STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

(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 000	INITIAL COMMENTS Complaint #s: NJ153991, #162696, #162723, #162811, #165585, #167108, #167957, and #168318 Survey Date: 02/06/2024 Census: 273 Sample: 35 sample + 3 closed records = 38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		3/8/24

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

Electronically Signed | 02/21/2024

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

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to serve all residents seated at a table their lunch trays in a timely manner for one (1) of five (5) tables observed, involving a total of four residents (Residents #90, #91, #133, and #148) reviewed for Resident Rights. This deficient practice was evidenced by the following: On 1/31/24 at 12:11 PM, the surveyor observed the [redacted] dining area having three Certified Nursing Aides (CNA), one (1) nurse, and 18 residents during lunch. There were five tables located in the [redacted] dining area with residents seated for lunch. The 1st lunch truck was already	F 550	Element One: Residents #91, #133, and #148 received their lunch trays. Kitchen staff were instructed to place meal trays of residents dining in the same area on the same truck, ensuring that all residents of each dining area receive their meals timely and in unison. Element Two: All residents who receive their meals in the communal dining areas have the potential to be affected by this deficient practice. Element Three: Department heads, Supervisors, and aides were in serviced to pass trays out in a timely fashion. Each dining room on each unit has a	

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F 550	Continued From page 2 in the process of being distributed at the time of the observation. On 1/31/24 at 12:12 PM, the surveyor observed table one, located near the wall with a total of 4 residents seated at the table. At table one there were two residents seated that had their lunch served at the time of the observation and two residents were already eating. At this time, the surveyor observed Table two with four residents seated. Resident # 90 seated at Table two was served with a lunch tray and started eating. The other residents at Table two did not receive their lunch trays, Resident #91, Resident #148, and Resident #133. On 1/31/24 at 12:16 PM, the surveyor interviewed CNA#1, a CNA who was distributing coffee to residents in the NJ Exec Orde dining area. CNA #1 could not explain why all the residents at Table two were not served lunch at the same time. CNA #1 agreed that all residents should get their lunch trays at the same time. CNA #1 could not explain why the trays for Resident #91, #148, and Resident #133 were not delivered yet. On 1/31/24 at 12:20 PM, the surveyor observed the second food truck arriving to the NJ Exec Orde dining area. On 1/31/24 at 12:21 PM, the surveyor observed lunch served to Resident # 91. On 1/31/24 at 12:22 PM, the surveyor observed lunch served to Resident # 148. On 1/31/24 at 12:23 PM, the surveyor interviewed CNA#2 regarding Table two. CNA #2 verified that	F 550	department head or designee assigned to be in attendance during mealtime, to ensure the timely distribution of meal trays. Element Four: The Administrator or designee will audit compliance daily for two weeks and weekly for six weeks. Director of food service will report updates and the status to the necessary parties to the QAPI committee quarterly.	

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F 550	Continued From page 3 Resident #133 still had not received their lunch tray. CNA #2 acknowledged that all the residents seated at the same table should receive trays at the same time. CNA #2 could not explain why residents seated at Table two did not receive their lunch trays at the same time. On 1/31/24 at 12:27 PM, the surveyor observed Resident #133 receive their lunch tray. On 1/31/24 at 3:02 PM, the surveyor asked the [redacted]) for the facility's policy regarding dining services. On 2/05/24 at 01:21 PM, the survey team met with the [redacted]) to inform them of the dining room observations and concern. On 2/06/24 at 8:39 AM, the [redacted] provided the facility's Meal Service Policy with an effective date of 01/01/99. The policy did not include the procedure for serving residents in the dining room. On 2/06/24 at 11:30 AM, the survey teams met with the [redacted] for facility responses. The [redacted] did not provide any additional information regarding this issue. On 2/06/24 at 1:35 PM, the survey teams met with the [redacted] for an exit conference. There was no additional information provided by facility management.	F 550		
F 578 SS=D	NJAC 8:39-4.1 (a) (12)(28) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		3/12/24

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F 578	Continued From page 4 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 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.	F 578		

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F 578	Continued From page 5 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 observation, interview, and record review, it was determined that the facility failed to ensure that the resident or resident's representative were offered the opportunity to formulate an NJ Ex Order 26.4(b)(1), a written statement of a person's wishes regarding medical treatment, often including a living will be made to ensure those wishes are carried out should the person be unable to communicate to them. This deficient practice was noted to 1 of 39 residents reviewed for AD, Resident #77. This deficient practice was evidenced by the following: On 2/5/24 at 10:15 AM, the surveyor observed Resident #77 lying in bed with eyes closed. The surveyor reviewed Resident #77's hybrid medical records. The Admission Record reflected that Resident #77 was admitted to the facility with medical diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status score [redacted] out of 15 indicating that the resident had NJ Exec Order 26.4b1. A review of the active physician's orders (PO) revealed that the resident was documented having a NJ Exec Order 26.4b1 indicating that [redacted]	F 578	Element 1: Social Services reached out to responsible party of Resident #77 to discuss NJ Ex Order 26.4(b)(1) for resident. Social Service department was provided education on Advance Directive or POLST to responsible party should the resident be unable to make decisions. Element 2: Social Services will ensure Advance Directive and/or POLST reflects all necessary information pertaining to each resident□s and or responsible parties□ wishes. The charts of all residents that are cognitively impaired with or without family involvement will be reviewed to ensure Advance Directive and/ or POLST are updated accordingly. Copies of completed Advance Directive and/ or POLST will be placed in each chart. Element 3: Director of Social Service will provide an in service to each department member on completion of Advance Directive and or POLST. Social Services will ensure Advance Directive and or POLST are reviewed and updated if applicable on a yearly basis to ensure both the residents and or responsible parties wishes are documented accordingly. Director of Social Service will create and implement an assessment tool	

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F 578	Continued From page 6 NJ Exec Order 26.4b1 would be implemented if the need arose. The surveyor was unable to locate any documentation that would indicate that the resident's NJ Exec Order 26.4b1 had been discussed or addressed with the resident's responsible party. A review of the form titled, "NJ Ex Order 26.4(b)(1) Up-Date 2023" dated [redacted], reflected under comments that Resident #77 was unable to make any changes due to their [redacted] Further review of the hybrid medical records revealed that the resident did not have a New Jersey NJ Ex Order 26.4(b)(1) [redacted] form (a written medical order from physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness). On 2/5/24 at 1:15 PM, the surveyor discussed the above concern with the facility's US FOIA (b)(6) [redacted] The [redacted] stated that if the resident does not have any [redacted] or [redacted] indicated upon admission, the code status will be defaulted as a [redacted]. On 2/6/24 at 10:30 AM, the surveyor interviewed the facility's US FOIA (b)(6)) assigned to Resident #77. The [redacted] informed the surveyor that she had not discussed the topic of [redacted] with the resident's responsible party. The [redacted] could not provide any further information as to why she did not discuss [redacted] with responsible party for Resident #77, being that the resident was [redacted]	F 578	which will be used immediately and upon admission to ensure Advance Directives and or POLST are completed accordingly, and documentation of completion is captured. Element 4: Social Services will create a spreadsheet of all Advance Directive and or POLST orders and will continue to audit and update monthly for six months to ensure accuracy. Director of Social Services will report updates and the status of Advance Directive and or POLST to the necessary parties every quarter to the QAPI committee.	

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F 578	Continued From page 7 NJ Exec Order 26.4b1, due to their NJ Exec Order 26.4b [redacted] A review of the facility's policy and procedure titled, "Advanced Directives" reflected under "#3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's legal representative." On 2/6/24 at 11:31 AM, the surveyor spoke with the US FOIA (b)(6) regarding the above concerns. There was no further information provided.	F 578		
F 584 SS=E	NJAC 8:39-4.1(a)11; 31.1(b) 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 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	F 584		3/13/24

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F 584	Continued From page 8 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, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide the residents with a safe, comfortable, clean, and homelike environment. This deficient practice was identified in one (1) of three (3) residents' rooms, (Resident #132) and one (1) of two (2) dining areas on the [NJ Exec] floor observed during environmental rounds. This deficient practice was evidenced by the following: 1. On 01/30/24 at 8:25 AM, the surveyor observed Resident #132 on the bed with an [NJ E	F 584	Element One: Resident #132 [NJ Exec O] [redacted], the fan, and the [NJ Exec Order 26.4b1] were cleaned. Broken nightstand was removed from Resident #49. The commode and the wood were taken out and disposed of. Element Two: The Director of Environmental Services performed and audit of all the rooms and common areas to ensure there is no dirty or broken equipment. Element Three: The plant manager in serviced all nursing staff, housekeeping	

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F 584	Continued From page 9 NJ Exec Order 26.4b1 in use, and NJ Exec Order 26 while on NJ Exec Order 26.4b1 , at NJ Exec Order 26.4b1 The surveyor observed that the NJ Exec Order 26 with scattered dried brownish color and resembled the color of the milk that was hung on the NJ Exec O and the surrounding floor area with the same dried brownish color. On that same date and time, the surveyor observed that the resident was on NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 ttached to a NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 had an accumulation of black and grayish substances around the NJ Exec Order 26.4b1 The electric fan was in use with an accumulation of a grayish substance around the metal part where it was blowing air. The fan was near the foot part of the resident's bed. The nightstand table near the window, the second drawer was broken, and no cover. On 01/30/24 at 02:06 PM, the surveyor asked Licensed Practical Nurse #1 (LPN#1) the assigned nurse of the resident to accompany the surveyor to Resident #132's room. Inside the resident's room, both the surveyor and LPN#1 observed the electric fan and the NJ Exe with an accumulation of grayish and blackish substances, the NJ Exec Order 26 and the floor beneath had brown dried substances, and the nightstand table near the window second drawer was broken with no cover.	F 584	staff, and maintenace staff on the importance of utilizing the maintenance communication log to report if anything needs to be cleaned or repaired. Element Four: The plant manager or designee will review the log daily and inspect all rooms on a weekly basis and report to QAPI committee quarterly.	

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F 584	Continued From page 10	F 584		

On that same date and time, the LPN stated that the dried brownish was from the milk residue, and she was not sure who should be cleaning it, LPN#1 confirmed it should be cleaned. The LPN further stated that the NJ Exec Order 26.4b1 should have been cleaned. The LPN wiped out the NJ Exec Order 26.4b1 with gloves on and noted grayish substances. The LPN also stated that it was the responsibility of the housekeeper to clean the dust around the fan and she will notify the housekeeper.

On 02/01/24 at 8:46 AM, the surveyor interviewed LPN#2 regarding the resident. The LPN informed the surveyor that Resident #132 was NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 with adls (activities of daily living), or NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1, and currently on NJ Exec

Afterward, the surveyor asked LPN#2 to accompany the surveyor inside the resident's room. Both the surveyor and LPN#2 observed that the electric fan was in use with an accumulation of dust, the floor where the NJ Exec Order 26 was located had dried milk from the formula, and the nightstand's second drawer was broken. LPN#2 confirmed the observation and stated that he will ask Maintenance for the fan and drawer and that the floor should have been cleaned.

The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of the resident as follows:

Review of the Admission Record (an admission summary) reflected that the resident was

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F 584	Continued From page 11	F 584		

admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted]

The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, an ARD (assessment reference date) of NJ Exec Order 26.4b, and NJ Exec Order 26.4b1 [redacted] showed that the resident's NJ Exec Order 26.4b1 [redacted] Section NJ NJ Exec Order 26.4b1 Status revealed that the resident was on NJ Exec [redacted]

On 02/05/24 at 10:48 AM, the surveyor interviewed the US FOIA (b)(6) [redacted] regarding the above concerns and findings. The US FOIA (b) [redacted] stated that there should be no broken supplies and equipment inside the resident's room, and if the nurse was aware, it should be logged in the maintenance book. She further stated that the room should be cleaned.

2. On 01/31/24 at 12:12 PM, the surveyor observed NJ Exec Orde [redacted] during lunchtime. There were a total of five tables in the dining area. The 1st table was toward the nursing station and the 5th table was toward Room NJ Exec [redacted] NJ Exec [redacted] NJ Exec [redacted] and NJ Exec [redacted]

In the dining area, near the 5th table, in front of rooms NJ Exec [redacted] and NJ Exec [redacted] the surveyor observed that there was a commode that was placed in the hallway, the leg part of the commode was noted with brownish, rust-like substances.

Furthermore, in the same dining area, the surveyor observed across was room NJ Exec [redacted] and

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NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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outside the room in the hallway were two blocks of wood. Inside room [NJ Exec O] the bed near the door (from [NJ Exec Order], had a nightstand table that was broken, with a missing wood cover for the first drawer, at that time the US FOIA (b)(6) was inside room [NJ Exec] washing her hands.

Afterward, the surveyor interviewed the [US FOIA (] when she came out of the room, and the surveyor asked why there were two blocks of wood outside the room. The [US FOIA (] confirmed that was the broken part of [NJ Exec Order 2] nightstand table for the 1st drawer and she did not know who put it outside. The [US FOIA (] further stated that it should not be placed outside in the hallway for safety. The [US FOIA (] confirmed that the broken nightstand table was for Resident #49. The surveyor then asked the [US FOIA (] about the commode outside which was near Table 5 and in the hallway as well. The [US FOIA (] stated that she did not know who the commode for and that it should not be there. The [US FOIA (] took the wood but did not remove the commode from the hallway while the residents were eating in the dining area.

On that same date and time, Resident #71 who was seated at Table 5 with three other residents, confirmed that a staff left the commode and the resident did not identify the staff. The resident further stated that someone left the commode because the lunch came and had to distribute the trays to the resident. The resident also stated that she was not bothered because the resident knew that it would be removed later.

On 01/31/24 at 12:25 PM, both the surveyor and LPN#3 observed the commode in the dining area. The LPN stated that she did now know who put the commode in the dining area. She further

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stated that the commode should not be there and would ask the [US FOIA (b)] to take it out.

At that same time, LPN#3 asked the [US FOIA (b)] to remove the commode. The surveyor observed the [US FOIA (b)] dragged the commode away from the [NJ] dining area.

On 01/31/24 at 3:02 PM, the surveyor asked the US FOIA (b)(6) for the facility's policy regarding the environment.

On 02/05/24 at 01:21 PM, the survey teams met with the US FOIA (b)(6). The surveyor notified the facility management of the above concerns and findings.

On 02/06/24 at 11:30 AM, the survey teams met with the US FOIA (b)(6) facility responses regarding the above findings and concerns. The [US FOIA (b)(6)] informed the surveyors that the facility had a log for cleaning the NJ Exec Order 26.4b1 in the building. The [US FOIA (b)(6)] stated that the facility had no cleaning log or accountability for other items that should include the [NJ Ex] and electric fans.

On that same date and time, the [US FOIA (b)] informed the surveyors that the nurse did not put it in the log for maintenance of the broken nightstand table. She further stated that the log was the nursing communication to the maintenance for repairs.

Furthermore, the [US FOIA (b)] stated that the wood should not be there for safety. The [US FOIA (b)] further stated that the commode should not be in the dining area. The surveyor then asked why was it important that the commode was not in the dining area, and the facility management did not

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F 584	Continued From page 14 respond. A review of the facility's Quality of Life-Homelike Environment Policy that was provided by the US FOIA (b)(6) with a revised date of August 2009 that included residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order and personalized furniture and room arrangements; pleasant. On 02/06/24 at 01:35 PM, the survey teams met with the US FOIA (b)(6) for an exit conference. There was no additional information provided by facility management.	F 584		
F 607 SS=E	NJAC 8:39-31.2 (e), 31.4(a)(b)(f) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		2/29/24

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F 607	Continued From page 15 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for five (5) of seven (7) newly hired licensed staff reviewed, Staff #2, #4, #5, #7, and #10 evidenced by the following: On 02/05/24 at 10:03 AM, the surveyor reviewed ten randomly selected new facility employee files. The review for license verification for seven of the new licensed employees revealed the following: 1. Review of Staff Member #2 (SM2), an US FOIA (b)(6), hired on NJ Exec Order 26, had a New Jersey Division Consumer Affairs (NJDCA) license verification printout (used to verify the status of a license for license verification) dated NJ Exec Order 26. The verification was completed after the	F 607	Element One:Staff Member # 2, Staff Member #4, Staff Member #5, Staff member #7, and Staff Member 10 employee files will have documented evidence that the license verification was done with a date of verification. All employees will have a license verification completed, dated and printed prior to the date of hire; including but not limited to NJDCA licenses for OTs and RNs, and NJDOH licenses for CNAs. Element Two: All residents have potential to be affected by this deficient practice. The HR department has completed an audit on all employee files to ensure that they are complete with documented evidence that the license verification was done.	

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F 607	Continued From page 16 staff member was hired. There was no documented evidence that SM2's license was verified prior to the date of hire (doh). 2. Review of Staff Member #4 (SM4), a US FOIA (b)(6), hired on NJ Exec Order 26.4b(1) did not have a NJDCA license verification printout. There was no documented evidence that SM4's license was verified prior to the doh. 3. Review of Staff Member #5 (SM5), a US FOIA (b)(6) hired on NJ Exec Order 26.4b, had a NJDCA license verification printout dated NJ Exec Order 26.4b. The verification was completed after the staff member was hired. There was no documented evidence that SM5's license was verified prior to the date of hire (doh). 4. Review of Staff Member #7 (SM7), a Certified Nursing Assistant (CNA #1), hired on NJ Exec Order 26.4b, had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which did not include the date that the verification was done. There was no documented evidence that SM7's license was verified prior to the doh. 5. Review of Staff Member #10, a Certified Nursing Assistant (CNA #2), hired on NJ Exec Order 26.4b had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. There was no documented evidence that SM10's license was verified prior to the doh. On 02/05/24 at 10:47 AM, in the presence of the US FOIA (b)(6)),	F 607	Element Three: The facility developed and implemented a policy for new employee hiring that ensures that licensed staff credentials are verified upon hire. The HR department has been in-serviced that all new hires must have their licenses verified prior to the date of hire. Element Four: The Facility Administrator or designee will audit all new employee files weekly for 4 weeks and then monthly for 5 months to ensure that licensed staff credentials are verified upon hire. All findings will be reported to the QAPI committee quarterly	

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the surveyor interviewed the US FOIA (b)(6) who worked previously in the Human Resources (HR) department regarding the process for new employee hiring. The US FOIA (b) stated that when she worked in HR she would perform license verification and that she used two different websites, one for CNAs and one for RNs as well as LPNs.

The surveyor asked if the license verification printouts were dated (to show which date they were performed). The US FOIA (b) was not sure if they were or were not dated. The US FOIA (b) explained that the doh was the first "physical" day that the employee worked at the facility. The US FOIA (b) verified that the license verification should be done "prior to them starting," the doh.

On 02/05/24 at 11:42 AM, the US FOIA (b) reviewed the employee files and confirmed that the five employees did not have documented evidence that the license verifications were done prior to the doh.

On 02/05/24 at 01:08 PM, the surveyor interviewed the US FOIA (b)(6) regarding the license verification. The US FOIA (b) stated that the license verification should be dated and done prior to the doh.

On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor discussed their concern with the US FOIA (b)(6) and US FOIA (b) regarding the five newly hired employees lacking documented evidence that their licenses were verified prior to their doh.

On 02/06/24 at 9:26 AM, the US FOIA (b)(6) stated that the facility did not have a specific policy for new

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F 607	Continued From page 18 employee hiring other than the checklist. The [US FOIA (b)(6)] provided two documents in lieu of a policy regarding new hires. The first document was an "Employee File Check List" which included the following: "The following shall be completed on each new employee as it pertains to his/her job ....Verification of License with Board of Nursing (if applicable) Date verified." The reviewed employee files did not include this or any check list. The second document was not titled but had entry areas for information that included the following: New Hire Orientation will be scheduled on .....Original Documents Needed ....Any licenses or certificates pertaining to your position. A review of the facility provided policy titled "Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure" dated 2022, included the following: The Facility will not employ or otherwise engage individuals who: A. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. B. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. C. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The facility did not provide any additional information.	F 607		

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F 607	Continued From page 19 N.J.A.C. 8:39-43.15(a)	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to report to the	F 609	Element One: US FOIA (b)(6) reported alleged violation of resident (#185) to NJDOH. US FOIA (b)(6) educated on proper	3/12/24

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F 609	Continued From page 20 New Jersey Department of Health (NJDOH) an NJ Exec Order 26.4b1 in accordance with federal and state requirements for reporting such injury to the state agency. The deficient practice was identified for one (1) of five (5) residents reviewed for NJ Exec O (Resident #185) and was evidenced by the following: Reference: According to Centers for Medicare and Medicaid Services (CMS) definition: "Injuries of unknown source" - An injury should be classified as an "injury of unknown source" when all of the following criteria are met: " The source of the injury was not observed by any person; and " The source of the injury could not be explained by the resident; and " The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." On 01/29/24 at 11:12 AM, the surveyor observed Resident #185 seated in a wheelchair in the day room of the unit. The surveyor observed a NJ Exec Orde on the resident's NJ Exec Order 26.4b1 The resident also had a NJ Exec Order 26.4b on the NJ Exe NJ Exec O of his/her NJ Exec Order 26.4b1. A review of Resident #185's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1	F 609	completion of incident. US FOIA (b)(6) educated on importance of consistency of details on investigation and policy of reporting to DON for compliance to NJDOH. Root cause analysis break in 24-hour reporting communications Element Two: All residents with incidents have potential to be affected by this practice. All incidents within the last quarter were reviewed by DON. All summaries and conclusions of incidents were reviewed to ensure all statements were completed in time required. All Documentation was reviewed for last quarter to ensure communications are following reporting as required. 24-hour report for last quarter was reviewed to ensure no missed communications and reconciled by DON to ensure no missed reporting was out of compliance All Licensed professional nurses were educated on 24-hour shift to shift reporting and alternate source of communications in emergency cases Element Three: Policy on Reporting was reviewed, and education completed on Licensed professionals Leadership Nursing Staff including DON by Administrator to ensure compliance with reporting. DON will be in communication with Leadership nursing staff on all shifts and ADON will cover in absence to report any alleged violations. DON will conclude all incidents in 72 hours and review weekly for compliance. Element Four: Logs for all incidents will be	

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F 609	Continued From page 21 NJ Exec Order 26.4b1 .	F 609	completed by DON with details of reporting of alleged incident and submitted to Administrator weekly to ensure compliance and accountability of DON responsibilities. DON will report updates at quarterly QAPI meeting.	

Resident #185's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated that Resident #185's NJ Exec Order 26.4b1. Further review of the MDS indicated that the resident had a NJ Exe in the NJ Exec Order 26.4b1 prior to admission/entry or reentry to the facility.

A review of Resident #185's Progress Notes included the following Nurses Note dated NJ Exec Order 26.4b 23:43: I was the nurse yesterday for patient on 3-11 PM. I saw resident cared for and resident had NJ Exec Order 26.4b1 his/her face then today when I came in I saw a NJ Exec Order 26.4b1 on resident's NJ Exec Order 26.4b1. I asked the resident what happen to head first he/she said he/she NJ Exec Order 26.4b1 then I told him/her that he/she had a NJ Exec Order 26.4b1 on his/her head that was not there yesterday. The resident then stated that he/she NJ E NJ Exec Order 26.4b1 and did not tell anyone ...

The only prior Nurses Note was on NJ Exec Order 26.4b1 05:59. There was no documentation to indicate that there was any witnessed incident that could have caused the NJ Exec Order 26.4b1

On 01/30/24 at 9:10 AM, the surveyor requested from the US FOIA (b)(6)) any incidents or accidents for Resident #185 since the resident's admission. The US FOIA (b) stated that Resident #185 had two incidents and that one

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was a [redacted] and one was a NJ Exec Order 26.4b1."

At 9:30 AM, the [redacted] stated that the '[redacted]' was associated with the resident's [redacted]. She added that the '[redacted]' was not there the day before according to the day shift nurse [that first observed the [redacted].

On 01/30/24 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6) regarding Resident #185. The [redacted] stated that the resident was at risk for [redacted] and that the resident would try to get up and NJ Exec Order 26.4b1 [redacted] She added that the staff watch the resident and that the staff reminded the resident NJ Exec Order 26.4b1. The [redacted] stated that she asked the resident what happened to his/her [redacted] and that the resident told her that he/she [redacted] but that when the [redacted] asked the resident where and how that the resident did not know.

On 01/30/24 at 12:37 PM, the surveyor attempted to interview Resident #185. The surveyor asked the resident if he/she could tell the surveyor the name of the facility where he/she was currently located at and the resident answered "[name redacted]. The resident NJ Exec Order 26.4b1 [redacted] The surveyor asked the resident if he/she knew how he/she got the NJ Exec Order 26.4b1 and if the resident had [redacted] Resident #185 stated that he/she was told that resident [redacted] but that resident NJ Exec Order 26.4b1 Resident #185 then stated that the [redacted] was that NJ Exec Order 26.4b1

On 01/30/24 at 01:58 PM, the surveyor reviewed the two facility provided incident report/investigations for Resident #185 which

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included the following information:

Incident report #1, dated [redacted] indicated a [redacted]

Incident report #2, dated [redacted] 09:13 indicated a [redacted]
Incident location: Unknown.
Incident description:
Nursing Description: Resident noted with [redacted] that was not present from the day before. Resident may have [redacted] as [redacted] and is closely monitored to prevent [redacted] The resident may have [redacted].
Resident description: Aide reported when she asked the resident how he/she got the [redacted] showed her [aide] the [redacted] blank. [redacted] blank. [redacted] blank.
Other Info: Resident [redacted] on the [redacted] because the resident [redacted] and is closely monitored to prevent [redacted]
Witnesses: No Witnesses found.
Notes: [redacted] Resident was received in [redacted] noted with a [redacted]. On assessment the resident [redacted] to the site. When asked what happened to him/her resident stated that [redacted] and then told aide he/she [redacted] and pointed to the [redacted] Doctor notified with orders for a [redacted] Family made aware. [redacted] IDCP Team met to discuss [redacted] on resident noted to be [redacted] and was not there prior. Nurse on the night shift reported that patient [redacted] during the night and was

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NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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leaning toward NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 and she [nurse] left pt (patient) was sleeping she [nurse] had seen resident leaning on NJ Exec Order 26.4b1 and had placed a pillow to prevent resident from NJ Exec Order 26.4b1. When morning aide came in he/she told her [aide] asked him/her what happened and resident told her [aide] he/she NJ Exec Order 26.4b1 ....No evidence of NJ Exec Orde or NJ Exec Order 2 noted.
There was one handwritten statement included with the incident report which was dated NJ Exec Order 26.4b shift 7-2 which included the following: On arrival on duty doing my rounds I saw my pt (patient) with NJ Exec Order 26.4b1 I told nurse. nurse said night shift said resident was moving around in bed and probably NJ Exec Order 26.4b1 so the[they] put pillow.

On 01/31/24 at 11:31 AM, the surveyor interviewed the US FOIA (b)(6)) who documented Incident report #2 regarding the process for an NJ Exec Order 26.4b1. The US FOIA stated that she would assess the resident, ask what happened, get NJ Exec Orde if ordered and get statements from previous shifts. The surveyor then asked the US FOI if Resident #185's NJ Exec Order 26.4b1 was an NJ Exec Order 26.4b1. The US FOI stated that it looked like it was. She added that she came in morning and saw the NJ Exec Orde and that she had the resident the day before and there was no NJ Exec Orde The US FOI stated that she did an incident report and an investigation was done. She added that the physician assessed the resident, an NJ Exec Orc was done and NJ Exec Order 26.4b1 were implemented. The US FOIA stated that a conclusion was done by the US FOIA (b and that the resident was on supervision and reminded to call for help. The US FOI stated that the resident NJ Exec Order 26.4b1 what the NJ Exec Orde was from. She added that initially the resident told her

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that the resident NJ Exec Order 26.4b1, then resident said maybe it was from the [redacted] and then resident told someone it was from the NJ Exec Order 2[redacted]. The surveyor asked if it was witnessed. The US FOIA [redacted] stated that it was NJ Exec Order 26.4b1 and that she considered it an NJ Exec Order 26.4b1.

