revealed that the previous activity director quit without notice in [redacted] and the facility started looking for a new candidate to fill	F 680	1. Corrective action for deficient practice: (a) A certified activity director with Activities Director Certification and also Certified Dementia Practitioner has been hired. 2. Residents with potential to be affected by deficient practice: (a) All residents could potentially be affected by deficient practice	8/18/23

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F 680	Continued From page 49 that position. He confirmed that the current Activity Director (AD) was not qualified but stated they were looking to fill the role with the right person, felt the current AD was the best fit and was in school and would be completing the program in [redacted]. The Administrator stated that finding staff currently "is very difficult, when faced with something like this, you just do your best." During an interview on 03/01/23 at 9:44 AM, the Activity Director (AD) stated she had been the AD, since the previous Activities Director left in [redacted]. She verified that she had not completed her schooling or certification as an Activities Director. AD stated she was currently enrolled and attending courses for Recreational Therapy and would be completed in [redacted]. Review of the undated job description titled, "Director of Recreation" reflects in part, "Accepts professional obligations and commitments to professional development, by actively supporting local , state, and national organizations for the Recreational/Activity Coordinator, participating in basic and continuing education through professional organizations and educational institutions, keeping abreast of Federal, State and local requirements regarding activity programming, as well as current developments in long term health care, and by identifying and correcting deficiencies inn knowledge and skills. NJAC 8:39-7.1(b)	F 680	3. Systemic change to make sure deficient practice does not recur: (a) Educate Regional Director of Activities on the need to verify candidates credentials/qualification before appointment to ensure that candidate is 'ADC' certified (b) New Activities director will train a qualified activities aide who could serve as interim if the Activities director resigns or is on vacation. 4. How to monitor corrective action: (a)Administrator to audit file od all newly hired activity director to ensure that they are Certified activity director, monthly for 12 months (b) Administrator and H/R director will audit files of newly hired and interim Activities director for licenses to ensure they have activity directors' certification upon hire or appointment. 5. Results of the monitoring will be presented to the monthly QAPI committee meeting for review and revision as deemed appropriate.	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)	F 685		8/18/23

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F 685	Continued From page 50 §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure broken NJ Exec Order 26.4b1 were repaired for one of five residents (Resident (R)6) reviewed for hearing devices in a total sample of 35 residents. Findings include: Review of an undated "Face Sheet," found in the "Profile" tab of the electronic medical record (EMR) revealed R6 was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 Review of R6's quarterly "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed R6 was assessed as NJ Exec Order 26.4b1 with a "Brief Interview for Mental Status (BIMS)" score of NJ ex of a possible 15 points. On 07/23/23 at 11:30 AM, R6 was observed in his room, sitting on the NJ Exec Order 2. When screened in the initial pool portion of the survey R6 stated his	F 685	1. Corrective action for deficient practice: (a) Resident #6 was re-assessed with NJ ex (b) NJ Exec Order 26.4b1 were replaced on NJ Exec Order 26 and resident #6 NJ Exec Order 26.4b1 was restored. A full house audit of all current residents who require treatment/devices to maintain hearing/vision was completed with consultation follow up if required. 2. Residents with potentials to be affected by deficient practice: (a) All residents that reside in the facility have the potential to be affected by the deficit practice. 3. Systemic change to make sure deficient practice does not recur:	

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F 685	Continued From page 51 main concerns were staffing, and that he had been asking for months for his NJ Exec Order 26.4b1 to be repaired. He stated the NJ Exec Order 26.4b1 don't work and had been stored on the nursing medication cart for months. When asked if he had alerted staff he said he told the Nurse Practitioner and the Activities staff. He stated the facility hadn't had a full time Social Worker (SW) for months. R6 said there had been some "temp" staff assisting, but "nothing gets done." A review of R6's EMR revealed his current physician orders had specific orders related to R6's NJ ex order 26.4b1 NJ ex order 26.4b1 " NJ ex order 26.4b1 accountability each shift ..." NJ ex order 26.4b1 NJ Exec Order 26.4b1 on in a.m. off at bedtime ..." NJ ex order 26.4b1 " NJ ex order 26.4b1 to (NJ Exec Order 26.4b1 ON in AM and OFF in PM every day and night shift Put on in AM and Remove in PM (Keep in Nurse's Cart)" NJ Exec Order 26.4 " .. NJ ex order 26.4b1 to (NJ Exec Order 26.4b1 ON in AM and OFF in PM every day and night shift for NJ Exec Order 26.4b1 ..."There were no SW notes to correspond with any of these orders. Review of a "Progress Note," found in the "Progress Note" tab of the EMR, revealed on NJ ex order 26.4b1 a nurse's note identified that R6's NJ Exec Order 26.4b1 was not functioning properly and a call was placed to the NJ Exec Order 26.4b1 and was told" ...a rep NJ Exec Order 26.4b1] would be in by the end of the week to repair." R6 stated on NJ ex order 26.4b1 at 11:30 AM, that the NJ ex order 26.4b1 and were in the nurses' medication cart. Continued review of the EMR revealed R6 had not received any SW assistance with his NJ Exec Order 26 . There were no social service visits in R6's	F 685	(a1) Social worker, Rehabilitation therapists, all licensed nurses and CNA's were educated to report immediately to DOM, ADON or administrator any report from residents about defective devices (a) Social Worker(s) were in-service on facilitating consultation in a timely manner when notified by the resident or the residents representative. (b) All Licensed nursing staff we re-educated on the facility□s policy and procedure on Maintaining residents' devices for hearing and vision and ensure proper functioning of the devices. (c) The DON/designee will continue in-services for licensed nursing staff on the facility policies and procedures on treatment/devices to maintain hearing/vision. 4. How to monitor corrective action: (a) Social Services/Designee will conduct an audit for all residents that require treatment /devices for complaints of malfunction. The audit will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X3. (a) DON/Designee will conduct random audits, for malfunctioning devices, (hearing aides, glasses) weekly X 4 weeks, bi-weekly X 4 weeks, then monthly.	

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F 685	Continued From page 52 EMR for over a year and none to respond to the multiple orders for his [NJ Exec Order 26.4b1] to be repaired. On 07/25/23 the Social Services Staff (SS) member was asked about R6's [NJ ex order 26.4b1] and stated the [NJ ex order 26.4b1] needed batteries. When asked if batteries had been provided SS stated as far as she knew they had not, she had been out on medical leave, but she would speak to the resident, and take care of that immediately. When asked if coverage was provided while she was out, she stated the facility had been trying to hire full time SW, but there were only temporary fill-ins while she was out for maternity leave. On 07/26/23 at 3:35 PM the Interim Director of Nursing was asked if she felt the medically appropriate services had been provided to R6 related to his [NJ Exec Order 26.4b1]. Her response was to shrug her shoulders and say, "I guess not - I'm interim until the DON's licensure issues are resolved and I don't know a lot of the things that I'm being asked." Review of a facility policy titled "Vision and Hearing Services," revised 09/20/22, revealed "It is the policy of this facility to ensure residents have access to and receive proper treatment and assistive devices to maintain hearing and vision abilities ...2. Employees should refer any identified need for hearing and vision services/appliances to the Social Worker (SW)or designee ...3. The social worker or designee is responsible to assist residents and/or families in locating and utilizing any available resources for the residents hearing and vision needs ...Assistive devices to maintain hearing include but are not limited to hearing aids and amplifiers ..."	F 685	5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 685	Continued From page 53	F 685		
F 700 SS=E	NJAC 8:39-27.5(a) Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and policy review, the facility failed to ensure the use of side rails was assessed, physician's orders obtained, care plans developed, and/or informed consent obtained for the use of side rails for five (Residents (R)5, R36, R95, R20, and R43) of eleven residents who were reviewed for accidents out of a total sample of 42 residents.	F 700	1. Corrective action for deficient practice: (a) Residents # 5, # 36, 95, 20, and #43 were immediately assessed by License nurse for any adverse effects from the NJ ex order 26.4b1, none observed on NJ ex order 26.4. (b) Resident # 5 NJ ex order 26.4b1 [redacted], plan of cared updated NJ ex order 26.4b	8/18/23

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F 700	Continued From page 54 Findings include: 1. R5's "Admission Record," dated NJ ex order 26.4b1 and found in the Electronic Medical Record (EMR) under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 . R5's admission "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD)of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" assessment score of NJ ex o out of 15 indicating R5 was NJ Exec Order 26.4b1 . The assessment indicated R5 required limited assistance from staff to complete all of his Activities of Daily Living (ADLs), including NJ Exec Order 26.4b1 , and indicated NJ Exec O were not in use for the resident. Review of R5's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" tab, revealed orders for the resident to have NJ Exec Order 26.4b1 applied to his bed as an enabler for NJ Exec Order 26.4b1 Review of R5's comprehensive care plan," dated NJ ex order 26.4b1 and found in the EMR under the "Care Plan" tab, indicated no care plan to address the resident's use of NJ Exec Order 26.4b . R5's most recent " NJ Exec Order 26.4b Assessment," dated NJ ex order 26.4b1 and found in the EMR under the "Evaluation" tab, indicated the resident was to have NJ Exec Order 26.4b1 placed on his bed to be used for an enabler for NJ Exec Order 26.4b1 in bed. Comprehensive review of R5's record revealed nothing to show informed consent had been	F 700	(c) Resident # 36 NJ ex order 26.4b1 obtained, plan of care updated NJ ex order 26.4b (d) Resident # 95 NJ ex order 26.4b1 , new bed ordered. (e) Resident # 20 NJ ex order 26.4b1 tighten NJ ex order 26.4b , new bed ordered. (f) Resident # 43 NJ ex order 26.4b1 , consent obtained NJ ex order 26.4b . 2. Residents with potentials to be affected by deficient practice: (a) All residents in the facility that use bed rails have the potential to be affected by this deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a) DON/designee performed a facility wide audit on all beds for loose bed rails, obtain consent forms, quarterly and initial assessments, physician orders, and update care plans appropriately. (b) DON/ designee will in-service all front-line staff on facility bed rail policy, inspecting and regularly checking the mattress and bed rails for gaps and areas of possible entrapment, checking rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time. 4. How to monitor corrective action:	

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F 700	Continued From page 55 obtained for the resident's use of [redacted]. R5 was observed in his room lying in bed or seated in his wheelchair on 07/23/23 at 1:53 PM, and on 07/25/23 at 9:36 AM, 10:44 AM, and 11:30 AM. The resident's bed was observed to have [redacted]. The resident stated he used his [redacted] for [redacted] in bed as well as to [redacted] in and out of bed to wheelchair. 2. R36's "Admission Record," dated [redacted] and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on [redacted] with diagnoses including type [redacted]. R36's quarterly "MDS" assessment, with an ARD of [redacted] and found in the EMR under the "MDS" tab, revealed a "BIMS" assessment score of [redacted] out of 15 indicating R36 was [redacted]t. The assessment indicated the resident [redacted], and indicated [redacted] were not in use for the resident. Review of R36's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" tab, revealed orders for the resident to have [redacted]. Review of R36's comprehensive care plan," dated [redacted] and found in the EMR under the "Care Plan" tab, indicated no care plan to address the resident's [redacted].	F 700	(a)DON/designee will perform bed rail audits daily x 3 weeks, weekly X3, bi-weekly X 4 and monthly x3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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R36's most recent "NJ ex order 26.4b1," dated NJ ex order 26.4b1 and found in the EMR under the "Evaluation" tab, indicated the resident was to have NJ ex order 26.4b1

Comprehensive review of R36's record revealed nothing to show informed consent had been obtained for the resident's use of NJ Exec Order 26.4b.

R36 was observed in her room seated in bed or on the side of her bed on 07/23/23 at 2:06 PM, on 07/24/23 at 10:17 AM, and on 07/25/23 at 9:33 AM. The resident's bed had NJ ex order 26.4b1 installed at the head of the bed. The resident stated she used her NJ Exec Order 26.4b for NJ Exec Order 26.4b1 in her bed as well as to NJ Exec Order 26 in and out of her bed to her wheelchair.

3. Review of R95's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R95 was admitted to the facility on NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1

Review of R95's "Physician's Orders," dated NJ ex order 26.4b1 and located under the "Orders" tab of the EMR, revealed an order for NJ ex order 26.4b1.