On 01/31/24 at 12:46 PM, the surveyor interviewed the US FOIA (2) [redacted] regarding Resident #185's NJ Exec Order 26.4b1 [redacted]. The US FOIA (2) [redacted] stated that she did not report the incident to the NJDOH because she did not think the incident was NJ Exec Order 26.4b1. She added that based on the information she had received, she could substantiate how the NJ Exec Or[redacted] happened and that she knew how it happened. The US FOIA (2) [redacted] stated that the nurse saw Resident #185's NJ Exec Or[redacted] against the NJ Exec Order 2[redacted] and placed a pillow.

On 02/01/24 at 10:21 AM, the US FOIA (2) [redacted] provided the surveyor an additional handwritten statement that was not initially provided with Resident #185's Incident Report #2's investigation documents to the surveyor. The surveyor asked the US FOIA (2) [redacted] what the process was for an incident investigation. The US FOIA (2) [redacted] stated that at the time of the incident the nurse would make an incident report and then gather statements from staff to determine if there was NJ Exec Order 26.4b1 and if the incident needed to be reported or not reported. She added that if the supervisor determines it was a reportable incident, then they would tell me and I would call it in. The surveyor asked the US FOIA (2) [redacted] what incidents were reportable. The US FOIA (2) [redacted] stated that they were NJ Exec Order 26.4b1. The surveyor asked the US FOIA (2) [redacted] if an NJ Exec Order 26.4b1 was reportable. The US FOIA (2) [redacted] stated that it was not. The surveyor asked the US FOIA (2) [redacted] why the statement that was just provided to the surveyor was not with the

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investigation. The [redacted] added that she had called the 11-7 nurse on the day of the incident and got a telephone statement from the nurse and then asked the nurse to write the statement. She added that the nurse left it with the 11-7 supervisor.

A review of the additional facility provided statement on 02/01/24 which was dated [redacted] included the following: I am the nurse in charge of Resident #185 on 11-7 shift. Around 11:30 PM I made my rounds and saw the resident trying to [redacted] and [redacted] his/her clothes which he/she usually does every time. Resident was reminded [redacted] and clothes was [redacted] and made him/her comfortable in bed. Bed kept at [redacted] and [redacted] was placed on both side of the bed on the floor. 12:30 AM resident [redacted] with [redacted]. I placed him/her back on the center of the bed and pillows were placed to both side of the [redacted] for [redacted] Resident was monitored frequently every hour. He/she was sleeping comfortably. 5:30 AM given [redacted] and morning care was done. 6:50 AM left resident sleeping.

There was no documentation in the statement that the resident was observed to have [redacted] their head on the [redacted] There was no documentation in the statement that indicated there was any observation of [redacted] or a [redacted] by the nurse.

On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor told the [redacted] the concern that Resident #185, who was coded as having

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NJ Exec Order 26.4b1, had an NJ Exec Order 26.4 that was not reported to the NJDOH.

On 02/06/24 at 9:26 AM, the US FOIA (b)(6) stated that the facility did not have a specific policy for NJ Exec Order 26.4 or specific policy for reporting.

On 02/06/24 at 9:54 AM, the US FOIA (6) provided the surveyor a Physician's Progress Note for Resident #185 which was not included in the Incident Report #2's investigation that was provided to the surveyor. A review of the document dated NJ Exec Order 26.4b included the following: Examined patient accompanied by nurse. Resident NJ Exec Order 26.4b1 when asked how he/she developed NJ Exec Order 26.4b1. He/she pointed to NJ Exec Order 26.4b said "He/she NJ Exec Order 26.4b1" in his/her NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 by nurse. Nurse placed pillow to prevent further NJ Exec Order

Further review of the document indicated that the document was faxed to the facility with a fax date of NJ Exec Order 26.4b 11:51p (11:51 PM).

On 02/06/24 at 12:08 PM, in the presence of the survey team, two federal surveyors and the US FOIA (b)(6) stated that the incident happened on the 11-7 shift and that the physician saw the resident at the time of incident. She added that the resident specifically told the physician. The US FOIA (6) stated that the nurse documented incorrectly. She added that the nurse came in late and did not listen to report from the night shift nurse. The surveyor asked the US FOIA (6) if the Physician's progress note should have been in the resident's medical file and included in the investigation file. The US FOIA (6) stated that it should be in the chart and a copy should be in the

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investigation file. She added that there was a break in communication. The [US FOIA (b)] stated that she reviewed the incident and wrote the summary.

On that same date and time, the surveyor asked what the definition of NJ Exec Order 26.4b1 was. The [US FOIA (b)] stated that the definition was if you cannot determine what happened. She added that for her, she did not consider it an [NJ Exec Order 26] [redacted]. The surveyor asked if anyone witnessed the resident [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that there was an obvious discrepancy. He added that the [US FOIA (b)] believed that she [US FOIA (b)] knew what happened.

The facility did not provide any additional information.

A review of the undated facility provided policy titled "Incident/Accident Reporting" included the following:
15. Reporting will be completed if necessary once abuse or neglect cannot be ruled out.

A review of the facility provided policy titled "Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure" dated 2022, included the following:
XIII. Response
A. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall
a) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source ....are reported in the proper timeframe pursuant to this policy ....
e) Facility will ensure that all alleged violations involving abuse, neglect, exploitation

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F 609	Continued From page 29 mistreatment, including injuries of unknown source ...are reported immediately, but not later than 2 hours after the allegation is made .... N.J.A.C. 8:39-5.1(a)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to complete a thorough investigation of a NJ Exec incident for one (1) of five (5) residents, (Resident #149) reviewed for NJ Exec C This deficient practice was evidenced by the following:	F 610	Element One: DON reinvestigated closed file and retrieved statement of staff who witnessed resident (#149) NJ Exec Staff educated on occurrence of these categories to report to DON immediately for determination of root cause analysis and written statement. All statements will be submitted to DON for review to determine based on Policy of reporting required and will be in written format not	2/29/24

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F 610	Continued From page 30 On 01/30/24 at 12:56 PM, the surveyor asked the US FOIA (b)(6)) for investigations and incidents/accident records of Resident #149, and the US FOIA (b) stated that she would get back to the surveyor. On that same date at 02:02 PM, the surveyor observed the resident laying on the bed, awake, NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 was off. The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of Resident #149 as follows: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 The quarterly Minimum Data Set (qMDS) with an assessment reference date (ARD) of NJ Exec Order 26.4b, and NJ Exec Order 26.4b1 Making showed that the resident was NJ Exec Order 26.4 A review of the Progress Notes (PN) dated	F 610	verbal and documented to be included in investigation conclusion. DON will report within the timeframe required based on policy and requirements. Element Two: All Residents who had a fall have the potential to be affected with noncompliance of reporting. All incidents from July 2023 to present were reviewed for possible non reporting by DON. All identified areas of concern were reconciled and reported as applicable by DON. Element Three: All Risk Management System will be reviewed in morning meetings and reported within the time frame required by DON. All Clinical Leadership including US FOIA (b) educated on requirements of reporting. Conclusion of all investigations will be completed daily to determine root cause analysis and maintain reporting standards. Log developed by Administrator for tracking was delegated to DON for completion with weekly reporting to Administrator for DON compliance with process and Binder with supportive documentation. Administrator will audit Risk Management System and ensure Facility is in compliance. Element Four: DON is gate keeper and will maintain responsibility of requirements to adhere to compliance. All investigative summaries will be reported on at each quarterly QAPI meeting minimally monthly for 3 months and then quarterly for six months.	

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NJ Exec Order 2[illegible] at 6:12 AM, the type of PN was an Incident Note that was electronically documented and signed by US FOIA (b)(6)) that "Resident was NJ Exec Order 26.4b1 by resident's assigned US FOIA (b)(6)) as she about to render am (morning) care. Resident was assessed for NJ Exec Order 26 NJ Exec Order 26.4b1 . Placed a call to Physician #1 (P#1) but was told that P#2 was on call. Placed a call to resident's responsible party (RP) and notified RP. 11-7 Supervisor notified. Will continue to monitor resident."

Further review of the PN showed that there was no further documentation what was the cause of the NJ Exe and what interventions were put into place to prevent the recurrence of the NJ Exec

A review of the NJ Exec Order 26.4b1) revealed that no NJ Exec O was done on NJ Exec Order 26 when the resident had a NJ Exec Order 26.4b1 .

The care plan revealed the following interventions for focus of NJ Exec
1. Was created by the US FOIA (b) on NJ Exec Order 26.4b included NJ Exec Order 26.4b Resident was assessed for NJ Exec Order 26 NJ Exec Order 26.4b1 . Placed a call to P#1 but was told that P#2 was on call. Placed a call to resident's RP and notified RP. NJ Exec Order 26.4b1 done NJ Exec O assessment done NJ Exec Orde ordered by md (medical doctor)."
2. Was revised by the US FOIA (b)(6)) on NJ Exec Order 26.4b ; " NJ Exec Order 26 : Resident was assessed for NJ Exec Order 26 NJ Exec Order 26.4b1 . Placed a call to P#1 but was told that P#2 was on call. Placed a call to resident's RP and notified RP. NJ Exec Order 26.4b1 done NJ Exec Order 26.4b1 done Encourage to attend activities and keep in supervised environment

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while awake NJ Exec Order ordered by md."
3. Was created on NJ Exec Order 26.4b by the US FOIA (b)
"Encourage to be in day room when awake and frequent room checks."

A review of the provided NJ Exec Order 26.4b1 showed the following:
1. Th US FOIA (b)(6)) provided the NJ Exec Order 26.4b1 on NJ Exec Order 26.4 at 11:26 AM for a NJ Exec Order 26.4b1 dated NJ Exec Order 2 that included information under Nursing Description: "Resident was noted NJ Exec Order 26.4b1, on resident's NJ Exec Order 26.4 by resident's assigned US FOIA (as she went to render am care. Vitals checked and was NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 noted no NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 brought back to bed. Due care rendered." The resident was unable to give a description and no witness was found. The person preparing the report was the US FOIA (b) There were no conclusions and summaries documented in the NJ Exec Order 26.4b1.
2. The US FOIA (provided the NJ Exec Order 26.4b1 on NJ Exec Order 26.4 at 10:35 AM for a NJ Exec Order 26.4b1 dated NJ Exec Order 2 that included "Resident was noted on the NJ Exec Or on resident's NJ Exec Order 26.4 by resident's assigned US FOIA (as she went to render am care NJ Exec was noted trying to get of NJ Exec Order 26.4b1. Vitals checked and was within NJ Exec Order 26.4b1 . NJ Exe No apparent NJ Exe of NJ Exec O or NJ Exec Order 26.4b1 Brought back to bed. Due care rendered." The resident was unable to give a description and no witness was found. The person preparing the report was the US FOIA (b)
On the last part of the investigation was a note dated NJ Exec Order 26 which did not reflect on the first investigation provided to the surveyor by the US FOIA (b)(6). The NJ Exec Order 2 notes included that the IDCP (interdisciplinary care plan) team met to

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discuss the plan of care for the resident and the plan to check the resident frequently and while awake and encourage to be in a day room or supervised environment, NJ Exec Order 26.4b1 care and frequently used items within reach.

Further review of the above showed that there were discrepancies on previously provided investigation of the US FOIA (b)(6) and that the submitted investigation of the US FOIA (b) included notes that reflected in the care plan interventions that were dated NJ Exec Order 26.4b for a NJ Ex incident that happened on NJ Exec Order 26 which was NJ Exec Order 26.4b after the incident. Also, there were no documented statements from the US FOIA (b)

On 02/01/24 at 12:09 PM, the surveyor interviewed the US FOIA (b) in the presence of the survey team. The surveyor asked the US FOIA (b) what was the facility's practices and policy regarding incidents/accidents and any reportables. The NJ Exec Or informed the surveyor that in the investigations process, we fill out the report in the electronic record in Risk Management. The US FOIA (b) stated that the nurse initiates it whenever it occurs, and gets statements if the incident was not witnessed, like for a NJ Ex that happened on NJ Exec Order 2 which was an NJ Exec Order 26.4b1.

On that same date and time, the surveyor asked the US FOIA (b) how long the facility would complete the investigation for the NJ Exec Order 26.4b1 that happened on NJ Exec Order 26 The US FOIA (b) stated that the investigation should have been completed and closed within a week. The US FOIA (b) confirmed that the meaning of complete and closed within a week was that the Risk Management NJ Exec Order 26.4b1 was considered closed and complete when you can not add more documentation or revise the

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investigation.

At this time, the surveyor asked the US FOIA (b) why there was a discrepancy between what the US FOIA (b)(6) and the US FOIA (b) provided NJ Exec Order 2 investigation from Risk Management and there was additional information that was added from the investigation from what the US FOIA (b) provided that was not seen in the investigation provided by the US FOIA (b)(6) Also, the surveyor notified the US FOIA (b) of the above findings and concerns.

The US FOIA (b) stated that she edited the information yesterday which did not reflect on the submitted Risk Management of the US FOIA (b)(6). She further stated that there were delays in completing of investigations. The US FOIA (b) also confirmed that the last note in the investigation was considered the conclusion wherein the interventions identified to prevent the recurrence of the falls should have been documented in the care plan. The US FOIA (b) had no response when asked why there was no US FOIA (b) statement. The US FOIA (b) did not respond also when asked by the surveyor, if the last note was the conclusion and included the interventions that were dated NJ Exec Order 2 and why it was reflected in the care plan interventions that they were created on NJ Exec Order 26.4(b).

On 02/05/24 at 01:21 PM, the survey team met with the US FOIA (b)(6) . The surveyor notified the facility management of the above concerns.

On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management. The facility management did not

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F 610	Continued From page 35 provide the facility's [NJ Ex] policy. On 02/07/24 at 8:58 AM, the surveyor called the [US FOIA (b)] and the [US FOIA (b)] did not call back.	F 610		
F 623 SS=C	NJAC 8:39-27.1(a)(b) 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 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	F 623		3/5/24

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	315458	A. BUILDING _____ B. WING _____	C 02/06/2024

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F 623	Continued From page 36	F 623		

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 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

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F 623	Continued From page 37 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 review of pertinent facility documentation, it was determined that the facility failed to provide written notification of the emergency transfer to the Office of the Long-Term Care Ombudsman (LTCO) for one (1) of two (2) residents (Resident #149), reviewed for hospitalizations. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated	F 623	Element 1: Director of Nursing reviewed and adjusted Ombudsman notification from [redacted] to reflect resident (#149). Director of Nursing reviewed last quarter□s notifications to ensure all required transfers and discharges were on Ombudsman notification and communicated. Element 2: Director of Nursing reviewed last quarter□s notifications to ensure all required transfers and discharges were on Ombudsman notification and	

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F 623	Continued From page 38 records) medical records of Resident #149. The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the New Jersey Universal Transfer Form (a form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs) showed that the resident was transferred to the hospital on [redacted] and the reason for the transfer was due to [redacted] The Progress Notes that were a late entry on [redacted] (created date) for an effective date of [redacted] that was documented by the [redacted] showed that the resident was transferred to the hospital due to [redacted] the physician and the responsible party was notified. On 01/31/24 at 10:54 AM, the surveyor reviewed the provided binder for the NJ Ex Order 26.4(b)(1) Report Long Term Care Acute Transfer [redacted] and showed that there was no notification for transfer to the acute care facility (hospital) for the date of [redacted]	F 623	communicated. The communication list was reviewed for last quarter and reconciled by Director of Nursing with the corrective communication required. Element 3: Director of Nursing will review all resident transfers and discharges and ensure proper notifications and communication are met within time frame of expectations are met Element 4: Director of Nursing will review list weekly of all transfers and discharges x 4weeks then Monthly. Nursing Secretary will report all confirmed communications and logs that have been completed at each quarterly QAPI meeting	

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F 623	Continued From page 39	F 623		

On 01/31/24 at 10:59 AM, the surveyor interviewed the US FOIA (b)(6) assigned person to LTCO notification of acute transfer (hospitalization). The US FOIA stated that the process of LTCO notification was that she checks the electronic medical records of residents who went out for acute transfer to the hospital, lists them, and put into draft. She further stated that she prepares the draft every 5th of the month, then submits it to the US FOIA (b)(6) for checking and verification of the admitting diagnosis and completeness of the report, when the US FOIA (b) is finished, the US FOIA will finalize and fax it to the U.S. FOIA (b) (6) She indicated that the submission to LTCO was done monthly.

On that same date and time, the surveyor notified the US FOIA of the concern regarding NJ Ex Order 26.7 that there was no notification to LTCO. The US FOIA confirmed also that no notification of LTCO was filed on the binder that was provided to the surveyor. The US FO stated that she did not know what happened or why there was no notification submitted to the LTCO. She further stated that she thinks that because the previous US FOIA (b) who reviewed the notification missed it.

On 02/01/24 at 9:08 AM, the US FOIA (b)(6) in the presence of the survey teams stated that there was no facility policy regarding Ombudsman notification of acute transfer and that the facility just follows the regulations.

On 02/05/24 at 01:21 PM, the survey teams met with the US FOIA (b)(6). The surveyor notified the facility management of the above concerns.

On 02/06/24 at 11:30 AM, the survey teams met

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F 623	Continued From page 40 with the US FOIA (b)(6) confirmed that there were no other responses. On 02/06/24 at 01:35 PM, the survey teams met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management.	F 623		
F 641 SS=D	NJAC 8:39-4.1(a)(32), 5.3; 5.4 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 observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for three (3) of 38 residents, Residents #77, #145, and #242, reviewed for accuracy of MDS assessment coding. This deficient practice was evidenced by the following: 1. On 02/05/24 at 10:15 AM, the surveyor observed Resident #77 lying in bed with eyes closed. The surveyor reviewed Resident #77's hybrid medical (combination of paper and electronic) records.	F 641	Element One: Resident # 77 and #242 NJ Exec Order 26.4b1 not documented correctly on MDS assessments. #77. MDS corrected on 2/5/23 to indicate resident did not NJ Exec Order 26.4b1. #242 MDS corrected 2/5/24 to indicate resident received NJ Ex NJ Exec Order 2 NJ Exec Order 26.4. Resident #145 MDS assessment was updated to reflect receiving NJ Exec Order 26.4b1. Element Two: All residents have the potential to be affected by this error in MDS Coding All residents vaccine status will be reviewed and updated in medical records. All residents receiving oxygen therapy will have their most recent MDS reviewed to ensure oxygen therapy was coded correctly.	2/29/24

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F 641	Continued From page 41 The Admission Record (AR, admission summary) reflected that Resident #77 was admitted to the facility with medical diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the most recent MDS assessment dated [redacted] under Section [redacted] NJ Exec Order 26.4b1 which reflected that Resident #242 received the [redacted] on [redacted] The surveyor interviewed the facility's US FOIA (b) [redacted] who stated that the [redacted] date did not reflect the most up to date for the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated those dates auto populate from the resident's electronic medical health record and she missed to check it. A review of the Resident Assessment Instrument with a revision date of NJ Exec Order 26.4b1 under page O-12, "Steps for Assessment 1.) Review the resident's medical record to determine whether an NJ Exec Order 26.4b1 was received in the facility for this year's NJ Exec Order 26.4b1 season." On 02/06/24 at 11:31 AM, the surveyor spoke with the US FOIA (b)(6) [redacted]) regarding the above concerns. There was no further information provided. 2. On 01/31/24 at 10:10 AM, the surveyor observed Resident #242 in the room lying in bed. The surveyor reviewed Resident #242's hybrid medical records.	F 641	Element Three: In-service to nursing staff on proper documentation on accuracy of assessments. MDS Coordinator will reference Flu vaccine list when completing assessments and correctly code resident's vaccine status. ADON and IP will review all Minimum Data Set for accuracy with Oxygen therapy and Flu Vaccines with MDS coordinator prior to lock and submission Element Four: Review Residents on Oxygen List monthly and audit affected MDS assessments by MDS Coordinator or designee. Flu Vaccine list will be reviewed monthly for six months by IC Nurse/or designee Director of Nursing will report updates to the necessary parties to the QAPI committee ever quarter.	

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F 641	Continued From page 42 The resident was admitted to the facility with diagnosis that included but not limited to [redacted] The surveyor reviewed the most recent MDS assessment dated [redacted] under Section [redacted] which reflected that Resident #242 did not receive the NJ Exec Order 26.4b1 for the year's NJ Exec Order 26.4b1 season. Further review of Resident #242's hybrid medical records revealed under NJ Exec Order 26.4b1 that the resident received the NJ Exec Order 26.4b1 on [redacted] The surveyor interviewed the facility's US FOIA (b)(6) who stated that the resident received the [redacted] and the MDS was coded in error. 3. On 01/30/24 at 11:39 AM, the surveyor observed Resident #145, resting in bed in their room. Resident #145 was NJ Exec Order 26.4b1 [redacted]. Resident #145 was receiving NJ Exec Order 26.4b1 [redacted] which was attached to a NJ Exec Order 26.4b1 [redacted] On 01/29/24 at 12:17 PM, the surveyor reviewed the hybrid medical records of Resident #145 which revealed the following: The resident's AR revealed that Resident #145	F 641		

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F 641	Continued From page 43 was admitted with diagnoses that included, but were not limited to, NJ Exec Order 26.4b1 [redacted] A comprehensive MDS dated NJ Exec Order 26.4b, indicated that the facility assessed the resident's NJ Exec Order 26.4b status using a Brief Interview for Mental Status (BIMS). The resident scored a NJ Ex out of 15 which indicated that the resident's had NJ Exec Order 26.4b [redacted] Section NJ E of the MDS assessment, the resident was not coded for NJ Exe [redacted] use. A physician order dated NJ Exec Order 26.4 read, 'NJ Exe at NJ Exec Order NJ Exec Order 26.4b1 FOR NJ Exec Order every shift for NJ Exec Order 26 On 01/30/24 at 12:25 PM, the surveyor interviewed the US FOIA (b)(6) about Resident #145's MDS assessment and NJ Exec Order 26.4b1 not being coded. The US FOIA (b)(6) stated she would review and provide further information. On 01/30/24 at 12:33 PM, the US FOIA (b)(6) informed the surveyor that it was a data entry error after reviewing the MDS assessment and the resident's medical records. She confirmed the resident was receiving NJ Exec Order 26.4b1 at the time of the assessment and it should have been coded on the assessment. On 02/05/24 at 01:35 PM, the surveyor informed the US FOIA (b)(6) about the above concern. There was no additional information provided. NJAC 8:39-33.2 (d)	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan	F 656		3/19/24

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F 656	Continued From page 44 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 45 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of medical records and facility documents, it was determined that the facility failed to develop and implement a comprehensive plan of care to meet residents' preferences and goals and address the resident's medical, physical, mental, and psychosocial needs. This deficient practice was identified for four (4) of 38 residents (Residents #19, #36, #132, and #267) reviewed for a care plan. This deficient practice was evidenced by the following: 1. On 01/29/24 at 12:54 PM, the surveyor observed Resident #19 in their room wit [redacted] The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of Resident #19 as follows: Resident's Admission Record (AR, admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; other	F 656	Element One: Resident #19 No care plan for [redacted] Care plan written [redacted]. Resident #132 No care plan for [redacted] Care plan written [redacted] Resident #36 No care plan for [redacted] Care plan written [redacted] Resident #267 No care plan for [redacted] Care. Resident [redacted] at facility [redacted]. Element Two: All residents can be potentially affected by not having their needs addressed in care plan. Element Three: MDS Coordinator in-serviced Professional Nursing staff regarding writing care plans for residents that address anticoagulant use by resident, potential for pain, engaging in smoking activity, and palliative care. Element Four: MDS Coordinator will Review care plans quarterly to ensure Anticoagulant use, Pain, Smoking, and Palliative care needs are addressed, if applicable by MDS Coordinator or designee. MDS Coordinator will report updates to the necessary parties to the	

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F 656	Continued From page 46 NJ Exec Order 26.4b1 [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) NJ Exec Order 26.4b showed in NJ Exec Order 26.4b1 [redacted] that the resident's NJ Exec Order 26.4b was NJ Exec Order 26.4b1. Section NJ Exec Order 26.4b1 revealed that the resident received an NJ Exec Order 26.4b1 [redacted] medication during the last seven days. The NJ Exec Order 26.4b1 Order Summary Report (OSR) revealed a physician order (PO) date of NJ Exec Order 26.4b for NJ Exec Order 26.4b1 [redacted] to give one tab via NJ Exec every 12 hours (hrs) of NJ Exec Order 26.4b1 [redacted] elated to NJ Exec Order 26.4b1 profile. The above order for NJ Exec Order 26.4b was transcribed to the NJ Exec Order 26.4b1 electronic Medical Records (eMAR) and signed daily by nurses as administered. A review of the personalized care plan revealed	F 656	quarterly QAPI committee.	

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F 656	Continued From page 47 that the resident did not have a plan of care for an NJ Exec Order 26.4b1 On 02/01/24 at 8:48 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who informed the surveyor that Resident #19 was NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b with activities of daily living (adls). The LPN stated that the resident was recently hospitalized and came back NJ Exec Order 26.4b1 ago with a diagnosis of NJ Exec Order 26.4b1) from the hospital. On that same date and time, LPN#1 stated that it was the responsibility of the US FOIA (b)(6)) to initiate, develop, and update the resident's care plan. The LPN further stated that there was no US FOIA for NJ Exec Order 26.4b1 and he did not know who does the care plan now. The LPN also stated there should be a care plan for NJ Exec Order 26.4b1 On 02/05/24 at 10:55 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the above concerns and findings. The US FOIA (b) stated that there should be a care plan for NJ Exec Order 26.4b1 2. On 01/30/24 at 8:25 AM, the surveyor observed Resident #132 on the bed with an NJ Exec while on NJ Exec Order 26.4b1 The surveyor reviewed the hybrid medical records of Resident #132. The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1	F 656		

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NJ Exec Order 26.4b1

The qMDS with an ARD of NJ Exec Order 26.4b, and NJ Exec Order 26 showed that the resident's NJ Exec Order 26.4b was NJ Exec Order 26.4b . NJ Exec Order 26.4b1 that the resident received an NJ Exec Order 26.4b1 medication during the last seven days.

The NJ Exec Order 26.4b1 OSR revealed a PO date of NJ Exec Order 26 for NJ Exec Order 26.4b1 to give one tab via NJ Ex two times a day for NJ Exec Order 26.4b1 prior to NJ Exec Order treatment.

The above order for NJ Exec Order 26.4b was transcribed to the NJ Exec Order 26.4b1 eMAR and signed twice a day by nurses as administered.

A review of the personalized care plan revealed that the resident did not have a plan of care for pain.

On 02/01/24 at 8:46 AM, the surveyor interviewed LPN#1 regarding Resident #132. The LPN informed the surveyor that the resident had multiple NJ Exec Order 26.4b1 and was currently on NJ Exec Order 26.4b1. The LPN further stated that the resident should have a care plan for NJ Exec Or He confirmed that he was not responsible for initiating and developing a care plan because it was the responsibility of the US FOIA

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On 02/01/24 at 10:57 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team. The US FOIA (b)(6) informed the surveyor that the care plan was the responsibility of the admitting nurse to start the care plan for example for falls, skin, certain medications including anticoagulants, and pain. The US FOIA (b)(6) stated that upon admission, the next morning when she came to work, the US FOIA (b)(6) also updated and revised the care plan. She further stated that anyone from nursing including the US FOIA (b) and US FOIA can write a care plan that requires a nursing care plan. She further stated that as an US FOIA (b)(6), care plans also are reviewed during a quarterly MDS and any comprehensive MDS and that would be her responsibility to make sure that care plan was there.

At that same time, the surveyor asked the US FOIA (b)(6) if the nurses in the unit were aware that they were responsible to initiate and update the care plan. The US FOIA (b)(6) stated, "I know from previous US FOIA (b) that all nurses knew that they will do the care plan, but I did not talk to nurses if they were aware." The US FOIA (b)(6) informed the surveyor that she started to work at the facility in NJ Exec Order 26.4b1.

Furthermore, the surveyor asked the US FOIA (b)(6) why was it important that the resident have a personalized care plan for NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that so the staff knows how to monitor side effects like NJ Exec Order 26.4b

In addition, the surveyor asked the US FOIA (b)(6) why was it important for the resident to have a personalized care plan for NJ Ex Orde. The US FOIA (b)(6) stated that it was important to make sure that

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NJ Exec O is controlled.