Review of R95's quarterly "MDS" with an ARD of NJ ex order 26.4b1 and located under the "MDS" tab of the EMR, revealed a "BIMS" was not attempted due to R95 NJ Exec Order 26.4b1 and that R95 had NJ ex order 26.4b1. It was recorded R95 NJ ex order 26.4b1,

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and NJ Exec Order 26.4b1; and NJ Exec Order 26.4b1

Review of R95's "Care Plan," dated NJ ex order 26.4b1 and located under the "MDS" tab of the EMR, revealed a focus related to R95 NJ Exec Order 26.4b1 The goal was R95 would remain safe. Interventions included to NJ Exec Order 26.4b1 at all times. Further review of R95's care plan revealed no focus, goals, or interventions related to R95's NJ ex or

Review of R95's "NJ Exec Order 26.4b Assessment," dated NJ ex order 26.4b1 and located under the "Evaluations" tab of the EMR, revealed R95 was NJ Exec Order 26.4b1, NJ ex order 26.4b1 for NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1, and previous interventions included lowering the bed to the floor, providing frequent staff monitoring at night, and periodic assistance to NJ Exec Order 26.4b1 for R95 at night. It was recorded that the recommendation for R95 was to use NJ ex order 26.4b1 on each side of the bed.

Review of R95's "Health Status Note," dated NJ ex order 26.4b1 at 9:28 PM and located under the "Progress Notes" tab of the EMR, revealed, " . . . Around 5:30 pm resident was observed NJ Exec O l, resident unable to give description, resident was assessed head to toe, NJ Exec Order 26.4b1 noted, v/s [vital signs] stable, resident remains NJ Exec O, with NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 noted . . . resident was properly NJ Exec Order 26.4b1 in bed and made comfortable, NJ Exec Order 26.4b1

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F 700	Continued From page 58 maintained, staff continue to monitor . . . " During an observation on 07/23/23 at 11:06 AM, R95 was observed lying in bed. There were half NJ ex order 26.4b1 in the up position on each side of the bed. R95 was moving about bed without intention. During an observation on 07/23/23 at 2:43 PM, R95's bed was observed. The NJ ex order 26.4b1 was noted to be NJ Exec Order 26.4b1. When the left NJ Exec O was pushed away from the mattress, a gap measuring six inches was created between the mattress and NJ Exec Order 26.4b1 During an interview on 07/23/23 at 2:50 PM, Certified Nurse Aide (CNA) 1 confirmed R95 did not use her NJ ex order 26.4b1 to NJ Exec Order 26.4b1 in the bed. During an interview on 07/25/23 at 9:12 AM, Unit Manager (UM) 1 stated the facility utilized an assessment on admission and conversations with the resident and the resident's family in order to determine if NJ Exec Order 26.4 would be used for a resident. UM1 stated R95 had been admitted to the facility prior to her employment but she knew R95 had a NJ ex order 26.4b1, and the NJ ex order 26.4b1 had most likely been implemented due to the NJ ex order 26.4b1 UM1 stated on NJ ex order 26.4b1, R95 had NJ Exec Order 26.4b1 and was found by staff with her NJ Exec Order 26.4b1 UM1 stated that was one reason she reinforced the use of the NJ Exec Order 26.4 on the NJ Exec O NJ Exec O. UM1 stated she would not confirm the NJ Exec O for R95 because whether R95 was in her bed or in her NJ Exec Order 26 chair, R95 would turn herself around. UM1 stated staff had to constantly NJ Exec Order 26.4b1 R95. UM1 stated she ensured the NJ Exec Order 26.4b1 for R95 by NJ Exec Order 26.4b1 and making frequent	F 700		

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rounds.

Continuing with the interview on 07/25/23 at 9:12 AM, UM1 stated the facility's policy related to the use of [NJ Exec Order 26.4] was to determine medical necessity before [NJ ex order 26.4b1] were used. UM1 stated R95 was [NJ ex order 26.4b1] UMCC stated she and the MDS Coordinator were responsible for ongoing assessments and evaluations to determine if [NJ ex order 26.4b1] were appropriate for any resident. UM1 confirmed the medical record contained no documentation to show what the medical necessity was for the use of [NJ ex order 26.4b1] for R95. UM1 was asked to provide the informed consent for the use of [NJ ex order 26.4b1] with R95. UMCC stated she believed the informed consent was completed on admission and she was unsure if the document was still in R95's clinical record.

During an observation and interview on 07/25/23 at 9:42 AM, UM1 and the surveyor observed R95's [NJ ex order 26.4b1]. UM1 was shown the gap between R95's mattress and [NJ Exe] [NJ ex order 26.4b]. UM1 stated, "It's an accident hazard." UM1 confirmed the [NJ ex order 26.4b1] was loose and needed to be tightened. UM1 stated it was her expectation that staff notify her and maintenance when a [NJ ex order 26.4b1] was noted to be loose.

During an observation and interview on 07/25/23 at 12:38 PM, the Maintenance Director (MD) and Regional Director of Plant Operations (RDPO) observed R95's [NJ ex order 26.4b1]. The MD confirmed the [NJ Exe] [NJ ex order 26.4b] was loose, needed to be tightened, and had a gap greater than four inches. The MD stated there should be no gap or a bolster should be placed in the gap area. The MD stated staff

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was expected to call, page, or text with any concerns such as [NJ Exec Order 26.4b1] or gaps between mattresses and [NJ Exec Order 26.4].

On 07/26/23 at 10:06 AM, UM1 stated it was her responsibility to develop a comprehensive care plan related to the use of [NJ Exec Order 26.4]. UM1 confirmed that R95's care plan did not address the use of [NJ Exec Order 26.4].

On 07/26/23 at 12:21 PM, the Interim Director of Nursing (DON) confirmed the facility could not find any informed consents for the use of [NJ Exec] for R95.

4. Review of R20's "Admission Record," located under the "Profile" tab of the EMR, revealed R20 was admitted to the facility on [NJ ex order 26.4b1] with diagnoses that included [NJ ex order 26.4b1]

Review of R20's "Physician Order," dated [NJ ex order 26.4b1] and located under the "Orders" tab of the EMR, revealed " . . . [NJ ex order 26.4b1] . . . "

Review of R20's "Care Plan," revised [NJ ex order 26.4b1] and located under the "Care Plan" tab of the EMR, revealed a focus related to the use of [NJ ex order 26.4b1] as a [NJ Exec Order 26.4b1]. It was documented R20 had been educated on the risks and benefits of [NJ Exec Order 26 NJ ex order 26.4b1] and provided consent for the use of the [NJ ex orde].

Review of R20's annual "MDS," with an ARD of [NJ ex order 26.4b1], revealed R20 had a "BIMS" score of [NJ ex] out of 15, which indicated R20 was [NJ ex order 26.4b1] It was recorded R20 required [NJ ex order 26.4b1],

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NJ Exec Order 26.4b1 . It was recorded R20 had NJ Exec Order 26.4b1 and NJ ex order 26.4b1 were not in use.

Review of R20's "NJ ex order 26.4b1 ," dated NJ ex order 26.4b1 and located under the "Evaluations" tab of the EMR, revealed R20 was NJ ex order 26.4b1 , had demonstrated NJ ex order 26.4b1 , NJ ex order 26.4b1 for their own safety or comfort, and had not expressed a desire to have NJ ex order 26.4b1 not be released while sleeping. There was no recommendation marked related to if NJ ex order 26.4b1 were recommended and if so, what type.

Review of R20's EMR and hard chart revealed no documentation related to the medical necessity for the use of NJ ex order 26.4b1 or an informed consent related to the use of the NJ ex order 26.4b1 .

During an observation and interview on NJ ex order 26.4b1 at 11:34 AM, R20 was observed in her bed. The bed had padded NJ ex order 26.4b1 in the up position on each side. CNA1 was assisting R20 with personal care. CNA1 stated R20 was NJ ex order 26.4b1 , and did not use the NJ ex order 26.4b1 as a NJ Exec Order 26.4b1 . R20 was unable to answer any questions related to orientation.

During an observation on NJ ex order 26.4b1 at 11:49 AM, the NJ Exec Order 26.4b1 on R20's bed was observed to be loose and unsecure. The NJ ex order 26.4b1 would move

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greater than one inch in all directions when in the up and locked position.

During an observation and interview on 07/25/23 at 9:12 AM, UM1 stated R20 had been using NJ ex order 26.4b1 . UM1 stated when R20 was sleeping, NJ Exec Order 26.4b1 UM1 stated the NJ Exec Order 26.4b1 were used for safety and to help NJ Exec Order 26.4b1 . UM1 confirmed R20 NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 herself. UM1 was asked what the facility's policy was related to the use of NJ ex order 26.4b1 . UM1 stated it depended on the resident or the family or if the NJ Exec O were medically necessary. UM1 stated she could not recall any interventions that had been attempted before using NJ ex order 26.4b1 on R20's bed. UM1 stated she did not know if there was an informed consent for the use of NJ ex ord with R20. UM1 and the surveyor observed R20's NJ ex order 26.4b1 UM1 confirmed R20's left NJ ex ord was loose and moved more than one inch in all directions when in the up and locked position.

4. Review of R43's "Admission Record," located under the "Profile" tab of the EMR, revealed R43 was admitted to the facility on NJ ex order 26.4b1 with NJ ex order 26.4b1

Review of R43's "Physician's Order," dated NJ ex order 26.4b1 and located under the "Orders" tab of the EMR, revealed, " . . . NJ ex order 26.4b1 . "

Review of R43's "Side Rail Assessment," dated NJ ex order 26.4b1 and located under the "Evaluations" tab of the EMR, revealed R43 was NJ ex order 26.4b1

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NJ Exec Order 26.4b1 [redacted] Interventions included lowering R43's bed to the floor and periodic assistance with [redacted] at night. Recommendations were listed as [redacted]. Review of R43's EMR and hard chart revealed no documentation of a more recent [redacted] assessment.

Review of R43's "Care Plan," revised [redacted] and located under the "Care Plan" tab of the EMR, revealed a focus related to the use of NJ ex order 26.4b1. It was recorded R43 knew the risks and benefits of having NJ ex order 26.4b1 and that they were used for safety to promote R43's independence. It was documented R43 provided consent for the use of the [redacted]

Review of R43's quarterly "MDS," with an ARD of [redacted] and located under the "MDS" tab of the EMR, revealed R43's "BIMS" score was [redacted] out of 15, which indicated R43 was [redacted] It was recorded R43 NJ ex order 26.4b1 [redacted]

During an observation on 07/23/23 at 11:11 AM, R43 was observed lying in bed. NJ ex order 26.4b1 [redacted] in the up position were noted on the bed. [redacted] were noted to be loose and would move greater than one inch in all directions when pushed. The bed was not in the lowest position.

During an interview on 07/25/23 at 9:15 AM, UM1 confirmed R43 NJ ex order 26.4b1 to the

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side of the bed and NJ ex order 26.4b1 . UM1 stated R43 did not use the NJ Exec Order 26.4 on her bed. UM1 confirmed there was no medical reason listed in the clinical record for the NJ ex order 26.4b1, that the latest NJ Exec Order 26 assessment was NJ ex order 26.4b1, and there was no signed informed consent contained in the medical record. UM1 confirmed NJ Exec Order 26 assessments were to be completed quarterly and stated she did not know why there was not one since NJ ex order 26.4b1. UM1 stated informed consents for the use of NJ ex order 26.4b1 were obtained on admission to the facility.

During an observation and interview on NJ ex order 26.4b1 at 9:42 AM, UMI confirmed R43's NJ ex order 26.4b1 were loose, unsecure, and moved more than one inch in all directions when in the up and locked position.

During an interview on 07/25/23 at 3:36 PM, the Interim Director of Nursing (DON) and Regional Nurse confirmed NJ Exec Order 26 assessments should be completed upon admission and quarterly thereafter. The Regional Nurse stated the NJ Exec O should be reassessed if there were any incidents and informed consents for the use of NJ Exec Order 26.4 should be obtained yearly. The Regional Nurse confirmed a comprehensive care plan should be developed for the use of NJ Exec Order 26.4.