On 02/05/24 at 10:48 AM, the surveyor interviewed the US FOIA (b) regarding the above concerns, and the US FOIA (b) stated that there should be a NJ Exec O care plan.

On 02/05/24 at 01:21 PM, the survey team met with the US FOIA (b)(6). The surveyor notified the facility management of the above concerns.

On 02/06/24 at 11:30 AM, the survey team met with the US FOIA (b)(6). The US FOIA (b) that she added an NJ Exec Order 26.4b1 care plan after the surveyor's inquiry for Resident #19. The US FOIA (b)(6) further stated that the care plan for NJ Ex Or for Resident #132 was added after the surveyor's inquiry.

3. On 01/29/24 at 01:01 PM, the surveyor observed Resident #36 in their room watching television. Resident #36 stated they are a NJ Exec Order 26 and the NJ Exec Order 26.4 area is on the NJ Exec Order 26. The resident further stated that the facility staff holds onto their NJ Exec Order 26.4b1.

The surveyor reviewed the hybrid medical records of Resident #36 as follows:

Resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 [redacted]

The annual MDS (aMDS) with an ARD [redacted] showed in Section [redacted] that Resident #36 was a current [redacted] user.

Resident #36 last [redacted] assessment (an assessment may help the facility determine how you can help a patient who [redacted] Variables worth assessing include amount [redacted] degree of [redacted] NJ Exec Order 26.4b1 [redacted] dated [redacted] indicated under Section [redacted] Safety subsection 9. "Plan of care is used to assure resident is safe while [redacted] was checked of as "yes."

A review of Resident #36's care plan, last reviewed on [redacted], did not show a resident focused care plan for [redacted]

A review a Federal Guideline 42 CFR 483.25(H) (1) and (2) also requires that the care plan for residents that states, "when [redacted] reflects specific information and that the resident's plan of care be reviewed and revised periodically as needed."

On 02/05/24 at 11:17 AM, the surveyor interviewed the [redacted] The [redacted] stated, on admission or re-admission the nursing department and MDS department create a care plan for each resident. The [redacted] further stated all residents who are [redacted] should have an

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individualized care plan that addresses the resident's goals and interventions with regards to [redacted].

On 02/05/24 at 01:21 PM, the survey team met with the [redacted]. The surveyor notified the facility management of the above concerns.

A review of the facility's Safe Smoking Policy that was provided by the [redacted] with a revised date of [redacted] stated under the procedure section; 1. "Any resident who wishes to [redacted] will be assessed by the nurse on admission and quarterly."

4. On 1/31/24 at 10:54 AM, the surveyor reviewed the closed record for Resident #267, who [redacted] in the facility.

The surveyor reviewed the hybrid medical records of Resident #267 as follows:

The [redacted] OSR revealed a physician order date of [redacted] for [redacted] Pt (patient) has [redacted] and choose [redacted] care.

A review of Resident #267's nursing progress notes revealed a nursing note dated [redacted] at 11:55 PM, "Resident placed on [redacted] Care. Now [redacted]."

The closed care plan dated [redacted] did not show a resident focused care plan for [redacted] care.

On 02/05/24 at 11:17 AM, the surveyor interviewed the [redacted]. The [redacted] stated, on

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admission, re-admission and/or as changes occur the nursing department and MDS department create and update care plans for each resident. The [US FOIA (b)] further stated any residents who are placed on [NJ Exec Order 26.(b)] care, should have an individualized care plan that addresses the resident's goals and interventions with regards to [NJ Exec Order 26.(b)] care.

On 02/05/24 at 01:21 PM, the survey team met with the US FOIA (b)(6). The surveyor notified the facility management of the above concerns.

On 02/06/24 at 11:30 AM, the survey team met with the US FOIA (b)(6). The [US FOIA (b)(6)] stated all the care plan concerns have reviewed and resident care plans will be updated as needed.

A review of the facility's Care Plans-Comprehensive Policy that was provided by the [US FOIA (b)(6)] with a revised date of December 2010 included an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. A review of the facility's Palliative/End-of-Life-Care Clinical Protocol that was provided by the [US FOIA (b)(6)] with a revised date of 11/27/23 revealed under the assessment and recognition section, 3. "The physician will review the resident's decision-making capacity and help the staff obtain maximum participation in the care plan." Under the treatment and management section of the policy it revealed, 5. "Nursing staff will implement comfort measures identified in the

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F 656	Continued From page 54 comprehensive care plan." On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-11.2 (e)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to ensure: a) medication was administered in accordance with manufacturer's cautionary specifications and professional standards of clinical practice for one (1) of three (3) nurses administered medications to one (1) of three (3) residents (Resident #69, observed during medication administration and b) care and services were followed for resident who was at risk for NJ Exec Order 26.4b1 for one (1) of two (2) residents, (Resident #55) reviewed for NJ Exec Order 26.4b1 according to physician's order, assessment and standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 658	Element 1: Educate nurse 1:1 for proper sequencing of medication specifically bronchodilator steroid and sequencing of medication with strict adherence to cautionary per manufacture requirement and potential side effects that can cause adverse effects of non-adherence. Assessed resident (#69) that was affected by professional standards not met with MD and responsible party notification. The nurse was evaluated by DON for proper sequencing of medication and was also able to verbalize skill and competence to prevent future reoccurrence. Resident #55 NJ Exec Order 26.4b1 was checked and assessments were reviewed for function and placement. All orders in place as required. Dates reconciled with staff for missing signatures.	2/29/24

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F 658	Continued From page 55 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 01/31/24 at 8:54 AM, during the medication (med) administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN#1) prepare eight meds for administration to Resident #69 which included the following: -NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 -NJ Exec Order 26.4b1 ; powder) one packet, one time a day for NJ Exec Order 26.4b1 At that time, the surveyor observed the LPN#1	F 658	Element 2: All Residents can be affected by this deficiency. All residents on bronchodilator steroid were assessed for possible side effects of potential incorrect actions by licensed professional nurses. All residents orders were checked and reviewed to ensure cautionaries were listed pertaining to bronchodilator steroid. Gatekeeper was assigned to review all TARs and Mars on compliance with documentation. All residents that are at risk for wandering assessment were reviewed by DON to ensure accuracy Element 3: All Licensed professional nurses were educated on administering medications according to manufacture requirements and maintain cautionaries sequencing and adverse effects of failure to comply during medication administration. Licensed professional was in serviced for wander guard documentation. All Licensed Professional Nurses were educated on Wandering Assessments and completing accurately Element 4: All Licensed Professional nurses were med passed observed by leadership nurses Nursing Supervisor. Will continue to monitor med pass weekly x 4 weeks Pharmacy Consultant will med pass Licensed professional Nurses as assigned by DON Monthly. QAPI on med pass will be reported on at each quarterly QAPI meeting. DON developed audit tool for wandering/elopement residents and will review all wandering assessments and compliance with all areas weekly x4 then	

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F 658	Continued From page 56 measure the NJ Exec Order 26.4 powder and dissolve the powder into water. On 01/31/24 at 9:12 AM, the LPN#1 informed the surveyor that she was ready to administer the meds to Resident #69 and proceeded into the resident's room. The resident was seated behind the meal tray table with the breakfast tray and drinks on top. The resident was NJ Exec Order 26.4b1 to the administration of his/her med. At that time, the LPN#1 administered the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to the resident followed by the dissolved NJ Exec Order 26.4 liquid and then the remainder of the resident's meds. The resident began to eat their breakfast. On 01/31/24 at 9:18 AM, the surveyor and the LPN#1 reviewed the cautionary sticker on the box for Resident #69's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Affixed on the box was a cautionary label that indicated "Rinse mouth thoroughly." On 01/31/24 at 9:20 AM, during an interview with the surveyor, the LPN#1 acknowledged that she should have read and followed the cautionary on the box of the NJ Exec Order 26.4b1 She stated that she should have provided water for the resident to rinse their mouth prior to administering the NJ Exec Order 26.4b This would have been the appropriate sequencing of the meds. At that time, the LPN#1 also acknowledged that the sequencing of the med administration was not in accordance with professional standards of clinical practice. The LPN#1 specified that she	F 658	monthly. DON will report compliance at each QAPI meeting	

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should have requested that Resident #69 rinse their mouth with water prior to administering an oral med that has to be swallowed, [redacted].

A review of Resident #69's Admission Record (AR) (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted].

Resident #69's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #69's [redacted].

A review of the manufacturer's specifications for [redacted]) Section 2.1 Administration Information. [redacted] should be administered as [redacted] twice daily (morning and evening, approximately 12 hours apart), every day by the orally inhaled route only. After [redacted] the patient should rinse the mouth with water, without swallowing.

Review of the manufacturer's specifications for [redacted] Section 5.4 Local Effects, included: Advise the patient to rinse his/her mouth with water without swallowing following inhalation to help reduce the risk of

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F 658	Continued From page 58 oropharyngeal candidiasis [mouth and throat fungal infection]. On 01/31/24 at 12:37 PM, during an interview with the surveyor, the US FOIA (b)(6) was made aware of the concerns that occurred during the med pass observation for Resident #69. A review of the LPN#1's competency for med administration performed by the facility's employed US FOIA (b)(6) dated NJ Exec Order 26.4b1 revealed that the LPN#1 was coached on the following: - Med storage - Special directions for preparation and administration are followed, i.e., liquids, shaken, give with food ... - External feeding tubes, checked for placement/residual. - A total of one (1) error was observed. A review of the facility provided policy of Administering Medications, dated/revised 4/2010, included the following under Policy Statement, "Medications shall be administered in a safe and timely manner as prescribed." Continued review of the Policy Interpretation and Implementation explained, "6. The individual administering the meds must check the label three (3) times to verify the right med... and the right method (route) of administration before giving the med." On 02/06/23 at 12:27 PM, the surveyor discussed the above concerns with the facility US FOIA (b) and US FOIA (b)(6) No additional information regarding the concerns discussed were provided.	F 658		

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2. On 01/30/24 at 11:36 AM, the surveyor observed Resident #55 NJ Exec Order 26.4b1 in the day room of the unit with a NJ Exec Order 26.4b1.

On 01/31/24 at 9:38 AM, the surveyor observed Resident #55 in their room with a NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1

A review of Resident #55's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1.

A review of Resident #55's most recent comprehensive MDS, dated NJ Exec Order 26.4, reflected that the resident had a BIMS score of NJ out of 15, which indicated that Resident #55's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. Further review of the MDS indicated that Resident #55 had a NJ Exec Order 26.4b1 used daily.

A review of the NJ Exec Order 26.4b1 Treatment Administration Record (TAR) revealed an order for NJ Ex Order 26.4(b)(1) every shift ...check placement every shift. Further review included the following:

There was no indication that the placement was checked on the day shift on NJ Exec Order 26.4b1.

There was no indication that the placement was checked on the evening shift on NJ Exec Order 26.4b1.

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F 658	Continued From page 60	F 658		

There was no indication that the placement was checked on the night shift on [redacted].

There was a total of ten shifts that a nurse did not sign, left blank on the [redacted] TAR to indicate the placement of the [redacted] was checked.

On 01/31/24 at 9:39 AM, the surveyor interviewed the LPN#2 regarding the process for a resident that had a [redacted]. LPN#2 stated that the [redacted] should be checked for placement every shift and that an alarm would go off if the resident went [redacted].

On 01/31/24 at 12:36 PM, the surveyor interviewed the [redacted] regarding the process for checking placement of the [redacted] The [redacted] stated that the nurse should have checked the placement of the [redacted] on each shift.

The [redacted] confirmed that Resident #55's [redacted] TAR had ten shifts that were blank. The [redacted] stated that there should not be any blanks on the [redacted] TAR.

A review of Resident #55's "[redacted]" dated [redacted] indicated the resident was a [redacted] with no risks associated with [redacted] documented. This was inconsistent with the surveyor's observation of the resident with a [redacted] and a diagnosis of [redacted] on the AR.

On 02/01/24 at 10:09 AM, the surveyor interviewed the [redacted] regarding the [redacted]. The [redacted] stated

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F 658	Continued From page 61 that it was a questionnaire in the computer. The surveyor showed the RN Resident #55's "NJ Exec Order 26.4b1 " form. The US FOIA stated that she would not expect that it would be blank. On 02/05/24 at 01:00 PM, the surveyor interviewed the US FOIA (b) regarding Resident #55's "NJ Exec Order 26.4b1 " form. The US FOIA (b) stated that Resident #55's NJ Exec Order 26.4b1 form looked like it was blank and that it should be filled out correctly. She added that she knew Resident #55 was at risk for NJ Exec Order 26.4b1 and that the resident's "NJ Exec Order 26.4b1 form was not completed correctly. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor informed the US FOIA (b)(6) of the concern that Resident #55's NJ Exec Order 26.4b1 TAR had ten blanks indicating that the NJ Exec Order 26.4b1 was not checked and that the "NJ Exec Order 26.4b1 " was not accurate. A review of the facility provided policy titled, NJ Exec Order 26.4b1) with an effective date of 02/28/2002, did not include any information about the NJ Exec Order 26.4b1 or the NJ Exec Order 26.4b1 ." On 02/06/24 at 12:20 PM, in the presence of the survey team and two federal surveyors, the US FOIA (b) did not provide any additional information. NJAC 8:39-27.1(a), 29.2 (d)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/18/24

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F 686	Continued From page 62 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to provide wound care in accordance with the facility's policy and professional standards of clinical practice for one (1) of one (1) resident reviewed and observed for NJ Exec Order 26.4b1, Resident #56. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and NJ Ex Order 26.4(b)(1), page last reviewed 01/08/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood,	F 686	Element One: Resident (#56) was assessed by DON for possible NJ Exec Order 26.4 of NJ Exec Order and MD notification. Nurse Practitioner will continue to monitor resident (#56) for NJ Exec Order status and address any NJ Exec Order 26.4b1 associated with deficient practice. US FOIA (b)(6) was re-educated on Policy of handwashing and competency on NJ Exec Order 26.4b1 treatment pass by Supervisor RN Element Two: All Resident with wound has the potential to be affected by this deficient practice. Immediate treatment pass was completed on all licensed professional nurses to ensure deficient practice is not repeated. All wounds were seen and evaluated by Wound Care Doctor to ensure this deficient practice is not affected by deficient practice. Element Three: Wound Care and Hand	

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F 686	Continued From page 63 body fluids or contaminated surfaces, and immediately after glove removal. In addition, wear gloves, according to Standard Precautions, when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur; gloves are not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment, and after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. On 02/05/24 at 10:47 AM, the state surveyor observed NJ Exec Order care performed for Resident #56 in the presence of a federal surveyor. The US FOIA (b)(6)) was scheduled to perform wound treatment on the left heel. During the NJ Exec Order treatment observation, the surveyors observed that the US FOIA (b)(6) did not perform hand hygiene on 12 of 17 opportunities. This was observed by the surveyors between 10:47 AM and 11:29 AM. Upon entry to the Resident #56's room, the US FOIA (b)(6) identified herself to the resident and asked if the resident had any NJ Exec O and she proceeded to check the resident's name bracelet to identify them. ~ US FOIA (b)(6) then washed her hands at the sink. ~ US FOIA (b)(6) gloved, cleaned the bedside table,	F 686	Washing Policy was reviewed by DON. All Licensed Professional Nurses were educated on wound care policy with competency on hand washing Weekly wound rounds will be reviewed by ADON in conjunct with Wound Care Nurse to ensure all standards are met in compliance with Policy of Wound Care. Director of Nurses provided treatment pass competency to be completed on all Licensed professional nurses to evaluate staff on competency. Element Four: RN Supervisor identified as gate keeper for treatment pass and handwashing compliance based on Policy and Procedure is completed with current Licensed Professional and New Hires weekly x 4weeks and quarterly. RN Supervisor will report on Treatment Pass Compliance at each quarterly QAPI meeting.	

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F 686	Continued From page 64	F 686		

removed her gloves, and did not perform hand hygiene.
~US FOIA (b)(6) proceeded to take the supplies from the NJ Exec Order care cart. NJ Exec Order 26.4b1 , trash bag, gloves, NJ Exec Order 26.4b1 tray being used for sterile gloves, tongue depressors, NJ Exec Order tape, trash bag).
~US FOIA (b)(6) gloved and did not perform hand hygiene.
~US FOIA (b)(6) was observed dropping the plastic cups she took out for supplies; she picked them up, removed gloves during the entire procedure (including removing her gloves because she forgot NJ Exec Order 26.4b1) but did not perform hand hygiene prior to starting NJ Exec Order care and removed the soiled dressing.
~US FOIA (b)(6) proceeded to redress the residents NJ Exec Order with bare hands and did not perform hand hygiene.
~US FOIA (b)(6) gloved to reapply the residents NJ Exec O prior to walking away to get the gauze and did not perform hand hygiene.

At this point the surveyor interrupted the process and asked the US FOIA (b)(6) to wash her hands prior to going into the NJ Exec Order care cart. After washing her hands and getting her supplies, the US FOIA (b)(6) gloved and proceeded with the NJ Exec Order care.
~US FOIA (b)(6) removed the residents NJ Exec Order 26.4b1 as well as the NJ Exec Order 26.4b measured the NJ Exec Order 2 took off her gloves and did not perform hand hygiene.
~With bare hands US FOIA (b)(6) opened the NJ Exec O kit to get the NJ Exec Order 26.4b1 on the cleaned bedside table covered with a barrier, then proceeded to open NJ Exec Order 26.4b1 onto the prep NJ Exec O She got a plastic cup and poured normal NJ Exec Order 26.4b1 in it and prepared another cup with

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F 686	Continued From page 65	F 686		

NJ Exec Ord in it. She dated and signed the NJ Exe with an opening date.
~ Without performing hand hygiene, US FOIA (b)(6) put on gloves, and placed the NJ Exec Order 26.4b pad under the resident's NJ Exec O
~ Without performing hand hygiene, US FOIA (b)(6) applied sterile gloves. She performed NJ Exec Order care on the NJ Exec Order 26.4b1 and NJ Ex Order 26 Without performing hand hygiene, US FOIA (b)(6) removed her gloves. She reached in her pocket to get a pen and proceeded to initial and date the resident's NJ Exec Order 26.4b1. to cover the resident's NJ Ex Orde
~ Without performing hand hygiene or changing her gloves, US FOIA (b)(6) proceeded to complete the left NJ Ex Order 26 NJ Exec Order care (a different area) with the same gloves.
~US FOIA (b)(6) then removed her sterile gloves, without performing hand hygiene changed gloves and proceeded to apply the NJ Exec Order 26.4b1 on the resident.
~US FOIA (b)(6) then proceeded with the same gloves to clean up the room, bedside table, pulled the trash and brought the trash to the dirty utility room.
~US FOIA (b)(6) was observed returning to the room, without gloves using hand foam sanitizer in the hallway.
~US FOIA (b)(6) applied gloves to clean bedside table and inserted a new trash bag.
~US FOIA (b)(6) then removed her gloves and properly washed her hands at the sink.

The surveyor reviewed the medical record for Resident #56.

The resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but were not limited to NJ Exec Order 26.4b1

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F 686	Continued From page 66	F 686		

NJ Exec Order 26.4b1

The resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26.4, revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 which indicated the resident's NJ Exec Order 26.4b1.

A review of the facility provided personalized care plan initiated on NJ Exec Order 26 and revised on NJ Exec Order 26.4b, with a focus of risk for NJ Exec Order 26.4b1 development related to related to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to care plan. Patient is at risk for NJ Exec Order 26.4b1

A review of the order summary report (OSR) revealed an order for NJ Exec Order 26.4b1

apply to NJ Exec Order 26.4b topically cover every 8 hours as needed for NJ Exec Order 26.4b. Apply NJ Ex Order 26.4(b) then NJ Exec Ord to NJ Exec Order 26

A review of the NJ Exec O and weekly note dated NJ Exec Order 26.4b indicated:

a.) NJ Exec Order 26.4b1),

b.) NJ Exec Order 26.4b1

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F 686	Continued From page 67	F 686		

On 02/05/24 at 11:45 AM, the surveyor interviewed the [US FOIA (b)(6)] and asked what the [NJ Exec Order] care process for the facility was. She responded, "introduce yourself, tell them what is happening, [NJ Exec Order 26.4b] and their identification band, clean your table, place a patient [NJ Exec Order 26.4b]. [US FOIA (b)(6)] stated, "I didn't use the [NJ Exec O] because they are not sterile." When the surveyor inquired about the facility [NJ Exec Order] care policy, [US FOIA (b)(6)] responded, "I don't know if the policy is the same or not, at this moment there is no infection preventionist in the building, the [US FOIA (b)(6)] is covering that role."

The surveyor reviewed the 13 opportunities out of 17 for handwashing.
with the [US FOIA (b)(6)] that was observed during the [NJ Exec Order] care. She responded,
"I didn't realize that."

Once the surveyor reviewed the observation with [US FOIA (b)(6)] she stated, "I agree I should have washed my hands for those instances and could have used a bottle of hand sanitizer on the top of the bedside table to perform hand hygiene more appropriately and frequently during the [NJ Exec Order] care."

On 02/05/24 at 01:15 PM, in the presence of the survey team, the surveyor interviewed the [US FOIA (b)] who stated, "hand washing is essential during [NJ Exec Order] care and having a clean environment while performing the [NJ Exec Order] care to protect against infection and the spread of germs."

A review of the facilities handwashing policy, dated 2001, revised 2009 documented:
#1 All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in

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F 686	Continued From page 68 preventing the transmission of healthcare associated infections. #2 All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. #8 The use of gloves does not replace handwashing/hand hygiene. A review of the facility's [redacted] Care Policy, dated 2001, revised 2010 provided by the [redacted]) indicated the purpose of the policy is to provide guidelines for the care of wounds to promote healing. Under the section "steps in the procedure" hand hygiene and gloves were instructed throughout the wound care process ... On 02/06/24 at 01:30 PM, the survey team met with the [redacted]. There was no additional information provided by the facility.	F 686		
F 690 SS=D	NJAC 8:39-11.2(b), 19.4(a), 27.1(a), 29.2(d) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		2/29/24

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F 690	Continued From page 69 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the NJ Exec Order 26.4b1 of resident's with NJ Exec Order 26.4b1 were monitored to ensure patency to further prevent any NJ Exec Order 26.4b1 This deficient practice was noted to two (2) of two (2) resident's reviewed with NJ Ex Resident #242 and Resident #266. This deficient practice was evidenced by the following: 1. On 01/31/24 at 10:10 AM, the surveyor observed Resident #242 in the room lying in bed.	F 690	Element One: Resident (#242) orders based on Evidence Based Practice and Updated Policy and Procedure were rectified by DON to monitor output on EMAR for quality improvement and compliance. Resident (#266) orders based on EBP and Updated Policy and Procedure were rectified by DON to monitor and document output on EMAR for quality improvement. Licensed Professional Staff Registered Nurse Licensed Practical Nurse and Certified Nursing Assistants were educated on Policy of Indwelling catheter monitoring and care.	

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F 690	Continued From page 70 The surveyor reviewed Resident #242's hybrid (combination of paper and electronic) medical records. The resident was admitted to the facility with diagnosis that included but not limited to [redacted] A review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score [redacted] out of 15 indicating that the resident had NJ Exec Order 26.4b1. A review of the Progress Notes (PN) dated [redacted] at 01:53 PM reflected that Resident #242 was transferred to the hospital due to NJ Exec Order 26.4b1 and were unable to [redacted] Further review of the PN dated [redacted] at 11:09 PM reflected that Resident #242 came back from the hospital at 10:50 PM with a new [redacted] A review of the active physician orders (PO) did not reflect that Resident #242 had a PO to monitor the [redacted] of the resident. On 02/01/24 at 12:05 PM, the surveyor interviewed the US FOIA (b)(6)) assigned to the resident who stated that for any resident with an [redacted] the [redacted] must be documented every shift in the electronic Medication Administration Record (eMAR).	F 690	Element Two: All residents residing in a facility with indwelling Catheter has potential to be affected by this outdated practice. Immediate audit was completed on all residents with indwelling catheters and orders were updated to ensure quality improvement in the area of output monitoring and documentation. All Licensed Professional staff completing admission and physician orders were educated for any new onset of use of Indwelling catheter must be completed in compliance with updated Policy and Procedure Element Three: DON developed QAPI tool to be completed for each resident on Indwelling catheter to monitor and evaluate compliance. Gatekeepers identified for Licensed professional on the 11-7 additional staff to complete audit tool and submit to DON who will review and ensure all areas of deficits are corrected weekly x 4 week and Monthly. Daily Clinical Rounding will be checked along with chart audit for compliance and finding will be addressed at the time of identification of any anomalies. Element Four: DON developed QAPI tool to be completed for each resident on Indwelling catheter to monitor and evaluate compliance. Gatekeepers identified for Licensed professional on the 11-7 additional staff to complete audit tool and submit to DON who will review and ensure all areas of deficits are corrected weekly x 4 week and Monthly. DON or	

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F 690	Continued From page 71 A review of the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 eMAR did not reflect any documentation for the NJ Exec Order 26.4b1 of the resident. On 02/01/24 at 01:49 PM, the surveyor discussed the above concern to the facility's US FOIA (b)(6) who stated that any residents with an NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 must be documented in the eMAR to ensure patency including the NJ Exec Order 26.4b1 characteristics which could indicate any infection. A review of the facility's policy and procedure (P&P) titled, " Emptying a Urinary Collection Bag" revealed under "General Guidelines 1. Empty the urinary collection bag at least every eight (8) hours or more often if needed to keep the bag from becoming full." Further review of the P&P revealed under "Documentation" The following information should be recorded in the resident's medical record: 2. The amount of urine emptied from the drainage bag" On 02/05/24 at 01:15 PM, the above concerns were discussed to the facility's US FOIA (b)(6) There were no further information provided. 2. On 01/29/24 at 10:45 AM, the surveyor observed Resident #266 seated up in bed. The surveyor observed Resident #266 had a NJ Exec Order 26.4b1 that was NJ Exec Order 26.4b1 into a NJ Exec Order 26.4b1 that was NJ Exec Order 26.4b1 on the side of the bed. Resident #266 stated that the NJ Exec Order 26.4b1 had been placed because he/she had trouble NJ Exec Order 26.4b1 Resident #266's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1	F 690	Designee will report in quarterly QAPI meeting.	

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NJ Exec Order 26.4b1 [redacted]

A review of Resident #266's most comprehensive MDS, dated NJ Exec Order 26.4b reflected that the resident had a BIMS score NJ Ex out of 15 indicating that the resident's NJ Exec Order 26.4b1.

A review of the active PO did not reflect that Resident #266 had a PO to monitor the NJ Exec Order 2 [redacted] of the resident.

A review of the NJ Exec Order 26.4b1 eMAR and electronic Treatment Administration Record (eTAR) did not reflect any documentation for the NJ Exec Order 26.4b1 of the resident.

On 02/01/24 at 9:31 AM, the surveyor interviewed the Certified Nursing Assistant #1 (CNA#1) regarding the documentation of Resident #266's NJ Exec Order 26.4b1. CNA#1 stated that the facility had placed the output in the computer system but that they did not have the computer system now and that they documented it in an ADL (Activities of Daily Living) binder. She added that she was not assigned to Resident #266.