The facility's "Proper Use of Side Rails Policy;" most recently revised in 09/2022, read, in pertinent part, "It is the policy of the facility to utilize a person-centered approach when determining the use of side rails;" and "3. If after an attempted alternative to side/bed rails has been made, and the alternatives do not meet the resident's needs, the facility shall: a. Evaluate the

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F 700	Continued From page 65 alternatives and document how these alternatives failed to meet the resident's assessed needs. If there is no appropriate alternative, document reason. b. Assess the resident for risks of entrapment, and other risks associated with the use of side/bed rails. c. Obtain informed consent from the resident, or the resident representative for the use of bed rails, prior to installation/use. d ... .and f. Obtain physician's orders for the use of side rails;" and "5. The use of side rails will be specified in the residents plan of care." NJAC 8:39-27.1(a)	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		8/18/23

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F 725	Continued From page 66 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record reviews, the facility failed to ensure sufficient staffing to meet the needs of the 141 residents in the facility. Five residents (Resident (R) 21, R36, R97, R17, R83, and R5) and staff members Certified Nursing Assistant (CNA 1), the facility's Medical Director, Licensed Practical Nurse (LPN anonymous), and Unit Manager (UM) 1 voiced concerns regarding sufficient staffing, and the facility exhibited multiple failures related to a lack of sufficient staffing throughout the survey. Findings include: 1. Review of the facility's [redacted] "Resident Census and Conditions of Resident," provided on paper by the Interim Director of Nursing, revealed the facility had a current census of 141 residents. Of those residents, 45 were dependent with bathing, 31 were dependent with dressing, 39 were dependent with transferring, 39 were dependent for toilet use, and 20 were dependent for eating. Additionally, 94 residents required assistance of one to two staff with bathing, 100 required assistance with dressing, 75 required assistance with transferring, 72 required assistance with toilet use, and 56 required assistance with eating. There were 83 residents who were occasionally or frequently incontinent of bladder, 64 residents with dementia, and 41 residents received antipsychotic medications.	F 725	1. Corrective action for deficient practice: (a)Provide adequate staffing by requiring all licensed management staff to report to work when staffing becomes a challange. (b)Other management staff to also report to assist when needed. (c)Facility has introduced "School On Us Program" which pays full school fees for staff interested in going to school for CNA training. (d) Enrolled Seven staff will start CNA training in September at Best Care College - all cost to be paid by Canterbury Care and Rehab. (e)Open house to be held on September 9th and every quarter thereafter to attract quality staff. (f)More robust advertising on INDEED (g)Sign on and employee referral bonuses is activated. 2. Residents with potentials to be affected by deficient practice: (a) All residents can potentially be affected by deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a) Continue "School On Us" program to	

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CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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F 725	Continued From page 67 Upon entry to the facility on 07/23/23 at 9:30 AM, there were two nurses and one aide observed on the 2nd floor to care for 49 residents. There were two nurses and one aide on the 3rd floor to care for 60 residents. 2. During Initial Pool interviews and observations, five residents voiced concerns related to a lack of sufficient staffing: a. R21's "Admission Record," dated NJ ex order 26.4b1 and found in the electronic medical record (EMR) under the "Profile Tab, revealed R21 was admitted to the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 R21's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, indicated a "Brief Interview for Mental Status (BIMS)" score of NJ ex out of 15 indicating R21 was NJ Exec Order 26.4b1. During an interview with R21 on 07/23/23 at 10:59 AM, she stated she was not able to get out of bed on that day to attend any activities because there was not enough (nursing) staff. She stated, "Only one aide and two nurses [are working today] so they told me they can't get me up. I have to stay in bed today. This happens frequently [on the weekends]." During an interview with R21 on 07/24/23 at 9:51 AM, she stated, "They [the facility] don't have anything [activities] on the weekends. Every weekend is like that. They [activities staff] will put something on the calendar but none of it happens. They don't have enough people. A lot of	F 725	ensure continued production of quality staff (b) Retention program to ensure staff turn over is at minimum. (c) All Manager Report To Work to be activated any time staffing is a challenge. 4.How to monitor corrective action: (a) Administrator or designee to review staffing schedule daily on continiuous basis. (b) DON or designee to audit weekend staffing twice weekly - on weekends for 4 weeks and then twice monthly for two months. (c) Managers on duty to randomly interview residents about staffing response to care request twice weekly and report to Administrator/DON or designee immediately when care needs are not being met. 5. Results of the audits will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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people stay in bed [instead of attending activities due to lack of nursing staff on the weekends]."

b. R36's "Admission Record," NJ ex order 26.4b1 and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1

R36's quarterly "MDS" assessment, with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" Tab, revealed a "BIMS" assessment score of NJ ex out of 15 indicating R36 was NJ ex order 26.4b1

On NJ ex order 26.4b1 at 11:26 AM, R36 stated there was not enough staff to care for the residents. R36 stated there was only one aide to care for the residents on the 3rd floor.

During an interview with R36 on 07/23/23 at 2:03 PM, she stated she had not received a shower in "who knows how long." She further stated, "There is no staff, and if no staff ...no shower. That's the way it is." The resident was observed to be unkempt during the interview and he hair appeared oily.

c. On 07/23/23 at 12:40 PM, R97 stated there was only one aide and two nurses on the 3rd floor. R97 stated the residents who smoked could not go smoke because there were not enough staff for supervision.

d. R17s "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile" Tab, revealed she was admitted to the facility on NJ ex order 26.4b1

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R17's admission "MDS" assessment, with an ARD of [redacted] and found in the EMR under the "MDS" Tab, revealed a "BIMS" assessment score of [redacted] out of 15 R17 was [redacted].

During an interview conducted with R17 on 07/23/23 at 1:01 PM, she stated there were not enough nursing staff on most days. She indicated she was not able to get out of bed as frequently as she wanted to because of frequent lack of nursing staff and stated, "We [residents] need help. It [the lack of nursing staff] isn't fair for the staff or for us [residents]. It [staffing shortage] used to be just on weekends but now it's most days. I'm supposed to be in my [wheelchair] twice a week at least. I only get in my chair once a month when my brother visits [because of lack of staffing]. They [nursing staff] have to have two staff and a lift to get me up, so I don't get up. They'll probably say I don't want to get up [out of bed] but that's not true."

e. On 07/23/23 at 1:42 PM, R83 and her family member stated there was not enough staff to meet the residents' needs. The family member stated they had made many complaints about the staffing but nothing was done. R83 stated she did not feel like the aides gave her a thorough bath because they did not have time to do so.

f. R5's "Admission Record," dated [redacted]3 and found in the EMR under the "Profile" Tab, revealed she was admitted to the facility on [redacted].

R5's admission "MDS" assessment, with an ARD of [redacted] and found in the EMR under the

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F 725	Continued From page 70 "MDS" Tab, revealed a "BIMS" assessment score of [NJ ex 6] out of 15 indicating R5 was [NJ ex order 26.4b1] [redacted]. During an interview with R5 on 07/23/23 at 10:48 AM, he stated, "There are two nurses and one CNA for this entire floor today. R5 indicated staffing had been very short on the weekends since his admission on [NJ ex order 26.4b1]. 3. Additional concerns related to short staffing were voiced by the staff during the survey: During an interview with Licensed Practical Nurse (LPN) LPN 5 on 07/23/23 at 11:56 AM, she indicated there were "almost" 60 residents on the third floor and there were only two nurses and one CNA working the day shift to take care of everyone on the floor and stated, "Staffing is like this [the observed one CNA and two nurses on the third floor] frequently on the weekend. Then us [sic] nurses can't do our job because we have to act as an aide. It is hard. Like today there aren't enough people to get everyone up, so residents will have to stay in bed." During an interview on 07/25/23 at 10:08 AM, Certified Nurse Aide (CNA) 1 stated the facility might put two aides on the schedule for the 2nd and 3rd floors, but only one would show up. CNA1 stated she was unable to provide the care the residents needed by herself. CNA1 stated it was all she could to do just keep the residents clean, and sometimes she could not do that. During an interview on 07/25/23 at 10:27 AM, the facility's Medical Director confirmed, "The facility is chronically understaffed."	F 725		

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During an interview on 07/25/23 at 10:44 AM with a Licensed Practical Nurse (LPN), who wished to remain anonymous, stated the facility had been hiring staff but they did not stay. The LPN stated one aide could not care for all the residents on the 2nd or 3rd floor. The LPN stated, "It's impossible."

During an interview on 07/25/23 at 3:10 PM, Unit Manager (UM)1 reported the family member of R20 had "showed up" with an ambulance and transferred R20 to a different facility because of the staffing concerns.

During an interview with LPN 4 and Unit Clerk (UC) UC 1 on 07/25/23 at 10:55 AM, both stated, "Weekends are bad for staffing." LPN 4 stated she worked every other weekend in the facility and though there were supposed to be at least five CNAs scheduled on the third floor, there were typically only one or two CNAs actually working on Saturdays and Sundays on the third floor. LPN 4 stated the staffing observations made by the survey team on Sunday 07/23/23 were typical for the facility. LPN 4 stated, "We need hands to be able to take everyone out [get everyone up from their beds] and so it happens where we cannot get everyone out of bed [on the weekends] and we get as much done as we can with ADLs/baths with the people [residents] we have but can't always get it [ADL care/bathing] done."

During an interview with CNA 3 on 07/25/23 at 11:04 AM, she indicated she worked full time on the third floor and was scheduled to work every other weekend. She stated nursing staffing was low on the weekends. She stated, "It happens that we have one or two aides on the weekends. I have had that happen more than two times

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recently. They offer a bonus if we come in. They ask people to come in but because of the shortage sometimes people don't want to come in." CNA 3 indicated showers could be done for residents who were ambulatory when staffing was short, but residents who were dependent upon staff to get out of bed were given bed baths on weekends when there was not enough staff.

During an interview with an anonymous frequent visitor to the facility/family member on 07/25/23 at 12:28 PM, she indicated she visited the facility most days and stated, "The weekends are terrible here for staff. I come here every weekend. I was [the resident's] care giver at home. I can't take care of him at home anymore, but he is my father! I found him in [redacted] last weekend. He was [redacted]. During the week they have staff. It's the weekends that are the problem."

4. During the survey from 07/23/23 through 07/26/23, the following deficient practices related to insufficient staffing were identified:

The facility failed to maintain residents' privacy during care in their rooms. Cross-reference F583: Personal Privacy/Confidentiality of Records.

The facility failed to provide adequate and timely incontinence care. Cross-reference F677: Activities of Daily Living Care Provided for Dependent Residents.

The facility failed to provide an individualized program of activities for dependent residents. Cross-reference F679: Activities Meet the Interests/Needs of Each Resident.

The facility failed to have a qualified activities

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director. Cross-reference F680: Qualifications of Activity Professional.

The facility failed to obtain informed consents, failed to conduct side rail evaluations, and failed to develop care plans related to the use of side rails. Cross-reference F700: Side Rails.

The facility failed to have a full-time Registered Nurse (RN) Director of Nursing (DON) from 06/01/23 through 07/11/23. Cross-reference F727: RN 8 Hours/7 days/Week, Full Time DON.

The facility failed to have sufficient/competent staff to meet the behavior health needs of residents. Cross-reference F741: Sufficient/Competent Staff for Behavioral Health Needs.

During an interview on 07/25/23 at 4:44 PM, the Administrator stated the facility had a mock survey on 07/20/23 where it had been identified the facility had a staffing shortage. The Administrator stated, "We've known about it for a while but identified it again on Thursday." The Administrator verbalized the facility was attempting to look at long-term staffing needs. The Administrator was asked why the unit managers, the Director of Nursing, and himself were not present at the facility on 07/23/23 when the survey began if they were aware of the staffing shortage. The Administrator did not comment. The Administrator was asked why the corporate nurses were not assisting in caring for the residents if it was known there was a staffing shortage. The Administrator did not comment.