On 02/01/24 at 09:34 AM, the surveyor interviewed Resident #266's assigned CNA#2. CNA#2 stated that she emptied the NJ Exec Order 26.4b1, measured the amount, documented the amount and gave it to the nurse. She added that it used to

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F 690	Continued From page 73 be in the computer and that now it was in the ADL binder. A review of Resident #266's ADL sheet for NJ Exec Order 26.4b1 did not include any amounts of NJ Exec Order 26.4b1. On 02/01/24 at 9:41 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that the NJ Exec Order 26. is monitored to see if was NJ Exec Order 26 but that the amount of NJ Exec Orde was not recorded anymore. On 02/05/24 at 01:01 PM, the surveyor interviewed the US FOIA (b) regarding NJ Exec Order 2 The US FOIA (b) stated that it depended on the policy. The US FOIA (b) stated that the facility did not document the NJ Exec Order 2 She added that for quality improvement would want it to be done. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor notified the US FOIA (b)(6) the concern that Resident #266 did not have their NJ Exec Orde of the NJ Exec Order 26. measured, documented and monitored. The facility did not provide any additional information. NJAC 8:39-33.2(c)5	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		2/29/24

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F 695	Continued From page 74 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that oxygen care and services were provided according to the standard of clinical practice and physician's order for three (3) of five (5) residents, (Residents #19, #145, and #235 reviewed for respiratory care. This deficient practice was evidenced by the following: 1. On 02/01/24 at 8:48 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who informed the surveyor that Resident #19 was NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 with activities of daily living (ADL). He further stated that the resident was recently hospitalized and came back three weeks ago for NJ Exec Order 26.4b1 On that same date and time, LPN#1 stated that it was the responsibility of the US FOIA (b)(6) to initiate and update the care plan of the resident including the care plan for NJ Exec Order 26.4b1 use. He further stated that there was no US FOIA for NJ Exec and a NJ Exec Order 26.4b1 and he did not know who does the care plan now. On 02/01/24 at 8:51 AM, the surveyor observed the resident laying in bed asleep with NJ Exec at NJ Exec Order 26.4b1	F 695	Element One: Resident #19 and #145 NJ Exec Order 26.4b1 was reviewed by DON and reconciled with orders care plan and all required documentation as required. MDS coordinator modify MDS for resident #19 and #145 to reflect NJ Exec Order 2 and care plan corrected. Resident #235 NJ Exec Order 2 was removed and new one was replaced with date. Element Two: All residents on Oxygen therapy are at risk for noncompliance practice. Immediate rounding on resident population was audited by DON to identify any other potential deficits in this area of focus. Communication and reconciliation with MDS were completed by DON to ensure all other areas of deficits rectified Licensed Professional nurses were educating to requirements with regards oxygen therapy. Element Three: DON developed an oxygen check list for compliance of all requirements based on policy compliance clinically. DON educated all Nursing staff on policy and requirements that pertain to oxygen therapy. MDS coordinator educated that prior to submission of MDS please verify with acuities to ensure capture and MDS coding is accurate with care plan compliance. MDS coordinator will complete bedside visits to residents prior to submission of	

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F 695	Continued From page 75 NJ Exec Order 26.4b1 [redacted] At that same time, the surveyor notified LPN#1 regarding the resident's [redacted]. The LPN stated that the resident's [redacted] should be at [redacted]. Then, the LPN went inside the resident's room, assessed the resident, and adjusted the [redacted] The surveyor reviewed the hybrid (a combination of paper-based and electronic health records that primarily involves tracking and storing a resident's health records in several formats and places) medical records of Resident #19 as follows: Resident's Admission Record (AR, admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) [redacted] showed in [redacted] that the resident's [redacted] was [redacted]. Section [redacted], Procedures, and Programs revealed that the resident was not on	F 695	MDS and communicate with nursing any identified areas of deficit for corrective measures. Element Four: Unit Manager or Designee identified as gate keeper to ensure compliance with oxygen therapy. Unit Manager or Designee will audit this weekly and ongoing for six months. Unit Manager Designee will report compliance at each quarterly QAPI meeting.	

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F 695	Continued From page 76 [redacted] while a resident of the facility for [redacted] A review of the Progress Notes (PN) showed that on [redacted] at 12:28 PM, [redacted] at 6:30 AM, and [redacted] at 10:06 PM, there was documentation that the resident had used the [redacted] A review of the [redacted] orders revealed that there was a physician's order (PO) created on [redacted] for [redacted] every eight hours as needed (PRN) for [redacted] The order for [redacted] at [redacted] was discontinued (d/c) on [redacted] and the reason for d/c was because the resident was hospitalized. The [redacted] Order Summary Report (OSR) showed that there was no order for [redacted] use. The personalized care plan did not include [redacted] use, goals, and interventions. Further review of the above information showed that the MDS did not capture the use of [redacted] in the resident's qMDS ARD of [redacted] On 02/05/24 at 8:23 AM, both the surveyor and LPN#1 went inside the resident's room and observed the resident was on [redacted] attached to a [redacted] and the resident was asleep. Outside the resident's room, the surveyor asked the LPN what was the order for [redacted] and he said that the order should be [redacted]. Then the surveyor notified the LPN of the above concerns. The LPN checked the electronic medical records and confirmed that there was no order, he stated that he would call the doctor to	F 695		

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obtain an order. He further stated that the admitting nurse should have obtained an order for [redacted] and it was missed when the resident came back from a recent hospitalization. He further stated that it was his fault too. He claimed that he should have seen that there was no order because he was taking care of the resident.

On 02/05/24 at 10:55 AM, the surveyor interviewed the [redacted]) regarding the above observations and findings. The surveyor asked the [redacted] if there should be an order and care plan for [redacted] use, and she stated "yes."

On 02/06/24 at 11:30 AM, the survey team met with the [redacted] and [redacted] The [redacted] stated that [redacted] should be part of a PO and the [redacted] care plan should be developed and initiated.

2. On 01/29/24 at 11:06 AM, the surveyor observed Resident #145, resting in bed in their room. Resident #145 was [redacted]. Resident #145 was receiving [redacted] which was attached to a [redacted] The surveyor observed there was no indicator visible on the [redacted] to show the LPM of [redacted] the resident was receiving. Resident #145 was not aware of the [redacted] that they should be receiving and stated that the nurses took care of it.

On 01/29/24 at 11:15 AM, the surveyor interviewed LPN#2 about Resident #145's [redacted]. LPN#2 stated the resident was ordered to receive [redacted]. The LPN accompanied the surveyor to the resident's bedside to check the resident's [redacted] setting on the

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NJ Exec Order 26.4b1 The LPN was unable to read the LPM of [redacted] the resident was currently receiving and acknowledged the setting of [redacted] could not be read on the [redacted] LPN#2 did not provide a [redacted] response as to when the [redacted] setting, or the [redacted] was last checked. LPN#2 called central supply to replace the [redacted] for the resident.

The surveyor reviewed the hybrid medical records of Resident #145 which revealed the following:

The resident's AR reflected that Resident #145 was admitted with diagnoses that included, but were not limited to, NJ Exec Order 26.4b1 [redacted]

The comprehensive MDS (cMDS) with an ARD [redacted], indicated that the facility assessed the resident's [redacted] using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the resident's had NJ Exec Order 26.4b1 .

A PO dated [redacted] read, "[redacted] at [redacted] every shift for [redacted]

A review of the [redacted] electronic Treatment Administration Record (eTAR) revealed there were five (5) of 85 entries were not signed by the nurses for [redacted] order.

On 01/31/24 at 01:12 PM, the surveyor informed the [redacted] about observation of [redacted] in use by Resident #145 and the [redacted] TAR with five entries not signed. The [redacted] acknowledged eTAR should be signed by the

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nurses and would follow up to provide further information.

On 02/05/24 at 01:35 PM, the surveyor informed the [redacted] and [redacted] about the above concern for the observation of Resident #145's [redacted]. The [redacted] stated the nurse changed the [redacted] right away for the resident. There was no further verbal response by the facility.

A review of the undated facility policy with the subject of "O2 THERAPY" under Policy read, "O2 therapy is administered only as ordered only by a physician or as an emergency measure until an order can be obtained". The policy did not further address O2 concentrator setting or checking O2 settings.

3. On 01/29/24 at 10:54 AM and 01/30/24 at 11:58 AM, the surveyor observed resident #235, out of bed in a wheelchair. The resident's [redacted] was not properly labeled with a date and the [redacted] equipment was not labeled. The [redacted] was sitting on the bedside table face down not in a bag or labeled with date and time. The residents' [redacted] were not labored. The [redacted] the resident was wearing was attached to an [redacted] with the [redacted]

The surveyor reviewed the hybrid medical records for resident #235.

The AR reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to [redacted] or has too

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NJ Exec Order 26.4b1).

The qMDS with an ARD NJ Exec Order 26 reflected a BIMS score of NJ Ex of 15 which revealed that resident #235's NJ Exec Order 26.4b1 was intact.

A review of the NJ Exec Order 26.4b1 Active OSR showed a PO dated NJ Exec Order 26 at 11 PM NJ Exec Order 26.4b1 There was another PO dated NJ Exec Order 26 at 6 AM "change NJ Exe NJ Exec Order 26 weekly, one time a day every Wednesday."

Further review of the NJ Exec Order 26.4b1 Active OSR revealed a PO dated NJ Exec Order 26 at 6 AM, "AR NJ Exec Order 26.4b1 one (1) vial NJ Exec Order 26.4b1 every 12 hours related to NJ Exec Order 26

The above orders for weekly change of NJ Exe NJ Exec Order 26 was transcribed and signed by nurses. On NJ Exec Order 26.4b1 the nurse signed the eTAR as the NJ Exec Order 26.4b1 was changed but the observation of the surveyor did not reflect that the NJ Exec Order 26.4b1 was dated and labeled.

The surveyor interviewed LPN#3, the assigned nurse on NJ Exec Order 26.4b1 at 12:02 PM. LPN#3 stated, "my practice is to check the resident and their NJ Exe prior to giving any treatments. The night shift is assigned to change the NJ Exec Orde weekly. When the NJ Exec Orde is changed it should be dated and labeled. If the equipment is not in use, it should be in a bag that is labeled and dated. Storage is to prevent infection until next use." The surveyor asked if it is the assigned nurse's responsibility to labeled and date the NJ Exec Orde if they found it not appropriate. The LPN stated, "yes, it should be

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done as needed not just the assigned day."

On 02/01/24 at 10:00 AM, the surveyor interviewed the [US FOIA (b)] in the presence of the survey team. The [US FOIA (b)] stated, "The [NJ Exec] should be administer based on the doctor order. The nursing staff is supposed to check the [NJ Exec] [NJ Exec Order 26.4b1] for volume flow correctness. They are to follow the schedule for changing the [NJ Exec Orde] and placing other [NJ Exec] and NJ Exec Order 26.4b1 into a bag that is labeled. It is to prevent NJ Exec Order 26.4b1. If there is an issue, they are supposed to inform me of it and write a note in the electronic medical record (eMR)."

A review of the undated policy titled, "Oxygen Administration Policy" provided by the DON indicated,
Purpose: The purpose of this policy and procedure is to provide guidelines for safe oxygen administration.
1. Verify that there is a physician order.
2. Review residents care plan to assess for any special needs of the resident.

A review of policy titled, "Nebulizer Therapy Policy" provided by the DON on indicated,
Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions.
Care of equipment: #7 Once completely dry, store nebulizer cup, mouthpiece, mask, in a plastic bag. #8 Change the nebulizer tubing every seventy-two hours or per facility policy.

On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) [redacted] for an exit conference, and there was no

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F 695	Continued From page 82 additional information provided by the facility management. NJAC 8:39-11.2(b); 25.2(c)3; 27.1(a)	F 695		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits at least once every sixty days and wrote progress notes to address NJ Exec Order 26.4b1 for a resident with NJ Exec Order 26.4b1 for one (1) of 10 residents, Resident #77 reviewed for NJ Exec Order 26.4 and was evidenced by the following: On 02/05/24 at 10:15 AM, the surveyor observed	F 710	Element One: Physician for resident (#77) was immediately contacted by DON and documentation was provided and added to medical record. Element Two: All resident care under this specific physician is at risk for non-complaint practice. An immediate review of all residents on specific physician medical records was reviewed and reconciled by DON with notification of	3/20/24

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F 710	Continued From page 83 Resident #77 lying in bed with eyes closed. The surveyor reviewed Resident #77's hybrid (both paper and electronic) medical records. The Admission Record (an admission summary) reflected that Resident #77 was admitted to the facility with medical diagnoses which included but not limited to NJ Exec Order 26.4b1 [redacted] The quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b [redacted] reflected that the resident had a Brief Interview for Mental Status score NJ Ex [redacted] of 15 indicating that the resident had NJ Exec Order 26.4b1 [redacted] A review of the interdisciplinary progress notes (PN) dated NJ Exec Order 26.4b [redacted] documented by the facility's dietician reflected that Resident #77 had a NJ Exec Ord [redacted]. Further review of the PN indicated the resident will be referred to the physician. A review of the interdisciplinary PN revealed that the most recent physician visit to Resident #77 was on NJ Exec Order 26.7 [redacted]. There was no additional documentation that the resident was seen and examined by the primary physician. On 02/06/24 at 10:30 AM, the surveyor interviewed the facility's NJ Exec Order 26 [redacted] who was responsible for Resident #77 who stated that for any resident who had NJ Exec Order 26.4b1 [redacted], she would refer them to the primary physician. On 02/05/24 at 01:15 PM, the above concerns	F 710	MD and retrieval of documentation. Element Three: US FOIA (b)(6) [redacted] were in serviced on Policy and Procedure of Physician Services and Supervised care requirement of facility policy and procedure. Unit Clerks and New Unit Managers were educated on requirements on Physician Policy and Procedure and documentation requirement to be readily available in chart. Gate Keeper identified as New ADON to oversee and follow up on tracking and ensuring physician documentation are in compliance with regulator. Element Four: Administrator contacted all Physicians to remind them of facility requirements. Audit will be completed by Unit Clerks and overseen by ADON. With tracking Log Physician Supervise care and Documentation will be monitored weekly x4 then monthly by ADON. Physician Supervise care and Documentation will be tracked and reported at each quarterly QAPI meeting.	

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	315458	A. BUILDING _____ B. WING _____	C 02/06/2024

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F 710	Continued From page 84 were discussed to the facility's US FOIA (b)(6) [redacted]. There were no further information provided. On 02/06/24 at 01:31 PM, the surveyor attempted to contact the physician but was unavailable for interview.	F 710		
F 728 SS=D	NJAC 8:39-27.1 (b) Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has	F 728		2/28/24

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F 728	Continued From page 85 worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure a) a non-certified Nurse Aide (NA) did not continue to work as an NA after the specified 120 days for one (1) of three (3) NAs reviewed during the Sufficient and Competent Nurse Staffing task (NA #1) and b) there was a delineated policy and/or program in place for the hiring, staffing, and assignments of non-certified NAs. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP (Long Term Care Facilities Training and Competency Evaluation Program) program and completed the	F 728	Element One: Removed NA immediately off the nursing schedule. All NA□s that are not within 120 days removed from nursing schedule. US FOIA (b)(6) [redacted] immediately reeducated as to the NJDH memorandum under the interpretation of CMS guidance. Element Two: All residents have the potential to be affected by this deficient practice. Audit of all NA files making sure they have all the required documentation and are within the 120 days□ timeframe. Element Three: Inservice US FOIA (b)(6) [redacted] on policy for NA hiring. Individuals who meet any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in NJ has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facility training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of	

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F 728	Continued From page 86 first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: I. TNAs A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE, whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP program and pass the exams. II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C.	F 728	employment. New tracking will be utilized by the HR department. Element Four: Administrator will audit weekly for 4 weeks and monthly for 5 months. LNHA will report findings to quarterly QAPI committee.	

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8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing.

On 01/29/24 at 10:22 AM, in the presence of a federal surveyor, the survey Team Coordinator met with the US FOIA (b)(6) for an entrance conference and requested a list of the facility's CNAs with their date of hire and license numbers listed.

On 01/30/24 at 9:10 AM, the surveyor asked the US FOIA (b)(6) for the list of the facility's CNAs with their date of hire and license numbers listed.

On 01/30/24 at 01:48 PM, the surveyor asked the US FOIA (b)(6) if he had the previously requested facility CNA list. The US FOIA (b)(6) stated that he had the list but that the license numbers were not on it and that someone was working on placing the license numbers on the list.

On 02/01/24 at 11:02 AM, the US FOIA (b)(6) informed the survey Team Coordinator that some of the CNAs that were on the list provided no longer worked at the facility. The US FOIA (b)(6) provided the survey team a new list of CNAs with the date of hire and license numbers listed. A review of the list revealed that some of the CNAs listed did not have a license number listed next to their name and that "certificate" was listed in lieu of a license number.

On 02/01/24 at 11:13 AM, in the presence of another surveyor, the surveyor interviewed the US FOIA (b)(6) regarding the staffing schedule of non-certified NAs. The US FO stated that she did not identify whether the staff was a CNA or a NA on the schedule and that the nurses on

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the floor knew who was not certified.

On 02/01/24 at 11:26 AM, the surveyor interviewed the US FOIA (b)(6) regarding the process of hiring CNAs. The US FOIA (b)(6) stated that she was new and that the US FOIA (b)(6) was not in. The US FOIA (b)(6) stated that the process was to perform a background check and a license verification. The surveyor asked what if the person did not have a license The US FOIA (b)(6) stated that they cannot work until they get a license. The surveyor asked if the facility had any NAs working. The US FOIA (b)(6) stated that it was her understanding that they did not have any NAs. She added that the U.S. FOIA (b) (6)) who worked previously in the Human Resources (HR) department would know. The surveyor requested NA #1's employee file.

On 02/01/24 at 11:34 AM, the surveyor interviewed the U.S. FOIA regarding NAs. The U.S. FOIA stated that she worked in HR from NJ Exec Order 26.4b1 . The U.S. FOIA stated that the facility had NAs and that as long as the NA was in school, passed the skills test and was observed by a US FOIA (b)(6) that the NA could continue to be on the schedule. She added that the NA was just waiting to take the written exam.

At that time, the U.S. FOIA stated that she would get proof of their school and that they passed the skills test. The surveyor asked if there was a certain time frame that they had to take the test and continue to work for. The U.S. FOIA stated that we tell them to take the written test as soon as possible.

The surveyor reviewed the facility provided employee file which revealed the following:

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NA #1, hired [NJ Exec Order 26.4b] had a photo copy of a document from the NJ DOH which included the following:
Exam Date: [NJ Exec Order 26]
Exam Name: NJ CNA Written
Exam Result: Pass
You MUST complete a CBI (New Jersey requires all new nurse aide candidates, new personal care assistant candidates, and nurse aides applying for recertification or reciprocity, and homemaker/home health aides to undergo a Criminal Background Investigation (CBI) application and schedule a fingerprint appointment before being considered for permanent certification in New Jersey.
Please note that a passing examination score is not a license.

There was no verification printout that NA #1 was licensed. There was no documentation that NA #1 was enrolled in school during their employment. The NA #1 was working at the facility for more than 120 days. It was [NJ Exec Order 26.4b1] since NA #1 passed the written exam.

On 02/01/24 at 12:35 PM, in the presence of another surveyor and the [US FOIA (b)] the surveyor interviewed the [US FOIA (b)(6)] regarding NAs. The [US FOIA (b)(6)] stated that he thought the NAs were CNAs and that they passed the skills test, had a certificate and were just waiting to take the written test. He added that he reviewed it with the Department of Health and that the NA could work for a year as long as there was a [US FOIA (b)(6)] in the facility.

On that same date and time, the surveyor asked who verified the NA had the required schooling and passed the skills test before the NA was

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hired on worked on the unit. The [US FOIA (b)] stated that she did not verify the information. The [US FOIA (b)(6)] stated that HR verified the information. The surveyor asked about NA #1 who had CNA listed on their employee file but did not appear on the NJDOH online Public Registry license verification website as having a license. The [US FOIA (b)] stated that NA #1 had a date of hire of [NJ Exec Order 26] and that during her interview she told me she was a [US FOIA (b)] She then stated that if they do not have a license then they are not a CNA. The [US FOIA (b)(6)] stated that HR checked everyone that was hired.

On 02/01/24 at 12:46 PM, in the presence of another surveyor and the [US FOIA (b)(6)] the surveyor interviewed NA #1 via telephone on speaker setting. NA #1 stated that she was waiting for her license to be mailed to her. NA #1 stated that she completed CNA school [NJ Exec Order 26.4b1]. She further stated that she had been working as a TNA at two other Nursing Home (NH) facilities. She stated that she worked at NH #1 from [NJ Exec O] [redacted] and NH #2 from [NJ Exec Order 26.4b1] [redacted]. NA #1 stated that she sent in the required application to get her license in [NJ Exec Order 26.4b1]

On 02/01/24 at 01:02 PM, in the presence of another surveyor and [US FOIA (b)(6)] the surveyor interviewed the [US FOIA (b)(6)] [redacted] via telephone on speaker setting. The HRM stated that the NAs are required to submit certificate from school that they completed their clinicals and passed the skills test and that they are waiting to take the written state test. She added that the facility had some TNAs in the past that that they had to enroll in school to continue to use them.

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F 728	Continued From page 91 At that time, the surveyor asked how long after they finished school and waiting to take test could the NA work. The US FOIA (b)(6) stated that she believed it was a year. She added that if they fail the test then they could not use them anymore. The surveyor asked if they were following a facility policy or a regulation. The US FOIA (b)(6) stated that they followed the state regulation regarding the Temporary Nurse Aide. She added that if they were not in school then they could not use them. On 02/05/24 at 11:01 AM, in the presence of the US FOIA (b)(6) the US FOIA (b)(6) stated that she thought they could accept anyone that was in enrolled in school and that they had one year to pass the written test. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor notified the US FOIA (b)(6) the concern that there was a NA that was working past the 120 days since their date of hire. On 02/06/24 at 9:26 AM, the US FOIA (b)(6) stated that the facility did not have a policy regarding NAs. On 02/06/24 at 12:06 PM, the US FOIA (b)(6) stated that they started a QAPI (Quality Assurance and Performance Improvement). The facility did not provide any additional information. N.J.A.C. 8:39-43.1	F 728		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review	F 730		3/19/24

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F 730	Continued From page 92 of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that the facility Certified Nursing Aides (CNA) received annual performance reviews for five (5) of five (5) CNA files reviewed. This deficient practice was evidenced by the following: On 1/29/24 at 10:22 AM, in the presence of a federal surveyor, the survey Team Coordinator met with the US FOIA (b)(6) for an entrance conference and requested a list of the facility's CNAs with their date of hire and license numbers listed. On 2/1/24 at 11:02 AM, the US FOIA (b)(6) provided the survey Team Coordinator an updated list of CNAs. The surveyor randomly chose five CNAs from the updated facility list and requested the education provided, annual performance reviews and competencies done for the five CNAs. On 2/5/24 at 11:16 AM, the surveyor still had not received the annual performance reviews for the selected 5 CNAs and once again requested them from the US FOIA (b)(6) The facility did not provide the requested performance reviews. There was no documented evidence that a performance review was	F 730	Element One: Human Resources reviewed all files for annual reviews, mandatory education, and competencies. All files out of compliance were addressed and corrective action was completed to achieve 100% compliance of each file. HR collaborated with Leadership RN to ensure reviews of education and competencies were completed. Element Two: All residents have potential to be adversely affected by this deficient practice. Immediate review of all personnel files was checked for the deficit areas identified and was reconciled and updated to reflect 100% compliance with collaboration of RN educator reviewer and competencies to meet clinical standards. All files were checked and audited by compliance officer. Element Three: Human resources was educated on required compliance of files. Compliance Officer reviewed files to ensure requirements were met in areas where deficit was identified. Spread sheet of Audit was developed by Administrator for Human Resource Audit to be quantified and submitted monthly to administrator. Element Four: Human resources will	

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F 730	Continued From page 93 conducted for the five CNAs randomly reviewed. On 2/5/24 at 1:53 PM, in the presence of the survey team and two federal surveyors, the surveyor discussed the concern related to the five CNAs who did not receive annual performance reviews, with the US FOIA (b)(6) . The facility did not provide any additional information. The facility did not provide a policy referring to the CNA annual performance review. N.J.A.C. 8:39-43.17 (b)	F 730	review files weekly x 1 month and monthly thereafter to ensure compliance. Any identified concerns will be addressed with the month of identification. This issue will be reported on at every Quarterly QAPI meeting.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		2/28/24

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F 732	Continued From page 94 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report was posted in a prominent place within the facility and readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 1/29/24 at 9:18 AM, the survey team entered the facility and observed that there was no Nursing Home Resident Care Staffing Report (NHRCSR) posted at the entrance area or elevator area. On 1/30/24 at 9:25 AM, after the surveyor did not observe a NHRCSR posted, the surveyor interviewed the Security staff in the front lobby regarding the posting of the NHRCSR. The Security staff stated that the Administration staff	F 732	Element One: Staffing Coordinator posted staffing information immediately. Posting was moved to the front desk so it would be immediately visible to all visitors and staff. U.S. FOIA (b) (6) was educated, and designee identified in her absence by Administrator of requirements and importance of daily staff posting. Element Two: All residents have potential to be affected by non-posting of staff in a timely manner. Element Three: Posting was moved to the front desk so it would be immediately visible to all visitors and staff. U.S. FOIA (b) (6) [redacted] was educated, and designee identified in her absence by Administrator of requirements and importance of daily staff posting.	

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	315458	A. BUILDING _____ B. WING _____	C 02/06/2024

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F 732	Continued From page 95 usually place the posting on the bulletin board that was behind the wall near the elevators. The Security staff confirmed that there was no NHRCSR posted on the bulletin board. On 1/30/24 at 9:31 AM, the surveyor interviewed the US FOIA (b)(6) regarding the posting of the NHRCSR. The US FO stated that she usually posted the NHRCSR in the lobby. She added that she did not post it today because she was running late. The surveyor told the US FO that the NHRCSR was not posted the previous day. The US FO confirmed that she had not posted the NHRCSR on 1/29/24 and 1/30/24. On 2/5/24 at 1:53 PM, in the presence of the survey team and two federal surveyors, the surveyor discussed with the US FOIA (b)(6) their concern that the 24-hour staffing report was not posted for two days in a prominent place within the facility readily accessible to the residents and the visitors. On 2/6/24 at 12:07 PM, in the presence of the survey team, two federal surveyors and the US FOIA (b)(the US FOIA (b)(stated that the person who usually posted the report had a medical emergency and came in late each day, NJ Exec Order 26.4b1 The US FOIA (b)(added that the facility recognizes that where the NHRCSR was usually posted was not a readily visible location. The facility did not have a policy on posting staffing. The facility did not provide any additional information.	F 732	Element Four: Staffing coordinator will report directly to Administrator and Compliance Officer and show binder of proof of staffing posting as required by NJDOH weekly for four weeks and monthly thereafter for 4 months. Staffing Coordinator will report compliance at each quarterly QAPI meeting of daily compliance.	