During an interview on 07/25/23 at 7:09 PM, the Interim DON reported the facility did not have a

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F 725	Continued From page 74 policy on sufficient staffing. The Interim DON stated the facility staffed related to the state requirements to the best of their ability. NJAC 8:39-25.2(a)(b)	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews and job description review, the facility failed to have a licensed Director of Nursing to oversee the care of all 141 current residents in the facility. This failure increased the risk that all residents would not be provided with appropriate and accurate care and assessments. Findings include: During an interview on 07/25/23 at 9:44 AM, the Director of Nursing (DON) stated that she was not currently working as the DON due to her Registered Nurse (RN) license being expired and waiting on it to be reinstated. Her RN license	F 727	1. Corrective action for deficient practice: (a) Interim DON was appointed on [redacted] and approved by the NJ Department of Health. 2. Residents with potentials to be affected by deficient practice: (a) All residents could potentially be affected by deficient practice. 3. Systemic change to make sure deficient practice does not recur:	8/18/23

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F 727	Continued From page 75 expired on [NJ Exec Order 26.4b redacted]. During an interview on 07/26/23 at 7:27 PM, the Administrator confirmed that he was notified on 06/02/23 by an email from corporate that the DON's RN license was expired and would need to be reinstated. The Administrator stated that the Interim Director of Nursing (iDON) was contacted about taking over as the Director of Nursing until the current DON's license was reinstated. He notified corporate to change the DON to the iDON on [NJ Exec. Order 26.4 redacted] stating that it took some time to get it worked out with the iDON. Review of the undated job description titled, "Director of Nursing Services" reflects in part, "Must possess a valid Registered Nurse (RN) license, in good standing in accordance with laws of this stated, from an approved NJ Nursing School of Nursing. A minimum of five (5) years full time or equivalent clinical experience is required and a minimum of two years of clinical experience in long term care nursing with one year in a management/administrative or supervisory capacity is preferred." NJAC 8:39-25.1(a)	F 727	(a) Human resources staff to be educated on License and Certificate tracking system by administrator (Education was done 8/18/23) (b) Human resources staff to be educated on license and certification renewal process by the Administrator. (Education was done on 8/18/23) 4. How to monitor corrective action: (a) Human resources director to routinely audit licenses and certificate monthly at an on-going basis. (b) H/R director to notify staff 90 days prior to license expiration, then followed by 60 days reminder. (c) H/R director to inform staff and supervisor and copy administrator 30 days prior, if license has not been renewed. (d) Administrator to randomly audit staff licenses and certificates, twice monthly for 3 months. 5. Results of the audits will be presented to monthly QAPI committee meeting for review and revision as deemed ppropriate.	
F 755 SS=D	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	F 755		8/18/23

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F 755	Continued From page 76 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide routine [NJ Exec O] medications as ordered by the physician for one of 35 sampled residents (Resident (R) 61). This had the potential to cause [NJ Exec Order 26.4b1] for R61. Findings include: Review of R61's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R61 was admitted to the	F 755	1. Corrective action for deficient practice: (a) Resident #61 was reassessed for [NJ Exec O] management with [NJ Exec Order 26.4b1] [redacted]. Medication was reordered on [NJ Exec Order 26] 2. Residents with potentials to be affected by deficient practice: (a) All residents receiving prescribed Controlled Substances in the facility have	

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F 755	Continued From page 77 facility on NJNJ ex order 26.4b with diagnoses that included NJ ex order 26.4b1 Review of R61's "Care Plan," dated NJ ex order 26.4b1 and located under the "Care Plan" tab of the EMR, revealed R61 NJ ex order 26.4b1 Review of R61's "Physician Orders," dated NJ ex order 26.4b1 and located under the "Orders" tab of the EMR, revealed R61 was to receive NJ Exec Order 26.4b1 one tablet by mouth four times daily for NJ Exec O, at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. Review of R61's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of NJ ex order 26.4b1 and located under the "MDS" tab of the EMR, revealed R61 scored an NJ ex out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated R61 was NJ ex order 26.4b1 . It was recorded R61 NJ ex order 26.4b1 NJ ex order 26.4b1 Review of R61's "Medication Administration Notes," dated NJ ex order 26.4b1 at 5:00 PM through NJ ex order 26.4b1 at 9:34 PM and located under the "Progress Notes" tab of the EMR, revealed documentation R61 NJ ex order 26.4b1 It was documented the medication had not been delivered by the pharmacy and that a total of 14 doses were missed.	F 755	the potential to be affected by the deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)The Unit Mangers were provided 1:1 in-service on Narcotic policy and procedure for steps to follow when the medication card is noted to be below the threshold. The Licensed nurse must fax the re-ordering form to the narcotics division at the facility's pharmacy provider. All Licensed nursing staff were in-service on facility Policy and Procedures on re-ordering all routine and PRN Controlled Substances medication on 8/2/23 DON/Designee completed an audit of all Narcotic declining sheets for availability of the Controlled Substances with no other discrepancies observed on 7/26/23 (b)DON/ADON/UM will conduct an audit to identify any residents re-ordering the Controlled Substance. 4. How to monitor corrective action: (a)DON/designee will perform random unit audits on residents with narcotic pain medication weekly x4, bi-weekly X4, monthly x 3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as	

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F 755	Continued From page 78 Review of R61's "Medication Administration Notes," dated NJ ex order 26.4b1 at 9:28 AM through NJ ex order 26.4b1 at 9:43 PM and located under the "Progress Notes" tab of the EMR, revealed documentation R61 NJ ex order 26.4b1 NJ ex order 26.4b1 as ordered by the physician. It was documented the medication had not been delivered by the pharmacy and that a total of four doses were missed. Review of R61's "Medication Administration Notes," dated NJ ex order 26.4b1 at 1:55 PM through NJ ex order 26.4b1 at 9:27 PM and located under the "Progress Notes" tab of the EMR and "Medication Administration Records (MARs), dated NJ ex order 26.4b1 and located under the "Orders" tab of the EMR, revealed documentation R61 NJ ex order 26.4b1 as ordered by the physician. It was documented the medication had not been delivered by the pharmacy and that a total of three doses were missed. Review of R61's "MARs," dated NJ ex order 26.4b1 from 5:00 PM through 9:00 PM and located under the "Orders" tab of the EMR, revealed documentation R61 NJ ex order 26.4b1 s ordered by the physician and missed two doses of the medication. Review of R61's "Medication Administration Notes," dated NJ ex order 26.4b1 at 9:06 PM and located under the "Progress Notes" tab of the EMR, revealed, ". . . Medication was re-ordered on NJ ex order 26.4b1 resident NJ ex order 26.4b1 Today NJ ex order 26.4b1 when nurse noticed medication was not yet delivered, nurse placed a call to pharmacy regarding medication refill, as per pharmacy tech . . . a script is needed for the	F 755	deemed appropriate.	

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refill. Nurse then placed a call to resident's primary [physician name withheld] to request the script in order to refill the medication, the doctor expressed anger toward nurse and demanded the DON [Director of Nursing] to call him. Unit Manager notified and called DON, unable to leave message . . . "

Review of R61's "MARs," dated NJ ex order 26.4b1 at 9:00 AM through 9:00 PM, revealed documentation R61 NJ ex order 26.4b1 as ordered by the physician. There were a total of four doses that were missed.

Review of R61's "Medication Administration Notes," dated NJ ex order 26.4b1 at 2:11 PM through NJ ex order 26.4b1 at 9:00 PM and located under the "Progress Notes" tab of the EMR, revealed documentation R61 NJ ex order 26.4b1 NJ Exec four times daily as ordered by the physician. There were a total of seven doses that were missed. It was documented that the facility was awaiting delivery of the medication from the pharmacy.

During an interview on 07/24/23 at 2:00 PM, R61 confirmed he did have NJ Exec O and there were times, sometimes days, when he did not receive his NJ Exec O medication. R61 stated the NJ ex order 26.4b1 but it would have been better if he had his NJ Exec O medication.

During an interview on 07/25/23 at 9:56 AM, Licensed Practical Nurse (LPN) 1 stated the facility's process for reordering NJ Exec Order 28 medications was to take the sticker off of the medication card and either contact the pharmacy through telephone, computer, or fax and reorder the medication. LPN1 stated the pharmacy

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should be called to see if there was a valid prescription on file if the medication was a [NJ Exec Order 26], and if not, the physician should be contacted to send a new prescription to the pharmacy. LPN1 stated staff might have to call the physician for a prescription but the pharmacy could call the physician as well. LPN1 stated if the medications did not arrive, staff should call the pharmacy. LPN1 stated the reason R61 went without his medications was because the pharmacy needed prescriptions for the refills, and they had difficulties in getting the prescriptions.

During an interview on 07/25/23 at 10:03 AM, Registered Nurse (RN) 1 stated medications, including [NJ Exec Order 26.4], should be reordered when the supply was down to the last row on the medication card. RN1 stated that with [NJ Exec Order 26.4], staff was supposed to call the pharmacy and ensure there was a refill available. RN1 stated if there was not a refill, the physician was to be called. RN1 stated if the medications did not arrive in time, staff could see if there was a supply in the emergency medication kit located on the fourth floor.

During an interview on 07/25/23 at 10:24 AM, the Medical Director confirmed his expectation was for staff to notify him if they were having a problem receiving medications from the pharmacy or with other physicians writing prescriptions for [NJ Exec Order 26] medications. The Medical Director stated, "They could call me, and I would cover and go after the primary [physician]."

During an interview on 07/25/23 at 10:29 AM, Unit Manager (UM) 1 stated the process for reordering [NJ Exec Order 26.4] consisted of reordering via computer,

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fax, or phone call when the supply was low. UM1 stated if a prescription was needed for the refill, the nurse might not know unless they called the pharmacy. UM1 stated if medications, including [NJ Exec Order 26.4b], were not available for a resident, the policy was for the staff member to check the emergency medication kit located on the fourth floor and then call the physician and let them know if a prescription was needed immediately. UM1 stated her expectation was for the staff to let her know if a medication was not available, and she would call the doctor herself to get a prescription. UM1 confirmed the emergency medication kit should have [NJ Exec Orde] in it but that R61 had not received any medication from the emergency medication kit.

Continuing with the interview on 07/25/23 at 10:29 AM, UM1 reviewed R61's medical record and stated she had called the nurse practitioner herself on [NJ Exec Order 26.4b] when R61 went without his [NJ ex order 26.4b1] for two days. UM1 confirmed she did not contact the Medical Director for his assistance at that time. UM1 stated the pharmacy and trying to obtain prescriptions were the problems with R61's medications. UM1 confirmed she had not involved the Medical Director in trying to ensure R61 had his [NJ ex order 26.4b1].

During an interview on 07/26/23 at 3:19 PM, the Pharmacy Consultant confirmed [NJ Exec Order 26] refills should be called or faxed in at least three days before the supply ran out. The Pharmacy Consultant stated if a prescription was needed, the pharmacy would contact the physician.

Review of the facility's policy titled, "Controlled Substances Policy," revised 08/2022, revealed no documentation related to the reordering of

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F 755	Continued From page 82 narcotic medications. NJAC 8:39-29.2(d)	F 755		
F 756 SS=D	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	F 756		8/18/23

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F 756	Continued From page 83 maintain policies and procedures for the monthly 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: Based on record review, staff interviews, and facility policy review, the facility failed to ensure the appropriate nursing/physician response/follow-up to pharmacist recommendations were completed for one (Resident (R)46) of five residents reviewed for unnecessary medication in a total sample of 35 residents. Findings include: R46's "Admission Record," dated NJ ex order 26.4b1 and found in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1. R46's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, indicated a "Brief Interview for Mental Status (BIMS)" of NJ ex out of 15 indicating R46 was NJ ex order 26.4b1. R46's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" tab, revealed orders for NJ ex order 26.4b1 The order indicated an initial order date of NJ ex order 26.4b1	F 756	1. Corrective action for deficient practice: (a)Resident #46 was re-assessed by a licensed nurse with NJ Exec Order 26.4b1. (b)Pharmacy recommendation was responded to by MD (c)Orrder was carried out by licensed nurse on NJ Exec Order 26 2. Residents with potentials to be affected by deficient practice: (a)All residents have the potential to be affected by the same deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)All Licensed RN/LPNs/Unit Manager/Primary Physicians were in-service on the pharmacy medication recommendation with completion on 8/4/23 (b)ADON/Designee will ensure that all monthly pharmacy reports with recommendations are completed by the 10th day after receiving the report. The primary physician will be made aware of the new recommendation and the license nurse will transcribe any new orders.	

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F 756	Continued From page 84 R46's "NJ ex order 26.4b1," dated NJ ex order 26.4b1 and found in the EMR under the "Care Plan" tab, indicated, "[R46] will be free from adverse reactions related to NJ ex order 26.4b1 through the review date." Interventions included, "Monitor/document/report to MD [Medical Doctor] PRN [as needed] s/sx [signs/symptoms] of NJ Exec Order 26.4b1 " and "Resident/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in NJ Exec Ord, Take precautions to NJ Exec Order 26.4b1, Signs/symptoms of NJ Exec Order 26.4b Avoid NJ Exec Order 26.4b1. These include NJ Exec Order 26.4b1 " Review of R46's "Pharmacy Consult Therapeutic Suggestions Report," dated NJ Exec Order 26.4b and provided directly to the survey team, indicated a recommendation to include a time duration for the administration of the resident's NJ Exec Order 26. Documentation of follow-up by the facility/resident's physician related to the pharmacist's recommendation or any attempt to add a time duration for the administration of R46's NJ ex order 26.4b could not be found in the resident's record. During an interview with the Interim Director of	F 756	(c)ADON/Designee will continue to in-service all licensed nursing staff on Pharmacy Consultant reports and procedures to ensure all recommendations have been addressed. 4. How to monitor corrective action: (a)DON/designee will perform random audits on pharmacy medication regimen daily x4, weekly x4, bi-weekly X4, monthly x3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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Nursing (iDON), the incoming Director of Nursing (DON), and Regional Clinical Director (RCD) on 07/25/23 at 3:57 PM, they confirmed the pharmacist was in the facility monthly to review every resident's medication regimen. The DON indicated she received the recommendations monthly via email and was then responsible for distributing the recommendations to the appropriate unit for follow-up. The iDON indicated she was then responsible for following up to ensure a response was received for each recommendation. The DON indicated it was her expectation that a response was received and initiated within 10 days of the pharmacist's recommendation. The DON and iDON indicated they had nothing to show a response to R46's pharmacy recommendation dated [NJ Exec Order 26.4b] after the initial recommendation was made and the DON indicated her expectation was follow-up should have occurred to ensure the resident was not receiving [NJ Exec Order 2] unnecessarily for too long.

During an interview with the Pharmacy Consultant on 07/26/23 at 9:57 AM, she indicated she was in the facility monthly to review resident medications and stated she had been having some trouble with getting a facility response to her recommendations. She stated she sent her report out every month on the following business day after her visit to the facility for facility/physician follow-up. She stated, "The concern is not receiving timely response [to her recommendations] from both the physician and nursing [staff]. The [NJ Exec. Order 26.4.b] [the floor on which R46 resided] doesn't have a unit manager and so that floor is more of a challenge." The Pharmacy Consultant stated, "I usually want them [residents] to switch to [NJ Exec Order 26.4b1] if [they are] on [NJ Exec Order 26] if I see they have been on it

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F 756	Continued From page 86 a while [longer than a month]." The facility's "Pharmacy Consultant Services Policy" dated 09/2022 read, in pertinent part, "It is the policy of this facility to use outside resources to furnish pharmacy services for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event." NJAC 8:39-29.2(d)	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		8/18/23

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F 757	Continued From page 87 Based on record review and staff interviews, the facility failed to ensure one (Resident (R)46) of five residents reviewed for unnecessary medication out of a total sample of 35 residents did not receive NJ Exec Order 26.4b1 for longer than generally recommended after a NJ Exec Order 26.4b1. Findings include: R46's "Admission Record," dated NJ ex order 26.4b1 and found in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1. The resident was readmitted to the facility on NJ ex order 26.4b1 after a NJ ex order 26.4b1 R46's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, indicated a "Brief Interview for Mental Status (BIMS)" of NJ ex out of 15 indicating R46 was NJ ex order 26.4b1. R46's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" tab, revealed orders for NJ ex order 26.4b1 every NJ ex order 26.4b1 The order indicated an initial order date of NJ ex order 26.4b1 R46's "NJ ex order 26.4b1," dated NJ ex order 26.4b1 and found in the EMR under the "Care Plan" tab, indicated, "(R46) will be free adverse reactions related to NJ ex order 26.4b1 through the review date." Interventions included,	F 757	1. Corrective action for deficient practice: (a)Resident # 46 was immediately assessed for any NJ Exec Order 26.4b1 MD was notified immediately for discontinuation of unnecessary medication on NJ ex order 26.4b. 2. Residents with potentials to be affected by deficient practice: (a)All residents that reside in the facility have the potential to be affected by this deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)DON/designee will in-service all License RN/LPNs/Primary Physician on the policy and procedures to ensuring the residents are free from unnecessary drugs. Pharmacy recommendations will be reviewed and completed within the 10 days of receiving the initial report. 4. How to monitor corrective action: (a)DON/ designee will randomly audit 10 pharmacy recommendations daily for new admissions, weekly x 4, bi-weekly X 4, and monthly x 3. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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"Monitor/document/report to MD (Medical Doctor) PRN (as needed) s/sx (signs/symptoms) of NJ Exec Order 26.4b1 and "Resident/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in NJ Exec Order, Take precautions to NJ Exec Order 26.4b1, Signs/symptoms of NJ Exec Order 26.4b, Avoid NJ Exec Order 26.4b1. These include NJ Exec Order 26.4b1 "

R46's "Pharmacy Consult Therapeutic Suggestions Report," dated NJ ex order 26.4b1 and provided directly to the survey team, indicated a recommendation to include a time duration for the administration of the NJ ex order 26.4b1.

Documentation of follow-up by the facility/resident's physician related to the pharmacist's recommendation or any attempt to add a time duration for the administration of R46's NJ ex order 26.4b1 could not be found in the resident's record.

During an interview with the Interim Director of Nursing (iDON), the incoming Director of Nursing (DON), and Regional Clinical Director (RCD) on 07/25/23 at 3:57 PM, the DON stated the administration of NJ Exec Order 26.4b1 was based on the resident's condition and the doctor's recommendation. She stated it was important for

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F 757	Continued From page 89 the doctor to receive and review pharmacy recommendations to ensure medications like [redacted] were not administered for too long of a duration (usually no longer than 30 days). During an interview with the Pharmacy Consultant on 07/26/23 at 9:57 AM, she indicated she stated, "I usually want them [residents] to switch to [redacted] if [they are] on [redacted] and I see they have been on it a while [longer than a month]." During an interview with R46's Physician/Medical Doctor (MD 1) on 07/25/23 at 1:53 PM, he indicated he was very familiar with the resident and stated, regarding the administration of the resident's [redacted], "I can't remember [redacted]. He is on NJ ex order 26.4b1) .....You're right. I should have changed it [to an NJ Exec Order 26.4b1 I do have to concede to the [redacted] [discontinuing it]. I will change it [the resident's NJ Exec Order 26.4b1	F 757		
F 803 SS=E	NJAC 8:39-29.2(d) Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		8/18/23

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F 803	Continued From page 90 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on resident council interview, staff interview, and record review, the facility failed to follow the menu and provide menus for meal selection for four (Resident (R)5, R21, R36, and R46) of 35 sampled residents. This deficient practice had the potential to affect 137 out of 141 (four residents received [redacted]) residents not affording them the opportunity to choose foods from the menu but instead receive whatever was being served. Findings include: On 07/23/23 at 10:32 AM during a tour of the kitchen, review of the menu for lunch revealed, BBQ Pork Lion, Country vegetable blend, baked beans, cornbread, margarine, and strawberry shortcake. The alternative was hamburger steak with grilled onions, brown gravy, seasoned spinach, and mashed potatoes.	F 803	1. Corrective action for deficient practice: (a) Educated staff on menu accuracy - Dietary manager (b) Administrator or DON will be notified of any menu changes by Dietary manager (c) Director of Dining services or designee to sign off on any menu changes 2. Residents with potential to be affected by deficient practice: (a) All residents could potentially be affected by deficient practice 3. Systemic change to make sure deficient practice does not recur: (a) Educate all dietary staff on menu accuracy - Dietary director	

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F 803	Continued From page 91 Observations of lunch on 07/23/23 at 12:30 PM revealed resident received BBQ Pork Lion, or hamburger steak, (no onions or gravy), country vegetable blend and mashed potatoes with ice cream. Residents were upset that strawberry shortcake was not provided as indicated. Observations of dinner on 07/24/23 at 4:30 PM revealed baked chicken, beef patty, sauteed green beans, mashed potatoes, and ice cream. The menu was country fried steak with mushroom gravy, sauteed green beans, mashed potatoes, dinner roll/bread, margarine, and vanilla ice cream. The alternative included garlic baked pork chop, buttered whole kernel corn (veg), and parsley noodles. During an interview on 07/24/23 at 4:33 PM with the Registered Dietician (RD) revealed whenever there is a menu substitution, "we have a substitution for that must be competed and I am required to sign off on the substitution. Staff can reach me or the other dietician to discuss menu substitutions." Review of the menu substitution log revealed the last substitution was noted on 06/22/23 although observations on 07/23/23 revealed menu substitutions. During an interview on 07/25/23 at 10:56 AM with the Director of Dining (DM), Assistant Director of Dining (ADM), and the Ambassador of Dietary Services (ADS), revealed when substitutions must be made to the menu, they are written on the substitution log. When asked how residents know about the substitution, the ADM indicated when "they [residents] get their trays."	F 803	(b) Dietary Director will audit 12 trays daily to make sure food being served is the ordered food 4. How to monitor corrective measures: (a) Test tray to be given to Administrator once daily for three weeks; then once a week for a month and; once a month thereafter. (b) Administrator will randomly call for test tray for any staff, twice weekly for three months. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 803	Continued From page 92	F 803		

1. R5's "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 NJ ex order 26.4b1

R5's admission "MDS" assessment, with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "BIMS" assessment score of NJ ex out of 15 indicating R5 was NJ ex order 26.4b1

Review of R5's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" tab, indicated orders for a NJ ex order 26.4b1

Review of R5's "Food Preferences Assessment," dated NJ ex order 26.4b1 and provided directly to the survey team, indicated "No food refusals, or specific likes or dislikes."

R5 was observed eating his lunch in his room on 07/23/23 at 1:41 PM. The resident was served two hot dogs with beans. The resident's menu indicated he was to be served strawberry shortcake and cornbread with his meal, but neither were observed on the resident's meal tray. R5 stated, "The menu had strawberry shortcake and corn bread and I did not get either of them today. We haven't been getting cookies or cakes for weeks now. The food is horrible. If we don't want what is on the menu, they give us whatever they choose. They ran out of coffee this morning. They keep telling us the ice machine is broken. We don't get ice a lot."

During an interview with R5 on 07/25/23 at 9:15

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AM, he stated, "Dinner last night was pork chops, and they were like rocks. The lunch peas yesterday were cold/almost frozen. This morning they ran out of sugar packets. They only have aspartame. They won't get it [regular sugar] until tomorrow, so I had no sugar with my oatmeal this morning."

R5 was observed eating his lunch in his room on 07/25/23 at 12:23 PM. The resident was served a double portion of peas, chicken, potatoes, and gravy. The resident's menu indicated he was to be served a chocolate chip cookie, but no cookie was observed to be served with the resident's meal. The resident instead received two small cups of diced peaches. R5 stated, "Them potatoes look like a rock in the garden. I don't know what those are. I was given pink sugar [Aspartame packets] instead of regular sugar and I don't like that pink stuff. I get regular sugar. They say they are out of it [sugar]. Those potatoes? Oh No I won't touch that."

2. R21's "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile tab, revealed R21 was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 [redacted].

R21's quarterly ("MDS" with an ARD of NJ ex order 26.4b1, indicated a "BIMS" score of NJ ex [redacted] out of 15 indicating R21 was NJ ex order 26.4b1.

Review of R21's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" tab, indicated orders for a NJ Exec Order 26.4b1 [redacted].

Review of R21's "Food Preferences

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Assessment," dated [NJ Exec Order 26.4b] and provided directly to the survey team, indicated the resident's regular diet and indicated no specific "food likes", but indicated the resident disliked eggplant parmesan. The assessment indicated the resident wanted to be served a baked cheese omelet every morning for breakfast.

During an interview with R21 on 07/24/23 at 9:59 AM, she stated, "Yesterday I didn't get the strawberry shortcake I was supposed to have with my lunch. I get an omelet with cheese on it [every day for breakfast]. I always get that. They [staff] know. Saturday morning, they sent scrambled eggs and no cheese, and it was cold. The [dietary staff working that day] didn't tell them [the cooks] ... ...They [staff] don't bring ice because the machine is broke [sic]. I like ice."

R21 was observed eating her lunch in her room on 07/25/23 at 12:09 PM. The resident was served her lunch tray with chicken, potatoes, peas, and iced tea with a pink (Aspartame) sugar packet. The chocolate chip cookie the resident's menu indicated she was to receive with the meal was not served. R21 was served pudding instead. R21 stated, "I was supposed to have a chocolate chip cookie and they gave me a pink sugar packet instead of real sugar. I would rather have real sugar."

3. R36's "Admission Record," dated [NJ ex order 26.4b1] and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on [NJ ex order 26.4b1] with [NJ ex order 26.4b1]

R36's quarterly "MDS" assessment, with an ARD of [NJ ex order 26.4b1] and found in the EMR under the

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"MDS" tab, revealed a "BIMS" assessment score of [redacted] out of 15 indicating R36 was [redacted]

Review of R36's "Order Summary Report," dated [redacted] and found in the EMR under the "Orders" tab, [redacted]

Review of R36's "Food Preferences Assessment," dated [redacted] and provided directly to the survey team, indicated the resident's [redacted] and indicated no specific "food likes," but indicated the resident disliked a variety of different kinds of prepared shrimp.