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F 732	Continued From page 96 N.J.A.C. 8:39-41.2 (a)(b)(c)	F 732		
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 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:	F 755		3/15/24

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F 755	Continued From page 97 Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a) labeling of medication with an expiration date, b) expired medication was removed from active inventory, c) beyond use date was in accordance with standard of practice, and d) discontinued medications were removed from active inventory. The deficient practice was identified for two (2) of six (6) medication carts, and (one) 1 of three (3) medication rooms and was evidenced by the following: Reference: USP Compounding Standards and Beyond-Use-Dates (BUDs; the date or time after which a compounded sterile preparation may not be stored or transported and is calculated from the date and time of compounding). According to the revised <795> -Non-preserved aqueous had a BUD of 14 days. 1) On 01/31/23 at 9:58 AM, in the presence of the Registered Nurse #1 (RN#1), the surveyor began the inspection of Cart A on the west wing of the fifth floor. The surveyor observed an open, and undated NJ Exec Order 26.4b1 for Unsampled Resident #104. The NJ Exec Order 26.4b1 vial reflected a received date of NJ Exec Order 26.4b1, without a date of when the bottle was opened and/or removed from the refrigerator. At 10:22 AM, during an interview with the surveyor, RN#1 stated that the NJ Exec Order 26.4b1 vial should have been dated once removed from the refrigerator for use. RN#1 informed the surveyor that she had not administered the medication (med) to the resident since the order was for	F 755	Element One: Medication was checked at the time of notification by DON for date of delivery to reconcile and ensure that medication of required manufacture requirements was not out of safety parameters for residents safety. Medications were removed and a new vial was ordered and dated upon opening. Compounded medication was immediately removed and verified with pharmacy to ensure that expiration and use will not harm or jeopardize residents health. Resident (#47) involved was checked and evaluated by Registered Nurse Specifically DON and communication to family and MD of potential issues. A new bottle was ordered with labelling and dating accurately. Resident (#104) was NJ Exec Order 26.4b1 by this practice. All licensed professional nurses were educated on checking dates and steps to follow if labeling is unclear. Resident (#100) and resident (#127) both were interviewed by DON and follow up about consenting to NJ Exec Order 26 both declined at this time and medication was returned to pharmacy All medication storage were checked for medications that were refused with focus on NJ Exec Order 26.4b1 and returned to pharmacy as required. Nurses were educated on return medication policy and process. Element Two: All residents that medications are stored in medication carts and refrigerator and Multi Dose Vials in medication and medication carts are at potential risk for this practice. Immediate rounds by DON and RN supervisor were	

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F 755	Continued From page 98 bedtime. A review of the manufacturer's specification for [NJ Exec Order 26.4b1] indicated that a [NJ Exec Order 26.4b1] opened, and in-use bottle that is refrigerated or at room temperature were in date for 28 days. 2.) On 01/31/24 at 11:53 AM, in the presence of the [US FOIA (b)(6)]), the surveyor began the inspection of the med room on the East side of the third floor. The surveyor observed an [NJ Exec Order 26.4b1] with a use by date of [NJ Exec Order 26.4b] for Resident #47. At that time, the [US FOIA] reviewed the bottle of [NJ Exec Order 26.4b1] and stated that the label on the bottle indicated the [NJ Exec Order 26.4b1] expired on [NJ Exec Order 26.4]. The LPN also stated that Resident #47 was assigned to med cart A, and the resident was a [NJ Exec Order 26.4b1] The LPN informed the surveyor that she was assigned to cart B on that day. The surveyor reviewed the hybrid medical record for Resident #47. A review of the Admission Record (AR, an admission summary) for Resident #47 revealed the resident was admitted with diagnoses that included [NJ Exec Order 26.4b1]	F 755	competed to ensure that this practice is not occurring in medication storage areas medication carts and refrigerators. Element Three: Policy of medication storage and return medications with appropriate documentation was reviewed and adjusted by DON. All staff were educated to ensure compliance with policy and documentation. 11-7 Supervisor is conducting rounding on all medication carts refrigerators and medication carts to maintain compliance. Pharmacy Consultant was contacted by DON to ensure compliance. Element Four: Form for unit inspection and medication storage and labelling created and implemented by DON with use for daily inspection of unit including medication carts and refrigerator. 11-7 Supervisor will audit during rounds x1 every 24 hours and ongoing. Pharmacy Consultant will check for compliance on Monthly consultation. This area will be reported on by 11-7 Supervisor at each quarterly QAPI meeting.	

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F 755	Continued From page 99	F 755		

NJ Exec Order 26.4b1

A review of the annual Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b under section NJ Exec Order for Brief Interview for Mental Status (BIMS) revealed a score of NJ out of 15 which indicated the resident had a NJ Exec Order 26.4

A review of the active Order Summary Report (OSR) as of NJ Exec Order 26.4b reflected an order for NJ Exec Order 26.4b1 one time a day for NJ Exec Order 26 with an order date of NJ Exec Order 26.4b.

A review of the electronic Medication Administration Record (eMAR) from NJ Exec Order 26.4b to NJ Exec Order 26.4b reflected the nurses signed the administration of NJ Exec Order 26.4b1 every day from the use by date of NJ Exec Order 26.4b1.

On 01/31/24 at 12:12 PM, during an interview with the surveyor, RN #2 stated she had administered the med to Resident #47 on that day.

At that time, RN#2 stated she should have looked at the expiration date on the bottle prior to administration.

At that time, RN #2 stated that all nurses on all shifts were responsible for ensuring that expired meds were not with the active inventory.

On 01/31/24 at 2:52 PM, the surveyor observed the US FOIA (b)(6) assessed the resident.

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F 755	Continued From page 100 A review of RN #2's med pass competency performed by the facility's employed Registered Nurse, dated [redacted], revealed RN#2 was coached to check the [redacted] with one error out of 20 medications passed. 3.) On 02/05/24 at 9:26 AM, the surveyor received an email correspondence between the pharmacy provider and the [redacted] The letter reflected that the expiration date for the [redacted] would be 30 days thereafter and that the pharmacy had randomly "pick an earlier date for the "use by" just to give the facility some extra runway, not to come to close to the expiration." On 02/06/24 at 10:31 AM, during an interview with the surveyor, the pharmacist from the provider pharmacy stated that [redacted] suspension had a shelf life of 14 days. The pharmacist had informed the surveyor that the compounded [redacted] consisted of [redacted] capsules with [redacted] and diluted in sterile water. A review of the [redacted] bottle revealed the med had a label from the pharmacy with a beyond use date (BUD) of 21 days. 4.) On 01/31/24 at 11:53 AM, during the med storage and labeling observation of the med room located on the [redacted] wing of the [redacted] floor, the surveyor observed the following: - A [redacted] labeled for Resident #100, dated [redacted]. - A [redacted] labeled for Resident	F 755		

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F 755	Continued From page 101 #127, dated [redacted].	F 755		

The surveyor reviewed the hybrid medical record for Resident #100.

A review of the AR for Resident #100 revealed the resident was admitted with diagnoses that included [redacted].

A review of the OSR from [redacted] revealed the [redacted] had an order date of [redacted] and an end date of [discontinued on] [redacted].

A review of the eMAR from [redacted] reflected that on [redacted] the nurse documented a number nine (9) which indicated, refer to the nurses' progress notes (PN).

A review of the nurses' PN for [redacted] did not reveal a documentation that the resident refused the administration of the [redacted] or that the [redacted] was administered.

The surveyor reviewed hybrid medical record for Resident #127.

A review of the AR for Resident #127 revealed the resident was admitted with diagnoses that included [redacted].

A review of the OSR from [redacted] revealed the [redacted] an order date of [redacted] and an end date

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F 755	Continued From page 102 of [discontinued on] [redacted].	F 755		

A review of the eMAR from [redacted] reflected that on [redacted] the nurse documented a number nine (9) which indicated, refer to the nurses' PN.

A review of the nurses' PN for [redacted] did not reveal a documentation that the resident refused the administration of the [redacted] or that the [redacted] was administered.

On 01/31/24 at 01:06 PM, in the presence of RN #2, the surveyor began the inspection of cart A on the [redacted] side of the [redacted] floor. The surveyor observed a box of [redacted]. The box was labeled for Unsampled Resident #172 with a date of [redacted].

At 01:16 PM, the surveyor and RN #2 reviewed the electronic Medical Record which indicated the [redacted] for Resident #172 was discontinued (d/c) and was not included in the active electronic Administration Record for [redacted].

At that time, RN #2 stated that all nurses on all shifts were responsible for ensuring that d/c meds were not with the active inventory.

On 01/31/24 at 02:24 PM, the surveyor discussed the concerns with the [redacted]

On 02/05/23 at 01:21 PM, in the presence of the survey team, the federal surveyors, the [redacted] and the [redacted] the surveyor discussed the concerns regarding the facility's failure to label with a date an opened biological, remove from active

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F 755	Continued From page 103 inventory expired and d/c meds. A review of the provided facility policy April 2010 included the following: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 3. The drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use d/c, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 9. Meds requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location ...Med must be stored separately from food and must be labeled accordingly. A review of the provided facility policy, Administering Meds, dated/revised on 4/2010, included under, Policy Interpretation and Implementation section 8. The expiration date on the med label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container. A review of the provided facility policy provided, Med Administration via Enteral Tube, included under Policy; It is the policy of this facility to ensure the safe and effective administration of meds via enteral feeding tubes by utilizing best practice guidelines. NJAC 8:39-11.2(b), 27.1(a), 29.4(a)	F 755		

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F 804	Continued From page 104	F 804		
F 804 SS=D	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: Complaint #: NJ 167957 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot foods served to the residents. This deficient practice was identified for one (1) of one (1) resident complaint, Resident #107, and confirmed during the lunchtime meal service on 01/31/24 for one (1) of three (3) nursing units tested for food temperatures and was evidenced by the following: A review of a complaint in-take form indicated the food is not received on time. 1. On 01/29/24 at 10:41 AM, during the initial tour, the surveyor observed Resident #107 sitting on his/her bed. The resident was NJ Exec Order 26.4 and stated, NJ Exec Order 26.4b1." At 12:05 PM, the surveyor interviewed Certified	F 804	Element One: FSD has meet with resident #107 to discuss their food preferences. Resident #107 reviewed menu choices and chose the options the he/she found appealing to their taste. Kitchen staff were instructed to place meal trays of residents dining in the same area on the same truck, ensuring that all residents of each dining area receive their meals timely and in unison. Element Two: All residents who receive their meals in the communal dining areas have the potential to be affected by this deficient practice. Element Three: FSD in-serviced dietary staff to place all meal trays of residents dining in the same area will be placed on the same truck, ensuring that all residents of each dining area receive their meals timely and in unison. The Food services director will take daily temperatures at point of service for two weeks and weekly for six weeks to ensure	3/18/24

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F 804	Continued From page 105 Nursing Assistant #1 (CNA #1) who stated there were four of them assigned to the west side of the fourth floor, at that time. The surveyor visually saw four CNA's adjacent to the dining area. At 12:12 PM, the surveyor entered the main dining area on the west side of the fourth floor, and observed eight residents seated in the main dining area. Their lunch had not arrived. At 12:34 PM, the surveyor observed CNA #1 pass sanitary wipes to the residents to wipe their hands. At that time, the surveyor observed the first meal truck arrive. The meal truck was an open system, covered by a clear plastic. Each plate had a plate cover on the tray. Two of the CNAs (CNA #2 and CNA#3) began passing the trays to the resident rooms which started at room [redacted] The CNAs passed the tray in sequence by room number. At 12:38 PM, the second meal truck arrived, and CNA #4, and CNA #1 began passing the trays to the other rooms of the west side. At that time, the first meal truck included the meal trays for the main dining area. CNA #1, CNA #2, and CNA #3 began passing the meal trays to the residents seated in the main dining area. The residents who received their lunch began to eat. At 12:46 PM, CNA #1, CNA #2 and CNA #3 continued to pass the lunch trays into the other rooms conjoined with the main dining area. 2. On 01/31/24 at 11:30 AM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F)	F 804	a meal does not lose temperature. Element Four: The Administrator or designee will audit compliance weekly for six weeks. Director of Food Service will report updates to the necessary parties to the QAPI committee every quarter .	

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F 804	Continued From page 106	F 804		

in the presence of the survey team.

At 12:06 PM, the surveyor, US FOIA (b)(6) observed the first food truck arrived at the 4th floor East unit. A regular diet consistency tray was identified by the surveyor and US FOIA (b)(6) This tray was removed from the food truck and placed at the nurse's station in the presence of the surveyor, US FOIA and two FS. The US FOIA replaced the resident's tray from the kitchen.

At 12:08 PM, the nursing staff began delivering the resident's food trays.

At 12:33 PM, the last tray was delivered to the residents' and the surveyor tested the food temperatures with the reserved tray in the presence of the US FOIA and two FS. The temperatures were as follows:

Beef Stew: 121.9 degrees Fahrenheit (F)
Boiled Potatoes: 125.5 degrees F
Peas and Carrots: 119.2 degrees F
Apple Juice: 55.2 degrees F
Hot Dog: 121.8 degree F
Milk: 55 degrees F

At 12:37 PM, the surveyor interviewed the US FOIA in the presence of two FS. The US FOIA stated that their kitchen equipment to maintain meal temperatures were working adequately and all the items on the lunch tray were within normal temperatures limits prior to leaving the kitchen, but the passing out of the lunch trays took entirely too long which caused the food items to lose their temperature.

On 02/05/24 at 01:23 PM, the survey team met with the US FOIA (b)(6)

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F 804	Continued From page 107 (US FOIA (b)(6) and the US FOIA (b)(6) The US FOIA (b)(6) acknowledged the food temperatures were below the recommended 135 degrees F for hot foods and below 40 degrees F for cold food and beverages. The US FOIA (b)(6) further stated, the facility is exploring options to pass out the meal trays in a timelier fashion. On 02/06/24 the US FOIA (b)(6) provided the surveyor with multiple facility policies which included, "Food: Quality and Palatability" and "Meal Distribution." Neither facility policy had a created or revised dated available. Under the policy statement for the Food: Quality and Palatability policy it states, "Food will be palatable, attractive and served at a safe and appetizing temperature." Under the policy statement for the Meal Distribution facility policy it states, "Meals are transported to the dining location in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner." Under the procedure section of the same policy it states, 2. "All food items will be transported promptly for appropriate temperature maintenance ...4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients." No further comments made by the US FOIA (b)(6) and/or US FOIA (b) prior to exiting the facility.	F 804		
F 812 SS=F	NJAC 8:39-17.2(a) 2, (e) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/15/24

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F 812	Continued From page 108 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 01/29/234 at 9:24 AM, the surveyor in the presence of the US FOIA (b)(6)) and a US FOIA (b)(6) observed the following during the kitchen tour: 1. On a tray cart, the surveyor observed multiple 6 ounce (oz) disposable individual cups that the US FOIA (b) stated the contained rice crispy cereal. No	F 812	Element One: All residents have the potential to be affected by this practice. All items that were improperly stored or sealed were discarded. Foods that required individual labels were labeled appropriately. Food items that did not have a use by date or received by date were discarded. Food substance that had built up in the chef preparation area was cleaned. The items left in the oven were taken out, and the dirty griddle was cleaned. The broken tiles were replaced, the air conditioner was cleaned and the items in the fridge were all lowered to the proper height. Element Two: The FSD performed an audit of the fridges, freezers, storage rooms and food racks for items that are lacking proper dates. An audit of the	

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F 812	Continued From page 109 labels with made or use by dates noted. [redacted] stated the cereal cups were put together yesterday but could not state why they were not labeled. 2. The juice machine was observed with a clear tubing from orange juice with brown colored spots on the tubing. [redacted] unable to state what the brown spots were but would call the service company to change the tubing. 3. Dietary aide (DA #1) was observed preparing salads with lettuce, cucumbers, and carrots. The Surveyor further observed DA #1 unwrapping the lettuce from plastic wrapper and not washing lettuce prior to chopping lettuce for salad. Both DA #1 and [redacted] both stated the lettuce does not need to be washed prior to prepping. Surveyor further observed manufactures plastic wrap for the lettuce that stated, "wash before eating." The [redacted] instructed DA #1 to wash all lettuce that was being used for today's salads. [redacted] stated the lettuce they normally are delivered in ready to use straight from the bag, but the lettuce they were delivered was different from their normal delivery. 4. Surveyor observed nine (9) individually wrapped loafs of white bread, all not labeled. The [redacted] stated all bread came from single box that was labeled with a delivery date, but unable to produce that box or state if individual breads should be labeled. 5. In dry pots and pans area, the surveyor observed 2, 1/4 tray pans with wet nesting, [redacted] stated all pots and pans in that area should be dry. 6. Surveyor observed the [redacted] perform hand	F 812	entire kitchen was done to ensure there are no broken or missing tiles. All kitchen equipment and utensils whether in use or not currently in use has been examined for condition and cleanliness. FSD and Staff were re-educated on safe hand washing. Element Three: All dietary staff were in-serviced on the importance of dating and labeling items individually, as well as items once they are open. An opening and closing cleaning schedule has been implemented for supervisors to sign off beginning and end of shift to ensure condition and cleanliness of all equipment. All dietary staff have been in-serviced on the importance and proper process of safe handwashing. Element Four: The Food Service Director will Audit all logs and compliance with new systems three times a week for four weeks and subsequently weekly for five months. The Food Service Director will report compliance to the Administrator and QAPI committee every quarter.	

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F 812	Continued From page 110	F 812		

hygiene. The [redacted] failed to scrub hands with soap for 20 seconds before rinsing as well as turning off the faucet with contaminated paper towels that the [redacted] used to dry their hands. [redacted] stated she used contaminated paper towel because the towel dispenser did not have any clean towels. Surveyor observed paper towels next to dispenser. [redacted] acknowledged hand washing was completed incorrectly.

7. Surveyor observed multiple packages of opened hamburger buns, not labeled with open or use by date. The [redacted] stated they do not label individualized packages of bread or buns, all bread products are labeled on the box they are delivered in, but unable to produce the box the hamburger buns were delivered in.

8. In the chef preparation area. The surveyor observed crumb-like debris in-between the upper and lower ovens of the dual standing oven. The [redacted] stated the ovens should be clean and wiped down after each use and when visibly soiled.

9. Surveyor observed a dual oven with six (6) range stove top and griddle. The [redacted] stated both ovens were not currently working. Inside the right side oven, surveyor observed two boxes of Adobo seasoning. [redacted] stated, "sorry that should be in there, they staff likes to take that home." In the left oven, surveyor observed two pots with a handle, the first contained partially melted butter with brown colored spots on non-melted area and second pot had used cooking grease/oil. Both pots were covered with plastic wrap and was dated 01/28/24. [redacted] stated, nothing should be stored inside those ovens, the butter and oil must have been left over from yesterday and not properly disposed of. The [redacted] had the [redacted]

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F 812	Continued From page 111	F 812		

dispose of the butter and oil.

10. On top of the flat top griddle was a removable cast iron flat top griddle that was observed with black debris. The [redacted] stated, the cast iron griddle should be cleaned after each use.

11. In the walk-in refrigerator #1, the surveyor observed multiple items stored 18 inches from top of ceiling as well as a black dust-like debris on light bulb and connected wiring. The [redacted] stated they had a food delivery was today and that was the reason for items being stored 18 inches from ceiling but could not explain the dust-like debris.

12. In walk-in refrigerator #2, the surveyor observed multiple items stored 18 inches from ceiling. The [redacted] could not state why the food items were stored that high.

13. In the walk-in freezers. Surveyor observed multiple items stored 18 inches from ceiling. The [redacted] could not state why the food items were stored that high.

14. In the dry storage area, all opened seasonings were observed with open dates, but no use by/discard dates noted. The [redacted] stated once the seasoning are opened, they are good for one year.

15. In the dry storage area, the air conditioning unit (AC) was observed with a thick layer of black colored debris on the vent. The [redacted] stated, they would call maintenance to clean the AC unit immediately. The [redacted] unable to state when the AC unit vent was last cleaned because the AC

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F 812	Continued From page 112 unit is cleaned by the maintenance department. 16. In the dry storage area, the surveyor observed multiple broken, partial moved, and missing ceiling tiles. The [redacted] stated the facility had been doing some repairs in the dry storage area but could not state why the ceiling tiles had not been replaced or put back. On 01/31/24 at 9:40 AM, the [redacted] provided the surveyor with multiple facility policies. The policies were titled; "dating and Labeling Policy" with a revised date 1/24/2017, "Pot Washing Policy" with created date 1/1/2017, "Handwashing/Hand Hygiene" with a revised date December 2009, and "Food Storage", no date available. The policy for dating and labeling states under the procedure section, 2. "Label products in storage with date the package was opened ...7. Keep all storage areas clean and dry." The pot washing policy states under the procedures section, 10. "Air dry all clean and sanitized pots and wares." The hand washing and hand hygiene policy states under the procedures section, 3." Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds under moderate stream of running water, at a comfortable temperature ...4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel." The food storage policy states under the storage section of the policy, "Dry and staple foods must be stores on shelving at least 6" (inches) from the floor and 18" from the sprinkler heads in clean well-ventilated rooms ...All fruits and vegetables upon receive shall be stored properly and must be wash before using for food preparation."	F 812		

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F 812	Continued From page 113 On 02/05/24 at 01:23 PM, the survey team met with the US FOIA (b)(6) The US FOIA (b)(6) stated all the kitchen issues will be addressed and corrected by the US FOIA (b) immediately. No further comments made. NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	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, interviews, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage compactor and dumpster free of garbage and debris. On 1/29/24 at 9:56 AM, the surveyor, in the presence of the US FOIA (b)(6) and a Federal Surveyor toured the kitchen and the designated garbage area observing the following: There was garbage debris that included food, cups, bottles, gloves, paper products, and brown paper bags, surrounding the garbage compactor and dumpster. The US FOIA (b) stated that the area should have been cleaned by the maintenance and dietary departments. On 2/5/24 at 1:23 PM, the surveyor informed the US FOIA (b)(6)) of the debris findings. The US FOIA (b)(6) clarified that the garbage	F 814	Element 1: Maintenance personnel immediately picked up the food, cups, bottles, gloves, paper products, and brown paper bags, surrounding the garbage compactor and dumpster. Element 2: This deficient practice has the potential to affect all residents. Maintenance Director inspected all dumpsters to ensure they are free of garbage and debris. Element 3: Maintenance Director provided in service to the dietary and maintenance personnel on the importance of maintaining a sanitary environment free of garbage ad debris. A daily cleaning log was implemented for the dumpsters and surrounding areas to be completed by maintenance personnel and inspected by director of maintenance or designee. Element 4: Maintenance Director will audit	2/28/24

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F 814	Continued From page 114 disposal area is shared with another facility on the same property but admitted that the facility maintenance department is responsible for keeping the area clean and free of debris. On 2/6/24 at 12:54 PM, the [redacted] provided the surveyor with a copy of the facility policy titled, "Food-Related Garbage and Rubbish Disposal," with a revised date of December 2008. Under the policy interpretation and implementation section of the policy it states, 7. "Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter." No further information was provided by the [redacted] prior to exiting the facility. NJAC 8:39-19.7	F 814	cleaning log and garbage area to ensure compliance twice a week for 6 weeks and report to QAPI committee every quarter.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		3/19/24

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F 842	Continued From page 115 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 116 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint NJ#162723, 162811 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for two (2) of 38 residents reviewed (Residents #470 and #269). This deficient practice was evidenced by the following: 1. On 02/05/24 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6) about where Certified Nurse Assistants (CNAs) documented resident care. The US FOIA showed the surveyor an ADL [Activities of Daily Living] binder at the nurses station. The ADL binder consisted of monthly forms which the CNAs would document CNA and ADL care for residents. The US FOIA stated the CNAs used to document electronically but now it was paper based. The US FOIA could not recall exactly when the change occurred and stated sometime last year. On 02/05/24 at 12:25 PM, the surveyor reviewed the closed hybrid (paper and electronic) medical records of Resident #470.	F 842	Element One: DON reconciled ADL flow sheet for resident (# 470) to complete medical record in compliance for closed chart. DON printed all documents and called medical director to provide documentation for resident (# 269) to meet requirements of closed medical chart Medical Records Unit Clerk Medical Doctors and Nursing Licensed Professionals were educated on documentation required for medical charts compliance including ADL flows sheet and Physician Discharge summary but not limited to Element Two: All residents have the potential to be affected by this deficient practice. Medical Records of all Discharged charts is at prospective for inadequate compliance. Medical Records Personnel educated on collaboration required between the unit clerks licensed professional and medical records for collection of all documents from hybrid charts. Medical Record Personnel reviewed all records in comparison of check list for compliance of closed chart within the last quarter. Reconciliation was completed as required for all charts out of	

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F 842	Continued From page 117 The Admission Record (AR, admission summary) reflected that Resident #470 had diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] A quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) NJ Exec Order 26 indicated the facility assessed the resident's NJ Exec Order 26.4b using a Brief Interview Mental Status (BIMS) test, Resident #470 scored NJ out of 15, which indicated the resident had NJ Exec Order 26.4b1 [redacted]. Under NJ Exec Order 26.4b1 Status, the resident was documented as needing NJ Exec Order 26.4b1 with personal hygiene and toilet use. NJ Exec Order 26.4b1 [redacted], the resident was documented as having occasional NJ Exec Order 26.4b1 episodes. Further review of the hybrid medical records revealed no documentation related to US FOIA (b) documentation of ADL care which included incontinence and hygiene care. On 02/05/24 at 12:45 PM, the surveyor requested from the US FOIA (b)(6) [redacted] documentation for ADL care of Resident #470 for NJ Exec Orde On 02/06/24 at 08:55 AM, the surveyor asked the US FOIA (b)(6) regarding the documentation requested for	F 842	compliance with last quarter. Element Three: DON reviewed policy for medical records and closed charts. All staff were educated on policy and checklist. Auditing and tracking of closed charts will be completed by medical records and reported to Administrator and DON for follow up. Daily review of all incoming closed charts will be monitored and tracked by Medical Records Element Four: DON created a check list of all required documents for closed charts inclusion. ADON will be assigned as gatekeeper and DON in absence of ADON to review all files before going to medical records. Unit Clerks will gather and print all documents and place them in a holding area for medical records. Medical records will return any charts that are incomplete to DON for corrective actions to be rectified and closed chart to be in compliance. Medical Records will track and record all findings in spread sheet and report at each quarterly QAPI meeting.	

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Resident #470. The US FOIA (b)(6) would have further information.

On 02/06/24 at 10:45 AM, the US FOIA (b) informed the surveyor that she was still looking to provide requested documentation for Resident #470.

On 02/06/24 at 12:40 PM, the US FOIA (b) did not provide any CNA or ADL care documentation for Resident #470. The US FOIA (b) was made aware of the concern that the documentation was not available. The US FOIA (b) could not provide a response as to why the documentation for Resident #470 was not available in the electronic and paper medical record of the resident.

2. On 01/30/24 at 8:25 AM, the surveyor asked the US FOIA (b) for closed records that included Resident #269, and the US FOIA (b) stated that she would get back to the surveyor.

The surveyor reviewed the hybrid medical records of Resident #269 as follows:

Resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Exec Order 26.4b1



A review of the most recent discharge MDS (dMDS) NJ Exec Order 26.4b1 Discharge status revealed

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that the resident had an unplanned discharge (d/c) from the facility to the community.

A review of the Progress Notes (PN), a late entry alert note that was electronically documented and signed by the [redacted] on [redacted] at 7:53 PM (created date) for an effective date on [redacted] at 01:44 AM included that the resident was [redacted]

On 01/31/24 at 02:15 PM, the surveyor reviewed the hybrid medical records again of the resident and revealed that there was no Discharge Summary from the physician when the resident was [redacted]

On 01/31/24 at 02:40 PM, the surveyor interviewed the [redacted] regarding the Discharge Summary, and she stated that the physician was responsible for the physician discharge summary. The [redacted] further stated that she was not sure what was the regulation on when they should do the discharge summary. She further stated that the discharge summary should be in the hard medical chart and not in the computer.

On that same date and time, the surveyor then asked the [redacted] to check the resident's medical records if there was a discharge summary of the physician. The [redacted] in the presence of the survey team checked and confirmed that there was no physician discharge summary. The [redacted] did not provide additional information as to why there was no discharge summary from the physician.

On 01/31/24 at 3:02 PM, the surveyor asked the [redacted] for the facility's policy regarding physician discharge summary and he stated that he would get back to the surveyor.

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F 842	Continued From page 120 On 02/01/24 at 9:08 AM, the US FOIA (b)(6) provided a copy of a policy that he stated was their facility's policy regarding transfer and discharge. The Policy had no date. The policy included that to ensure that residents being transferred or discharged are subject to a standardized process that ensures regulatory compliance and ethics as well as maintenance of the resident's quality of care. When the facility transfers or discharges a resident under any of the circumstances specified in Section I. (A-F), the facility shall ensure that the transfer or discharge is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider. ....B. The documentation must be made by: a. the resident's physician when transfer or discharge is necessary under section I. A or section I. B of this policy; and b. a physician when transfer or discharge is necessary under Section I.C or section I.D of this policy....F. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care....X Residents that sign out of the Facility or leave Against Medical Advice (AMA); A. The facility shall not force, pressure, or intimidate a resident or resident representative into leaving AMA, which would be considered to be a facility-initiated discharge. On 02/05/24 at 01:21 PM, the survey team met with the US FOIA (b)(6) The surveyor notified the facility management of the above concerns. On 02/06/24 at 11:30 AM, the survey team met with the US FOIA (b)(6). The US FOIA (b)(6) stated that the physician had sent the note that included the	F 842		

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F 842	Continued From page 121 discharge summary of the resident that was kept on file. The [US FOIA (b)(6)] provided a copy of the PN and Certification paper dated [NJ Exec Order 26.4b] for a Discharge Summary. The PN and Certification paper had a piece of fax information from the physician and included a date of [NJ Exec Order 26.4b] 10:47p (10:47 PM). The surveyor asked why it was not on the file that the surveyor had reviewed and why the information was faxed on [NJ Exec Order 26.4b] after the surveyor's inquiry. Both the US FOIA (b)(6) had no response. On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management.	F 842		
F 867 SS=F	NJAC 8:39-35.2 (d)(12)(15)(16), (e) QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		2/29/24

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F 867	Continued From page 122 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems	F 867		

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level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 124 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility provided documents, it was determined that the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. This failure had the potential to affect all 273 residents who currently live in the facility. Refer to F607E, F728E, F730E, F804D, F883E, and S0560 The deficient practice was evidenced by the following: On 01/29/24 at 10:22 AM, during the entrance conference held with the facility's Licensed US FOIA (b)(6) , the surveyor in the presence of another surveyor requested information regarding the QAA (Quality	F 867	Element One: The QAPI plan form was revised to include dates and goals and to be reflective of a comprehensive QAPI plan. Element Two: All residents have the potential to be affected by this deficient practice. Element Three: The US FOIA (b)(6) , members of the QAPI committee, as well as al the department heads, were in serviced and trained by Corporate compliance on the importance of reviewing annually and updating QAPI Plan based upon facility needs. Corporate Compliance In-serviced all appropriate staff on the utilization of the new QAPI tools. Element Four: Corporate compliance will review updated QAPI every quarter and	

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F 867	Continued From page 125 assessment and assurance) committee, last three quarters sign in sheets for QAPI meetings, and QAPI plan. On 02/05/24 at 01:09 PM, the surveyor reviewed the facility provided QAA (a committee composition and frequency of meetings in nursing facilities requires facilities to develop and implement appropriate plans of action to correct identified quality deficiencies) Committee Information did not include the Infection Preventionist as members. Further review of the provided documents, the facility's QAPI Policy was last reviewed in December 2021. The listed QAPI procedure included that the QAPI will be reviewed annually and upon any significant change at the facility. In addition, the QAPI Program did not have a review date. The QAPI Plan included departments: Social Services (SS), Housekeeping/Maintenance (H/M), Nursing: All 2019 POCs (plan of corrections), Infection Control (IC), MDS (Minimum Data Set), Admissions, Food Services (FS), Dietician, Rehab and Recreation. The goal descriptions for departments: SS, H/M, IC, and FS were on December 31, 2019. The goal descriptions for departments: Nursing, MDS, and Admissions were in 2019. The goal description for the Dietician was to be completed by the 10th of each month in 2019 and Recreation was each month in 2019. There was no documented evidence in the minutes and the documents that were provided to the surveyor to confirm plans of action, developed and implemented appropriate plans of action to	F 867	ensure plan is reviewed by Governing Body annually. Corporate Compliance officer will ensure reports of any QAPI committee members have substitute coverage to ensure all areas are addressed for 100% compliance	

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F 867	Continued From page 126	F 867		

correct identified quality deficiencies for the last four years. A review of the above information showed that the last QAPI Plan was for 2019.

On 02/06/24 at 10:07 AM, the surveyors met with the [redacted] and discussed the QAPI and QAA. The surveyor asked the [redacted] how often the facility reviews the QAPI plan, QAA, and Program. The [redacted] stated that "I" review every quarterly before the upcoming QAPI. The surveyor showed the [redacted] the provided QAPI Plan, QAA Committee Information, QAPI Program, and QAPI Plan. The surveyor then notified the [redacted] of the above findings and concerns.

At that same date and time, the [redacted] had no answer when asked by the surveyor why the QAPI plan was for 2019. Later on, the [redacted] showed a piece of paper with no title and not dated. The [redacted] stated that the untitled and undated paper was the facility's QAPI plan. The surveyor reviewed the paper in the presence of another surveyor, then asked the [redacted] if that was the QAPI plan and why there was no goals determined in each department: Human Resources, MDS, Rehab, Activities, SS, Dietitian, FS, and Maintenance. Also, the surveyor asked why Nursing and Infection Control were not included, and the [redacted] did not respond.

The heading statement that was documented in the provided piece of paper of the [redacted] included: "QAPI all documents uploaded in [electronic medical record]. Appointments. I will help them set up an audit." The document was not reflective of a comprehensive QAPI plan as stipulated in the facility's previously submitted QAPI plan for 2019.

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F 867	Continued From page 127 On that same date and time, the surveyor asked the US FOIA (b)(6) based on the back and forth communications between the facility management and the survey team, what were the areas of concerns that the survey team had identified that the facility were not able to identify in their QAPI. The US FOIA (b)(6) stated that the surveyor's identified concerns about employee files, non certified Nursing Aides, staffing, vaccinations of staff and residents, and other areas of concerns with food temperature. On 02/06/24 at 11:30 AM, the survey team met with the US FOIA (b)(6), and the surveyor notified the facility management of the above concerns. The US FOIA (b)(6) further stated that there was no additional information that the facility could provide and the survey team could proceed with the decision-making. A review of the facility's QAPI Policy dated 12/2021 included that it is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life, and residents' choice. The QAPI Plan will be reviewed annually and upon any significant change at the facility. On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management. N.J.A.C. 8:39-33.1(a)(b); 33.2(b)(d); 34.1(a)(b)(d)	F 867		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	F 868		3/13/24

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F 868	Continued From page 128 §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent	F 868	Element One: QAPI Committee will	

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F 868	Continued From page 129 facility documentation, the facility failed to have the Infection Preventionist present for three (3) of three (3) quarterly Quality Assurance Performance Improvement (QAPI) meetings. This failure had the potential to affect all 273 residents who currently live in the facility. The deficient practice was evidenced by the following: On 02/05/24 at 8:45 AM, the surveyor in the presence of the US FOIA (b)(6) interviewed the US FOIA (b)(6) regarding the submitted QAPI Attendance for the last three quarters: 5/11/23, 9/07/23, and 11/30/23. The surveyor asked the LNHA to confirm who attended the last three quarters of QAPI because the 5/11/23 QAPI Attendance did not include the title and department for some attendees. During an interview, the US FOIA (b)(6) confirmed that on 5/11/23, 9/07/23, and 11/30/23 there was no Infection Preventionist (IP) who attended the quarterly QAPI meetings. The US FOIA (b)(6) acknowledged that IP was part of the key members of the QAPI team that should be present in the QAPI meetings. A review of the facility's provided QAA (Quality Assessment and Assurance, a committee composition, and frequency of meetings in nursing facilities requires facilities to develop and implement appropriate plans of action to correct identified quality deficiencies) Committee Information that was provided by the Nursing Clerk showed that the QAPI Meetings are held quarterly in the 2nd-floor conference room. Also, according to the QAA Committee Information, the	F 868	schedule meeting times to ensure that the Infection Preventionist will be in attendance. Element Two: All residents have the potential to be affected by this deficient practice. Element Three: invitations for QAPI meetings will be emailed out in advance so all members required to attend will have sufficient time to schedule accordingly. QAPI Committee and Infection Preventionist were in serviced by Corporate compliance on the requirement to attend and if any members cannot attend the meetings will be rescheduled accordingly. Element Four: Corporate compliance will review updated QAPI every quarter and ensure plan is reviewed by Governing Body annually.	

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F 868	Continued From page 130 members included the US FOIA (b)(6) [redacted].	F 868		

Further review of the QAA Committee Information above revealed that the IP was not included in the list of members.

On 02/05/24 at 01:21 PM, the survey team met with the US FOIA (b)(6). The surveyor notified the facility management of the above concerns.

02/06/24 at 10:07 AM, the two surveyors met with the US FOIA (b)(6) and discussed the QAPI and QAA. The US FOIA (b)(6) again confirmed that no IP attended the last three quarters of QAPI meetings. The US FOIA (b)(6) also confirmed that the QAA Committee Information that was submitted above did not include the IP as part of the committee list and the US FOIA (b)(6) had no answer why the IP was not listed.

On that same date and time, the surveyor asked the US FOIA (b)(6) what were the areas that the survey team had identified as concerns during the survey period and the facility did not identify. The US FOIA (b)(6) stated a few concerns that the survey team identified as concerns were testing for COVID-19 and vaccinations for both residents and staff. The US FOIA (b)(6) confirmed that they were all important parts of infection control which is the Infection Preventionist's responsibility.

A review of the facility's QAPI Policy dated

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F 868	Continued From page 131 12/2021 included that it is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life, and residents' choice. The Quality Assessment and Assurance Committee consists at a minimum of: The US FOIA (b)(6) , or his/her designee; at least three other members of the facility's staff. On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-33.1 (b)	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		3/19/24

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 133 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to: a) conduct [redacted] testing and to conduct appropriate surveillance for [redacted] during an outbreak, for three (3) of three (3) residents (Residents #62, #121 and #155) and three (3) of (3) staff members reviewed for unit-based testing, b) follow appropriate storage of PPE (personal protective equipment) for one (1) of one (1) nurse (Licensed Practical Nurse #1 [LPN#1]), and c) follow appropriate hand hygiene practices for two (2) of three (3) staff (LPN#2 and Certified Nursing Aide #3), in accordance with the facility's policies and Centers for Disease Control and Prevention (CDC) guidelines for infection control. The deficient practice was evidenced by the following: According to the CDC guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" with an updated date of	F 880	Element One: Residents (#62 #121 #155) logs were reconciled and added tracking to reflect testing compliance. Educated staff on testing and days as required. Hand washing Inservice and reminder with focus on timing 20 seconds scrubbing. Staff were educated on use and disposal of masks. Garbage cans were placed in residents bathrooms. Element Two: All residents have the potential to be affected by this deficient practice. Ongoing education of all staff on testing with updates and changes per CDC. Ongoing Education on handwashing with signage posting at common areas for reminders. Ongoing education on use and disposal of PPE including masks. Housekeeping rounded and ensured all resident bathrooms had garbage can. Element Three: . Education and In-service was completed by IP to nursing supervisors [redacted] on testing requirements. DON created a Logging system for tracking of testing and result monitoring. Infection Preventionist educated on the logging system. Intermittent rounding for spot check of handwashing timing and process DON	

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F 880	Continued From page 134 Sept. 23, 2022, included the following: Perform SARS-CoV-2 Viral Testing Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ... Nursing Homes ... Responding to a newly identified SARS-CoV-2-infected HCP (Health Care Personnel) or resident When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative	F 880	reviewed and updated policy to reflect the 20 seconds and all staff was educated on accurate practice. Education and In-service was completed by IP or designee for all new hires and current staff on PPE handwashing. Infections control rounds will be completed weekly and will include checking for garbage cans. Element Four: Infection Preventionist will report to DON and Administrator all education testing logs weekly. Infection Control Nurse will ensure Binders with Tracking of all supportive documentation is kept for reference as required Infection preventionist will report on Handwashing, PPE, and Testing at quarterly QAPI meeting.	

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test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5...

According to the CDC Hand Hygiene in Healthcare Settings, Healthcare Providers, last reviewed: January 8, 2021, ... When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers...

1. On 01/31/24 at 01:12 PM, the surveyor interviewed the US FOIA (b)(6) who stated the facility's most recent NJ Exec Order 26.4b1 NJ Ex Order 26.4(b started in NJ Exec Order 26.4b1. The US FOIA (b) further explained contact tracing was initiated when there was a NJ Ex Order 26.4 NJ Exec Order 26.4b1 case in the facility and if unable to conduct contact tracing wider based testing would be conducted. The surveyor requested the line list for the NJ Exec Order 26.4b1 NJ Ex Order 26.4(b) and any contact tracing conducted.

On 02/01/24 at 10:00 AM, the US FOIA (b) provided the surveyor a line list for the most recent NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(The US FOIA (b) to provide further documentation on the contact tracing and testing at onset of the NJ Exec Order 26.4b1. A review of the line list indicated on NJ Exec Order 26.4 Resident #252 tested positive for NJ Exec Order 26.4b1

A review of the electronic medical record for Resident #252 indicated the resident presented on NJ Exec Order 26.4b with symptoms that included NJ Exec Order The resident was given

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a NJ Exec Order 26.4b1, which resulted as NJ Exec Order 26.4 and the resident was placed on NJ Exec Order 26.4b1 . The physician was made aware, and the physician ordered NJ Exec Order 26.4b1 medication treatment for Resident #252. The resident remained on NJ Exec O for 10 days.

On 02/01/24 at 10:57 AM, the surveyor interviewed the US FOIA (b)(6) who stated the facility's infection control practice was based on the facility policies, along with CDC guidance, state, and federal regulations.

On 02/05/24 at 9:28 AM, the U.S. FOIA (b) (6) provided resident and staff testing documentation for the NJ Exec Order 26.4b1 from the US FOIA (b)

A sample of three residents and three staff members were reviewed for the NJ Ex Order 26.4 case of NJ Exec Order 26.4b1 on NJ Exec Order 26.4b. Residents #62, 121, and 155 were tested on NJ Exec Order 26.4b1. Staff members, Certified Nursing Aide #1 (CNA#1), CNA#2, and Registered Nurse #1 (RN#1) were tested on NJ Exec Order 26.4b1. The residents and staff members were tested on Day 1 and Day 4. They were not tested on Day 1, 3, and 5 as indicated by CDC guidance and facility policy.

On 02/05/24 at 10:13 AM, the surveyor interviewed the US FOIA (b) who stated NJ Exec Order 2 testing for potentially NJ Ex Order 26.4(b individuals through contact tracing or unit based tested should be performed day 1, then day 3, and day 5. The surveyor discussed the concern with the NJ Exec Order 26.4b1 testing

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reviewed. The [redacted] believed that the testing conducted followed the testing policy of Day 1,3, and 5.

On 02/05/24 at 01:35 PM, the surveyor informed the [redacted] about the above concerns of [redacted] testing not following facility policy and national standards.

On 02/06/24 at 8:34 AM, the surveyor interviewed RN#2 who worked during [redacted] RN#2 stated residents and staff were being tested twice a week. RN#2 further stated that the nurse supervisor performed [redacted] testing.

On 02/06/24 at 10:53 AM, the surveyor interviewed the [redacted]) over the phone. The [redacted] stated the facility policy for [redacted] testing when there was a [redacted] case in the facility was day 1, day 3, and day 5. The [redacted] further stated that she conducted testing for residents and staff at the time of the positive case on [redacted]. The [redacted] also stated the [redacted] and previous [redacted] would oversee [redacted] testing.

On that same date and time, the surveyor discussed testing documentation on [redacted]. The [redacted] stated she thought she did the testing, and that she did tests on [redacted]. The [redacted] acknowledged the testing dates were not on day 1, 3 and 5. The [redacted] further stated she did a lot of testing at the time and all staff would come to get tests done. The [redacted] stated nurses would also perform testing for residents on the unit.

On 02/06/24 at 11:30 AM, the survey team met with the [redacted]. No additional

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information was provided by the facility.

A review of the provided facility policy Outbreak Plan with an updated date of 02/12/2023 read under Testing Procotol- COVID-19: " ...Testing of all residents and HCP will be conducted as directed by federal, state, or local governing bodies, or facility medical directorship ..."

A review of the provided facility policy titled "Coronavirus Disease (COVID-19)- Testing Residents" with a revised date of September 2022 read under Broad-Based Testing: "12. When utilizing broad-based testing, all residents and staff identified as close contacts or on the affected unit (s) are tested, regardless of vaccination status ... 13. Testing is done immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ..."

2. On 01/30/24 at 8:12 AM, the surveyor observed CNA#3 for an NJ Exec Order 26.4b1 check of Resident #107. Afterward, the CNA performed handwashing inside the resident's room for 11 seconds.

On that same date, outside the resident's room, the surveyor interviewed CNA#3 regarding handwashing. The CNA notified the surveyor that it was theUS FOIA (b)(6) whom she forgot the name was, who provided education and training about hand hygiene. CNA#3 stated that handwashing should be at least 20 seconds by singing a Happy Birthday song. The surveyor then asked the CNA if she did follow the protocol for

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handwashing, and CNA#3 stated that she "probably" did not because she was hurrying up, and she claimed that she did handwashing for 10 seconds.

3. On 01/30/24 at 02:06 PM, the surveyor asked LPN#1, the assigned nurse of the resident to go to the resident's room. The LPN took a surgical mask from her uniform pocket and used it and donned (put) a pair of gloves from the PPE box outside the room before entering the resident's room. The LPN informed the surveyor that the resident was not in [redacted NJ Exec Order 26.4]

4. On 01/31/24 at 8:36 AM, the surveyor observed LPN#2 administered the medications to Resident #179. The surveyor observed the LPN performed handwashing inside the resident's toilet room for 11 seconds. There was no garbage can inside the toilet room and the LPN placed the used paper towels on top of the sink and stated that he would let the housekeeper know later about the missing garbage can.

On 02/01/24 at 8:34 AM, the surveyor interviewed LPN#2 regarding hand hygiene. The LPN stated that handwashing should be at least 40 seconds. The surveyor notified the LPN of the above concerns and the LPN stated that he believed the surveyor for 11 seconds observations of handwashing during medications administration because he was not counting at that time. He further stated that he was hurrying up.

On 02/05/24 at 10:41 AM, the surveyor interviewed the [redacted US FOIA (b)] regarding the above concerns for infection control. The [redacted US FOIA (b)] informed the surveyor that the infection control education including hand hygiene, PPE use, and the like

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was a collaborative effort between the US FO 3-11, and 11-7 shift Supervisors. The US FOIA (b) stated that for the use of sanitizer, at least 15 seconds until dry. The US FOIA (b) further stated that handwashing the whole process is 40 seconds, scrubbing both hands for 20 seconds under the water. The surveyor then asked the US FOIA (b) if that was the facility's protocol and policy, the US FOIA (b) stated that the policy was at least 15 seconds of hand scrubbing. The surveyor then asked the US FOIA (b) what should the facility staff follow, the US FOIA (b) stated it should be the policy for 15 seconds.

On that same date and time, the surveyor also asked if it was appropriate for the staff to store their surgical mask inside their uniform pocket. The US FOIA (b) responded that "no," because of the bacteria on the mask that will go to the uniform pocket, and it will be considered contaminated. At this time, the surveyor notified the US FOIA (b) of the concerns regarding CNA#3, LPN#1, and LPN#2.

On 02/05/24 at 01:21 PM, the survey team met with the US FOIA (b)(6). The surveyor notified the facility management of the above concerns.

On 02/06/24 at 11:30 AM, the survey team met with the US FOIA (b)(6). The US FOIA (b)(6) stated that there should be one garbage can inside Resident #179's toilet room.

A review of the provided Handwashing/Hand Hygiene Policy that was provided by the US FOIA (b)(6) with a revised date of December 2009 included that this facility considers hand hygiene the primary means to prevent the spread of infections. Employees must wash their hands for at least 15 seconds using antimicrobial or non-microbial soap and water under the following

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F 880	Continued From page 141 conditions: when coming on duty; when hands are visibly soiled and before and after direct resident contact. On 02/06/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) for an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-5.1(a), 19.4 (a)	F 880		
F 881 SS=C	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to ensure facility-wide implementation of the Antibiotic Stewardship program, which included a system for routine feedback reports and tracking measures of outcome surveillance related to antibiotic use was followed, as per facility policy and national standards. This deficient practice was evidenced by the following:	F 881	Element One: All resident information to meet Mc Greer criteria was reconciled with outgoing infection preventionist and DON. Log immediately completed and binder by Infection Preventionist Element Two: All residents treated with antibiotics are potentially at risk for this deficient practice. Staff were educated on antibiotic stewardship requirements. McGreer Criteria binder with tool placed on all units by Infection Preventionist to maintain compliance.	2/29/24

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F 881	Continued From page 142 On 01/31/24 at 01:12 PM, the surveyor interviewed the US FOIA (b)(6) who stated the US FOIA (b)(6) was responsible for Antibiotic (ABT)Stewardship. The US FOIA (b) further explained the newly hired US F was still in training and that the facility was in contact with the previous US F who left approximately two weeks ago. The US FOIA (b) stated the facility had access to the former US FOIA reports and antibiotic tracking documentation. The surveyor requested for the US FOIA (b) to provide the facility's antibiotic stewardship policy, reports, and documentation. On 02/01/24 at 9:40 AM, the US FOIA (b) informed the surveyor she was still gathering the requested documents. On 02/01/24 at 10:37 AM, the surveyor interviewed the former US F over the phone. The former US FO stated her last day of work was on NJ Exec Order 26.4. The US F stated she was responsible for antibiotic review and infection surveillance during her time in the facility. The US FO stated she reported to the US FOIA (b)(6), who would have all the documentation related to ABT stewardship and ABT tracking reports. On 02/01/24 at 10:57 AM, the surveyor interviewed the US FOIA (b)(6) who stated infection control was discussed in QAPI meetings and on an as needed basis. The US FOIA (b)(6) confirmed the US F would report to him and the US FOIA (b) The US FOIA (b)(6) stated he and the US FOIA (b) would provide documentation of ABT stewardship including ABT tracking, surveillance and trend reports completed by the US FO On 02/05/24 at 9:20 AM, the US FOIA (b)(6) provided the	F 881	Element Three: Infection Preventionist Educated Clinical Staff on McGreer Criteria. A tracking log was created by DON and put in place for IP to update. Binder in Place where hard copy of log and supportive documentation is readily accessible to Administrator and DON Element Four: DON reviewed and adjusted Policy for Antibiotic Stewardship Policy and Procedure and education completed with Infection Preventionist. Infection Preventionist will complete Monthly tracking as required and report to DON and Administrator for compliance. Infection Preventionist will report at quarterly QAPI on this concern.	

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surveyor with the facility's policy titled "Antibiotic Stewardship Program".

On 02/05/24 at 10:13 AM, the surveyor interviewed the [redacted] about ABT stewardship. The [redacted] stated the former [redacted] reviewed residents who were prescribed antibiotics using the Mcgreer's criteria (a set of guidelines used to assess the appropriateness of ABT initiation) to determine the reason for the ABT treatment and to ensure an appropriate treatment was carried out. The [redacted] further explained that there was no standardized assessment form used in the facility for ABT use assessment. The [redacted] acknowledged she was responsible for overseeing infection control processes and ensuring IP duties were being completed. The surveyor requested the [redacted] to provide any documentation for ABT stewardship recently conducted.

On 02/05/24 at 10:35 AM, the [redacted] provided the surveyor with an untitled and undated document that she stated was the ABT tracking for December 2023 that was completed by the [redacted] No additional information was provided at this time.

A review of the untitled document consisted of a list of residents, the start date of their prescribed ABT, the stop date for their ABT and their diagnosis. There was no information documented regarding diagnostic testing, type of organism if any identified, and signs/symptoms of the residents.

On 02/05/24 at 01:35 PM, the surveyor informed the US FOIA (b)(6) regarding the concern for ABT stewardship as there was no documentation of comprehensive assessment of prescribed

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antibiotics, no documentation of feedback reports, trend reports, and surveillance provided. There was no verbal response by the facility at this time.

On 02/06/24 at 8:34 AM, the surveyor interviewed a staff US FOIA (b)(6) about ABT stewardship. The US FOIA stated it was to ensure appropriate ABT use. The US FOIA further explained the nurses ensure to follow up with physicians for the order of appropriate diagnostic tests, such as cultures, and to review results to ensure the ABT ordered by the physician was appropriate. The US FOIA stated it was also important for the ABT order to include a stop date to establish the duration of the ABT treatment.

On 02/06/24 at 11:25 AM, the US FOIA (b)(6) provided an email documentation of a summary for 3rd quarter QAPI for infection control review sent by the former US F to the US FOIA (b and US FOIA (b)(6) on NJ Exec Order 26.4b. No additional information was provided by the facility.

A review of the provided email documentation included a list of residents (identified by number) who were on antibiotics in July, August, and September. For each resident, the category of infection (such as "CAI [catheter acquired infection]" or "soft tissue infection") was documented, whether the resident received an ABT, and whether the resident met McGreers criteria. There was no detailed information on the specific ABT prescribed, diagnosis, or microorganism of infection identified. The document did not indicate further why a resident met or did not meet McGreers criteria. The email documentation did not detail the tracking ofABT resistant microorganisms and infections. There

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F 881	Continued From page 145 was no trend report or QAPI report for October, November, and December 2023 provided. No additional information was provided by the facility. A review of the facility's policy titled, "Antibiotic Stewardship Program" with effective date of March 2018, under Policy it read: "New Vista Nursing and Rehabilitation c Center ASP [Antibiotic Stewardship Program] activities should, at a minimum, include these basic elements: leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents and families about ABT resistance and opportunities for improvement ..." Under Procedure, 2. Accountability it read, " ...The ASP [Antibiotic Stewardship Program] Team may consist of: ASP Physician Champion and/or Medical Director, Administrator, Director of Nursing, Infection Preventionist (IP), pharmacy consultant, and laboratory representative. As a team they will: i. Review infections and monitor ABT usage patterns on a regular basis ...ii. Obtain and review antibiograms for institutional trends of resistance ...iii. Monitor ABT resistance patterns (MRSA, VRE, ESBL, CRE, etc.) and Clostridium difficile infections ...iv. Report on number of antibiotics prescribed (e..g. days of therapy) and the number of residents treated each month ...v. Include a separate report on the number of residents on antibiotics that did not meet criteria for active infection ..."	F 881		
F 883 SS=E	NJAC 8:39-19.4(d)(g) Influenza and Pneumococcal Immunizations	F 883		3/19/24

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F 883	Continued From page 146 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 147 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure: a) that the resident's medical record included documentation that indicated the consent for administration or refusal of the NJ Exec Order 26.4b1 for four (4) of six (6) residents (Resident #7, #132, #149, and #214) reviewed for NJ Exec Order 26.4b1 and b) the NJ Exec Order 26.4b1 was administered to the residents, (Residents #100 and #127) identified during the medication storage and labeling observation for one (1) of three (3) medication rooms. This deficient practice was evidenced by the following: Reference: A review of the Centers for Disease and Control Prevention (CDC) guidelines for Pneumococcal vaccination included: For adults who only received the Pneumococcal	F 883	Element One: The timelines was completed by DON for resident (#7 #132 # 149 # 214) and reconciled documentation consents and resolution to resident refusal or representative and medical record reflects. Infection Preventionist hired by Administrator to ensure process and compliance has direct oversight and tracking. MDS coordinator modified assessment to reflect actual updated vaccination. Consents and copy of consents will be kept in a Binder and uploaded to the Electronic Medical records. Resident #100 and resident 127 were both revisited and both declined to receive the NJ Exec Order 26.4b1 and consents reflects as resident #100 and #127 both declined when asked by DON Element Two: All residents have potential	

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F 883	Continued From page 148 polysaccharide vaccine (Pneumovax/PPSV 23) regardless of risk and condition, should received one (1) dose of Pneumococcal conjugate vaccine (PCV 15 or PCV20) at least one year after the most recent PPSV23. 1. On 02/1/24 at 9:55 AM, the surveyor reviewed the hybrid (paper and electronic record) medical records of Resident #7. The resident's Admission Record (AR, an admission summary) reflected that Resident #7 had diagnoses that included but were not limited to, NJ Exec Order 26.4b1 [redacted]. A quarterly Minimum Data Set (qMDS), assessment tool used to facilitate the management of care, with an assessment reference date (ARD) [redacted], indicated that the facility assessed the resident's [redacted] status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the resident's had NJ Exec Order 26.4b1 [redacted]. Section [redacted] NJ Exec Order 26.4b1, Procedures, and Programs indicated last NJ Exec Order 26.4b1 received on [redacted]. A review of the resident's paper chart on the unit, revealed there was no documentation for NJ Exec Order 26.4b1 for this season. There was no documentation to indicate administration or declination of the vaccine. The paper chart also indicated the resident had a resident representative who was involved in the resident's care planning and was the responsible party for the resident.	F 883	to be affected by this oversight and presence of direct oversight of Policy and Procedure. The immunization record EMAR Consents were reviewed by leadership staff to resolve lack of tracking. Consents were filed for resident population. Master Binder will be kept by Infection Preventionist for all required vaccinations with tracking log and supporting documentation of Consent proof of administration and immunization tracking reflected in Echart. Element Three: Policy and Procedure reviewed by DON for Flu and Pneumonia vaccination and revised accordingly. All Staff educated on Policy and Procedure and importance of primary level of health. Daily checks of charts and review of new admission and referrals to reconcile and reflect immunization status Supervisors and Infection Preventionist. Infection preventionist will collaborate and share tracking log with Administrator DON and MDS coordinator. MDS coordinator will reflect accurate data by cross checking against tracking log of resident immunization for accurate MDS data and submission. Element Four: Director of Nursing incorporated tracking log with Binders and endorsed Infection Preventionist for gate keeping and compliance. Infection preventionist will review medical records daily for 1 month then weekly for 3 months then monthly. Infection Preventionist will report on consent, supportive documentation of	

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F 883	Continued From page 149 A review of immunizations listed in the electronic medical record (EMR) documented an NJ Exec Order 26.4b [redacted] for Resident #7 completed on NJ Exec Order 26 [redacted]. There was no documentation for NJ Exec Or [redacted] to indicate administration or declination of the NJ Exec Order 26.4b [redacted] A review of physician orders (PO) revealed there was no PO for NJ Exec Order 26.4b1 administration from NJ Exec Order 26.4b1 to NJ Exec Order 26 [redacted] On 02/01/24 at 01:15 PM, the surveyor informed the US FOIA (b)(6)) of the above concerns that no NJ Exec Order 26.4b1 status for Resident #7 found in the hybrid medical records. The US FOIA (b) stated she would follow up to provide further information. On 02/05/24 at 10:13 AM, the surveyor interviewed the US FOIA (b) regarding NJ Exec Order 26.4b [redacted] for Resident #7. There was no information provided at this time. The US FOIA (b) stated she had not been able to follow up yet. The US FOIA (b) stated NJ Exec Order 26.4b1 were assessed upon admission and as needed. The US FOIA (b) further explained for NJ Exec Order 26.4b1 it was offered to residents every flu season, beginning end of NJ Exec Order 26.4 [redacted] A consent form would be completed by the resident or resident representative. The US FOIA (b) stated the infection preventionist would be responsible for keeping track of resident NJ Exec Order 26.4b [redacted] On 02/05/24 at 01:35 PM, the surveyor informed the US FOIA (b)(6) [redacted] about the concerns that there was no documentation found regarding Resident	F 883	immunization, and record tracking. Compliance and log and Binder for resident Population at quarterly QAPI meeting	

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F 883	Continued From page 150 #7's NJ Exec Order 26.4b1 status. There was no verbal response at this time. On 02/06/24 at 11:30 AM, the survey team met with the US FOIA (b)(6) . The US FOIA (b) provided an NJ Exec Order 26.4b1 declination form for Resident #7. A review of the untitled document regarding Resident #7's NJ Exec Order 26.4b1 status. The form was dated NJ Exec Order 26.4 and indicated with a check mark "Do NJ Exec Order 26.4b1 to an NJ Exec Order 26.4b1 " On the form written in ink it read "[resident representative] said no." There was a line with at the bottom with the name of Resident #7 and there was a signature line with an unknown signature. On 02/06/24 at 12:30 PM, the surveyor interviewed the US FOIA (b) about the provided form. The US FOIA (b) stated the signature was from a nurse who completed the form. The US FOIA (b) stated the form was found in separate binder and did not specify which binder. The US FOIA (b) provided no verbal response as to why the form would not be found in the resident's paper chart. The surveyor asked the US FOIA (b) if the documentation on the form was appropriate for obtaining consent. There was no documentation in the EMR to confirm vaccination discussion with the resident's representative and no documentation found in the resident's paper chart. The US FOIA (b) provided no further verbal response. 2. The surveyor reviewed the hybrid medical records of Resident #132 as follows: The AR reflected that the resident was admitted to the facility with diagnoses that included but	F 883		

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F 883	Continued From page 151 were not limited to NJ Exec Order 26.4b1 [redacted] The qMDS with an ARD of NJ Exec Order 26.4b1 and Section NJ Exec Order 26.4b1 showed that the resident was severely impaired. NJ Exec Order 26.4b1, Procedures, and Programs indicated the last NJ Exec Order 26.4b1 was received on NJ Exec Order 26.4b [redacted]. A review of the resident's paper chart on the unit revealed there was no documentation for NJ Exec Order 26.4b1 for this season. There was no documentation to indicate administration or declination of the NJ Exec Order 26.4 The paper chart also indicated the resident had a resident representative who was involved in the resident's care planning and was the responsible party for the resident. A review of immunizations listed in the EMR documented an NJ Exec Order 26.4b1 for Resident #132 completed on NJ Exec Order 26.4b [redacted]. There was no documentation for NJ Exec Or [redacted] to indicate the administration or declination of the NJ Exec Order 26.4b1 [redacted]. A review of PO revealed there were no PO for influenza vaccination administration from NJ Exec Order 26.4b1 [redacted]. 02/01/24 08:46 AM, the surveyor interviewed the US FOIA (b)(6) [redacted]) regarding the resident's influenza NJ Exec Order 26.4b1 The US FOIA [redacted] confirmed that if the resident's electronic record in NJ Exec Order 26.4b1 did not have the NJ Exec Or [redacted]	F 883		

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NJ Exec Order 26.4b1 and nothing in the chart, then the resident did not receive the NJ Exec Order 26.

3. On 01/30/24 at 12:30 PM, the surveyor reviewed the hybrid medical records of Resident #149 as follows:

The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1

The qMDS with an ARD of NJ Exec Order 26.4b, and Section NJ Exec Order 26.4b1 showed that the resident was NJ Ex Order 26.4(b)(1). NJ Exec Order 26.4b1, Procedures, and Programs indicated the last NJ Exec Order 26.4b1 was received on NJ Exec Order 26.4b

A review of the resident's paper chart on the unit revealed there was no documentation for NJ Ex Order 26.4(b)(1) for this season. There was no documentation to indicate administration or declination of the NJ Exec Order 26. The paper chart also indicated the resident had a resident representative who was involved in the resident's care planning and was the responsible party for the resident.

A review of NJ Exec Order 26.4b1 listed in the EMR documented an NJ Exec Order 26.4b1 for Resident #149 completed on NJ Exec Order 26.4b. There was no

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documentation for [redacted] to indicate the administration or declination of the [redacted]

A review of PO revealed there were no PO for [redacted] from [redacted].

On 02/01/24 at 10:57 AM, the surveyor interviewed the [redacted] in the presence of the survey team. The [redacted] informed the surveyor that the MDS for [redacted] section, "I checked" the EMR [redacted] record. She stated that if a resident is a new admit, the hospital record will be checked, and then I reflect it in MDS. She further stated that if she did not see record of [redacted] it will be reflected in the MDS.

On that same date and time, the surveyor asked the [redacted] if she asked nursing if she did not find any record for [redacted] and the [redacted] did not respond.
The surveyor then notified the [redacted] of the above concerns regarding Residents #132 and #149's that the [redacted] last received according to MDS documentation was from [redacted]. The surveyor also notified the [redacted] that there was no documentation that it was offered and declined.

At that time, the [redacted] confirmed that the [redacted] was not given and that there was no documentation that showed that it was offered and declined that was why she documented in MDS Section that the [redacted] last received on [redacted] for both residents.

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F 883	Continued From page 154 4. On 02/05/24 at 9:23 AM, the surveyor reviewed the hybrid medical records for Resident #214. The AR for Resident #214 revealed that they were admitted to the facility with diagnoses included but not limited to NJ Exec Order 26.4b with other NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 [redacted] The comprehensive MDS (cMDS) with an ARD of NJ Exec Order 26.4b and NJ Exec Order 26.4b1 with a BIMS score of NJ out of 15 which reflected that the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. NJ Exec Order 26.4b1, Procedures, and Programs indicated the NJ Exec Order 26.4b1 was received on NJ Exec Order 26.4b Review of the POs from NJ Exec Order 26.4b1 lacked any orders for administering the NJ Exec Order 26.4b [redacted] to Resident #214. A review of the provided facility policy titled, "Immunization: Influenza/Pneumococcal" with a revised date of July 2020 under Procedure 1b. it read: " ...Influenza vaccine is offered in the fall of each year according to Influenza management Program ..." Under Procedure #4 it read: " ...Document: a. Immunizations given and date in resident's Medical Records ...b. Immunizations given on Medication Administration Record (MAR) ...c. If Immunization refused, document resident's or decision maker's refusal of immunization and education and counseling given regarding the benefit of immunization in the resident's Medical records (interdisciplinary progress notes)"	F 883		

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A review of the provided, undated facility policy titled, "Infection Control Policy and Procedure" under Procedure IV it read: " ...a. Before offering the influenza immunization each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; b. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period; c. The resident or the resident's representative has the opportunity to refuse immunization; and d. The resident's medical record includes documentation that indicates at a minimum, the following: i. That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and ii. That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal ..."

A review of the provided, undated policy titled, "Influenza Vaccine" under Policy Interpretation and Implementation it read: " ...6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record ..."

On 02/05/24 at 10:30 AM, the surveyor interviewed the [redacted] and requested any information related to the administration or refusal of the NJ Exec Order 26.4b1 for this year's NJ Exec Order 26.4b1 [redacted] No further information was provided.

5. On 01/31/24 at 11:53 AM, during the medication storage and labeling observation of

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the medication room located on the [NJ Ex Or] wing of the [NJ Ex Or] floor, the surveyor observed the following:
-A NJ Exec Order 26.4b1 labeled for Resident #100, dated [NJ Exec Order 26.].
-A NJ Exec Order 26.4b1 labeled for Resident #127, dated [NJ Exec Order 26].

The surveyor reviewed the hybrid medical records for Resident #100.

The AR for Resident #100 revealed the resident was admitted with diagnoses that included [NJ Exec Orde]

The qMDS with an ARD of [NJ Exec Order 26.4b], and Section NJ Exec Order 26.4b1 with a BIMS score of [NJ Ex] out of 15 which reflected that the resident was NJ Exec Order 26.4b1.

Further review of the qMDS dated [NJ Exec Order 26.4b1] under NJ Exec Order 26.4b1 Was the resident's NJ Exec Order 26.4b1 ? The response was marked zero, which reflected a NJ Exec Order 26.4b1 . Section B. indicated the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1.

The active PO for NJ Exec Order 26.4b1 did not include an order for the NJ Exec Order 26.4b1.

Review of the EMR under immunization for the resident under NJ Exec Order 26.4b1 reflected an undated documentation of "NJ Exec Order 26.4b1."

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The surveyor reviewed the resident's physical medical record which included a New Jersey NJ Exec Order 26.4b1 Information System that indicated "NJ Exec Order 26.4b1 ."

Further review of the physical chart did not include a NJ Exec Order 26.4b1 informed consent form or a refusal form.

6. The surveyor reviewed the hybrid medical records for Resident #127.

The AR for Resident #127 revealed the resident was admitted with diagnoses that included NJ Exec Order 26.4b1

The cMDS with an ARD of NJ Exec Order 26.4b and NJ Exec Order 26 with a BIMS score of NJ Ex out of 15 which reflected that the resident was NJ Exec Order 26.4b1.

Further review of the cMDS dated NJ Exec Order 26.4, under NJ Exec Order 26.4b1 indicated the resident's NJ Exec Order 26.4b1 was up to date.

The active PO for NJ Exec Order 26.4b1 did not include an order for the NJ Exec Order 26.4b1.

Review of the electronic medical record under immunization for the resident under NJ Exec Order 26.4b1 the resident received NJ Exec Order 26.4b1.

Review of the physical chart did not include a NJ Exec Order 26.4b1 informed consent form or a refusal form.

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F 883	Continued From page 158 On 02/05/24 at 12:48 PM, during an interview with the surveyor, the US FOIA (b)(6) [redacted] stated that when she completed the MDS for the resident she reviewed the progress notes from the nurse and the NJ Exec Order 26.4b1 record on the hybrid medical record. The US FOIA (b)(6) informed the surveyor that she did not check for the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 form when answering section NJ Exec Order 26.4b1 of the MDS. On 02/05/24 at 01:21 PM, in the presence of the survey team, US FOIA (b)(6), the surveyor discussed the concern regarding the NJ Exec Order 26.4b1. At 2:30 PM, during a follow-up interview with the surveyor, the US FOIA (b) stated the nurse who placed the order for the NJ Exec Order 26.4b1 should have obtained the informed consent/refusal form from the resident. The US FOIA (b) also stated the nurse who received the refusal from the resident should have obtained the informed refusal form [which included the benefit versus risk of the refusal]. On 02/06/23 at 12:27 PM, during a meeting with the survey team, the US FOIA (b)(6), did not provide an additional information regarding the concerns discussed yesterday. A review of the provide facility policy Immunization: Influenza/Pneumococcal reviewed/revised 7/2020 under Procedure section 1. Upon admission, request permission from resident or healthcare decision maker for pneumovax and annual influenza vaccine. Use Pneumococcal/ Influenza informed consent form. On 02/06/24 at 01:35 PM, the survey team met	F 883		

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F 883	Continued From page 159 with the US FOIA (b)(6) [redacted] or an exit conference, and there was no additional information provided by the facility management. NJAC 8:39-19.4 (h), (i)	F 883		

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S 000	Initial Comments Complaint #s: NJ#162696 and #167957 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ162696, NJ162723, NJ162811 REPEAT DEFICIENCY Part A Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows:	S 560	Element One: The Center will maintain the NJ minimum direct care staff to resident ratios utilization of Agency staff are currently being engaged to help maintain staff-to-resident ratios. Additional Agency were contacted for secondary support Human Resources immediately contacted all current employees for documentation of influenza vaccination files were reconciled to reflect Impromptu Clinic was held to reoffer for those who missed prior vaccination clinics	2/29/24

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

Electronically Signed | 02/21/24

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 01/14/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -01/14/24 had 21 CNAs for 264 residents on the day shift, required at least 33 CNAs. -01/15/24 had 26 CNAs for 264 residents on the	S 560	Element Two: All residents have the potential to be affected by this deficient practice. Element Three: Agency staff are currently being utilized to help maintain staff-to-resident ratios. The Administrator, Director of Nursing and Staffing Coordinator were re-educated on the NJ minimum staffing mandate. The Center will continue its recruiting efforts using various forms of media to increase the number of applicants. The Center will convert temporary CNAs into permanent CNAs. Agency contracts will be posted to bring in outside staff. The Center will also have weekly staffing calls with the regional support team and as needed. Administrator will audit staffing ratios with staffing coordinator bi-weekly. Employee tracking log and binder with consent and declination completed with Human resources and Infection Preventionist Element Four: The Human Resources Manager, Staffing Coordinator and Director of Nursing will manage a list of on-going recruiting efforts and document the results of these attempts five days a week. The Administrator will audit daily staffing sheets to determine if Center is meeting the minimum staff-to -resident ratios. The Administrator /Director of Nursing or Designee will report findings to the Quarterly QAPI Committee. The Administrator and DON will ensure all options are maximized to attain the staffing requirements. The Administrator and DON will maintain census control to	

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S 560	Continued From page 2 day shift, required at least 33 CNAs. -01/16/24 had 27 CNAs for 264 residents on the day shift, required at least 33 CNAs. -01/17/24 had 20 CNAs for 264 residents on the day shift, required at least 33 CNAs. -01/18/24 had 25 CNAs for 264 residents on the day shift, required at least 33 CNAs. -01/19/24 had 27 CNAs for 272 residents on the day shift, required at least 34 CNAs. -01/20/24 had 23 CNAs for 272 residents on the day shift, required at least 34 CNAs. -01/21/24 had 22 CNAs for 272 residents on the day shift, required at least 34 CNAs. -01/21/24 had 24 total staff for 272 residents on the evening shift, required at least 27 total staff. -01/22/24 had 28 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/23/24 had 27 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/24/24 had 28 CNAs for 274 residents on the day shift, required at least 34 CNAs. -01/25/24 had 27 CNAs for 273 residents on the day shift, required at least 34 CNAs. -01/26/24 had 25 CNAs for 273 residents on the day shift, required at least 34 CNAs. -01/27/24 had 22 CNAs for 273 residents on the day shift, required at least 34 CNAs.	S 560	maintain resident population safety and have a all hands on deck approach if deficit is identified Employee Immunization Tracker will be reported on at each quarterly QAPI meeting	

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S 560	Continued From page 3 2. As per the "Nurse Staffing Report" completed by the facility for the 1 week of staffing from 09/24/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -09/24/23 had 24 CNAs for 279 residents on the day shift, required at least 35 CNAs. -09/25/23 had 24 CNAs for 279 residents on the day shift, required at least 35 CNAs. -09/26/23 had 27 CNAs for 277 residents on the day shift, required at least 35 CNAs. -09/27/23 had 28 CNAs for 277 residents on the day shift, required at least 35 CNAs. -09/28/23 had 28 CNAs for 277 residents on the day shift, required at least 35 CNAs. -09/29/23 had 24 CNAs for 277 residents on the day shift, required at least 35 CNAs. -09/30/23 had 24 CNAs for 276 residents on the day shift, required at least 34 CNAs. On 01/30/24 at 9:31 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing. The SC stated that she was aware of the mandated CNA ratios. The surveyor asked the SC if the facility was meeting the ratios. The SC stated that on days the facility had call outs, the facility may not meet the ratio. She added that she would try to place more staff on the units that needed more help due to the careplan needs of the resident. She added that she would call in perdiem and part time staff and that they use agency staff also.	S 560		

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S 560	Continued From page 4 On 02/06/24 at 9:49 AM, the surveyor interviewed the Director of Nursing (DON) regarding staffing. The DON stated that she was aware of the mandated CNA ratios. The surveyor asked the DON if the facility was meeting the ratios. The DON stated that the facility was not meeting the ratios on a daily basis especially on holidays. She added that she will have extra nurses and herself come in to work. The facility assessment did not include any information on staffing. A review of the facility provided policy titled, "Staffing" with a revised date of April 2007, included the following: 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. 3. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are adequately staffed to ensure that resident needs are met. 4. Our facility furnishes information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each shift during at least one (1) week of each quarter to appropriate state agencies as required. Such workweek is selected by the state survey agency. 5. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.	S 560		

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S 560	Continued From page 5 The policy did not include any information regarding the mandated CNA ratios. 3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 1-week period involved in a complaint investigation beginning 2/12/23 and ending 2/18/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 4 of 7 day shifts. The facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -02/12/23 had 27 CNAs for 266 residents on the day shift, required at least 33 CNAs. -02/15/23 had 28 CNAs for 265 residents on the day shift, required at least 33 CNAs. -02/17/23 had 27 CNAs for 264 residents on the day shift, required at least 33 CNAs. -02/18/23 had 21 CNAs for 264 residents on the day shift, required at least 33 CNAs. On 02/06/24 at 11:42 AM , the surveyor discussed the lack of required staff with the DON and Licensed Nursing Home Administrator (LNHA) who did not provide any further information. Part B Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure staff were NJ Exec Order 26.4b1 [redacted] and maintain a record of staff NJ Exec Order 26.4b1 as per statute and facility policy. This deficient practice was identified for four (4) of 234 staff with no information documented of their NJ Ex Order 26.4(b) NJ Exec Order 26.4b1 status and was evidenced by the following:	S 560		

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S 560	Continued From page 6 c. Reference: NJDOH memo, dated 10/7/2020, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 26:2H-18.79, Influenza vaccination in health care facilities", indicated the New Jersey Governor signed into law P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as "the Statute") effective 1/13/2020, in which healthcare facilities are required to: For the purposes of its annual influenza vaccination program, each health care facility shall:(1) annually provide an on-site or off-site influenza vaccination to each of its employees;(2) require that each employee at the facility receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease Control and Prevention, which vaccination shall be provided by the health care facility, except that an employee may, in lieu of receiving the influenza vaccination at the facility, present acceptable proof, comprising:(a) an attestation from the employee, which shall be submitted in a form and manner designated by the facility, of a current influenza vaccination if the employee receives the vaccination from another vaccination source, which attestation shall include the lot number of the vaccination the employee received or;(b) a medical exemption, which shall be submitted using a form designated by the Department of Health, stating that the influenza vaccination for that employee is medically contraindicated, as enumerated by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. An attestation of a medical exemption shall be subject to approval by the facility following a review by the facility to confirm the medical exemption is consistent with standards	S 560		

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S 560	Continued From page 7 enumerated by the Advisory Committee on Immunization Practices;(3) maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee and report to the Department of Health, in a manner and according to a schedule prescribed by the commissioner, the vaccination percentage rate of its workforce in receiving influenza vaccinations as part of the facility's annual vaccination program or by other means as attested to by the workforce, as applicable. The report may also include other information that the facility deems relevant to its vaccination percentage rate, including, but not limited to, the number of employees who received medical exemptions. On 01/31/24 at 01:12 PM, the surveyor requested from the DON the NJ Exec Order 26.4b1 for the facility staff. On 02/05/24 at 9:28 AM, the DON provided the surveyor the list of NJ Exec Order 26.4b1 information for the facility staff. A review of the untitled and undated document, detailed a list of staff members by name, title and information of NJ Exec Order 26.4 administration for the 2023/2024 NJ Exec Order 26.4b1. There were four (4) of 234 staff with no information documented of their NJ Exec Order 26.4b1 status. On 02/05/24 at 10:03 AM, the surveyor interviewed the LNHA who stated all facility staff were required to be NJ Exec Order 26.4b1 unless they had a medical exemption. The LNHA stated it was facility policy that all staff should be NJ Exec Order 26.4b1 by January 1st of the NJ Exec Order 26.4 season. On 02/05/24 at 10:13 AM, the surveyor	S 560		

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S 560	Continued From page 8	S 560		

interviewed the DON about staff NJ Exec Order 26.4b1 . The DON stated NJ Exec Order 26.4b1 for staff was mandatory unless there was a medical exemption, and all staff NJ Exec Order 26.4b1 status should be completed by the end of December of the NJ Exec Order 26.4b1 season. The DON further explained facility staff were educated on the importance of NJ Exec Order 26.4b1 and the facility's policy on NJ Exec Order 26.4b1. The surveyor reviewed the provided staf NJ Exec Order 26.4b1 list with DON and asked about the four staff who did not have any NJ Exec Order 26.4b1 information documented. The DON stated she was not aware of the four staff members' NJ Exec Order 26.4b1 and would have to follow up to provide further information.

On 02/06/24 at 10:16 AM, the DON stated she followed up with the one of the four staff members who stated she had received the NJ Exec Order 26.4b1 outside of the facility. The DON stated she still had to follow up with the other three staff members. The DON could not provide any NJ Exec Order 26.4b1 documentation for the four staff members. The DON stated the previous NJ Exec Order 26.4b1 was responsible for NJ Exec Order 26.4b1 at the time. The DON acknowledged that documentation of the staff's NJ Exec Order 26.4b1 should have been completed by December and records kept by the facility.

On 02/06/24 at 11:30 AM, the surveyor informed the LNHA and the DON of the above concerns. There was no additional information provided by the facility at this time.

A review of the facility's undated policy titled, "ANNUAL INFLUENZA VACCINATION PROGRAM POLICY" read under Policy: " ...It is

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S 560	Continued From page 9 the Facility's policy to implement and operate an annual influenza vaccination program that includes a medical exemption, record keeping, educational, and program evaluation component ..." Under Procedure II. Influenza Vaccination Program of the policy it read, " ...For the purposes of its annual influenza vaccination program, the Facility shall: a. Require that each employee at the Facility receive an influenza vaccination annually, no later than December 31 of the current influenza season as determined by the federal Centers for Disease Control and Prevention; ...An attestation from the employee, which shall be submitted in a form and manner designated by the Facility, of a current influenza vaccination if the employee received the vaccination from another vaccination source. The attestation shall include the lot number of the vaccination the employee received ..." Under Procedure III. Retention of Records and Reporting of the policy: it read, "A. The Facility shall maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee."	S 560		
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery,	S 830		3/19/24

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S 830	Continued From page 10 and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.) This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to obtain a Criminal Background (CB) check prior to the date of hire (doh) for new employees. This deficient practice was identified for four (4) of ten (10) newly hired employees reviewed (Staff #3, #7, #8 and #9) and was evidenced by the following: On 02/05/24 at 10:03 AM, the surveyor reviewed ten randomly selected new employee files for CB which revealed the following: Staff #3, an Assistant Director of Nursing, hired [NJ Exec Order 2], had a CB entered (ordered) on [NJ Exec Order 26.4] and completed (reported) on the same date. The CB was completed after the doh. Staff #7, a Certified Nursing Assistant (CNA), hired [NJ Exec Order 2], did not have a CB in their employee file. There was no documented evidence that a CB was done.	S 830	Element One: Staff members 3, 7, 8, and 9 employee files were checked to ensure that a current CB was on file. HR department was educated to ensure Criminal Background checks are done prior to employees first day of hire. All employee files will have documented evidence that the Criminal Background check verification was done. Element Two: The HR department audited all employee files to ensure that they are complete with documented evidence that the Criminal Background check was done. All residents have the potential to be affected by this deficient practice. Element Three: The HR department was in-serviced that all new hires must have their licenses verified prior to the date of hire the facility will develop and implement a policy for new employee hiring that	

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S 830	Continued From page 11 Staff #8, an Activity Aide, hired [NJ Exec Order 23], had a CB entered (ordered) on [NJ Exec Order 23] and completed (reported) on the same date. The CB was completed after the doh. Staff #9, a Housekeeper, hired [NJ Exec Order 23], had a CB entered (ordered) on [NJ Exec Order 23] and completed (reported) on the same date. The CB was completed after the doh. On 02/05/24 at 10:47 AM, in the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor interviewed the Director of Activities (DoA) who worked previously in the Human Resources (HR) department regarding the process for new employee hiring. The DoA stated that when she worked in HR she would perform a CB on every new employee and that it should be done prior to the doh. On 02/05/24 at 11:42 AM, the DoA reviewed the employee files and confirmed the four employees did not have documented evidence that a criminal background check was done prior to the doh. On 02/05/24 at 01:08 PM, the surveyor interviewed the Director of Nursing (DON) regarding the criminal background check. The DON stated that a criminal background check should be done prior to the doh. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor notified the LNHA and DON the concern that four newly hired employees did not have documented evidence that a criminal background check was done prior to their doh. On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a specific policy for new	S 830	ensures that Criminal Background check prior to first day of employment. Element Four: The Facility Administrator or designee will audit all new employee files weekly for 4 weeks and then monthly for 5 months to ensure that staff Criminal Background check is verified prior to hire. All findings will be reported every quarter to the QAPI committee.	

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S 830	Continued From page 12 employee hiring other than the checklist. The LNHA provided a document titled "Employee File Check List" which included the following: The following shall be completed on each new employee as it pertains to his/her job ....Criminal Background Check. The reviewed employee files did not contain the check list. The facility did not provide any additional information. A review of the facility provided policy titled "Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure" dated 2022, included the following: The Facility will not employ or otherwise engage individuals who: A. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; B. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; C. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	S 830		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the	S1405		2/29/24

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S1405	Continued From page 13 first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided pertinent documentation, it was determined that the facility failed to ensure that six (6) of ten (10) newly hired employees (Staff #2, #3, #4, #8, #9 and #10) had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: On 02/05/24 at 10:03 AM, the surveyor reviewed ten randomly selected new employee files which revealed the following: Staff #2, an Occupational Therapist (OT), hired [NJ Exec Order 26], did not have a Nurse Assessment completed upon hire. The OT had a Physician Assessment (an examination) dated [NJ Exec Order 26].	S1405	Element One: Human resources manager and Director of Nursing was reeducated on requirements for all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. Staff file for # 2, 3, 4, 8, 9, and 10 were updated with History and Physical requirements Element Two: All residents have the potential to be affected by this deficient practice. Element Three: Human resource manager and Director of Nursing was in-serviced on the NJ employee physical examination requirements. Human resources will audit all employees file to ensure and reconcile	

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S1405	Continued From page 14 Staff #3, an Assistant Director of Nursing (ADON), hired [NJ Exec Order 26], did not have a Nurse Assessment completed upon hire. The ADON had a Physician Assessment dated [NJ Exec Order 26.4b]. Staff #4, a Registered Nurse (RN), hired [NJ Exec Order 26.4b] did not have a Nurse Assessment completed upon hire and did not have a Physician Assessment completed. Staff #8, an Activity Aide (AA), hired [NJ Exec Order 26], did not have a Nurse Assessment completed upon hire. The AA had a Physician Assessment dated [NJ Exec Order 26]. Staff #9, a Housekeeper, hired [NJ Exec Order 26], did not have a Nurse Assessment completed upon hire and did not have a Physician Assessment completed. Staff #10, a Certified Nursing Assistant (CNA #2), hired [NJ Exec Order 26] did not have a Nurse Assessment completed upon hire. CNA#2 had a Physician Assessment dated [NJ Exec Order 26]. On 02/05/24 at 10:47 AM, in the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor interviewed the Director of Activities (DoA) who worked previously in the Human Resources (HR) department regarding the process for new employee hiring. The DoA stated that the physicals were normally done within 30 days of the date of hire. She added that a nurse usually did an assessment upon hire and then the doctor would do the physical. On 02/05/24 at 11:42 AM, the DoA reviewed the employee files and confirmed that the Nurse Assessment was not done and that the physicals	S1405	and update with History and Physical to meet standards and requirements for current existing employee files and ongoing for new perspective files Element Four: Human resource manager or designee will audit employee physicals for all new hires monthly x 3 months. Human resources manager or Designee will report findings every quarter to the QAPI Committee. The Quarterly QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S1405	Continued From page 15 were more than 30 days after the date of hire. On 02/05/24 at 01:08 PM, the surveyor interviewed the Director of Nursing (DON) regarding the process for new hire. The DON stated that physicals were done on orientation before the staff started. She added that the Medical Director performed the physical upon hire. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor told the LNHA and DON the concern that the six employees did not have a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a specific policy for new employee hiring other than the checklist. The LNHA provided a document titled "Employee File Check List" which included the following: The following shall be completed on each new employee as it pertains to his/her job ....Physical Exams. The reviewed employee files did not contain the check list. The facility did not provide any additional information.	S1405		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux	S1410		3/18/24

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S1410	Continued From page 16 tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a NJ Exec Order 26.4b1 as required for new employees hired for NJ Exec Order 26.4b1 for NJ Exec Order 26.4 and NJ Exec Order 26 screening upon hire or within the previous year. This deficient practice was identified for four (4) of ten (10) employee files (Staff #3, #4, #6 and #9) reviewed and was evidenced by the following: On 02/05/24 at 10:03 AM, the surveyor reviewed five randomly selected new employee health files for NJ Ex screening which revealed the following:	S1410	Element One: Human resource manager and Director of Nursing was educated on the NJ Exec Order 26.4b1 requirements for all new hires. Staff Member #3 is no longer employed. Staff Staff Member #6 NJ Exec Order 26.4b1 was completed for NJ Exec Order 26.4b1, and NJ Ex test was redone to be in compliance. Staff member #4 and #9 files were located while completing audit of all files. Element Two: Human resources manager, DON or designee will audit new hires health files within the past 30 days to	

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S1410	Continued From page 17 Staff #3, an Assistant Director of Nursing, hired [NJ Exec Order 26.] did not have any documented evidence that a [NJ Exec Order 26.4b1] test was done. Staff #4, a Registered Nurse, hired [NJ Exec Order 26.4b1] did not have any documented evidence that a [NJ Exec Order 26.4b1] test was done. Staff #6, a Nurse Aide, hired [NJ Exec Order 26.4b], had a document from their school with a [NJ Exec Order 26.4b1] that was done. The first step was administered on [NJ Exec Order 26.] and the second step was administered on [NJ Exec Order 26.]. The timeframe between the two administrations was greater than the required one to three week timeframe. Staff #9, a Housekeeper, hired [NJ Exec Order 26.] did not have any documented evidence that a [NJ Exec Order 26.4b] was done. On 02/05/24 at 10:47 AM, in the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor interviewed the Director of Activities (DoA) who worked previously in the Human Resources (HR) department regarding the process for new employee hiring. The DoA stated that the PPD was a [NJ Exec Order 26.4b1] and that the first one was administered on the first day and that the second was usually administered two weeks after. On 02/05/24 at 11:42 AM, the DoA reviewed the employee files and confirmed that the four employees did not have the correct [NJ Exec Order 26.4b1] test upon hire. On 02/05/24 at 01:08 PM, the surveyor interviewed the Director of Nursing (DON) regarding the process for new hire. The DON stated that the [NJ Exec Order 26.4b] was a [NJ Exec Order 26.] that the facility administered. She added that if the employee had a [NJ Exec Order 26.4b1] within the year	S1410	ensure compliance of employee Mantoux requirements. Element Three: Human resource manager, DON or designee will audit employee health files for all new hires monthly x 3 months. Element Four: Human resources manager, DON or Designee will report findings every quarter to the QAPI Committee monthly for three quarters. The QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S1410	Continued From page 18 that the facility would accept it but that if it was over a year then a new [NJ Exec Order 26.] would be started. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor told the LNHA and DON the concern that four employees did not have the required [NJ Exec] On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a specific policy for new employee hiring other than the checklist. The LNHA provided a document titled "Employee File Check List" which included the following: The following shall be completed on each new employee as it pertains to his/her job ....Mantoux Test. The reviewed employee files did not contain the check list. The facility did not provide any additional information.	S1410		
S2905	8:39-43.1(a)(2) Certification of Nurse Aides (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey: 2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or	S2905		3/6/24

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S2905	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation and interview with facility staff, it was determined that the facility failed to ensure that two (2) of three (3) non-certified Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility reviewed during the Sufficient and Competent Nurse Staffing task (NA #1 and NA #2). This deficient practice was evidenced by: On 01/29/24 at 10:22 AM, in the presence of a federal surveyor, the survey Team Coordinator met with the Licensed Nursing Home Administrator (LNHA) for an entrance conference and requested a list of the facility's CNAs with their date of hire and license numbers listed. The LNHA stated that the facility did not have any NAs. On 01/30/24 at 9:10 AM, the surveyor asked the LNHA and Director of Nursing (DON) for the list of the facility's CNAs with their date of hire and license numbers listed. On 01/30/24 at 01:48 PM, the surveyor asked the LNHA if he had the previously requested facility CNA list. The LNHA stated that he had the list but that the license numbers were not on it and that someone was working on placing the license numbers on the list. On 01/31/24 at 10:10 AM, the facility provided a list of CNAs which had their date of hire but did not have the license numbers listed. The surveyor randomly chose five CNAs from the facility provided list and requested from the Human	S2905	Element One: Removed NA immediately off the nursing schedule. All NA□s that are not within 120 days removed from nursing schedule. HR personnel, LNHA and DON immediately reeducated as to the NJDH memorandum under the interpretation of CMS guidance. Element Two: All resident have the potential to be affected by this deficient practice. Audit of all NA files making sure they have all the required documentation and are within the 120 days□ timeframe. Element Three: In-service LNHA, HRM, HR on policy for NA hiring. Individuals who meet any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in NJ has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facility training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment. New tracking will be utilized by the HR department. Element Four: Administrator will audit weekly for 4 weeks and monthly for 5 months. LNHA will report findings every quarter to QAPI committee.	

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S2905	Continued From page 20 Resource Manager (HRM) the education provided, performance review and competencies done for the five CNAs. On 02/01/24 at 11:02 AM, the LNHA told the survey Team Coordinator that some of the CNAs that were on the list provided no longer worked at the facility. The LNHA provided the survey team a new list of CNAs with the date of hire and license numbers listed. A review of the list revealed that some of the CNAs listed did not have a license number listed next to their name and that "certificate" was listed in lieu of a license number. On 02/01/24 at 11:13 AM, in the presence of another surveyor, the surveyor interviewed the Staffing Coordinator (SC) regarding the staffing schedule of non-certified NAs. The SC stated that she did not identify whether the staff was a CNA or a NA on the schedule and that the nurses on the floor knew who was not certified. On 02/01/24 at 11:34 AM, the surveyor interviewed the DoA regarding NAs. The DoA stated that she worked in HR from NJ Exec Order 26.4b1 until NJ Exec Order 26.4b1. The DoA stated that the facility had NAs and that as long as the NA was in school, passed the skills test and was observed by a Registered Nurse that the NA could continue to be on the schedule. She added that the NA was just waiting to take the written exam. On that same date and time, the DoA stated that she would get proof of their school and that they passed the skills test. The surveyor asked if there was a certain time frame that they had to take the test and continue to work for. The DoA stated that we tell them to take the written test as soon as possible.	S2905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06730	A. BUILDING: _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2905	Continued From page 21 A review of the facility provided NA employee files revealed the following: NA #1, hired [NJ Exec Order 26], completed CNA training course on [NJ Exec Order 26.4]. NA #1 was not currently enrolled in a course during their employment. NA #2, hired [NJ Exec Order 26.4], completed CNA training course on [NJ Exec Order 26.4] NA #2 was not currently enrolled in a course during their employment. On 02/05/24 at 11:01 AM, in the presence of the LNHA, the DoA stated that she thought they could accept anyone that was enrolled in CNA school and that they had one year to pass the written test. On 02/05/24 at 01:53 PM, in the presence of the survey team and two federal surveyors, the surveyor notified the LNHA and DON the concern that the two NAs were not enrolled in an approved nurse aide training course during their employment with the facility. On 02/06/24 at 9:26 AM, the LNHA stated that the facility did not have a policy regarding NAs. The facility did not provide any additional information.	S2905		

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
315458 Y1	A. Building B. Wing Y2	5/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0710	Correction	ID Prefix F0804	Correction	ID Prefix F0842	Correction
Reg. # 483.30(a)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	03/20/2024	LSC	03/18/2024	LSC	03/19/2024
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/6/2024	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315458 Y1	A. Building B. Wing Y2	5/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0578	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	03/08/2024	LSC	03/12/2024	LSC	03/13/2024
ID Prefix F0607	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	02/29/2024	LSC	03/12/2024	LSC	02/29/2024
ID Prefix F0623	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	03/05/2024	LSC	02/29/2024	LSC	03/19/2024
ID Prefix F0658	Correction	ID Prefix F0686	Correction	ID Prefix F0690	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	02/29/2024	LSC	03/18/2024	LSC	02/29/2024
ID Prefix F0695	Correction	ID Prefix F0710	Correction	ID Prefix F0728	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.30(a)(1)(2)	Completed	Reg. # 483.35(d)(1)-(3)	Completed
LSC	02/29/2024	LSC	03/20/2024	LSC	02/28/2024

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315458 Y1	A. Building B. Wing Y2	5/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0730	Correction	ID Prefix F0732	Correction	ID Prefix F0755	Correction
Reg. # 483.35(d)(7)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/19/2024	LSC	02/28/2024	LSC	03/15/2024
ID Prefix F0804	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	03/18/2024	LSC	03/15/2024	LSC	02/28/2024
ID Prefix F0842	Correction	ID Prefix F0867	Correction	ID Prefix F0868	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	03/19/2024	LSC	02/29/2024	LSC	03/13/2024
ID Prefix F0880	Correction	ID Prefix F0881	Correction	ID Prefix F0883	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	03/19/2024	LSC	02/29/2024	LSC	03/19/2024

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/6/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
06730 Y1	A. Building B. Wing Y2	5/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/29/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
06730 Y1	A. Building B. Wing Y2	5/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S0830	Correction	ID Prefix S1405	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-9.3(b)	Completed	Reg. # 8:39-19.5(a)	Completed
LSC	02/29/2024	LSC	03/19/2024	LSC	02/29/2024
ID Prefix S1410	Correction	ID Prefix S2905	Correction	ID Prefix	Correction
Reg. # 8:39-19.5(b)(1)	Completed	Reg. # 8:39-43.1(a)(2)	Completed	Reg. #	Completed
LSC	03/18/2024	LSC	03/06/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	**300 BROADWAY** **NEWARK, NJ 07104**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/30/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/30/24 and was found not to be in compliance with 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. New Vista Nursing and Rehabilitation Center is a six-story building first occupied in 1926 according to staff. The facility is constructed of Type II (222) construction with concrete flooring, block bearing walls and concrete roofing with a complete automatic sprinkler system and a complete fire alarm system. The facility has a 400-kilowatt (KW) diesel generator. The residential units are noted as 300, 400, and 500 units. The 600 unit is a smoking area for residents. A recent generator analysis found the facility generator to be operating a 99% of capacity while under load. The generator also services an adjoining dialysis clinic separated by a two-hour fire wall. The first floor or ground floor is a service area for laundry. The second floor is administrative. The facility has 15 smoke zones and currently has 274 occupied beds.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING **01** B. WING _____	**02/06/2024**

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K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure seven of 520 photo electric smoke detectors were greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect 10 residents on three of three floors. Findings include: An observation on 01/30/24 at 11:00 AM of a smoke detector in the corridor near bedroom 302 revealed the smoke detector was 16 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) .	K 341	Element 1: immediately maintenance staffs relocated the heating and . cooling diffuser 36 inch + away from the smoke detector. Element 2: director of maintenance and staffs made sure not to Install any smoke detector near the heating or cooling Diffuser must be 36 inches away. Element 3: the plant manager in-serviced all maintenance staff On how important it is to keep the smoke detector away 36	3/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 341	Continued From page 2 An observation on 01/30/24 at 11:00 AM of a smoke detector in the corridor near bedroom 305 revealed the smoke detector was 24 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) . An observation on 01/30/24 at 11:20 AM of a smoke detector located in the Clubhouse on the third floor near the elevators revealed the smoke detector was 19 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) . An observation on 01/30/24 at 11:30 AM of a smoke detector in the soiled linen room near bedroom 405 revealed the smoke detector was 8 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) . An observation on 01/30/24 at 11:40 AM of a smoke detector in bedroom 414 revealed the smoke detector was 18 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) . An observation on 01/30/24 at 11:40 AM of a smoke detector in bedroom 413 revealed the smoke detector was 16 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) . An observation on 01/30/24 at 11:50 AM of a smoke detector in bedroom 514 revealed the smoke detector was 4 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6) . A review of the facility contractor report titled "Fire	K 341	Inches away from any vents. Element 4: the plant manager and the maintenance manager will Audit all the rooms and common area to make sure all Smoke detectors are correctly away from the vents. Maintenance director will audit smoke detectors quarterly and after any renovations or changes that may affect smoke detector s. Report to QAPI committee quarterly upon finishing the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING **01** B. WING _____	**02/06/2024**

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K 341	Continued From page 3 Alarm Inspection Report," dated 08/21/23, 02/23/23, 10/10/22, and 03/15/22 revealed no mention of the smoke detectors proximity to the air diffusers noted. During an interview at the time of each observation the US FOIA (b)(6) verified the distance of the smoke detectors from the air diffuser. NJAC 8:39-31.1 (c), 31.2(e) NFPA 70, 72	K 341		
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 observations, record review, and interview, the facility failed to complete a smoke detection sensitivity test for all 520 photo electric 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 274 residents. Findings include: A review of the facility's fire safety records, located in a white binder under the "Fire Alarm"	K 345	Element 1 All Residents living in areas where this deficient practice was identified had the potential to be affected by this deficient practice Immediately an external company was hired and retained to conduct and support testing on all 520 smoke detectors in order to complete task within the POC date	2/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. BUILDING **01** B. WING _____	**02/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	**300 BROADWAY** **NEWARK, NJ 07104**

(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 345	Continued From page 4 tab, provided by the Maintenance Director revealed the most recent fire alarm inspections "Fire Alarm Inspection Report," dated 08/21/23, 02/23/23, 10/10/22 and 03/15/22 did not include a smoke detection sensitivity test. On page 16 of 16 of the report dated 03/15/22, the contractor suggests "sensitivity testing is not part of this test and should be conducted in two-year intervals." An observation on 01/30/24 from 10:45 AM to 1:30 PM revealed the facility had smoke detection in all corridors every 30 feet and in all resident bedrooms. The facility did not have a smart fire alarm system to continuously monitor for sensitivity. During an interview on 01/30/24 at 3:30 PM, the US FOIA (b)(6) verified the smoke detection sensitivity test had not been completed. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	Element 2 All residents had the potential to be affected by this deficient practice Smoke detection sensitivity testing process was evaluated by Plant Manager and the retention of the external company was expedited through additional financial resource to correct and maintain all 520 smoke detectors in accordance of regulatory requirements for 100% compliance Log was created by Plant Manager and tracked and update with all data to reflect 100% compliance of completion Element 3 Plant Manager created a monitoring system with log to ensure this process and corrective measures are tracked and documented which was included and updated in Binder to reflect Contract of external company and retained agreement completed and in place to ensure available resource to maintain 100% compliance Element 4 The Facility Administrator Assigned The plant Manager As The Gate Keeper to monitor compliance of this process The Plant Manager will report to the QAPI Committee Weekly x 4 weeks then Monthly x 4 months and continue Quarterly there after	

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	315458	A. BUILDING **01** B. WING _____	**02/06/2024**

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K 363	Continued From page 5	K 363		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		3/13/24

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K 363	Continued From page 6 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure four corridor doors resisted the passage of smoke in accordance with NFPA 101 (2012 edition) section 19.3.6.3, on two of three floors. This deficient practice had the potential to affect 75 residents on the fourth and fifth floors. Findings include: An observation on 01/30/24 at 11:30 AM of a room labeled "Pantry" near bedroom 452 revealed a louver at the lower section of the corridor door measuring 26 inches wide x (by) 14 inches high as measured by the US FOIA (b)(6) . An observation on 01/30/24 at 11:45 AM of a room labeled "Pantry" near bedroom 406 revealed a louver at the lower section of the corridor door measuring 26 inches wide x 14 inches high as measured by the US FOIA (b)(6) An observation on 01/30/24 at 11:55 AM of a room labeled "Pantry" near bedroom 506 revealed a louver at the lower section of the corridor door measuring 26 inches high x 14 inches high as measured by the US FOIA (b)(6) An observation on 01/30/24 at 11:55 AM of the bedroom 510 corridor door revealed a 36-inch split in the door as measured by the US FOIA (b)(6) .	K 363	Element 1: on Jan 31,2024 plant manager bought metal sheets to cover the Louver at the lower section of the corridor doors(pantry)and were Installed by maintenance staff. Immediately bedroom 510 corridor Door was replaced. Element 2: maintenance staff will check all bedroom corridor doors monthly. If any finding will be corrected immediately, and report it to the director of maintenance. Element 3: in □ services given to maintenance on the importance of Maintaining a safety environment free of any broken corridor door Or louver at any of pantry doors. Element 4: doors will audit monthly by maintenance director, and report to QAPI committee quarterly upon finish.	

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K 363	Continued From page 7 During an interview at the time of each observation, the US FOIA (b)(6) verified the size of the louvers and split in the door. NJAC 8:39-31.2(e)	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure three of nine smoke barrier walls were continuous from the floor to ceiling above in accordance with NFPA 101 (2012 edition) section 8.5.2. This deficient practice had the potential to affect 54 residents on two floors. Findings include: An observation on 01/30/24 at 1:15 PM of the smoke barrier wall at the cross-corridor doors near bedroom 422 above the ceiling tile revealed two holes measuring 3-inches x (by) 3-inches.	K 372	Element 1 All residents in the environment where the 3 areas identified as out of compliance within the regulatory requirement Smoke Barrier has the potential to be affected by this deficient practice Areas identified 422 530 and 522 were immediately resolved with use of endothermic product to correct this deficient practice Additional rounds were completed immediately supervised and observed by	2/24/24

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K 372	Continued From page 8 An observation on 01/30/24 at 1:25 PM of the smoke barrier wall at the cross-corridor doors near bedroom 530 above the ceiling tile revealed one hole in the shape of a square measuring 4-inches x 4-inches. An observation on 01/30/24 at 1:30 PM of the smoke barrier wall at the cross-corridor doors near bedroom 522 above the ceiling tile revealed one hole the diameter of 3-inches. During an interview at the time of each observation, the US FOIA (b)(6) verified the holes in the above noted smoke barrier wall. NJAC 8:39-31.1(c), 31.2(e)	K 372	Plant Manager to ensure that there were no other smoke barriers standards were deficient no other was identified Element 2 All residents has the potential to be affected by this deficient practice Daily rounding was implemented with log by Plant Manager to continually monitor and track and identify with resolution of any identified areas new or potentially at risk for non compliance with Smoke Barrier Regulations This log will be reviewed daily by Plant Manager to ensure all areas out or regulatory standard will be rectified immediately Element 3 Plant Manager educated and updated all key personnel responsible to conduct these rounds with regulatory requirements including approved product with properties required for use and log system and process to track and maintain compliance Plant Manager will review and ensure log and system is completed with corrective measures and compliance of any newly and potentially areas are addressed and meeting the regulatory expectations to maintain 100% compliance Element 4 Plant Manager was assigned as gate keeper by Administrator to monitor	

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K 372	Continued From page 9	K 372	maintain and report on this area and ensure compliance Plant manager will report on this aspect of Smoke Barrier compliance and meeting regulatory standard at each QAPI meeting weekly x 4 weeks and then monthly x 4 month then Quarterly there after	
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 541	Element 1: maintenance	3/13/24

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K 541	Continued From page 10 failed to ensure one of six soiled linen/laundry chute doors were self-closing in accordance with NFPA 101 (2012 edition) sections 9.5.1.1. to 8.3. to 8.3.3.3. This deficient practice had the potential to affect 25 residents on the fifth floor. Findings include: An observation on 01/30/24 at 11:55 AM revealed the linen chute door inside the soiled linen room was not self-closing. When the chute door was pulled wide open and allowed to release by the US FOIA (b)(6), the door closed and popped open remaining ajar two inches. The chute door did not latch. Two additional attempts were made in the same manner with the same results. During an interview at the time of the observation, the US FOIA (b)(6) indicated he would repair the chute door so it would close and latch. NJAC 8:39-31.1(c), 31.2(e)	K 541	replaced the hardware immediately on linen Shute inside solid room on 5th floor. We also installed new Self-closing door hinges. Element 2: Maintenance will check the shute door and make sure is self-closing and secure. housekeeping will report any problem with the linen Shute to Maintenance director. Element 3: plant manger in-serviced both housekeeping and maintenance on more communication with the maintenance director to make the environment is safer by report and take care of any unsafe issue ASAP. Laundry supervisor or designee will cheek on a weekly basis to ensure proper latching and closing of the chutes. Element 4: director of Maintenance will take care of any issue occurring with the linen Shute and report it to the plant manager and QAPI committee quarterly.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101	K 741		3/13/24

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K 741	Continued From page 11 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, the facility failed to ensure the smoking area contained a metal, self-closing container in accordance with NFPA 101 (2012 edition) section 19.7.4. This deficient practice had the potential to affect 67 residents who smoked. Findings include: An observation on 01/30/24 at 12:10 PM of the	K 741	Element 1: 1- Smoke Room on 6th Floor trash can was removed and replaced with a metal container with Self-closing cover. 2-Added 6 more metal ashtrays with a lid for cigarettes butt on the tables 3- Installed two metal standing ashtrays for cigarette butts□ disposal.	

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K 741	Continued From page 12 outside smoking area covered patio located on the sixth floor revealed a smoking area containing a garbage can that was open at the top. The garbage can was full of paper and plastic garbage as well as cigarette butts and ashes. The floor of the smoking area was coated in ashes. During an interview at the time of the observation, the US FOIA (b)(6) verified the finding of the ashes on the floor and the lack of a self-closing metal container in the area. Review of the facility's policy titled, "Safe Smoking Policy," dated 01/31/20, revealed the policy did not address a self-closing metal container in the smoking area or safe use of ash trays while smoking. NJAC 8:39-31.2(e), 31.6(e)	K 741	Element 2: smoke monitor (always on site from the open to close time) will direct the Smoker to use the ash tray for the cigarette□s butts. Also keeping the floor Free from ash and cigarettes butt. Element 3: housekeeping manager will monitor and check the smoke room during the Round daily and in-serviced the smoke monitor on how to keep the smoke Area clean. Element 4: plant manager and housekeeping manager will monitor the smoke room During their round daily and report any finding to QAPI committee quarterly.	

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{E 000}	Initial Comments	{E 000}		
{K 000}	The facility was found to be in compliance INITIAL COMMENTS An off-site/desk review of the Life Safety Code Plan of Correction conducted on 05/06/24 and the facilty was found not to be in compliance with 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, specifically K345 and K372. New Vista Nursing and Rehabilitation Center is a six-story building first occupied in 1926 according to staff. The facility is constructed of Type II (222) construction with concrete flooring, block bearing walls and concrete roofing with a complete automatic sprinkler system and a complete fire alarm system. The facility has a 400-kilowatt (KW) diesel generator. The residential units are noted as 300, 400, and 500 units. The 600 unit is a smoking area for residents. A recent generator analysis found the facility generator to be operating a 99% of capacity while under load. The generator also services an adjoining dialysis clinic separated by a two-hour fire wall. The first floor or ground floor is a service area for laundry. The second floor is administrative. The facility has 15 smoke zones and was certified for 340 beds.	{K 000}		
{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	{K 345}		5/13/24

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

Electronically Signed | 05/09/2024

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

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{K 345}	Continued From page 1 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 review of the facility's Plan of Correction, the facility failed to submit evidence that a smoke detection sensitivity test for all 520 photo electric smoke detectors was performed 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 274 residents. Findings include: During the 02/06/2024 Recertification survey, the facility was cited for not conducting a smoke detection sensitivity test every two years. An observation on 01/30/24 from 10:45 AM to 1:30 PM revealed the facility had smoke detection in all corridors every 30 feet and in all resident bedrooms. The facility did not have a smart fire alarm system to continuously monitor for sensitivity. During an interview on 01/30/24 at 3:30 PM, the US FOIA (b)(6) verified the smoke detection sensitivity test had not been completed. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	{K 345}	1. All residents have the potential to be affected by the deficient practice. An external vendor was retained to conduct and support testing of all smoke detectors. 2. As all residents have the potential to be affected by the deficient practice, the facility's fire alarm inspection process was amended to include a smoke detection sensitivity test to be conducted by an external vendor every two years. 3. The US FOIA (b)(6) was in-serviced on the requirement that all smoke detectors receive a smoke detection sensitivity test every two years. 4. A quarterly review of the most recent test results will be conducted to ensure the facility remains in compliance. Results of the review will be presented at the facility's quarterly Quality Assurance meetings. The Plan Manager will ensure compliance.	
{K 372} SS=E	Subdivision of Building Spaces - Smoke Barrie	{K 372}		6/3/24

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{K 372}	Continued From page 2 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Plan of Correction, the facility failed to provide evidence that three of nine smoke barrier walls were sealed with a material that had either intumescent, endothermic or elastomer properties in accordance with NFPA 101 (2012 edition) section 8.5.2. This deficient practice had the potential to affect all residents on two floors. Findings include from the 02/06/2024 Recertification survey: An observation on 01/30/24 at 1:15 PM of the smoke barrier wall at the cross-corridor doors near bedroom 422 above the ceiling tile revealed two holes measuring 3-inches x (by) 3-inches. An observation on 01/30/24 at 1:25 PM of the smoke barrier wall at the cross-corridor doors near bedroom 530 above the ceiling tile revealed one hole in the shape of a square measuring	{K 372}	1. All residents have the potential to be affected by the deficient practice. All penetrations identified were immediately sealed utilizing endothermic sealant. 2. As all residents have the potential to be affected by the deficient practice, an audit of all smoke barriers was conducted to ensure they were free of penetrations. 3. All Maintenance staff were in-serviced on the requirement that all smoke barrier walls remain continuous and free of penetrations. 4. A quarterly audit of all smoke barriers will be conduct to ensure they remain continuous and free of	

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{K 372}	Continued From page 3 4-inches x 4-inches. An observation on 01/30/24 at 1:30 PM of the smoke barrier wall at the cross-corridor doors near bedroom 522 above the ceiling tile revealed one hole the diameter of 3-inches. During an interview at the time of each observation, the US FOIA (b)(6) verified the holes in the above noted smoke barrier wall. NJAC 8:39-31.1(c), 31.2(e)	{K 372}	penetrations. Results of these audits will be presented at the facility's quarterly Quality Assurance meetings. The Plan Manager will ensure compliance.	

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
315458 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/6/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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 K0341	03/25/2024	LSC K0363	03/13/2024	LSC K0541	03/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0741	03/13/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315458 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING & REHABILITATION CTR	300 BROADWAY NEWARK, NJ 07104

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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0345	05/13/2024	LSC K0372	06/03/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	

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FOLLOWUP TO SURVEY COMPLETED ON	
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