R36 was observed eating her lunch in her room on 07/23/23 at 1:41 PM. The resident was served a peanut butter and jelly sandwich. The resident's menu indicated she was to be served strawberry shortcake with her meal, but it was not observed on the resident's meal tray. R36 stated, "I did not get my strawberry shortcake." The resident further stated desserts had not recently been served per the menu. She stated, "We haven't been getting dessert like strawberry shortcake and cookies for weeks." R36 stated the facility kept running out of ice because the ice machine was broken.

R36 was observed eating her lunch in her room on 07/25/23 at 12:19 PM. The resident was served peas, chicken, potatoes, and gravy. R36 stated, "I'm not eating those potatoes. I don't like potatoes anyway....and those are burnt." R36 stated she was supposed to have been served a sugar cookie per her menu, but the cookie was not served with her meal. The resident was

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F 803	Continued From page 96	F 803		

instead served a container of ice cream and a small bowl of canned peaches.

4. R46's "Admission Record," dated [NJ ex order 26.4b1] and found in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [NJ ex order 26.4b1] with diagnoses including [NJ ex order 26.4b1]

R46's significant change " MDS" with an ARD of [NJ ex order 26.4b1], indicated a "BIMS" of [NJ ex] out of 15 indicating R46 [NJ ex order 26.4b1].

R46's "Order Summary Report," dated [NJ ex order 26.4b1] and found in the EMR under the "Orders" tab, revealed orders for the resident to receive a [NJ ex order 26.4b1].

Review of R46's "Food Preferences Assessment," dated [NJ Exec Order 26.4b] and provided directly to the survey team, indicated the resident's regular mechanical soft diet and indicated the resident liked cranberry juice and disliked/was unable to have a large variety of foods including potatoes.

During an interview with R46 on 07/24/23 at 10:56 AM, the resident indicated he could not eat potatoes, but potatoes were frequently served with his meals.

R46 was observed eating his lunch in his room on 07/25/23 at 12:46 PM. The resident was served mashed potatoes, chicken and gravy (chopped), and peas. The resident again indicated he did not eat potatoes and was not supposed to be getting them. In addition, the resident was not served a sugar cookie per his menu. R46 was served pudding instead. R46 stated he wanted the

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F 803	Continued From page 97 cookie that was indicated on his diet card. NJAC 8:39-17.2(b) NJAC 8:39-17.4(e) NJAC 8:39-18.4(e)	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, and interview, the facility failed to provide meals that were palatable and attractive to two residents (Resident (R)5 and R36) out of a sample of 35 residents. Specifically, the potatoes that were served to residents were burnt. Findings include: Observation of the serving line for lunch 07/25/23 revealed lunch being served was baked chicken, peas, roasted potatoes, the alternative was meatballs, mashed potatoes, and peas. Dessert was mixed fruit. In the preparation of the plates, it was asked if the potatoes were burnt, the cook replied, "only on the top" and they continued to fix plates to go out residents. During an interview on 07/25/23 at 11:50 PM with	F 804	1. Corrective action for deficient practice: (a) Educated cook on palatability of food - Regional Director of food services. (b) All food will be inspected for palatability by Assistant dietary director, dietary director, and cooks prior to each meal service. (c) Food found to be unsatisfactory will be substituted. 2. Residents with potentials to be affected by deficient practice: (a) All residents could potentially be affected by the deficient practice 3. Systemic change to ensure deficient practice does not recur	8/18/23

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F 804	Continued From page 98 the Assistant Director of Dietary (ADM) revealed some problems with the oven not cooking evenly, and that was why they had not been able to bake cookies in the oven. Observations of lunch trays being served to the second floor; the burnt potatoes were on the resident's plates. 1. R5's "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 [redacted] R5's admission "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" assessment score of NJ ex out of 15 indicating R5 was NJ ex order 26.4b1 . R5 was observed eating his lunch in his room on 07/25/23 at 12:23 PM. The resident was served a double portion of peas, chicken, potatoes, and gravy. R5 stated, "Them [sic] potatoes look like a rock in the garden. I don't know what those are. Those potatoes? Oh No I won't touch that." 2. R36's "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with NJ ex order 26.4b1 [redacted] . R36's quarterly "MDS" assessment, with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "BIMS" assessment score of NJ ex out of 15 indicating R36 was NJ ex order 26.4b1	F 804	(a) Dietary director to educate cooks to follow recipe and cooking time instruction 4. How to monitor corrective action: (a) Meal tasting for palatability will be completed by staff selected dietary director, 3 x daily for three weeks: then 3 x weekly for three weeks and then: 3 x monthly for three months. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 804	Continued From page 99 NJ ex order 25 R36 was observed eating her lunch in her room on 07/25/23 at 12:19 PM. The resident was served peas, chicken, potatoes, and gravy. R36 stated, "I'm not eating those potatoes. I don't like potatoes anyway....and those are burnt." During an interview on 07/25/23 at 3:06 PM with the Director of Dining (DM), Assistant Director of Dining (ADM), and the Ambassador of Dietary Services (ADS), in talking about the potatoes being burnt during lunch, no one commented. The DM that was assisting on the serving line revealed "some of the potatoes were over cooked." NJAC 8:39-17.4(a)2 NJAC 8:39-17.4(e)	F 804		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure the ice machine was functioning properly to ensure residents received ice. Three of 35 sampled residents (Resident (R)5, R36, and R21) and five residents in a group meeting (R6, R13, R97, R114 and R130) expressed frustration that the facility ice machine was down, and the facility had not supplied sufficient ice despite voiced concerns by residents.	F 908	1. Corrective action for deficient practice (a) During the equipment breakdown sufficient ice was ordered (b) Ice machine was fixed on July 25th, 2023 2. Residents with potential to be affected by deficient practice:	8/18/23

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F 908	Continued From page 100 Findings include: 1. During the initial observation of the kitchen on 07/23/23 at 10:32 AM, the ice machine had very little ice. The freezer contained three five-pound bags of ice. The Dietary Aide (DA) indicated the ice machine was down and had been down for about a week or so and "we are having to bring ice into the facility. At one point it was over filling, now it is not making ice." 2. R5 was observed eating his lunch in his room on 07/23/23 at 1:41 PM. R5 stated, ". . . They keep telling us the ice machine is broken. We don't get ice a lot . . ." R5's admission "Minimum Data Set (MDS)" assessment with an assessment reference date (ARD) of NJ ex order 26.4b1 and found in the EMR under the "MDS" Tab, revealed a "Brief Interview for Mental Status" assessment score of NJ ex out of 15 NJ Exec Order 26.4b1 3. R36 was observed eating her lunch in her room on 07/23/23 at 1:41 PM. R36 stated the facility kept running out of ice because the ice machine was broken. R36's quarterly "MDS" assessment with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" Tab, revealed a "BIMS" assessment score of NJ ex out of 15 NJ ex order 26.4b1 4. During an interview with R21 on 07/24/23 at 9:59 AM, she stated, "They [staff] don't bring ice because the machine is broke. I like ice." R21's quarterly "MDS" with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" Tab,,	F 908	(a) All residents could potentially be affected by deficient practice. 3. Systemic changes to make sure deficient practice does not recur: (a) Routine maintenance of ice machine will be performed by maintenance director as required manufacturers (b) Dietary staff to monitor equipment operation daily for functionality. (c) Kitchen will immediately notify maintenance if ice production falls below par level. 4. How to monitor corrective action: (a) Maintenance director to inpect ice machine once daily for three weeks; once weekly for five weeks and monthly thereafter. (b) Maintenance director to respond to addition calls from dietary staff resulting from their observation. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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	315204	A. BUILDING _____ B. WING _____	C 07/26/2023

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F 908		F 908		

Continued From page 101

indicated a BIMS score of [redacted] out of 15
NJ ex order 26.4b1

5. A group meeting was held on 07/24/23 at 11:00 AM with five NJ Exec Order 26.4b1 residents present (R6, R13, R97, R114 and R130). There was at least one resident from each hall/unit in attendance to represent the other residents. The residents stated the ice machine had been down for nearly a month and they cannot even get a cold drink. They have complained about not having any ice in the middle of summer "but nothing ever happens."

6. During an interview on 07/24/23 at 4:14 PM, the Registered Dietitian (RD) stated without ice in cups, residents are not likely to drink their drinks, because they are not cold, which could cause some hydration problems.

During an interview on 07/25/23 at 10:56 AM, the Ambassador of Dietary Services (ADS) revealed the ice machine has been broken for "about a week or so. Our corporate maintenance people have been working on it and finally decided they will need to order a part. At this point we are having a company drop off bags of ice and keeping it in the cooler and on the units for residents."

Review of "Proposal No: 6432 from Automatic Ice Maker Co," dated 07/24/23 revealed a controller board has been ordered for and the date of acceptance was 07/24/23.

During an interview on 07/25/23 at 11:49 AM, the ADS indicated, corporate has been coming back and forth to fix the ice machine and yesterday got the quote for the controller board. They have

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F 908	Continued From page 102 been working on the ice machine for a couple of weeks now. The ADS was asked to provide documentation of the work being done on the ice machine. This information was not provided. During an interview on 07/26/23 at 12:43 PM, the Maintenance Director (MD) revealed a technician that worked with the corporate company has been coming in to work on the ice machine. The MD stated the technician was in the building on Monday (07/24/23) working on the ice machine, and a part had been ordered. The ice machine was taking double the time to fill. The MD indicated he had been on the job for almost two weeks and the machine has been broken since he started, since Monday (07/24/23) we have been getting bags of ice for the residents. Review of the policy titled "Safe Operation of Equipment" revised 01/02/18 under "Maintenance Service" revealed, "Maintenance service shall be provided to all areas of the building, grounds and equipment. The maintenance department is responsible for maintaining the building's grounds and equipment in a safe and operable manner at all times. Providing routinely scheduled maintenance service to all areas, including but not limited to: . . . Dietary equipment . . ." NJAC 8:39-31.2(e)	F 908		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased	F 909		8/18/23

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F 909	Continued From page 103 separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure physical bed inspections were routinely conducted related to the use of side rails for five (Residents (R) R5, R36, R95, R20, and R43) of eleven residents who were reviewed for accidents out of a total sample of 35 residents. Findings include: 1.R5's "Admission Record," dated NJ ex order 26.4b1 and found in the Electronic Medical Record (EMR) under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with diagnoses including NJ ex order 26.4b1 R5's admission "Minimum Data Set" assessment, with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" assessment score of NJ ex out of 15 indicating R5 was NJ ex order 26.4b1 t. The assessment indicated the resident required limited assistance from staff to complete all of his Activities of Daily Living (ADLs), including NJ Exec Order 26.4b in and out of bed, and indicated NJ Exec were not in use for the resident. R5's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" tab, indicated orders for the resident to have NJ ex order 26.4b applied to his bed as an enabler for positioning.	F 909	1. Corrective action for deficient practice: (a)Resident5's bed was inspected by Maintenance on NJ Exec Order 26. (b)Full house audit was conducted by maintenance staff and all inspection was completed on 8/2/23. 2. Residents with potentials to be affected by deficient practice: (a)All residents could potentially be affected by the deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)Maintenance staff will be educated on 'bed inspection for safety' by RDEVS. (b)Nursing staff to be educated by DON on Documentation 4. How to monitor corrective action: (a)RDEVS or designee to audit bed inspection once weekly for 4 weeks, bi-weekly for 4 weeks and once monthly. 5. Results of the monitoring will be presented monthly QAPI committee meeting for review and revision as deemed appropriate.	

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F 909	Continued From page 104	F 909		

R5 was observed in his room lying in bed or seated in his wheelchair on 07/23/23 at 1:53 PM, and on 07/25/23 at 9:36 AM, 10:44 AM, and 11:30 AM. The resident's bed was observed to have NJ ex order 26.4b1 installed at the head of the bed. The resident stated he used his NJ ex order 26.4b1 for positioning in bed as well as to NJ Exec Order 26 in and out of bed to wheelchair.

Comprehensive review of R5's record indicated nothing to show the resident's bed had been physically inspected for safety since his admission to the facility on NJ ex order 26.4b1

2.R36's "Admission Record," dated NJ ex order 26.4b1 and found in the EMR under the "Profile" tab, revealed she was admitted to the facility on NJ ex order 26.4b1 with diagnoses including type NJ ex order 26.4b1

R36's quarterly "MDS" assessment, with an ARD of NJ ex order 26.4b1 and found in the EMR under the "MDS" tab, revealed a "BIMS" assessment score of NJ ex out of 15 indicating R36 was NJ Exec Order 26.4b1 . The assessment indicated the resident NJ ex order 26.4b1 including NJ ex order 26.4b1 , and indicated NJ ex order 26.4b1 were not in use for the resident.

R36's "Order Summary Report," dated NJ ex order 26.4b1 and found in the EMR under the "Orders" Tab, indicated orders for the resident to have NJ ex order 26.4b applied to her bed as an NJ Exec Order 26.4b1 .

Comprehensive review of R5's record indicated nothing to show the resident's bed had been

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physically inspected for safety since his admission to the facility on [redacted].

R36 was observed in her room seated in bed or on the side of her bed on 07/23/23 at 2:06 PM, on 07/24/23 at 10:17 AM, and on 07/25/23 at 9:33 AM. The resident's bed had [redacted] installed at the head of the bed. The resident stated she used her [redacted] for [redacted] in her bed as well as to [redacted] in and out of her bed to her [redacted].

3. During an observation on 07/23/23 at 2:43 PM, R95's bed was observed. The [redacted] was noted to be [redacted] and loose. When the [redacted] was pushed away from the mattress, a gap measuring six inches was created between the mattress and the [redacted].

During an observation and interview on 07/25/23 at 9:42 AM, Unit Manager (UM1) and the surveyor observed R95's [redacted]. UM1 was shown the gap between R95's mattress and [redacted]. UM1 stated, "It's an accident hazard." UM1 confirmed the [redacted] was loose, unsecure, and needed to be tightened. UM1 stated it was her expectation that staff notify her and maintenance when a [redacted] was noted to be loose. UM1 stated she would have the [redacted] tightened immediately.

4. During an observation on 07/23/23 at 11:49 AM, the [redacted] on R20's bed was observed to be loose and unsecure. The [redacted] would move greater than one inch in all directions when in the up and locked position.

During an observation and interview on 07/25/23 at 9:12 AM, UMI confirmed R20's [redacted]

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F 909	Continued From page 106	F 909		

was loose and moved more than one inch in all directions when in the up and locked position.

5. During an observation and interview on 07/25/23 at 9:42 AM, UMI confirmed R43's NJ ex order 26.4b1 were loose, unsecure, and moved more than one inch in all directions when in the up and locked position

During an observation and interview on 07/25/23 at 12:38 PM, the Maintenance Director (MD) and Regional Director of Plant Operations (RDOP) observed R95, R20, and R43's NJ Exec Order 26.4b. The MD confirmed the NJ Exec Order 26.4b were loose and needed to be tightened. The MD and RDOP confirmed that bed and NJ Exec Order 26 inspections should occur annually and that the inspections consisted of observing for damaged mattresses, loose railings, remotes that were not working, and the general function of the beds. The MD and RDOP stated the facility did conduct the inspections yearly. They were asked to provide the bed and NJ Exec Order 26 inspection reports for the past year.

During an interview on 07/25/23 at 2:15 PM and 4:45 PM, the surveyors again requested the inspection reports from the Administrator.

Review of the facility's Maintenance Records indicated nothing to indicate routine physical inspections were being conducted for any of the beds in the facility with NJ Exec Order 26.4b applied to them.

During an interview with the interim Director of Nursing (iDON), the incoming Director of Nursing (DON), and the Regional Clinical Director (RCD) on 07/25/23 at 3:35 PM, they confirmed their expectation was routine physical inspections of any resident bed with NJ Exec Order 26.4b was to be done to

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F 909	Continued From page 107 ensure resident safety. During an interview with the Administrator on 07/25/23 at 5:20 PM, he confirmed the facility was unable to locate any documentation to show routine physical inspections of resident beds with [redacted] applied to them. He stated, "I feel safe to say they [the inspections] have not been done." The facility's "Proper Use of Side Rails Policy;" most recently revised in 09/2022, read, in pertinent part, "It is the policy of the facility to utilize a person-centered approach when determining the use of side rails;" and "6. d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and rails." NJAC 8:39-31.2(e) NJAC 8:39-31.4(a)(c)	F 909		

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{F 000}	INITIAL COMMENTS Survey Date: 7/26/23 Revisit Date: 9/14/23 Census: 141 An onsite revisit was conducted to verify the implementation of the facility's POC for the Recertification survey conducted on 7/26/23. The facility was found to not be in compliance and deficiencies were cited during this revisit survey.	{F 000}		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to have a system in place to ensure that facility garbage receptacles were covered, and all garbage was contained and removed timely to prevent a buildup of refuse, and that the receptacles including a trash compactor and the surrounding areas were maintained in a clean manner to prevent the accumulation of debris, pests and foul odors. The deficient practice was evidenced as follows: On 9/14/23 at 9:20 AM, two surveyors arrived at the facility's back parking lot and observed mounds of uncontained garbage bags approximately three to six feet high and approximately 50 feet long alongside the right side of the fence leading to a dumpster and trash	F 814	1. Corrective action for the deficient practice. (a) Empty compactor was secured on 9/14/23 (b) All trash/garbage bags on the ground were put in the compactor on 9/14/23 (c) The whole area was swept of debris and washed with water hose on 9/14/23 2. Residents with potentials to be affected by the deficient practice. (a) All residents could potentially be affected by deficient practice. 3. Systemic change/s to make sure deficient practice does not recur.	9/25/23

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

Electronically Signed | 09/25/2023

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F 814	Continued From page 1 compactor towards the back fence. The surveyors observed garbage bags piled at least six feet high behind and between two fences at the juncture of the right and back fence of the back parking lot. The rust-colored metal mesh dumpster was uncovered and overflowing with cardboard, with additional cardboard piled along the left side of the dumpster approximately five feet high. The door of the trash compactor could barely be accessed due to piled bags of clear and black bags of garbage. Multiple bags were ripped open exposing food debris and soiled briefs. There were an enormous amount of flies and yellow jacket bees at the dumpster's. There were additional black bags of garbage piled approximately six feet high behind the dumpster up to the back fence. There was a strong foul smell that permeated the parking lot. At 9:25 AM, the survey team entered the facility, and the receptionist informed the surveyors that the Licensed Nursing Home Administrator (LNHA) had not yet arrived at the facility. Shortly after, the LNHA arrived and stated that the garbage was supposed to be picked up today and the facility was having "trouble" with the refuse company. He further stated that he was going to call the refuse company again today and that the garbage should be picked up today. He stated, "corporate" had a contract with the refuse removal company. The LNHA further stated that he could not speak to how long it has been since the garbage was picked up. At approximately 9:35 AM, the surveyor took pictures and a video of the outdoor refuse area and the extensive buildup of debris. At 9:40 AM, a family member approached the	F 814	(a) A new trash/garbage removal company was engaged. (b) Trash compactor will be replaced weekly or as soon as notified by facility; whichever comes first. (c) All Dietary and housekeeping staff were educated by House keeping director and Dietary Director on 'monitoring compactor' daily and to report to supervisor when compactor begins to fill up. (d) Administrator to be notified as soon as trash compactor is full before the scheduled pick up day. (e) administrator to call garbage removal company for immediate pick up if trash compactor is full before the scheduled pick up day. 4. How to monitor corrective action (a) Director of environmental services to monitor trash compactor twice weekly for four weeks; then weekly for eight weeks. (b) DEVS to monitor areas around trash compactor to make sure no trash is left on the grounds daily. 5. Results of the monitoring will be presented to monthly QAPI committee for review and revision as deemed appropriate.	

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F 814	Continued From page 2	F 814		

survey team and stated that the outside garbage area "is like that all the time."

At 10:17 AM, the surveyor interviewed the Food Service Director (FSD) about the garbage disposal process and the buildup of refuse at the dumpster area in the presence of a second surveyor. He stated, "I don't know what to tell you about it. They were supposed to pick it up. I think they come once a week on Friday." He acknowledged that there was a buildup of uncontained garbage. The FSD stated that clear garbage bags were used by housekeeping and that the black garbage bags were for kitchen refuse. He further stated that maybe once or twice before there were extra garbage bags outside the dumpster. He stated that he has no direct oversight for garbage pickup and did not have the contact information for the refuse removal company. In addition, the FSD stated that if he noticed a pile up of garbage that he emailed the LNHA and the Regional FSD.

At 10:30 AM, the FSD provided the surveyor a copy of an email titled "GARBAGE", dated 9/7/23. The email was sent to the LNHA, the Regional FSD and three others. Review of the email indicated the following content: "GOOD AFTERNOON, TOMORROW IS FRIDAY AND THE GARBAGE IS OUT OF CONTROL. CAN WE GET AN ETA ON PICKUP? THANK YOU ..."

At 11:00 AM, the surveyor interviewed the Director of Maintenance in the presence of a second surveyor. He stated that he started five days ago. He stated that when he started there was an overflow of garbage and further stated, "I have no idea" why the contractor had not picked up the garbage. In addition, he stated that he was

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F 814	Continued From page 3	F 814		

told that part of his job was to keep that area clean and that because he was new, he "cannot speak to much yet."

At 11:40 AM, the surveyor interviewed the Director of Environmental Services (DES) in the presence of a second surveyor and the Regional of Environmental Services (RES). The DES stated, "It is my role to make sure trash goes into the compactor and to police the area around the compactor and the parking lot area to make sure there's no debris." He stated that the compactor was emptied today, and the RES stated that occurred at 9:10 AM. The DES further stated, "I think they come for the compactor biweekly." The RES stated that approximately 30 days ago corporate started negotiations with another waste management company and "we think that is why the current company are not picking up that frequently." The DES stated that the last time the garbage was picked up was "three to four weeks ago."

At 11:53 AM, the surveyor interviewed the LNHA in the presence of a second surveyor. He stated that "corporate handles the contractor." He stated that "we are having constant problems with the company" and were notified that corporate is negotiating with a new company and "as of 10/1/23, we will be using the new company." The LNHA stated that the refuse company came today at 6 AM to get the old compactor and drop off an empty one. He stated, "I have been calling corporate and the contractor for the last 2 weeks - It's not the correct thing to do to have the garbage build up."

The LNHA further stated, "I asked them to bring two other open containers for the extra garbage

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CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 4	F 814		

on the ground, but what I ask and what they do are two different things." He stated that this was the second time that he had trouble with this company, which was a month ago. The LNHA stated that it was his responsibility to call the contractor when the garbage needed to be picked up and that he did not think there were set days for pickup indicated in the contract. He stated that the DES or the FSD notified him when the compactor was almost full and then he called for service. He acknowledged that the directors were not usually the staff to dispose of garbage and that the directors relied on their staff to communicate when the compactor or dumpster were full. The LNHA could not speak to if this was part of the staff's job descriptions. In addition, he stated that he felt because corporate was changing waste management companies that "retaliation" was the reason the contractor had not picked up the garbage.

At 12:45 PM, three surveyors and the LNHA toured the outside of the facility. The LNHA acknowledged that the buildup of garbage was unacceptable and acknowledged the foul odor including the odor of soiled briefs. He acknowledged that there was an extraordinary amount of uncontained and ripped open garbage bags and pests. He also acknowledged that it was difficult to access the door of the compactor due to having to step on and over open bags of garbage and swarms of pests. The LNHA also acknowledged that the cardboard dumpster was uncovered and that the cardboard debris was overflowing. He stated that the cardboard refuse was not picked up today and could not speak to the last time it was picked up. He could not speak to how frequently it gets picked up and stated that he calls when it is full. In addition, he stated, "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 5	F 814		

didn't see it was that full till today" and that the cardboard on the left side of the dumpster was "probably from one day." The LNHA stated that he called the Procurement Officer multiple times for invoices of service and for a copy of the contract for refuse disposal with the waste management company.

At 1:40 PM, the LNHA provided the surveyor copies of email exchanges between himself and corporate starting from 9/4/23. Review of the emails indicated the following:

On 9/4/23 at 10:35 AM, the LNHA emailed the Procurement Officer an email titled "Trash Compactor." The content indicated " ... I called, [name redacted] on Friday regarding emptying the compactor. The trash is now being dumped on the ground with the result that the whole area smells and maggots are all over. I am sure that sooner than later, the neighbors, residents and visitors alike will start calling both local and state dept's. Please help ..."

On 9/4/23 at 11:38 AM, the Procurement Officer responded and included seven other email addresses. The email was titled "Trash compactor." The content indicated, "Team please see below so we can assist canterbury Thanks."

On 9/5/23 at 7:24 PM, an email was sent to the LNHA from someone who he stated was "my direct boss." She included seven others on the email titled "Trash compactor." The content indicated, "This is very concerning do we have a response here?"

On 9/12/23 at 1:12 PM, the LNHA sent an email to the Procurement Officer, his "direct boss" and

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	315204	A. BUILDING _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 6	F 814		

included six others on an email titled "Trash compactor." The content indicated "Good afternoon all, Any updates on trash pickup? The trash on the grounds at this point will fill up two containers and require two staff x 8 hours to throw into the containers. Can we rent open containers while waiting to resolve issue with waste management? Thanks ..."

On 9/12/23 at 4:25 PM, the LNHA sent an additional email to the same recipients noted above. The email was titled "Trash compactor" and indicated the following content "[name redacted] from Cedar Grove Health Dept. just called and spoke with the maintenance director stating that they have multiple calls from neighbors complaining about trash on our parking lot."

At 1:45 PM, in the presence of the survey team, the LNHA stated there was no facility policy related to garbage disposal or the maintenance of the dumpster area.

At 1:54 PM, the LNHA provided two unsigned invoices from the waste management company dated 7/25/23 and 8/15/23, which he received from the Procurement Officer. He stated that he requested a copy of the waste management contract multiple times today from corporate but was unable to provide it.

At 2:25 PM, in the presence of the survey team, the Chief Clinical Officer and the LNHA stated that they do not have a policy for garbage disposal or maintenance of the dumpster area.

Review of the two unsigned invoices provided to the surveyor from waste management company

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 7 #1 indicated that the facility was billed for services invoice number 00886246 dated 7/25/23 for "7/19/23 30 cubic yard trash compactor 14.49 tons and 7/25/23 30 cubic yard trash compactor 3.14 tons, and invoice number 00886265 dated 8/15/23 for "7/20/23 30 yard open top container 5.93 tons - Emergency/Expedited Service." Review of the job descriptions the facility provided to the surveyor, did not include evidence that there was any specific delineation of responsibility to notify the LNHA for the need to notify the waste management company for refuse pickup. The job descriptions provided and reviewed were as follows: Assistant Manager & Executive Chef of Dining Services (undated), Food Service Aide (undated), Environmental Services Director (undated), six additional housekeeper positions (undated) and the Maintenance Director (undated). NJAC 8:39-31.4(b); 31.5(a)	F 814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060729	A. BUILDING: _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was identified for CNA staffing for residents 14 of 14-day shifts, deficient in total staff for residents on 2 of 14 evening shifts and deficient in total staff for residents on 1 of 14 overnight shifts. The findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1. Corrective action for deficient practice: (a) Employment open house was held September 19th. Nursing staff, CNAs, hospitality Aides and NAs were hired and are being processed. (b) Employment open house to be held every quarter or sooner to attract quality staff. (c) Facility has introduced "School On Us Program" which pays full school fees for staff interested in going to school for CNA training. (d) Six staff signed up for the CNA training in September at Best Care College - all cost to be paid by Canterbury Care and Rehab.	9/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060729	A. BUILDING: _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 08/27/23 through 09/09/23, revealed the staffing to resident ratios did not meet the minimum requirements as documented below: - 08/27/23 had 8 CNAs for 143 residents on the day shift, required at least 18 CNAs. - 08/27/23 had 13 total staff for 143 residents on the evening shift, required at least 14 total staff. - 08/27/23 had 8 total staff for 143 residents on the overnight shift, required at least 10 total staff. - 08/28/23 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. - 08/29/23 had 10 CNAs for 143 residents on the day shift, required at least 18 CNAs. - 08/30/23 had 11 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S 560	(e) Provide adequate staffing by requiring all licensed management staff to report to work when staffing becomes a challenge. (f)Other management staff to also report to assist when needed. (g)More robust advertising on INDEED (h)Sign on and employee referral bonuses is activated. 2. Residents with potentials to be affected by deficient practice: (a) All residents can potentially be affected by deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a) Continue "School On Us" program to ensure continued production of quality staff (b) Retention program to ensure staff turn over is at minimum. (c) All Manager Report To Work to be activated any time staffing is a challenge. 4.How to monitor corrective action: (a) Administrator or designee to review staffing schedule daily on continuous basis. (b) DON or designee to audit weekend staffing twice weekly - on weekends for 4 weeks and then twice monthly for two months. (c) Managers on duty to randomly interview residents about staffing response to care request twice weekly and report to Administrator/DON or designee immediately when care needs are not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060729	A. BUILDING: _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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S 560	Continued From page 2 - 08/31/23 had 11 CNAs for 143 residents on the day shift, required at least 18 CNAs. - 09/01/23 had 9 CNAs for 143 residents on the day shift, required at least 18 CNAs. - 09/02/23 had 8 CNAs for 143 residents on the day shift, required at least 18 CNAs. - 09/03/23 had 8 CNAs for 142 residents on the day shift, required at least 18 CNAs. - 09/03/23 had 12 total staff for 142 residents on the evening shift, required at least 14 total staff. - 09/04/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. - 09/05/23 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs. - 09/06/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs. - 09/07/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs. - 09/08/23 had 8 CNAs for 139 residents on the day shift, required at least 17 CNAs. - 09/09/23 had 7 CNAs for 139 residents on the day shift, required at least 17 CNAs. There was no additional information provided.	S 560	being met. 5. Results of the audits will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

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
315204 Y1	A. Building B. Wing Y2	9/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0567	Correction	ID Prefix F0578	Correction	ID Prefix F0583	Correction
Reg. # 483.10(f)(10(i)(ii)	Completed	Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023
ID Prefix F0584	Correction	ID Prefix F0623	Correction	ID Prefix F0625	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.15(d)(1)(2)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023
ID Prefix F0641	Correction	ID Prefix F0644	Correction	ID Prefix F0645	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.20(k)(1)-(3)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023
ID Prefix F0657	Correction	ID Prefix F0677	Correction	ID Prefix F0679	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.24(c)(1)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023
ID Prefix F0680	Correction	ID Prefix F0685	Correction	ID Prefix F0700	Correction
Reg. # 483.24(c)(2)(i)(ii)(A)-(D)	Completed	Reg. # 483.25(a)(1)(2)	Completed	Reg. # 483.25(n)(1)-(4)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315204 Y1	A. Building B. Wing Y2	9/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0725	Correction	ID Prefix F0727	Correction	ID Prefix F0755	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023
ID Prefix F0756	Correction	ID Prefix F0757	Correction	ID Prefix F0803	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(d)(1)-(6)	Completed	Reg. # 483.60(c)(1)-(7)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023
ID Prefix F0804	Correction	ID Prefix F0908	Correction	ID Prefix F0909	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.90(d)(2)	Completed	Reg. # 483.90(d)(3)	Completed
LSC	08/18/2023	LSC	08/18/2023	LSC	08/18/2023

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/26/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315204	A. Building B. Wing	9/27/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0814 Reg. # 483.60(i)(4) LSC	Correction Completed 09/25/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060729	A. Building B. Wing	9/27/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/25/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING **01** B. WING _____	**07/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 07/24/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/24/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Canterbury at Cedar Grove is a four-story building that was built in 1984. It is composed of Type II protected construction. The facility is divided into 12 - smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 139 of 180. .	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or	K 281		8/18/23

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

Electronically Signed | 08/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING **01** B. WING _____	**07/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 281	Continued From page 1 capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency lighting was operative at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 139 residents. Findings include: An observation on 07/24/23 at 01:15 PM revealed the emergency lighting was not operative at the emergency generator transfer switch located in the electrical room. The Maintenance Director was present at the time of the observation and confirmed the emergency lighting was not operative at the emergency generator transfer switch. NJAC 8:39-31.2(e) NFPA 99, 110 .	K 281	1. Corrective action for deficient practice: (a)Emergency lighting was fixed on 7/25/23 by Regional director of Environmental Services (RDEVS). 2. Residents with potentials to be affected by deficient practice: (a) All residents in the facility could potentially be affected. 3. Systemic change to make sure deficient practice does not recur: (a)Educate Maintenance staff on routine monitoring and daily inspection of emergency lighting to ensure lighting is operable □ by Regional Director of Environmental Service (b)Maintenance staff to inspect light daily and fix or replace as needed. 4. How to monitor corrective action: (a)Audit monitoring to be conducted by maintenance director once daily for thirty days, twice weekly for four weeks and then weekly for four weeks. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING **01** B. WING _____	**07/26/2023**

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K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 139 residents. Findings include: A document review of the facility's binder provided by the Maintenance Director contained inspection and testing reports for the fire alarm system for the calendar years 2022 and 2023. The facility's fire alarm "Inspection and Testing Reports" dated 05/16/23 revealed no reference to a smoke detection sensitivity test. The fire alarm "Inspection and Testing Reports" dated 2022 revealed no reference to a smoke detection sensitivity test. An observation of the facility's smoke detectors on 07/24/23 from 12:00 PM to 3:30 PM revealed smoke detectors were located in the corridors at	K 345	1. Corrective action for deficient practice: (a)Smoke sensitivity testing scheduled was conducted by ADT on september 11, 2023. 2. Residents with potentials to be affected by deficient practice: (a)All residents could potentially be affected by deficient practice 3. Systemic change to make sure deficient practice does not recur: (a)Maintenance Director was educated on the requirement for smoke detector sensitivity testing by Administrator on 7/27/23 4. How to monitor corrective action: (a)The maintenance director or designee will create a schedule for all required inspections and testings including smoke detector sensitivity testing	8/18/23

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	315204	A. BUILDING **01** B. WING _____	**07/26/2023**

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CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 345	Continued From page 3 the smoke barriers and other concealed areas throughout the building. During an interview on 07/24/23 at 3:10 PM the Maintenance confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	(b)The maintenance Director or designee will maintain and review facility binder monthly to ensure all inspections are completed timely and when due. (c)Random audit will be conducted by RDEVS monthly to ensure that all inspections and testings are completed timely. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on document review, observations and interview, the facility failed to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition)	K 761	1. Corrective action for deficient practice: (1)Maintenance Staff inspected and tested all fire doors as as of 7/27/23 (2)Inspection tags dated 7/27/23 were	8/18/23

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K 761	Continued From page 4 7.2.1.15. This deficient practice had the potential to affect all 139 residents. Findings include: A document review of the facility's binder, dated 2022 and 2023 provided by the Maintenance Director, revealed fire door inspections were not conducted. Observations from 12:00 PM to 3:30 PM revealed no inspections had been conducted on any of the facilities' fire doors in that the doors lacked the required inspection tags that are to be placed on the door(s) after the inspection. At the time of the observation, the Maintenance Director confirmed the doors had not been inspected. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761	placed on all fires doors 2. Residents with potentials to be affected by deficient practice: (a)All residents could potentially be affected by deficient practice. 3. Systemic change to make sure deficient practice does not recur: (a)Educate all maintenance staff on inspection requirement on facility's fire doors - by RDEVS. 4. How to monitor corrective action: (a)The maintenance director or designee will maintain and review preventative maintenance task sheets twice yearly. (b)Maintenance director or designee to inspect and test fire doors and smoke doors yearly. (c)Maintenance director to inspect all fire doors on the 30th of July every year to ensure annual inspection has been done. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		8/18/23

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	315204	A. BUILDING **01** B. WING _____	**07/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 918	Continued From page 5 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the three-year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had	K 918	1. Corrective action for deficient practice: (a)Three-year load bank test scheduled with Genserve for 8/15/23 2. Residents with potentials to be affected by deficient practice:	

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K 918	Continued From page 6 the potential to affect all 139 residents. Findings include: A document review of the facility's binder for 2022 and 2023 provided by the Maintenance Director revealed a three year load bank test had not been completed for the emergency generator. During an interview at 3:10 PM on 07/24/23 the Maintenance Director confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110 .	K 918	(a)All residents could potentially be affected by deficient practice 3. Systemic change to make sure deficient practice does not recur: (a)Maintenance director will be educated by RDEVS on the need/requirement to complete a three-year load bank test. 4. How to monitor corrective action: (a)The maintenance director or designee will review the facility binder monthly to ensure all inspections and tests are completed timely including load bank test when due. (b)Maintenance director or designee to review facility binder and schedule any inspections or tests accordingly. 5. Results of the monitoring will be presented to monthly QAPI committee meeting for review and revision as deemed appropriate	

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
315204 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	08/18/2023	LSC K0345	08/18/2023	LSC K0761	08/18/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	08/18/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO