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	315359	A. BUILDING _____ B. WING _____	C 11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: Census: 126 Sample: 26 + 24 = 50 Complaint #: NJ155973, NJ158982 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. The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Deficiencies were cited.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including 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	F 584		1/19/23

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

Electronically Signed | 12/23/2022

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F 584	Continued From page 1 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of pertinent documentation, it was determined that the facility failed to provide a clean, and comfortable homelike environment to residents who resided at the facility. The lack of oversight to ensure equipment, and the environment was clean created a potential environmental hazard to the residents who	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment Level E Audit tool done All Policies and procedures must be reviewed and dated.	

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F 584	Continued From page 2 resided at the facility. The deficient practice was observed in 10 rooms on 1 of 4 Resident units, and was evidenced by the following: On 11/07/22 from 10:10 AM to 11:47 AM, the surveyor conducted a tour of the [redacted] Unit [redacted] and observed the following: The heating/cooling units in Rooms [redacted], [redacted] revealed that all the heating and cooling units were covered with various bed linen, and the metal bases were covered with a rust like substance. The unit covers were missing in some of the rooms exposing copious amounts of embedded dirt, and dusty filters and debris stacked inside the heating and cooling units. Observations of Rooms # [redacted] revealed that the curtains surrounding the resident's beds were visibly soiled with various colors of splatters and spots. Observation of Room [redacted] revealed a brown substance splattered on the wall and brown substance on the floor. There was a [redacted] emerging from the room. The bed linen including the pillow were [redacted] and there were [redacted] in the room. The surveyor accompanied the Unit Manager (UM) to the room where we both observed the same and the observation was confirmed by the Unit Manager. The UM stated that the resident was non-compliant with care. Observation of Room [redacted] revealed brown stains on the floor by the bed, and an [redacted] was prominent throughout the room and the bathroom. An interview with the Certified Nursing Assistant (CNA) of the unit revealed that Resident #19 had a behavior of urinating on the floor and inside the closets in the room.	F 584	I. Immediate Attention a) Bed linens, Towels removed; every heating/cooling unit throughout the building was checked and cleaned immediately. b) The missing unit covers were replaced immediately. c) The identified soiled curtains were washed and replaced; all curtains in the facility were checked. d) Room #315 walls were washed and re-painted e) Room [redacted] floor tiles will be replaced. f) The bed linen was changed, and the pillows were replaced. g) Room #316, Room [redacted] Room [redacted] and all the floor on [redacted] floor was cleaned, waxed and buffed immediately h) Handrails on the [redacted] floor was adjusted and mounted properly. i) Room [redacted] □s window glass was replaced j) Room [redacted] heating/cooling unit was replaced k) Room [redacted], Room [redacted] and Room 348 heating and cooling unit was replaced. l) Room [redacted] heating/cooling unit was replaced with a [redacted] unit m) Room [redacted] holes in the walls were plastered and painted n) Room [redacted] light fixture was replaced o) Room [redacted] toilet was unclogged immediately p) Room [redacted] was cleaned immediately and all debris removed. q) Rooms [redacted] and # [redacted] □s room temperatures were checked and found to	

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F 584	Continued From page 3 Observations of Room [redacted] revealed the curtains were stained with red substance. Observation of Room [redacted] revealed stained flooring, and the bed linen and curtain surrounding the bed was [redacted] stained. Observation on 11/07/22 at 10:45 AM of the [redacted] Unit [redacted] side, revealed flooring with brownish stains, stained walls, heating, and cooling units in disrepair with large amount of dust and debris, and holes noted in the wall (Room [redacted]. Observations on 11/07/22 at 11:15 AM revealed a handrail not mounted properly on the [redacted] unit [redacted] side exposing jagged edges. The same was verified with the Unit Manager. On 11/07/22 at 11:30 AM, the surveyor interviewed the occupant in Room [redacted]. The resident revealed that the heating and cooling unit had not been working and the room was cold all the time. The temperature 61.9 F (Fahrenheit) was measured with the maintenance staff member. The surveyor observed the heating and cooling unit covered with blankets and was stacked with sheets and towels. The surveyor verified the observation with the maintenance staff and the Unit Manager. On 11/07/22 at 2:30 PM, during an interview with the surveyor, the Regional Licensed Nursing Home Administrator (RLNHA) stated that he would expect that the building be kept clean and in good working condition by maintenance and the housekeeping staff. The RLNHA further stated if repairs needed to be completed, they	F 584	be within range. The heating/cooling units were cleaned to ensure proper flow of heat and to ensure temperatures are within range. II. Identification of others a) The staff were in serviced to identify maintenance issues and put in work orders in the maintenance logbook that was kept at the nurse□s station. b) Maintenance worker will check the room to maintain the required temperatures between 71-81 degrees Fahrenheit in all the rooms all a daily basis and input the numbers in the logbook III. Systemic Changes a) The Policy and Procedure for routine Room Cleaning was reviewed by the Administrator and House Keeping Director and found to be in compliance. b) The Policy and Procedure for Maintaining Proper Room Temperature was reviewed by the Administrator and Maintenance Director and found to be in compliance IV. Quality Assurance " Audits will be conducted by the House Keeping Director of all areas including but not limited to maintenance and cleaning, general cleaning, and floor cleaning, a) Audits will be done by the Housekeeping Director/Supervisor and Maintenance Director weekly x 4 weeks, monthly x 2 months, quarterly x 3	

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F 584	Continued From page 4 should be addressed immediately. He informed the survey team that he would take care of the concerns. However, the next day the surveyor entered Room # [redacted] and observed that the heating and cooling unit was still stuffed with sheets and towels. Room # [redacted] was observed with large amounts of debris, empty juice container, gloves, towels, and sheets. On 11/09/22 at 8:40 AM, random room temperatures were taken with the maintenance worker, and the following temperature were recorded: Room [redacted], 66.2 F, Room [redacted], 65 F, and Room [redacted], 67 F. On 11/09/22 at 8:45 AM, the surveyor observed Room [redacted] with linen on the floor. At that time, the surveyor interviewed the Unit Manager who revealed that the CNAs were all aware that the linen should be bagged not be placed on the floor. The temperature of the room registered 66.2 F. During a tour and interview on 11/09/22 at 8:58 AM, the Maintenance worker explained they had a maintenance log that was kept at each nurse's station. He stated he checked the log each morning when he made rounds and he prioritized the work that needed to be done. He stated that he was not made aware of any work repair for the [redacted] unit. On 11/09/22 at 9:05 AM, the surveyor reviewed the log with the maintenance worker and verified that there was no work order regarding the heating and the cooling unit not working in the rooms. Random room temperatures were	F 584	quarters. b) Any negative findings will be brought to the Administrator immediately. c) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. V. Person Responsible: Housekeeping Director Maintenance Director	

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F 584	Continued From page 5	F 584		

checked with the Maintenance worker and the temperatures registered below 71 F. Normal room temperature for Long Term Care Facility (LTC) should range between 71 F to 81 F. The maintenance worker confirmed that the heating and cooling units needed to be cleaned, the bases were rusty, and multiple units were stuffed with sheets and towels. In the presence of the Unit Manager, the maintenance worker stated that the heating and cooling units were to be cleaned and checked yearly. He confirmed that the heating and cooling units had not been cleaned. He could not provide any documentation regarding when the heating and cooling units were last serviced.

On 11/09/22 at 9:17 AM, during an interview with the surveyor, the Unit Manager confirmed that the unsampled resident in Room [redacted] had reported that the heating and cooling unit had not been working last month but she forgot to place a work order for repair.

Observations of Room [redacted] at 9:21 AM, revealed a copious amounts of debris piled in the corner of the room and splattered black substance on the wall. The resident who occupied the second bed called the surveyor to the room and pointed at the base of the cooling and heating unit where a large amount of brown substance was coated. The wall was visibly and soiled.

Observation of Room #340 and #344 at 9:35 AM, revealed the heating and cooling unit covers were missing exposing the dusty filters and rusty parts. The resident stated that the room was always cold at night. In the presence of the Unit Manager the resident stated, "room very, very cold, when you asked for a blanket, the staff would say there

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F 584	Continued From page 6	F 584		

were no blankets." The surveyor asked for the linen PAR (amount of linen the unit required to have for care of the residents). There were no blankets in the clean utility room to offer to the resident, but the facility had enough blankets in the laundry room. The resident was provided with a blanket that same day.

On 11/09/22 at 10:02 AM, the surveyor observed Room [redacted] with one urinal on the floor and two [redacted] on the bed rails with [redacted] in them. Observations also revealed black substance splattered on the wall, holes on the wall, and food debris and clothing on the floor.

Observation of Room #338 at 10:27 AM, revealed a heating and cooling unit covered with blankets. The resident indicated that the unit was not working, and he/she informed the staff. The Temperature in the room read 61.9 F. The resident room temperatures for LTC facilities should be maintained between 71-81 F for the comfort and well-being of the residents.

Observation of Room #342 at 11:35 AM, revealed a glass window broken in multiple areas being held in place with tape. At that time, the surveyor interviewed the resident who revealed that the window had been broken for months but could not provide a specific date. A review of the Maintenance log for the last 3 months failed to address the broken window. The surveyor also observed that the heating and cooling unit of Room [redacted] was stacked with towels, the exposed filter was covered with dust, and the unit base was very rusty.

Observation of Room [redacted] at 12:30 PM, revealed a broken light fixture and clogged toilet

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F 584	Continued From page 7	F 584		

in the bathroom. The resident stated that he/she reported the concern since yesterday and had not been addressed.

On 11/10/22 at 10:10 AM, the surveyor revisited the [redacted] Unit only to observe that the above concerns were not addressed. The heating and the cooling units were still stacked with towels, sheets, and large amounts of debris.

On 11/10/22 at 10:30 AM, during an interview with the surveyor, the resident in Room # [redacted] revealed that the cooling and the heating unit was leaking, and the facility's staff stacked the units with sheets and blankets to stop the water leakage.

On 11/10/22 at 11:03 AM, the surveyor accompanied the Maintenance Director and the Regional Nurse to the [redacted] Units where we all witnessed the same pile of towels and sheets inside the heating and the cooling units.

On 11/10/22 at 11:30 AM, during an interview with the surveyor, the Maintenance Director stated that he was just hired by the facility and had not prioritized the concerns that needed to be addressed immediately. He added that he had never seen something like the towels and sheets stacked in the heating and cooling units before. He further stated that it would be a concern that needed to be addressed immediately.

On 11/14/22 at 9:50 AM, the surveyor entered Room [redacted] and observed large amounts of debris on the floor. The resident told the surveyor there was no housekeeping service for the weekend. An interview with the housekeeping staff assigned to the floor that day, revealed she

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F 584	Continued From page 8 was off for the weekend and could not comment why the rooms were not cleaned. On 11/14/22 at 10:10 AM, the surveyor interviewed the Housekeeping Director (HD) who stated that staff were scheduled to work and could not explain why the rooms we not being cleaned. The surveyor toured the units with the HD and noted some curtains visibly soiled and stained. The surveyor and HD observed Rooms # [redacted], # [redacted] and # [redacted] with stained flooring and large amounts of debris. On 11/16/22 at 11:20 AM, a family member walked in the room and informed the surveyor that she visited on [redacted] evening and informed the staff that the room needed to be cleaned. The family member was very upset that the room had not been cleaned and wanted the issue to be addressed. On 11/16/22 at 11:40 AM, the surveyor accompanied the HD to the room where we both previously had observed large amounts of debris on the floor. The HD stated that she would clean the room. The HD stated that staff were expected to clean resident's rooms and common areas daily and follow a cleaning schedule. The HD confirmed that the work performance was poor, and she would have to follow up with some disciplinary actions. On 11/16/22 at 11:30 AM, the surveyor observed Room # 318 with brownish stains on the flooring. The bed linen was visibly soiled with food particles. The housekeeper on the unit stated the bed linen was in the same condition yesterday and she alerted the staff after cleaning the floor.	F 584		

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F 584	Continued From page 9 On 11/16/22 at 12:30 PM, the above issues were again discussed with the HD. She stated that she would clean and buffer the rooms today. She further added she developed a schedule for the curtains to be replaced and or cleaned. On 11/23/22 at 12:30 PM, the Regional Administrator stated that a plan was developed to address the above concerns. NJAC 8:39-4.1 (a)	F 584		
F 658 SS=E	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 pertinent documents, it was determined that the facility failed to a.) apply physician ordered interventions that the staff signed as administered for Resident #105, 1 of 4 residents reviewed for [redacted] treatments, and b.) administer medication with food as prescribed by the physician and improperly dispose of non-administered medication, for Resident #105 and an unsampled resident during medication administration observation. The evidence was as follows. a.) On 11/15/22 at 9:04 AM, Surveyor #2 observed Resident #105 lying in bed on his/her [redacted] with both [redacted] in direct contact with the [redacted] Surveyor #2 observed there were no [redacted]	F 658	I. Immediate Action A. 1) Resident #105 was assessed by the RN to determine if any harm came to the resident for not having the [redacted] applied while in bed. The resident was reapproached and [redacted] medications were administered. No change in condition noted. 2) LPN #2 was reinserviced on the importance of following doctor's order and proper procedure and steps to follow when [redacted] devices are not available and timely notification of the unit manager. 3. [redacted] were obtained	1/19/23

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F 658	Continued From page 10 [redacted] on the resident and no [redacted] of the resident's [redacted] A review of Resident #105's medical records revealed the following: An Admission Record revealed he/she was admitted with diagnoses which included but were not limited to [redacted]. An Order Summary Report which included the following orders: dated [redacted] 1 to apply [redacted] in the morning and remove at bedtime; dated 1 [redacted] while at rest every shift; dated [redacted] every shift check placement; dated [redacted] when in bed every shift; dated [redacted] every shift; and dated [redacted] [redacted] on when in bed every shift. The ongoing Care Plan (CP) revealed a focus area dated [redacted] 1, [redacted] to [redacted]) related to [redacted] and [redacted]. The goal revealed resident's [redacted] will improve and heal as evidenced by closure within the next review date, and the [redacted] will improve and heal as evidence by closure. Interventions included but were not limited to position resident off affected area and [redacted] [redacted] when in bed. Another focus area undated, potential for [redacted] secondary to [redacted], [redacted]	F 658	immediately and applied to resident's [redacted] The resident was evaluated and it was determined the ace wrap was no longer necessary and the order was discontinued. 4. Assigned staff were in-serviced on resident #105 plan of care to include [redacted] of resident's [redacted] through use of [redacted]. 5. The C.N.A. accountability record was updated to include the use of [redacted] while in bed. B. 1) Resident #105 was assessed by RN to determine if any harm came to the resident for not receiving the medication with food. No change in condition noted. 2) LPN #2 was reeducated on importance of reading the entire doctor's order and giving medications according to the MD order. LPN #2 demonstrated understanding of the same. 3) LPN #2 was reeducated on the facility's policy and procedure on proper disposal of medication using the "drug buster" for disposal of all medications. 4) LPN#2 was also counseled, reviewed job description, duties, responsibilities and expectations of a nurse were reviewed with her. II. Identification of others: A. 1) An audit will be conducted for all residents with orders for [redacted] or [redacted] devices to determine if the physician's orders were being followed and if devices were available. 2) If any devices are missing, they will be	

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F 658	Continued From page 11 [redacted]. The goal revealed Resident #105 would have care needs met as evidenced by no[redacted]. Interventions included but were not limited to[redacted] devices on bed and wheelchair. The quarterly Minimum Data Set (MDS an assessment tool) dated[redacted] revealed Resident #105 had a Brief Interview for Mental Status (BIMS) of[redacted] indicating the resident was[redacted]. [redacted], indicated the resident has not exhibited any behaviors of rejection of care. [redacted], Functional Status, indicated Resident #105 required extensive assistance of at least one staff member for dressing which included putting on and removing items.[redacted] Conditions, revealed[redacted] for bed in use and application of[redacted]. The Treatment Administration Record (TAR) dated up to[redacted] revealed the Licensed Practical Nurse (LPN) #2 caring for Resident #105 had signed off as administered, the [redacted]] and the[redacted] [redacted] on[redacted] and[redacted]. On 11/15/22 at 9:21 AM, during an interview with Surveyor #2, Resident #105 was asked about the [redacted] on his/her[redacted] and if he/she was ever provided with[redacted]. Resident #105 stated that the staff never puts[redacted] him/her or[redacted] for under his/her[redacted] On 11/16/22 at 8:00 AM, during an interview with Surveyor #2, LPN #2 who had been caring for the resident, stated the resident would be seen by [redacted] care weekly. LPN #2 stated the nurses	F 658	replaced immediately. 3) All negative findings to be reported to the Administrator, Director of Nursing, and the resident's Primary Care Physician. 4) An immediate reeducation will be given to any nurse who failed to ensure that the plan of care has been followed. B. 1) An audit was conducted for all residents with orders for medications to be given with food to ensure that the medication has been given in accordance with the physician's order and at the proper time. 2) Facility-wide in-services will be conducted by the staff educator to ensure all nurses are aware of facility's policy and procedure on the proper reading of MD orders, to ensure the 5 rights of medication administrator including but not limited to the right medication, to the right resident, in the right dosage, at the right time by the right route. This also includes the proper disposal of medications utilizing the "drug buster" container. III. System Changes a) The Policies and Procedures on Medication Administration and Medication disposal systems were reviewed by the Administrator, Director of Nursing, and Medical Director and no revisions were necessary. IV: Quality Assurance A.	

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F 658	Continued From page 12 would do [redacted]. When asked about any other interventions required for Resident #105's [redacted], LPN #2 stated there was nothing else to be done for the [redacted] on his/her [redacted] LPN #2 stated that all orders wound show up on the Medication Administration Record (MAR) or the TAR in the electronic medical records in the computer. On 11/16/22 at 10:03 AM, Surveyor #2 observed Resident #105 sleeping in bed. Surveyor #2 observed no [redacted] had been applied, no [redacted] were applied, and [redacted] was done. Resident #105's [redacted] were lying directly on the bed. Surveyor #2 observed there were no [redacted] visible in the room and no extra pillow available for [redacted] the [redacted] On 11/18/22 at 10:10 AM, Surveyor #2 observed Resident #105 in bed with his/her [redacted] on the side of the bed. Surveyor #2 observed no [redacted] on the resident. Again the surveyor observed there were no [redacted] available for [redacted] g the [redacted] On 11/18/22 at 11:27 AM, Surveyor #2 reviewed the CNA tasks in the electronic medical system. There were no interventions listed for the CNAs to apply the [redacted] or to [redacted] the resident's heels/feet. On 11/18/22 at 12:02 PM, during an interview with Surveyor #2, the Director of Nursing (DON) stated the resident should always have [redacted] or [redacted] applied while in bed. The DON stated that the application of the [redacted] and the [redacted] would be documented in the MAR. The DON further stated if the resident	F 658	1) Audits will be conducted by Director of Nursing/Assistant Director of Nursing/Unit Manager/Designee on all residents with orders for [redacted] and [redacted] devices to ensure availability of devices, compliance with doctor's orders and residents' plan of care weekly x4, monthly x2, and quarterly x 4. 2) Any missing devices will be replaced immediately. 3) All negative findings will be brought to the Director of Nursing and Administrator for immediate correction. 4) Results of all audits will be brought to Quality Assurance and Performance Improvement committee quarterly x 4 quarters B. 1) Audits will be conducted by the / Director of Nursing/Assistant Director of Nursing Unit Manager/Designee on all residents with orders for medication to be administered with food to ensure that established parameters are being followed weekly x4, monthly x2, and quarterly x4 quarters. 2) Any nurse found not to be following the MD orders as written will be re inserviced and will receive disciplinary counseling. 3) All negative findings will be brought to the Director of Nursing for immediate correction. 4) Results of all audits will be brought to Quality Assurance and Performance Improvement committee quarterly x4 quarters. IV. Person responsible: Director of	

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refused, she would expect to see that documentation in the MAR or TAR as well as documentation that the doctor was notified of any refusal of treatment or medication.

On 11/18/22 at 12:40 PM, Surveyor #2 observed Resident #105 awake lying in bed with both [redacted] directly on the bed with [redacted], [redacted] and [redacted] applied. The surveyor asked Resident #105 if he/she had any [redacted] that were put on his/her [redacted] to keep his/her [redacted]. Resident #105 stated, "nobody ever gives me anything like that." The surveyor observed the resident's room and did not see any [redacted] Resident #105 stated that he/she didn't have any.

On 11/21/22 at 9:24 AM, the surveyor observed Resident #105 sitting on the side of the bed with his/her [redacted] over the side of the bed by the floor. The surveyor observed [redacted] on [redacted], but [redacted] or [redacted].

On 11/21/22 at 11:01 AM, Surveyor #2 observed Resident #105 lying in bed asleep with his/her [redacted] directly on the [redacted]. The resident did not have [redacted] applied and his/her [redacted] were not [redacted] The surveyor observed the room and could not locate any [redacted] or extra [redacted].

On 11/21/22 at 11:04 AM, Surveyor #2 asked LPN #2 to access Resident #105's orders. Surveyor #2 and LPN #2 reviewed the orders, and LPN #2 acknowledged the order for [redacted] [redacted], [redacted], and to [redacted] LPN #2 and Surveyor #2 went to Resident #105's room and observed [redacted], [redacted] and no [redacted] of the resident's

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F 658	Continued From page 14 [redacted] t. LPN #2 acknowledged that the [redacted] were not in the resident's room. On 11/21/22 at 11:07 AM, Resident #105 informed LPN #2 and Surveyor #2 that the [redacted] had been gone for months and he/she never got them back. Resident #105 could not recall who took the [redacted] or the exact date they were taken but that it was "months ago". On 11/21/22 at 11:10 AM, in the presence of Surveyor #2, LPN #2 reviewed the physician orders and acknowledged she had not been applying the [redacted] to Resident #105. LPN #2 stated she should not have been signing off that she had applied the [redacted] and [redacted]. LPN #2 stated that without the [redacted] the resident's [redacted] more. LPN #2 further stated that Resident #105's [redacted] could get [redacted] was not applied. LPN #2 stated she would need to reorder and replace immediately "the supplies he/she should have had." LPN #2 acknowledged again that she had been signing off the [redacted] [redacted] of the resident's [redacted] without having had applied them. LPN #2 stated that the resident had not refused any treatments. On 11/21/22 at 11:17 AM, during an interview with Surveyor #2, the DON stated if a resident had orders for [redacted], and [redacted] and they were not applied, they should not be signed as done. The DON stated Resident #105's [redacted] could become worse without the ordered treatments. The DON stated the [redacted] floor did not have a unit manager but there was an Assistant Director of Nursing (ADON) who	F 658		

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F 658	Continued From page 15 should have been monitoring. A review of the facility provided, "Licensed Practical Nurse Job Description" undated, included but was not limited to purpose: to provide direct nursing care to the residents. Nursing Care Functions: review the resident's chart for specific treatments, etc, and administer professional services. A review of the facility provided, "Documentation in the EMR (electronic medical record)" dated [redacted] included but was not limited to purpose: ....to ensure residents receive appropriate medical care with appropriate documentation. Documentation about treatments received will be located in the TAR. This will include the treatment ordered, frequency and location to administer treatment as well as the date/time administered and who performed the treatment. On 11/22/22, the above concerns were addressed with the facility administration. On 11/23/22, the facility administration had informed Surveyor #2 that LPN #2 had been in-serviced. b.) On 11/16/22 at 7:51 AM, during medication administration observation on the [redacted] floor, Surveyor #2 observed LPN #2 as she prepared two medications to administer to Resident #105. LPN #2 reviewed the orders and poured one [redacted] milligrams (mg) tablet, give 1 tablet by mouth one time a day; and one [redacted] (used to [redacted] g, give 1 tablet by mouth one time a day .....give with food. LPN #2 entered Resident #105's room with the pills and water. Surveyor #2 observed that there	F 658		

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was no breakfast tray in the room, no visible food, and LPN #2 did not offer any food. LPN #2 handed Resident #105 the cup with the two pills. Resident #105 stated, "I take my medicine with food. I can't take that now." LPN #2 exited the room with the medications and discarded the two pills into the sharp's container (a hard plastic container to put sharp items in) on the side of the medication cart.

A review of the Admission Record revealed Resident #105 was admitted with diagnoses which included but was not limited to [redacted]

A review of Resident #105's, Order Summary Report included an order dated 09/14/21 for [redacted] mg give 1 tablet by mouth one time a day for [redacted]). An order dated [redacted] for [redacted] tablet [redacted] mg give 1 tablet by mouth one time a day for [redacted] Give with food.

A review of the Care Plan included a focus area, undated, "has [redacted] and is on [redacted] The Interventions included to give the medication as ordered.

On 11/16/22 at 7:56 AM, Surveyor #2 observed LPN #2 prepare medications for an unsampled resident. LPN #2 reviewed the order for [redacted] tablet [redacted] give 1 tablet by mouth two times a day ... ...with food. LPN #2 dropped the tablet onto the medication cart. She picked up the pill and discarded it into the sharp's container on the side of the medication cart. LPN #2 poured the [redacted] and three

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additional medications into the medication cup. LPN #2 entered the resident's room with the pills and water, handed the resident the medications, and observed the resident swallow the pills. Surveyor #2 observed there was no breakfast tray in the room, no visible food in the room, and LPN #2 did not offer any food. Surveyor #2 inquired about when the breakfast trays would be delivered. LPN #2 stated the breakfast trays usually arrive about 8:00 AM.

A review of the Admission Record revealed the unsampled resident was admitted with diagnoses which included but were not limited to [redacted].

A review of the Order Summary Report included an order dated [redacted] for [redacted] mg give 1 tablet by mouth two times a day for [redacted] "GIVE WITH FOOD".

On 11/16/22 at 8:24 AM, Surveyor #2 observed the carts with the breakfast trays arrived on the unit and the staff were beginning to hand them out to the residents.

On 11/16/22 at 8:25 AM, during an interview with Surveyor #2, LPN #2 stated it was the facility policy to dispose of unused medications in the sharp's container. LPN #2 stated she had no reason why she did not bring in food to offer since the breakfast trays were not there yet. LPN #2 stated that the purpose of some medications being taken with food was to coat the resident's stomach.

On 11/16/22 at 8:31 AM, during an interview with Surveyor #2, the uncertified Infection Preventionist Registered Nurse (UIP/RN) stated

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that if medication was ordered to be given with food, the nurse should administer the medication when breakfast was served or provide milk, or cookies, or crackers to coat the stomach.

On 11/16/22 at 11:47 AM, during an interview with Surveyor #2, the DON stated that there was a pill buster in each medication cart to be used for the destruction of unused medications.

On 11/18/22 at 12:01 PM, Surveyor #2 asked the DON what the facility policy was on medication destruction. The DON stated the facility provided disposal system referred to the "drugbuster" container in the medication carts.

On 11/21/22 at 9:16 AM, during an interview with Surveyor #2, LPN #3 stated if a medication was not administered it would be placed in the drug buster. LPN #3 showed Surveyor #2 the drug buster located in the medication cart.

On 11/21/22 at 9:19 AM, during an interview with Surveyor #2, LPN #4 stated medications not given but poured, would be discarded in the drug buster. LPN #4 stated the medication should not be discarded anywhere else because someone could see it and take it.

A review of the facility provided, "Licensed Practical Nurse Job Description" undated, included but was not limited to purpose: to provide direct nursing care to the residents. Drug Administration Function: prepare and administer medications as ordered by the physician. Dispose of drugs and narcotics as required, and in accordance with established procedures.

A review of the facility provided medication pass

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F 658	Continued From page 19 observation for LPN #2, dated 08/02/22, included but was not limited to reviewing medication orders, medication pass oral medications, and documentation nurses notes; use the documentation guidelines for charting. All three tasks were signed off as having been demonstrated to the RN on 08/02/22 and that LPN #2 had successfully completed the skills and was able to work independently. A review of the facility provided, "Medication Administration and Documentation Policies, Procedures & Information' dated 07/01/22, included but was not limited to policy: 4. The Electronic Medication Administration Record (EMAR) is the form which all medication orders are transcribed .....from which medications are poured and administered ... ...; procedure: 1. Ensures all equipment is clean and organized, and adequate supplies are available. A review of the facility provided, "Medication Disposal/Destruction" dated 08/13/22, included but was not limited to procedure: A. 2. Non-controlled medications may be destroyed by licensed nurse employed by the facility as per state regulations. C. 1. ... ...the nurse will place refused medication in the facility provided disposal system. A review of the facility provided, "Sharps Containers" dated 07/13/22, included but was not limited to Policy: ... .to ensure sharps containers are used for the disposal of all sharps .....General Information: Only sharps should be disposed in the sharps containers. NJAC 8:39-27.1(a)	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		1/19/23

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F 677	Continued From page 20 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documents, it was determined that the facility failed to provide appropriate care for resident's who were dependent on staff to provide Activity of Daily Living (ADL) care. This deficient practice occurred for 4 of 4 dependent residents (Resident #49, #34 and #101 and #114) and on two of four resident care units ([redacted] and [redacted] floor) reviewed for ADL care and was evidenced by the following: 1. On 11/07/22 at 10:15 AM, the surveyor toured the [redacted] Unit of the facility and observed Resident #49 in bed with the head of the bed elevated, and was facing the door, and both [redacted] rested directly on the [redacted], and eyes were closed. The [redacted] were observed as [redacted] d, and contained a [redacted] substance underneath all of the [redacted]. The [redacted] and [redacted] were covered with [redacted]. When inquired about the resident's status to the Certified Nursing Assistant (CNA) observed in the resident's room at the time, the CNA stated, "All [he/she] does was sleeping all day". On 11/07/22 at 11:30 AM, the surveyor returned to the room and observed Resident #49 in bed and was facing the door and his/her eyes were closed. The [redacted] remained [redacted] with a [redacted] and the [redacted] was still present.	F 677	I. Immediate Action The following pertains to residents #49, #34, #101 and #114 a) Residents' [redacted] were [redacted] and [redacted] b) Residents' facial hair was shaved c) Reinserviced CNAs on proper turning and repositioning of residents while in bed and timeliness of meal set-up on d) Unit Manager was reinserviced on unit rounds to ensure proper resident ADL care is checked to include [redacted] check, [redacted] e) Resident #114's call bell was replaced and checked for proper function f) Reinserviced Unit Manager and CNAs on proper ADL care provided for all residents g) Resident's care provided by CNAs is documented on the EMR instead of the book on the unit II. Identification of others: a) All residents have the potential to be affected by the deficient practice. b) An audit will be completed by the Assistant Director of Nursing/Unit Managers for all residents to ensure that [redacted] has been provided appropriately for all residents which include [redacted] and [redacted] and [redacted].	

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F 677	Continued From page 21 On 11/07/22 at 11:45 AM the surveyor returned to the 300's unit and observed the lunch meal. The lunch cart arrived on the floor at 11:50 AM. Resident #49 remained in bed in the same position as the surveyor observed one and one-half hours later. The surveyor went to the room at 12:05 PM, and Resident #49 was still sleeping in the same position. Observations on 11/07/22 at 12:15 PM, revealed Resident #49 was in bed. His/her lunch tray was behind the door on the bedside table, and the meal tray was not set up and Resident #49 could not access the tray. On 11/07/22 at 2:03 PM, Resident #49 was still in bed, ADL (Including, but not limited to the following [redacted] care was not provided, remained and [redacted] substance was still present [redacted] On 11/09/22 at 11:30 AM, the surveyor reviewed Resident #49's electronic medical record. According to the admission Face Sheet, Resident #49 had diagnoses which included, but were not limited to, [redacted]. Review of the most recent Annual Minimum Data Set (an assessment tool), dated [redacted] revealed that Resident #49 was [redacted] for daily [redacted] and required assistance with most activities of daily living.	F 677	c) Audits will be conducted on all units for residents on Turning and Positioning every 2 hours to ensure residents are being turned and positioned as per order. d) Any resident who is not repositioned properly will be immediately repositioned e) An immediate reeducation will be given to any CNAs who did not follow the residents plan of care. f) All negative findings will be reported to the Director of Nursing for immediate correction III. System Changes a) The Policies and Procedures on ADL care was reviewed by the Administrator and the Director of Nursing and no revision needed. IV: Quality Assurance a) An audit tool was created to be utilized on unit manager rounds related to ADL care b) Audits will be conducted by the Director of Nursing/Assistant Director of Nursing/Unit Manager/Designee on all residents to ensure [redacted] are provide as per policy weekly x 4, monthly x 2, and quarterly x 4. c) All negative findings will be brought to the Director of Nursing for immediate correction. d) Results of all audits will be brought to Quality Assurance Performance Improvement committee quarterly x 4 quarters. IV. Person responsible: Director of Nursing	

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F 677	Continued From page 22 Review of Resident #49's Care Plan (CP) dated 05/2019 revealed he/she was care planned for ADL/self care performance deficit related to dementia. The goal was for Resident #49 to improve current level of function in [redacted] The interventions included the resident required staff participation to use toilet, requires staff participation with transfers, oral hygiene and personal care. Required supervision to turn and reposition, required setup and assistance with meals. On 11/09/22 at 11:30 AM, the surveyor interviewed the CNA responsible for providing care to Resident #49 during the 7:00 AM to 3:00 PM shift. The CNA stated that Resident #49 was totally dependent on staff for care, had not been able to feed self and could not ambulate. The CNA further stated Resident #49 had an [redacted] that had been cared for by the nurse. Resident #49's [redacted] were not [redacted]. [redacted] remained present on the [redacted], and the [redacted] after morning care was completed. On 11/10/22 at 9:15 AM, the surveyor observed Resident #49 in bed laying on the backside. Resident #49 had remained in bed in the same position during the morning shift. The surveyor asked the CNA to check Resident #49's [redacted], the [redacted] was [redacted]. The CNA stated that she had not provided care yet to the resident. On 11/10/22 at 11:10 AM, the surveyor interviewed the Licensed Practical Nurse /Unit Manager regarding ADL care for dependent residents. The UM stated that [redacted] was	F 677		

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completed every [redacted] and there was a reminder on the daily assignment to complete nail care. The surveyor reviewed the daily assignment with the UM, there was no notation regarding nail care. The surveyor then asked the UM how she supervised the care provided by the staff to the residents. The UM stated she knew the staff and she "trusted them." The surveyor then accompanied the UM to Resident #49, #34 and 101's Room, where we both the surveyor and UM observed that [redacted] had not been provided. The resident's [redacted] were [redacted] and had a [redacted] embedded from [redacted].

On 11/10/22 at 12:15 PM, the UM stated she attempted to [redacted] the resident on [redacted] but the resident refused. The surveyor asked the UM to provide the documentation where Resident #49 refused care. She could not provide the surveyor with any documented evidence to support the resident's refusal.

On 11/10/22 at 1:30 PM, the UM provided a note dated [redacted], that she confirmed she had as a late entry after the surveyor's inquiry. The Progress Notes revealed: "Attempted to [redacted], resident was [redacted]. The surveyor accompanied the UM and the Regional Nurse to Resident #49's room where we all observed that Resident #49's [redacted] remained [redacted]

2. Resident #34 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]

On 11/07/22 at 10:25 AM, the surveyor observed

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Resident #34 lying in bed with the eyes closed. The head of the bed was elevated. The [redacted] were noted to be [redacted].

On 11/09/22 at 09:50 AM, the surveyor observed Resident #34 in bed with the head of the bed elevated. The [redacted] with a [redacted] the [redacted]. The [redacted] of the [redacted] were [redacted] into the [redacted] of the [redacted]. The surveyor observed a [redacted] placed to the [redacted].

On 11/10/22 at 09:30 AM, the surveyor observed Resident #34 in a [redacted] by the bed, eyes closed, Resident #49 did not initiate conversation and did not respond to the surveyor's greetings.

On 11/10/22 at 11:00 AM, the surveyor interviewed the CNA who cared for Resident #34. The CNA stated that Resident #34 was [redacted] and was totally dependent on staff for all activities of daily living. The CNA also stated that Resident #34 got out of the bed daily. The surveyor asked the CNA to open Resident #34's [redacted], the [redacted], and a [redacted] was noted when the [redacted] was opened.

On 11/10/22 at 11:50 AM, the surveyor accompanied the UM to Resident #34's room where we both observed all of Resident #34's [redacted] were [redacted] and there was a [redacted] the [redacted]

On 11/10/22 at 12:30 PM, review of the most recent Quarterly Minimum Data Set (MDS) dated [redacted] revealed that Resident #34 was [redacted] Resident #34 scored [redacted] on the Brief Interview for Mental

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F 677	Continued From page 25 Status (BIMS). [redacted] of the MDS which referred to Activities of daily living, Resident #34 was coded as [redacted] indicative of [redacted] with [redacted]. Review of Resident #34's care plan dated [redacted] revealed that Resident #34 was not care planned for activities of daily living. Resident #34's care plan addressed the following concern: Resident #34 has a [redacted] of pulling out his/her [redacted] and [redacted] [redacted] f related to [redacted]. The goal was for Resident #34 will have fewer episodes of that behavior by review date (not specified). The interventions included to anticipate and meet needs. Document behaviors, and resident response to interventions. [redacted] his/her [redacted] on a daily basis. The surveyor observed Resident #34 on 11/07/22 10:25 AM, 11/09/22 at 9:50, and 11/10/22 at 9:30 AM. During all three observations, the surveyor observed the [redacted] were all [redacted]. On 11/14/22 at 12:50 PM, the surveyor again interviewed the UM regarding care for dependent residents. The UM stated that the CNA and nurses were to check the [redacted] during shower day and a general assessment was to be completed. The surveyor requested the shower log for review. On 11/14/22 at 1:15 PM, the lead CNA provided the shower log for review, and the surveyor observed that the shower log had not been filled out consistently. Resident #34 most recently completed shower log, which included the daily [redacted] assessment, for [redacted] was not completed.	F 677		

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The Treatment Administration Record (TAR) was signed off and indicated that the [redacted] was performed every [redacted] on the 7:00 AM-3:00 PM shift. The UM did not have any comment.

3. On 11/07/22 at 11:10 AM, the surveyor observed Resident #101 in bed. The head of the bed was slightly elevated. Resident #101 did not initiate conversation but smile when asked questions. Resident #101 was noted with [redacted] around [redacted]. The [redacted] were observed as [redacted].

On 11/09/22 at 8:41 AM, the surveyor observed Resident #101 in bed eating breakfast, the [redacted] were [redacted].

11/09/22 at 10:46 AM, the surveyor returned to the room after care was provided and observed the [redacted] remained [redacted] with a [redacted] the [redacted].

On 11/09/22 at 11:30 AM, the surveyor reviewed Resident #101's electronic medical record. The Admission Face Sheet reflected that Resident #101 had diagnoses which included, but were not limited to, [redacted]

Review of the the most Quarterly Minimum Data Set (MDS) dated [redacted], revealed that Resident #101 was [redacted]. Resident #101 received a score of [redacted] on the Brief Interview for Mental Status (BIMS) indicative of [redacted].

Section E 0008 of the MDS which addressed

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F 677	Continued From page 27 rejection of care was coded with a [redacted] value, indicative of compliance with care. Review of Resident #101's undated Care Plan provided by the facility revealed a care plan for ADL self care performance deficit related to decrease mobility. The goal was for Resident #101 to improve current level of function in bed mobility, transfers eating, dressing, toilet use and personal hygiene. The interventions included praise all efforts at self care. Encourage to participate to the fullest extent possible with each interaction. Monitor, document report to MD PRN [physician as needed] any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. On 11/10/22 at 11:45 AM, the surveyor accompanied the UM to the room where we both observed that [redacted] had not been addressed. Resident #101's [redacted] were not [redacted]. Resident #101 did not have a [redacted] completed in the shower log to indicate the last time [redacted] assessment included [redacted] were last performed. The UM informed the surveyor that resident's care was documented on the Kiosk (Computer system located in the hallway for direct care staff to document care) . On 11/10/22 at 2:00 PM, the Regional nurse accompanied the surveyor and the CNA to the computer to view the care performed for the resident. In the presence of the Regional Nurse, the CNA was unable to show where she documented the care for Resident #101. On 11/14/22 at 12:00 PM, the surveyor observed Resident #101 out of the bed for the first time	F 677		

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during the survey. An interview with the CNA who cared for Resident #101 revealed that Resident #101 was dependent on staff for care, and had no behavior.

On 11/14/22 at 12:15 PM, the surveyor reviewed the Physician Progress notes and noted an order for [redacted] assessment on the day shift for [redacted] Also noted was an order for [redacted] with [a brand name [redacted] frequency not specified.) The surveyor observed Resident #101 in bed on 11/07, 11/09 and 11/10/22. The surveyor observed Resident #101 out of the bed for the first time on 11/14/22.

On 11/14/22 at 12:50 PM, An interview with the UM regarding Resident #101's care revealed that the CNA and nurses were to check the [redacted] and [redacted] and performed a general assessment on shower day. The surveyor then asked the UM to elaborate on her day. The UM stated, she made rounds, greeted the residents, took care of appointments, checked the assignment, reviewed 24 report, checked the medication carts, attending meeting and made any follow up. The UM did not include following up on resident care to be provided by the staff and she was not aware that [redacted] had not been provided during her rounds.

On 11/15/22 at 1:30 PM, the surveyor interviewed the CNA who cared for Resident #101 on 11/7, 11/09 and 11/10/22. The CNA stated that Resident #101's [brand name [redacted] pad was soiled and had to be sent to the laundry for cleaning. The CNA stated that Resident #101 had only one [brand name [redacted], and she was unable to get Resident #101 out of the bed.

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F 677	Continued From page 29 On 11/21/22 at 11:03 AM, the surveyor observed Resident #101 sitting in the room. [redacted] noted on [redacted] was still visible. The surveyor informed the UM and she replied that she was not aware that Resident #101 was [redacted] On 11/22/22 at 09:02 AM the surveyor interview a random CNA assigned to the [redacted] Unit [redacted] side. The CNA stated it was not on the assignment to provide shaving care for residents. On 11/07/22 at 11:45 AM, the surveyor observed Resident #114 in a wheelchair in their room watching television on the roommate's side of the room. The surveyor observed there was no call bell in the resident's reach. The surveyor asked the resident about using the call bell and Resident #114 stated, "I don't even know if it works, and when they come, they come, and I cannot say on time". The surveyor reviewed the electronic medical record for Resident #114 which revealed: The Admission Record revealed diagnoses which included, but were not limited to, [redacted] The quarterly minimum data set, dated [redacted], revealed the resident scored [redacted] on the Brief Interview for Mental Status which indicated a [redacted]n. The [redacted] revealed the resident was totally dependent on one person for toileting. [redacted] revealed the resident was always [redacted]r. The resident had a Care Plan focus for [redacted], Initiated [redacted], with a goal to have less than [redacted] episodes per day, Date initiated: 02/11/22 with a Target Date:	F 677		

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F 677	Continued From page 30 11/11/22. The resident had an ADL self-care performance deficit due to [redacted] post hospitalization care plan. The Goal was to improve current level of function in ...toilet use ...Target Date: 11/11/22, Interventions included Toilet Use: totally dependent on staff for toilet use. On 11/16/22 at 7:59 AM, the surveyor observed Resident #114 awake in bed, the call bell was not attached to the wall. The Certified Nurse Aide (CNA) assigned to Resident #114 was in the room and asked about the call bell and he stated, "it is not there". The surveyor inquired to the CNA how many [redacted] should be used on residents, and he stated one. When asked if he had ever found [redacted] on residents, he confirmed he has. On 11/16/22 at 8:06 AM, the surveyor asked Resident #114 how many [redacted] the staff had put on him/her and the Resident stated, [redacted] at that time the CNA stated he was looking for the linen. On 11/16/22, at 8:14 AM, the CNA went to the room to complete [redacted] care on Resident #114. The surveyor inquired to the CNA to confirm how many [redacted] the resident was wearing. The CNA proceeded to show the surveyor the corners of [redacted] and confirmed resident #114 was wearing [redacted] On 11/16/22 at 8:22 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who was overseeing the unit at that time, regarding how many [redacted] should be on a resident. The ADON stated "one", the ADON accompanied the	F 677		

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surveyor to Resident #114's room and asked the CNA how many [redacted] were on the resident. The CNA stated [redacted]. The surveyor also inquired about the resident's call light and stated, "oh yeah", and confirmed there was no call light attached to the wall.

On 11/16/22 at 8:31 AM, the surveyor requested the ADL policy, and any training related to how many briefs should be used on a resident. The ADON stated, "I know the night staff is doing it" (using [redacted]).

On 11/16/22 at 12:00 PM, the Director of Nursing provided a copy of an ADL inservice Dated [redacted]. The summary of Presentation revealed: all CNA's when doing [redacted] and resident [redacted] should follow the protocol to do changing. [redacted] every two hours or as needed. Note: [redacted] Application at all, this is strictly a must!!

On 11/22/22 the surveyor reviewed the facility's ADLs policy dated 07/09/07 and last revised 08/14/22.

The policy read, "It it the policy of the facility to provide ADL care to all residents based on assessment of needs. ADL care consist of but it is not limited to:
Bathing
Dressing
Eating
Transfers
Toileting
Bed Mobility
Nail Care
Foot care.
Purpose: To ensure all resident's needs are met.

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F 677	Continued From page 32 Responsibility Licensed Nurse : Assesses resident to determine ADL needs. Completes instructions to reflect residents needs for all aspects of ADL care. CNA reviews nursing instructions for each resident before providing care. Provides care and assistance with care in accordance with the nursing instructions (plan of care) Reviews the shower schedule to ensure that shower is given on designated day as scheduled". On 11/22/22 at 1:30 PM, during the pre-exit conference the DON stated it was her expectation that dependent residents be provided with ADL,s care.	F 677		
F 684 SS=E	NJAC 8:39-27.2 (g) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to: a.) ensure that medications were administered in accordance with the physician order for 6	F 684	I. Immediate Action A. 1a. Residents #3 was assessed by the RN for harm due to missed doses and the physician was made aware. No changes	1/19/23

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F 684	Continued From page 33 residents reviewed (Resident #3, #14, #24, #42, #92, #102) for two days (11/15/22 and 11/16/22), and b.) implement physician ordered interventions for 1 of 1 resident (Resident #105) reviewed for [redacted] concerns. This deficient practice was evidenced by the following: a.) Surveyor #1 conducted a medication Pass Observation on 11/16/22 on the [redacted] Unit of the facility and observed that some of the medications were not available for administration. Resident #3 had diagnoses of [redacted]. Resident #3 had an order for [redacted] to be administered daily for [redacted]. The documentation found on the Medication Administration Record (MAR) reflected that Resident #3 did not receive the [redacted] on 11/15/22 and 11/16/22. Resident #14 had diagnoses of unspecified [redacted]. The Physician Order sheet dated, [redacted], revealed orders for [redacted] (medication to reduce [redacted] mg (milligrams) daily, [redacted] mg [redacted] daily for [redacted] mg daily for [redacted], and [redacted] mg daily for [redacted] Resident 14's medications were not available for administration on 11/15/22 and 11/16/22. Resident #24 had diagnoses of [redacted]. Resident #24 did not receive the following medications for 2 days: [redacted] mg daily, [redacted] mg daily, and [redacted] (medication to [redacted]) [redacted] mg daily.	F 684	in condition noted 1b. Resident #14 was assessed by the RN for harm due to missed doses and the physician was made aware. No changes in condition noted 1c. Resident #24 was assessed by the RN for harm due to missed doses and was made aware. No changes in condition noted 1d. Resident #42 was assessed by the RN for harm due to missed doses and MD was made aware. No changes in condition noted 1e. Resident #94 was assessed by the RN for harm due to missed doses and MD was made aware. No changes in condition noted 1f. Resident #102 were assessed by the RN for harm due to missed doses and MD was made aware. No changes in condition noted harm due to missed doses and MD was made aware. No changes in condition noted 2) An investigation was completed, and MD notified. 3) Upon identification of unavailable medications, the facility contacted the pharmacy for stat delivery and all medications were delivered on the same day. 4) LPNs were reinserviced on facility□s policy and procedure regarding unavailable medications and timely reordering of medications. B. 1) Resident #105 was assessed by the RN to determine if any harm came to the resident for not having the [redacted] applied while in bed. No change in	

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F 684	Continued From page 34 Resident #42 had diagnoses of [redacted] Resident #42 had an order for [redacted] (a [redacted]) [redacted] mg to be administered [redacted] daily and [redacted] mg to be administered every [redacted] hours for [redacted]. Resident #42 did not receive the [redacted] and the [redacted] on 11/15/22 and 11/16/22. Resident #94 had diagnoses of [redacted]. Resident #94 had a physician order for [redacted] mg to be administered daily for [redacted]. Resident #94 did not receive the medication on 11/15/22. Resident #102 had diagnoses of [redacted] Resident #102 had a Physician Order for [redacted] mg to be administered daily for [redacted] and [redacted] mg daily for [redacted] Resident #102 did not receive these medications on 11/15/22 and 11/16/22. Further review of the Progress Notes revealed that there was no documentation to show that the resident's Physicians were notified that the medications were not available to be administered to the residents. On 11/16/22 at 11:30 AM, Surveyor #1 interviewed the Unit Manager Licensed Practical Nurse (LPN/UM) who administered medications on the [redacted] of the [redacted] Unit on 11/14/22. The LPN/UM stated that she was aware that some of the medications were not available. She further stated that the pharmacy was informed. She was unable to comment on the facility's process to reorder medications.	F 684	condition noted. 2) LPN #2 was reinserviced on the importance of following doctor□s order and what to do when equipment is not available. 3) Facility wide in-service will be conducted on application of [redacted] devices as per MD order and facility protocol. II. Identification of others: A. 4) An audit was completed by the unit managers/designee of all med carts to identify missing medication and ensure timely reordering of refills. a) All negative findings were reported to the Administrator and Director of Nursing for immediate correction. 5) An immediate reeducation was given to any nurse who does not follow policy and procedure on reordering medications. B. 6) An audit was completed unit managers/designee for all residents receiving [redacted] devices to determine if orders were being followed and if devices were available. 7) All negative findings were reported to the Administrator, Director of Nursing, and the residents□ Primary Care Physician. 8) An immediate reeducation was given to any nurse/CNA who did not follow the residents□ plan of care. III. System Changes a) The Policies and Procedures on reordering medication were reviewed by	

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F 684	Continued From page 35 On 11/16/22 at 2:30 PM, Surveyor #1 discussed the above issues with the Director of Nursing (DON). The DON stated that she was made aware that only the medication [redacted] was missing and was not administered. The DON stated that medications should be reordered when 8 doses of medications were left on the Bingo (a medication delivery system) card. The DON stated that she was unsure if all staff were aware of the process. On 11/16/22 at 2:45 PM, the surveyor reviewed the Delivery Order Form from the pharmacy and confirmed with the nurse that the medications were not available to be administered. The Bingo card received from pharmacy after 1:30 PM was untouched. On 11/21/22 at 9:02 AM, during an interview with the DON, who stated that residents were to receive medications according to the a Physician order. The surveyor reviewed the facility's policy titled, " Medication Reordering" dated 04/01/17 last revised 09/15/22. The policy revealed: It is the policy of the facility to reorder medications when supply is running low (2 days prior), Purpose: To ensure that all meds [medications] are available in sufficient quantity to fulfill MD [Physician orders]. Procedure: Individual: Physician/NP 1. Orders medication in the electronic clinical record. Pharmacy: Delivers a 28-day supply of all medications unless ordered for a specific amount of time. Licensed Nurse: Receives medications and verifies appropriate medication. If medication is not received in a timely manner, recalls the pharmacy to obtain estimated delivery time.	F 684	the Administrator, Director of Nursing, and Medical Director and no revision was necessary. b) The policy and procedure for off-loading and positioning devices was reviewed by Administrator and Director of Nursing and no revision was necessary. IV: Quality Assurance A. a) An audit of all med carts will be conducted by the unit managers/designee to ensure that all medications are ordered in a timely fashion weekly x 4, monthly x 2, and quarterly x 4. b) All negative findings will be brought to the Administrator and Director of Nursing for immediate correction. c) Results of all audits will be brought to QAPI committee quarterly x 4. B. a) Audits will be conducted by the unit managers/designee on all residents with orders or off loading and positioning devices to ensure availability of devices and compliance with doctor□s orders and residents□ plan of care weekly x 4, monthly x 2, and quarterly x 4. b) All negative findings will be brought to the Administrator and Director of Nursing for immediate correction. c) Results of all audits will be brought to Quality Assurance Performance Improvement committee x4 quarters V. Person responsible: Director of Nursing	

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Notifies nursing supervisor or manager. Responsibility: Licensed Nurse: If medication is not available for the specific medication, notifies MD/NP to obtain hold order or substitute medication which may be available in emergency stock. Reorders medication from the pharmacy. (The process was not being followed. There was no documented evidence that the physicians were made aware that the above residents did not receive their prescribed medications on 11/15/22 and 11/16/22)

b.) On 11/15/22 at 9:04 AM, Surveyor #2 observed Resident #105 lying in bed on his/her left side. The surveyor observed visibly soiled [redacted] on [redacted], the [redacted] of the [redacted] stuck to it, and both [redacted] were in direct contact with the [redacted]. The surveyor observed there were no [redacted] on the resident, and there was [redacted] of the resident's [redacted] observed.

At that time, Resident #105 stated he/she was not in [redacted] at that time and that his/her [redacted] had been changed yesterday.

A review of Resident #105's medical records revealed the following:

An Admission Record revealed he/she was admitted with diagnoses which included but were not limited to [redacted].

An Order Summary Report which included the

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following orders: dated [redacted] to apply [redacted] ([redacted] to [redacted] from [redacted] in the morning and remove at bedtime; dated 1[redacted] to [redacted] above [redacted] while at rest every shift; dated [redacted] every shift check placement; dated [redacted] when in bed every shift; dated [redacted] every shift; and dated [redacted] 1 [redacted] [redacted] on when in bed every shift.

The ongoing Care Plan (CP) revealed a focus area dated [redacted], [redacted] with [redacted] to [redacted]) related to [redacted] and [redacted]. The goal revealed resident's wound will improve and heal as evidenced by closure within the next review date, and the [redacted] will improve and heal as evidence by closure. Interventions included but were not limited to position resident off affected area and [redacted] when in bed. Another focus area undated, potential for [redacted] secondary to [redacted], decreased mobility, and PVD. The goal revealed Resident #105 would have care needs met as evidenced by no [redacted]. Interventions included but were not limited to [redacted] devices on bed and wheelchair.

The quarterly Minimum Data Set, an assessment tool, dated [redacted], revealed Resident #105 had a Brief Interview for Mental Status (BIMS) of [redacted] out of [redacted] indicating the resident was [redacted]. [redacted], Behavior, indicated the resident has not exhibited any behaviors of rejection of care. [redacted], Functional Status, indicated Resident #105 required [redacted] of at least one staff

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F 684	Continued From page 38 member for [redacted] which included putting on and removing items. [redacted] revealed [redacted]), [redacted] device for bed in use and application of [redacted] to [redacted] On 11/15/22 at 9:09 AM, during an interview with Surveyor #2, the Certified Nursing Aide (CNA) #1 stated she had been caring for Resident #105 for at least a few months. CNA #1 stated the resident was alert, takes care of most of his/her own activities of daily living (ADL-bathing, dressing, eating, etc), and that she would need to offer to him/her a shower. CNA #1 further stated the wounds on the resident's [redacted] were better and that the nurse would apply cream to his/her [redacted] CNA #1 stated there was nothing she was responsible to do for Resident #105's [redacted]. CNA #1 stated she would get a report in the morning from the nurses, and at that time she would be told if [redacted] were required for any resident. On 11/15/22 at 9:21 AM, during an interview with Surveyor #2, Resident #105 was asked about the [redacted] on his/her [redacted] and if he/she had ever been provided with [redacted] or [redacted] Resident #105 stated that the staff never put any [redacted] on him/her, or a [redacted] for under his/her [redacted] Resident #105 asked the surveyor what was meant by [redacted] for his/her [redacted] On 11/16/22 at 8:00 AM, during an interview with Surveyor #2, LPN #2 who was caring for the resident, stated the resident would be seen by [redacted] care weekly. LPN #2 stated the nurses would do daily [redacted] changes. When asked about any other interventions required for Resident #105's [redacted] the LPN stated there	F 684		

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was nothing else to be done for the [redacted] on his/her [redacted]. LPN #2 stated that all orders would show up on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) in the electronic medical records in the computer.

On 11/16/22 at 8:31 AM, during an interview with Surveyor #2, the Assistant Director of Nursing (ADON) #1, stated that if a resident had an order to [redacted] or use [redacted], the information would be documented in a book on the unit for the nurses and CNAs to review daily. At that time, CNA #1 was present and stated there was no book and that the nurses would tell them (CNA) and the task would be listed in kiosk (electronic medical computer).

On 11/16/22 at 10:03 AM, Surveyor #2 observed Resident #105 sleeping in bed. The surveyor observed no [redacted] had been applied, no [redacted] were applied, and the [redacted] were not [redacted]. Resident #105's feet were lying directly on the bed. Surveyor #2 observed there were no [redacted] in the room and no extra [redacted] available for [redacted] eels.

On 11/18/22 at 10:10 AM, Surveyor #2 observed Resident #105 in bed with his/her [redacted] on the side of the bed. The surveyor observed there were no [redacted], or Ace bandages on the resident. Again, the surveyor observed there were no [redacted], or an [redacted] available for [redacted].

On 11/18/22 at 11:27 AM, Surveyor #2 reviewed the CNA tasks in the electronic medical system. There were no interventions listed for the CNAs to apply the [redacted] [redacted] the resident's

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On 11/18/22 at 12:02 PM, during an interview with Surveyor #2, the Director of Nursing (DON) stated the resident should always have offloading or [redacted] applied while in bed. The DON stated that the application of the [redacted] and the [redacted] would be documented in the MAR. The DON further stated if the resident refused, she would expect to see that documentation in the MAR or TAR as well as documentation that the doctor was notified of any refusal of treatment or medication.

On 11/18/22 at 12:40 PM, Surveyor #2 observed Resident #105 awake lying in bed with [redacted] directly on the [redacted] with [redacted], no [redacted] of the [redacted], and [redacted] applied. The surveyor asked Resident #105 if he/she had any [redacted] that were put on his/her feet or a [redacted] to keep his/her [redacted]. Resident #105 stated, "nobody ever gives me anything like that." The surveyor observed the resident's room and did not see any [redacted]. Resident #105 stated that he/she didn't have any.

On 11/21/11 at 9:22 AM, during an interview with Surveyor #2, CNA #2 stated the care she would provide to Resident #105 would be to give him/her clean clothes and towels. CNA #2 stated the resident had [redacted], but the "nurses would take care of all that". CNA #2 stated she would know what care to provide because the nurses would give report in the morning.

On 11/21/22 at 9:24 AM, Surveyor #2 observed Resident #105 sitting on the side of the bed with his/her [redacted] dangling over the side of the bed by

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the floor. The surveyor observed dressings on both [redacted], but no [redacted] or [redacted].

On 11/21/22 at 11:01 AM, Surveyor #2 observed Resident #105 lying in bed asleep with his/her [redacted] directly on the bed. The resident did not have [redacted] applied and his/her [redacted] were not [redacted]. Surveyor #2 observed the room and could not locate any [redacted].

On 11/21/22 at 11:04 AM, Surveyor #2 asked LPN #2 to access Resident #105's orders. Surveyor #2 and LPN #2 reviewed the orders, and LPN #2 acknowledged the order for [redacted] [redacted], [redacted], and to [redacted] LPN #2 and Surveyor #2 went to Resident #105's room and observed no [redacted], no [redacted], and [redacted] of the resident's [redacted]. LPN #2 acknowledged that the [redacted] were not in the resident's room.

On 11/21/22 at 11:07 AM, Resident #105 informed LPN #2 and Surveyor #2 that the [redacted] had been gone for months and he/she never got them back. Resident #105 could not recall who took the [redacted] or the exact date they were taken but that it was "months ago".

On 11/21/22 at 11:10 AM, in the presence of Surveyor #2, LPN #2 reviewed the physician orders and acknowledged she had not been applying the [redacted] to Resident #105. LPN #2 stated she should not have been signing off that she had been applying the [redacted]. LPN #2 stated that without the [redacted] on, the resident's [redacted] could swell more. The LPN further stated that Resident

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F 684	Continued From page 42 #105's [redacted] could get worse if the [redacted] was not applied. LPN #2 stated she would need to reorder and replace immediately "the supplies he/she (Resident #105) should have had." The LPN acknowledged again that she had been signing off the [redacted] of the resident's [redacted] without having applied them. LPN #2 stated that the Resident #105 had not refused any treatments. On 11/21/22 at 11:17 AM, during an interview with Surveyor #2, the DON stated if a resident had orders for [redacted] Ace wraps, and [redacted] and they were not applied, they "should not be signed as done". The DON stated that if the [redacted] [redacted] were removed, they should have been replaced immediately. The DON stated Resident #105's [redacted] could become worse without the ordered treatments. The DON stated the [redacted] floor did not have a unit manager but there was an ADON who should have been monitoring these things. On 11/21/22 at 11:20 AM, during an interview with Surveyor #2, ADON #2 stated he had only been in the facility since [redacted]. ADON #2 stated his involvement with resident care would be to have a "proper endorsement of shift" but that has not started yet. He stated he was in charge of [redacted] care "as of now" and he was trying to figure out how many times he should go on [redacted] care rounds. On 11/22/22 at 10:02 AM, during an interview with Surveyor #2, the DON was asked about the [redacted] [redacted] and [redacted] not being applied to Resident #105. The DON was also asked about the facility's [redacted]	F 684		

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protocol. The DON stated she was not aware of the policy and not aware of how the placement (of the ordered treatments) was being monitored. The DON stated she would need to "get back to us".

On 11/22/22 at 10:23 AM, Surveyor #2 attempted to call the [redacted] nurse. There was no answer and no availability to leave a voice mail. The surveyor made a second call at 10:25 AM, to an alternate phone number and there was no answer and no availability to leave a voice mail.

The facility provided the [redacted], "Progress Note" details dated [redacted], and [redacted]. A review of the reports revealed the following:

[redacted]. Duration date of initial [redacted] evaluation [redacted]. Context [redacted] is of [redacted] origin. Diagnoses included [redacted] with [redacted] and [redacted].

[redacted] #2 [redacted] is [redacted] improved. "Measurements [redacted] and [redacted]."

[redacted] is [redacted], no change. "Measurements [redacted] and a [redacted]. There is no change noted in the [redacted] progression."

[redacted], initial exam.

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F 684	Continued From page 44 "Measurements [redacted] [redacted] orders: [redacted] #2 included facility [redacted] protocol, and [redacted] per facility protocol. [redacted] #7 included facility [redacted] prevention protocol, and [redacted] per facility [redacted] #8 included to cleanse and apply prescribed cream. [redacted]: [redacted] in [redacted]. Duration date of initial [redacted] evaluation [redacted] Context [redacted] etiology is of diabetic origin. Diagnoses included [redacted], [redacted] and [redacted] [redacted] #2 [redacted] is [redacted] and "not healed". Measurements remained the same as [redacted] [redacted] #7 [redacted], "not healed". "Measurements [redacted] and a [redacted] [redacted] #9 [redacted] is [redacted], initial exam. "Measurements are [redacted] " orders: [redacted] #2 included facility [redacted] r prevention protocol, and [redacted] per facility protocol. [redacted] #7 included [redacted] prevention protocol, and [redacted] per facility protocol. [redacted] #9 cleanse and apply cream. 1[redacted] [redacted]. Duration date of initial [redacted] evaluation [redacted]. Context	F 684		

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[redacted] is of [redacted] origin. Diagnoses [redacted] and [redacted].

[redacted] #2 [redacted] is [redacted]. "Measurements [redacted], with an area of [redacted]." [same measurements as [redacted]].

[redacted] #7 [redacted] is [redacted], "no change". "Measurements [redacted]

[redacted] orders: [redacted] #2 included facility [redacted] protocol, and [redacted] per facility protocol. [redacted] #7 included [redacted] prevention protocol, and [redacted] per facility protocol.

All three reports noted that the plan of care was discussed with the facility staff.

A review of the facility provided, [redacted] Application" in-service dated [redacted] revealed all staff must carry out doctor's orders [redacted], [redacted] application. The sign in sheet did not include the LPN.

A review of the facility provided, "Licensed Practical Nurse Job Description" undated, included but was not limited to purpose: to provide direct nursing care to the residents. Nursing Care Functions: review the resident's chart for specific treatments, etc, and administer professional services.

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F 684	Continued From page 46 A review of the facility provided competencies for LPN #2, dated [redacted], included but was not limited to reviewing treatment orders and documentation nurses notes; use the documentation guidelines for charting. The competencies revealed that LPN #2 had successfully completed the above skills and was able to work independently and was signed by the Registered Nurse. A review of the facility provided, [redacted] Prevention" dated 07/21/22, included but was now limited to ensures that interventions indicated to address the resident's skin risk factors are implemented as per plan of care. Will assess resident to evaluate for any preventative devices (i.e. pillows, booties). A review of the facility provided, "Assistive, Adaptive, and [redacted] Devices" dated 07/12/22, included but was not limited to policy: to use assistive, adaptive, and [redacted] devices to aide and improve our residents' quality of care, as well as to prevent [redacted] devices may include j. [redacted]s. Procedure: MD (physician) will initiate an order, enter order in the EMR (electronic medical record) along with pertinent instruction. Instructions for the device management will be entered into CNAs task where appropriate. Education regarding device placement and management will be provided to nursing where appropriate. Device placement and management will be monitored by unit charge nurse. NJAC 8:39-27.1(a)	F 684		

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	315359	A. BUILDING _____ B. WING _____	C 11/23/2022

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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.) there was no delay in implementing recommendations made by the consulting [redacted] care Nurse Practitioner (NP), b.) care planned interventions to promote [redacted] healing were implemented for a resident who was identified at risk for developing a [redacted] and developed a [redacted] and c.) a thorough assessment for [redacted] risk factors was completed. This deficient practice was identified for 1 of 5 residents reviewed (Resident #49) for [redacted] who developed a [redacted] on [redacted] and was evidenced by the following: On 11/07/22 at 10:15 AM, the surveyor toured the [redacted] Unit of the facility and observed Resident #49 in bed with the head of the bed elevated, facing the door, the [redacted] rested on the [redacted], and the eyes were closed. When inquired about the resident's status, the Certified Nursing	F 686	I. Immediate action: 1) Resident #49 was reassessed by the Rehabilitation Therapist for ability to participate in activities of daily living (ADL) with special attention for eating and bed mobility and determined the resident required extensive assistance. Resident was reassessed by nursing and a [redacted] was completed. 2) Resident #49's incontinence checks and timely [redacted] care will be conducted when turned and repositioned. 3) Resident #49 was also assessed by the [redacted] physician and determined that the [redacted] was improving. 4) Resident #49's ADL care plan was updated to reflect the resident's abilities in all activities of daily living (ADL). a. Resident now requires extensive assist of 1 to eat b. Resident now requires extensive	1/12/23

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F 686	Continued From page 48 Assistant (CNA) observed in the room stated, "All he/she does is sleep all day". On 11/07/22 at 11:30 AM, the surveyor returned to the room and observed Resident #49 in bed, the same position as observed at 10:15 AM, facing the door and his/her eyes were closed. On 11/07/22 at 11:45 AM, the surveyor returned to the [redacted] Unit to observe the lunch meal. The lunch cart arrived on the floor at 11:50 AM. Resident #49 was not in the dining room. Resident #49 was observed still in bed and in the same position as the surveyor's prior two observations. The surveyor returned to the room at 12:05 PM, to find Resident #49 was still sleeping. The Unit Manager followed the surveyor into the room and stated that the resident could feed his/herself after being set up. However, Resident #49 was observed in bed and the lunch tray was left behind the door and inaccessible to the resident. On 11/07/22 at 12:15 PM, the surveyor observed Resident #49 in bed. His/her lunch tray was observed on the bedside table behind the door. The tray was untouched, and Resident #49 could not access the lunch tray. On 11/07/22 at 12:49 PM, the surveyor observed a CNA enter the room and then assisted Resident #49 with the lunch meal (approximately one-hour after the meal truck arrived on the unit). Resident #49 consumed [redacted] of the lunch meal. On 11/09/22 at 11:30 AM, the surveyor reviewed Resident #49's electronic medical record.	F 686	assist of 1 in bed mobility, and turning and positioning every 2 to 3 hours and as needed. 5) Resident #49's [redacted] prevention and [redacted] care plans were updated to reflect interventions of [redacted] with [redacted] and turning and positioning every 2 to 3 hours and as needed. 6) The CNA Accountability tasks for resident #49 were updated to reflect the changes in status. 7) [redacted] were ordered for resident #49, obtained and labeled for resident #49 8) Staff assigned to resident #49 were updated on resident's status and educated on eating, bed mobility, need to provide frequent [redacted]e checks and timely changes, turning and positioning every 2 to 3 hours and as needed and application of [redacted] at all times while in bed. 9) The staff were inserviced on timely notification of resident changes to nurse supervisor, physician and dietician. The nurse's instructions were updated to reflect same. II. Identification of others: 1) The facility respectfully states that all residents may be potentially affected by this deficient practice. 2) An audit will be conducted for all residents with activities of daily living (ADL) requiring extensive assistance or total dependence for bed mobility, eating and turning and positioning was in place, entered in the care plan and in the nurse's	

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F 686	Continued From page 49 According to the Admission Face Sheet, Resident #49 had diagnoses which included, but were not limited to, [redacted] Review of the Annual Minimum Data Set (MDS), dated [redacted] revealed that Resident #49 was [redacted] for daily decision making as indicated by the score of [redacted] on the Brief Interview for Mental Status, and required assistance with most activities of daily living, including [redacted] care and transfers. [redacted] of the MDS which addressed Functional Status, revealed that Resident #49 required supervision with setup help only for eating. Review of the Quarterly MDS dated [redacted] revealed that Resident #49 was assessed as required extensive assistance with one person assist for eating. Review of the Order Summary Report dated [redacted], reflected a Physician Order Sheet with an original date of [redacted] for Skin Assessment every shift every [redacted] and [redacted] To check for skin impairment document using the following codes: 0- no skin impairments 1-previous skin impairment present 2-Newly identified skin impairment. If you respond with a "2", further documentation in progress notes was required. Review of Resident #49's facility provided Care Plan revealed an undated Focus for potential [redacted]. Two undated Goals revealed the Ressident will have care needs met as evidenced by [redacted] will heal while at the facility. The interventions included: Keep skin clean and dry, sheets as wrinkle free as	F 686	instructions. All negative findings will be corrected immediately and brought to the attention of the Director of Nursing and Administrator to ensure appropriate follow up. 3) An audit will be conducted of all residents who eat in their room to observe for proper placement of meal trays by staff when eating in room and to determine if proper set up was provided before the meal. 4) All Certified Nursing Assistants (C.N.A.'s) will be reinserviced on the proper way to prepare a resident for a meal including but not limited to sitting resident up in chair or bed, placing meal tray within reach, washing hands, opening tray, cutting up meat etc. and placing tray near resident to eat. III. System Changes 1) The Policy and Procedure entitled [redacted] Prevention and [redacted] Management was reviewed by The Director of Nursing and Administrator and noted to be in compliance. 2) An inservice on [redacted] Injury prevention with attention to [redacted] application of [redacted] and turning and positioning will be given by the Staff Educator to all nurses and Certified Nursing Assistants (C.N.A.s) on a quarterly basis. IV. Quality assurance 1) Audits will be conducted of all residents who require turning and positioning to ensure that staff are turning and positioning residents according to	

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F 686	Continued From page 50 possible. Notify physician of any changes in skin integrity. Observe skin during bathing, turning, and [redacted] care for early signs of [redacted]. [redacted] devices on bed and wheelchair. Turn and reposition every 2 hours and as needed. Use proper positioning, transferring, and turning techniques to minimize skin injury due to friction and shear forces (There were no updated goals or indterventions related to the [redacted] identified on [redacted] Review of the "[redacted]" for predicting [redacted] Risk dated [redacted], revealed that Resident #49 was assessed to be at [redacted] for [redacted]. Resident #49 had a score of [redacted] which indicated being at [redacted] On 11/09/22 at 11:30 AM, the surveyor interviewed the CNA responsible for taking care of Resident #49 during the 7:00 AM to 3:00 PM shift. The CNA stated that Resident #49 had been [redacted] him/herself, and could not turn and reposition him/herself. The CNA stated that Resident #49 was totally dependent on staff and required [redacted] with most activities of daily living. Resident #49 was unable to ambulate. The CNA further stated, Resident #49 had an [redacted] to the [redacted] cared for by the nurse. On 11/10/22 at 9:15 AM, the surveyor observed Resident #49 in bed laying on his/her backside. Resident #49 had remained in bed in the same position during the morning shift. At 11:30 AM, the surveyor asked the CNA to come to the room to check Resident #49. At that time the surveyor had observed that Resident #49's [redacted] f was [redacted] and inquired to the CNA about the care she had provided to the	F 686	their plan of care. a. These audits will be conducted by the nursing supervisor on all shifts weekly x 4, then monthly x 2 months and quarterly x 3 months. 2) Audits will be conducted during meal passes to ensure the proper set up of all residents who eat in the room to ensure that the resident is set up properly and the tray was placed appropriately in front of the resident so he/she can reach the tray. a. These audits will be conducted by the nursing supervisor on all shifts weekly x 4, then monthly x 2 months and quarterly x 3 months. 3) All negative findings will be corrected immediately and brought to the attention of the Director of Nursing and Administrator. 4) All results of these audits will be brought to the Quality assurance committee quarterly x 4 quarters. IV. Person Responsible: Director of Nursing/Infection Preventionist/Administrator	

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resident. The CNA stated that she had not provided any care to the resident yet.

On 11/14/22 at 9:02 AM, the surveyor observed Resident #49 in their room sitting in a wheelchair. Resident #49 was awake and more alert than previous observations. The surveyor remained on the unit at the nursing station, from 9:30 AM until 1:10 PM (over three hours) and observed Resident #49 remained in the dayroom sitting, in the wheelchair and had not been assisted with toileting or having their [redacted] changed.

On 11/14/22 at 12:52 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who cared for Resident #49. The LPN stated that Resident #49 had a [redacted] which was cared for weekly by the [redacted] Care Specialist, and that the facility's staff would perform [redacted] care daily. The LPN stated that documentation for [redacted] care could be viewed on the computer under the Assessment Task.

On 11/14/22 at 1:15 PM, the surveyor reviewed the electronic medical record and noted the following under the "Assessment Task":

"Visit Report for Resident #49 on [redacted]. Chief Complaint [redacted]: " [redacted] resolved. New [redacted] was noted. Diagnoses: [redacted] of [redacted], [redacted]. Progress Note Details: "Resident was seen today for evaluation and management of the [redacted] as requested by nursing staff. Staff reports that the [redacted] was noted recently. Current treatment includes [redacted] and [redacted] Assessment: [redacted] #4 is a [redacted] and has received a status of Not Healed. [redacted]

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encounter measurements are [redacted] with an area of [redacted] and a [redacted] of [redacted]. [redacted] has been noted... Integumentary system: noted [redacted] Orders [redacted] Facility [redacted] Prevention Protocol. [redacted] per facility protocol. Wheelchair [redacted] per Facility Protocol. [redacted] with [redacted]. Apply: [redacted] with: [redacted]. Additional Orders: Plan of Care discussed with Facility Staff.

The surveyor reviewed the electronic Progress Notes, there was no documentation prior to [redacted] regarding any [redacted] to the [redacted] that had been identified by the facility.

Visit Report for Resident #49 on [redacted]. Progress Note Details: "Resident was seen today for evaluation and management of the [redacted] as requested by nursing staff. Staff reports that the [redacted] was noted recently. Current treatment includes [redacted] and [redacted] Assessment: [redacted] is a [redacted] and has received a status of [redacted]. [redacted] encounter measurements are [redacted], with an area of [redacted]. No signs of infection, weight [redacted] lbs [pounds]. [redacted] Orders: [redacted], Facility [redacted] Protocol. [redacted] per facility protocol. Wheelchair [redacted] per Facility Protocol. Other, Cleanse [redacted]

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F 686	Continued From page 53 [redacted]. Apply: [redacted] and [redacted] area. [redacted] with [redacted]. Change Daily and as needed for [redacted], or accidental removal. Additional Orders, Plan of Care discussed with Facility Staff. Visit Report for Resident #49 on [redacted]. Progress Note Details: "Resident was seen today for evaluation and management of the [redacted] as requested by nursing staff. Staff reports that the [redacted] was noted recently. Current treatment includes [redacted] cream and [redacted]. [redacted] Assessment: [redacted] #4 [redacted] is a [redacted] and has received a status of [redacted]. Subsequent [redacted] encounter measurements are [redacted] There is small amount of [redacted] noted which has no odor. [redacted] has [redacted] and no [redacted] present. [redacted] Orders: [redacted] Facility Pressure Ulcer Prevention Protocol. [redacted] Mattress per facility protocol. Wheelchair [redacted] per Facility Protocol. [redacted], Cleanse [redacted] Apply: [redacted]. Cover [redacted] with [redacted] g. Change Daily and as needed for s[redacted], or accidental removal. Additional Orders, Plan of Care discussed with Facility Staff. (There was no documentation in the electronic Progress notes to indicate that direct care staff were made aware of the action plan. There was no note in the dietary section to indicate that the dietitian was made aware of a [redacted] on	F 686		

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F 686	Continued From page 54 [redacted] The care plan was not revised. The care plan did not include revised interventions to prevent further breakdown) On 11/15/22 at 11:47 AM, the surveyor observed that Resident #49, in the resident's room, and was out of the bed. An observation of the mattress revealed that the mattress was [redacted] and [redacted]. The mattress was observed as [redacted]. On 11/15/22 at 11:52 AM, the surveyor interviewed the Unit Manager (UM) who stated that Resident #49 had a [redacted]. The surveyor accompanied the UM to the room where both observed the [redacted]. The UM confirmed that the [redacted] and could not provide [redacted]. The UM stated that the [redacted] was not suitable for a resident who had a [redacted] injury. The UM stated that direct care "staff did not report" that the [redacted] needed to be changed. On 11/15/22 at 1:25 PM, the surveyor interviewed the UM regarding Resident #49 sitting in the chair all day. The UM stated she attempted to shift the resident today. However, the surveyor observed Resident #49 sitting in the wheelchair from 8:55 AM-1:30 PM. Resident #49 had not been escorted to the room to be changed for over four hours, which included, before the lunch meal. The surveyor asked to view the "Task" tab on the computer where direct care staff documented the care provided, no documentation was available for review (The Care Plan did not provide interventions related to the amount of time sitting was appropriate for Resident #49).	F 686		

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F 686	Continued From page 55 The Visit Report for Resident #49, dated [redacted] revealed: Progress Note Details: Resident was seen today for evaluation and management of the [redacted] as requested by nursing staff. Staff reports that the [redacted] was noted recently. Current topical treatment includes [redacted] and [redacted] Assessment: [redacted] #4 [redacted] is a [redacted] and has received a status of [redacted]. Subsequent [redacted] encounter measurements are [redacted]. [redacted] has been noted... There is a small amount of [redacted], [redacted]. No [redacted] ... The [redacted] texture is normal (The [redacted] size from the [redacted] report), [redacted] Orders: Pressure [redacted] Facility [redacted] Protocol. [redacted] per facility protocol. Wheelchair [redacted] per Facility Protocol. Other, Cleanse [redacted]. Apply: [redacted] Cover [redacted] with keep open to air. Change Daily and as needed for [redacted], or accidental removal. Additional Orders, Plan of Care discussed with Facility Staff. Treatment Goals: Staging Care. [redacted] of care will be required due to [redacted]. Short Term Goals: Patient /Caregiver will have understanding to care for [redacted] and will improve and maintain without exacerbation or deterioration. The [redacted] will be [redacted]. Long Term Goals: Patient /Caregiver will understand need for continued care when health problems are identified. A Nursing Progress Note dated [redacted] 2 at 10:56 read: "[redacted] and [redacted]	F 686		

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F 686	Continued From page 56 [redacted] Resident was seen by [redacted] team today. [redacted] change from [redacted] to [redacted] New recommendation were to change treatment to [redacted] cream every shift, [redacted]. NP (Nurse Practitioner) informed recommendation approved and carried out". On 11/18/22 at 11:10 AM, the surveyor observed the LPN performed wound care to the [redacted]. Scattered wound noted on the [redacted] and [redacted] area. During the [redacted] care, the LPN acknowledged that the [redacted] had [redacted]. A [redacted] was noted on the [redacted] and the LPN cleansed the [redacted] area and did not measure [redacted]. On 11/18/22 at 11:59 AM, the surveyor interviewed the LPN who performed the [redacted] care. The LPN stated that she had been off for the weekend. She performed [redacted] care on [redacted] 2, and noticed that the [redacted] had [redacted] She further stated that she informed the Unit Manager of the [redacted] condition on [redacted] The LPN stated that she also had a conversation with the CNA who cared for the resident and the CNA stated that she did not report the [redacted] condition because she thought that other staff were aware of the condition of the [redacted] since [redacted] care were being done daily. The LPN stated that she continued with the same treatment orders. She attempted to notify the Nurse Practitioner, but she was unable to leave a message. On 11/18/22 at 12:11 PM, the surveyor asked the LPN for documentation of the [redacted] observation she made on 11/[redacted], during [redacted] care. The LPN stated that she did not document her	F 686		

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F 686	Continued From page 57 findings. When asked if she informed the physician, revised the care plan, or checked the [redacted] condition, the LPN stated that she did not (The UM was aware and verified the condition of the [redacted] s on [redacted], and failed to notify the physician and address the concern with the [redacted] Care Coordinator. Resident #49 remained on the worn and [redacted] unti[redacted] On 11/18/22 at 12:25 PM, the surveyor reviewed the electronic Progress Notes with the UM and the LPN assigned to the [redacted] unit [redacted] side and could not find any documentation regarding the [redacted]. Although aware of a change in condition since [redacted], both the LPN and the UM failed to notify the physician, involve the dietitian, or implement interventions to promote [redacted] healing. The [redacted] assessment signed by the LPN on [redacted] did not reflect that the [redacted] had [redacted]. The care plan had not been revised. On 11/18/22 at 12:30 PM, the UM confirmed that she was made aware of the change in the [redacted] condition on [redacted], by the LPN. She could not comment on the interventions implemented after she was informed. The UM entered a note in the clinical record that she had informed all involved parties in the resident's care on [redacted]. On 11/18/22 at 1:15 PM, the LPN stated that she should have documented her findings. The LPN stated, "I reported the condition of the [redacted] to the Unit Manager. I continued the treatment since I knew that Resident #49 was going to be seen on [redacted] by the [redacted] Specialist". On 11/19/22 at 10:30 AM, the surveyor reviewed again the electronic clinical record and there was	F 686		

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F 686	Continued From page 58 no entry from the dietitian regarding the [redacted] and the [redacted]. On 11/19/22 at 15:44 PM (3:44 PM), the following entry was noted and revealed: Nutrition Note (SPN) Note Text: [redacted] note of [redacted]; Resident #49 [redacted] injury is a [redacted]. He/she is receiving [redacted] and [redacted] daily to [redacted]. There are no recent labs to assess. RD [Dietitian] will recommend for [redacted] #[redacted]. He/she has [redacted] [redacted]# [pound] x 1 month. He/she has had no significant weight changes x [redacted] although he/she is having a [redacted]. He/she continues a [redacted] r diet with [redacted] ft consistency, consuming approximately [redacted] of meals served. He/she does need assistance from staff during meals. Will assess further once lab results are available. On 11/21/22 at 8:42 AM, the surveyor interviewed the dietitian who confirmed that she was not made aware of Resident #49's [redacted] until [redacted]. She stated that she added a note in the electronic medical record and will formulate a plan. On 11/21/22 at 11:45 AM, the surveyor asked the dietitian if she would assist to obtain Resident #49's [redacted]. The dietitian accompanied the surveyor to the [redacted] Unit and assisted staff with the weight. Resident 49's weight was [redacted] in the presence of the UM, Assistant Director of Nursing (ADON) and the Director of Nursing (DON). The	F 686		

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F 686	Continued From page 59 last weight taken on [redacted] was [redacted]. This was a [redacted] pound ([redacted]) in less than one month. The facility was not aware that Resident #49 [redacted] and had been [redacted] him/herself, was [redacted], and did not notify the Dietitian. On 11/22/22 at 9:21 AM, the surveyor interviewed the ADON regarding his role as the [redacted] Care Coordinator. The ADON stated he had just taken on the role and had not assessed fully what needed to be done. The surveyor then asked the ADON to elaborate on the [redacted] assessment performed weekly by the facility. The ADON stated that [redacted] Assessment" entailed checking the whole body on shower day. Resident prone to [redacted] should have random [redacted] check. Findings should be reported to the [redacted] Care Coordinator and discussed with the [redacted] Care Specialist. The ADON added he had not had the opportunity to review yet the recommendations dated [redacted], and [redacted], regarding Resident #49's [redacted]. On 11/22/22 at 9:33 AM, the surveyor accompanied the ADON to Resident #49's room, where both observed Resident #49 in bed, the [redacted] rested directly on the [redacted]. Resident #49 had no heel protectors on. Resident #49's [redacted] were [redacted]. The [redacted] was [redacted] and [redacted] The ADON stated that Resident #49 should have had [redacted] on. Resident #49 had an order to [redacted] dated [redacted]. The Care Plan failed to address the recommendation to [redacted] On 11/16/22, Resident #49 was referred to Occupational Therapy for evaluation. The Occupational Therapy notes dated [redacted]	F 686		

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F 686	Continued From page 60 documented the following: "Resident #49 assessed for her/his ability to [redacted] herself/himself. Due to [redacted] in [redacted] and [redacted] following commands, Resident #49 requires [redacted] for [redacted], Resident #49 can [redacted] and [redacted] at times, but other times requires [redacted] assist. Due to [redacted] in [redacted] Resident #49 requires [redacted] staff assist for meals. Allow Resident #49 to participate as much as she can and allow him/her to [redacted] if he/she desires. Risk Factors: Due to the documented physica[redacted] and associated [redacted] Resident #49 is at risk for : [redacted]. Resident #49 was not assessed for a change in condition. The facility did not initiate a significant change although Resident #49 had a [redacted] started [redacted], and develop a new [redacted] 2, and had some [redacted] as reported by the direct care staff. Resident #49's care plan was not revised to include interventions such as, limited sitting while out of bed, intake monitoring during meals, and frequent incontinence care to prevent [redacted] and promote [redacted] of the [redacted] Staff was not in- serviced to reflect understanding of the policy regarding change in condition and preventive measures to promote wound healing. Resident #49 was not provided with a [redacted] until [redacted]. The UM was aware and confirmed on 1[redacted], that	F 686		

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the [redacted] was [redacted] and was not suitable for a resident with a [redacted]. The [redacted] Care Coordinator was not aware of the recommendations made by the [redacted] Care Specialist. There was no evidence that the IDCP (Interdisciplinary Care Team) discussed measures needed to be implemented since the [redacted] was identified on [redacted], to ensure that preventive measures were in place. The dietitian was not informed of the [redacted] Injury until [redacted]. The facility did not identify the causal factor and implement meaningful interventions to prevent the [redacted] from [redacted], and the above concerns was discussed with the facility on [redacted] at 2:00 PM.

On 11/23/22 at 9:42 AM, the DON and the Regional Nurse both stated there was a discrepancy in the [redacted] documentation. They both acknowledged there was no system in place to review [redacted] care. They stated they would provide the wound tracking form with their investigation of the [redacted].

On 11/23/22 at 11:33 AM, the DON provided the following report: She acknowledged that a [redacted] was identified on [redacted], which measured [redacted] had [redacted] in size related to [redacted] in size but continue to have [redacted] and [redacted] and documented Resident is [redacted]. The document further indicated that Resident #49 was assessed by Occupational Therapy on [redacted], and it was determined that Resident #49 needed

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F 686	Continued From page 62 [redacted] of one for [redacted]. The resident was [redacted] yesterday, and recent [redacted] was identified. The dietitian was made aware and new interventions were put in place. An Interdisciplinary Team meeting will be scheduled for the resident to ensure all interventions are in place to prevent further [redacted] and [redacted] As of [redacted] the new ADON was in charge of the wound care tracking at the facility, and the ADON will ensure all policies and procedures would be followed. According to the DON, Resident #49 had a new [redacted] to the [redacted] that was not identified by the nurse who had been provided daily [redacted] care. She admitted that there was no documentation in the clinical record that the Physician was made aware of the [redacted] and no documentation of any [redacted] before the [redacted] was identified by the [redacted] Care Specialist. The [redacted] Care Specialist indicated in the Progress Notes of [redacted], that staff reports the [redacted] was noted recently. The facility could not provide documentation regarding when the [redacted] was identified and what interventions were implemented. A review of the facility's policy titled, "[redacted] and [redacted] Management/[redacted] Risk Assessment" dated 11/01/18, last revised 07/21/22, revealed: Policy: A skin risk assessment will be conducted on each resident to identify the resident's level and nature of risk for developing [redacted] This assessment will be done on admission, readmission then quarterly, annually, significant changes in condition and as deemed appropriately.	F 686		

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F 686	Continued From page 63 Purpose: To identify the individual residents at risk for developing [redacted]; as well as identifying and evaluating risk factors and changes in the resident's condition, in an attempt to stabilize, reduce or remove underlying factors that place the resident at risk. Procedure: Licensed Nurse: Assesses the resident's risk for [redacted], using the [redacted] Risk Assessment at the time of admission, readmission then quarterly assessment and comprehensive annual assessment, significant change in condition or as deemed appropriate. Implement preventative measures and or actual measures determined to be appropriate for each individual resident. Dietitian: will assess resident to evaluate caloric needs and determine if supplements or dietary changes are indicated. will communicate recommendations to physician. Nurse Manager: Oversees the assessment process for all new residents ensuring the care plan and interventions address the risk factors and skin care needs taking into consideration causes and potentialities. The facility's Policy titled, "Change in condition" dated 10/16/20, with a revised date of 06/07/22, revealed, "It is the facility policy to identify and communicate changes in condition to the physician and other team members to implement interventions to prevent further deterioration and possibly prevent hospitalization. Purpose: To provide prompt and appropriate interventions to promote resident's health and	F 686		

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well-being and positive outcomes.

General Information: "All staff are encouraged to promptly report changes in condition to the charge nurse, supervisor or DON/ADON or designee immediately".
A complete assessment will be conducted of all systems. The nurse will contact the physician or Nurse Practitioner, discuss findings, and formulate a plan.

Entries will be made each shift to monitor condition.
The resident will be placed on the 24 hours report.
The resident will be monitored until condition significantly improved.
The facility failed to follow their own policies.
The facility did not notify the physician, did not reassess the resident, revise the care plan, the resident, involved the Interdisciplinary Team to develop interventions to prevent the [redacted] from worsening.

A review of the Comprehensive Care Planning Policy, Effective 05/29/20, revealed, "it is the policy of the [facility name] to develop and implement a comprehensive person-centered care plan to each resident consistent with rights set forth ... ...that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.
Procedure: Interdisciplinary team, 4. Updated care plan as needed with changes in treatment, needs, and condition.

NJAC 8:39-27.1 (a)

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F 689	Continued From page 65	F 689		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to: a.) ensure interventions to prevent [redacted] were in place per a resident care plan, b.) complete a [redacted] assessment post fall per facility policy, and c.) determine the causal factor after each resident fall and implement appropriate interventions to prevent recurrence. This deficient practice was identified for 1 of 1 resident (Resident #119) reviewed for falls, had experienced four[redacted], and was evidenced by the following: On 11/07/22 at 11:35 AM, the surveyor observed Resident #119 in the room, sitting in a wheelchair. The resident was [redacted] with the surveyor due to a [redacted] A nurse informed the surveyor that there were staff that were able to communicate in Resident #119's [redacted] On 11/14/22 at 11:45 AM, the surveyor interviewed Resident #119's Certified Nurse Aide (CNA #1), who stated she was able to communicate with the resident in his/her [redacted] The surveyor asked CNA #1 if	F 689	I. Immediate Action Concern A, B, C a) A [redacted] checklist was developed by the Director of Nursing to ensure that all procedures are followed and completed after every [redacted], to include but not limited to, ensuring new intervention is put in place to prevent falls, complete [redacted] risk assessment after every [redacted] and to determine causal factors of [redacted] to prevent further [redacted] b) The call bell of Resident #119 was replaced and checked for function. c) A facility-wide in-service was conducted to educate staff on appropriate use of side rails. II. Identification of others: a) An audit was completed by the Rehabilitation Director for all residents with side rails to ensure that side rails were appropriate for them. b) All negative findings were reported to the Administrator, Director of Nursing, and the residents primary care physician.	1/19/23

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F 689	Continued From page 66 Resident #119 had any [redacted] and the CNA stated "no". On 11/14/22 at 10:49 AM, The surveyor reviewed the electronic medical record (EMR) which revealed the following: A Rehabilitation [redacted] document, signed by the Rehabilitation Director on [redacted], revealed Date/Time of [redacted] at 12:50 PM, "at around 12:50 PM, the UM [unit manager] nurse was called to resident's room by assigned CNA. Upon entering the room, resident was noted sitting on the floor in front of the [wheelchair]. He/she was facing the bed while wearing [redacted] ...the Notes revealed ...is [redacted] with [redacted] ...No therapy indicated ..." A Rehabilitation [redacted] signed by the Rehabilitation Director on [redacted] revealed date/Time of [redacted] at 2:45 PM, "per nursing notes: Resident was observed sitting in front of wheelchair at approximately 2:45 PM. Resident was assessed from head to toe with no abnormalities noted. He/she was assisted back to bed by assigned CNA and stated he/she was trying to go to the bathroom. A Nursing Progress Note, (NPN) dated 1[redacted] at 15:51 [3:51 PM], "Resident seated on side of bed [redacted] and [redacted] with Assigned CNA who reported to writer of [redacted] seen during AM care around 11:00 am... " A NPN dated [redacted] at 6:52 [6:52 AM], revealed, There was a call from the room went immediately and found resident sitting on the floor with [his/her] legs outstretched facing the door.	F 689	c) An immediate reeducation will be given to any staff member who did not follow the residents□ plan of care. III. System Changes a) The Policies and Procedures on accidents/incidents and siderails was reviewed by the Administrator, Director of Nursing, and Medical Director and no revision was necessary. b) Reeducation will be given to all staff members by Staff Educator on facility□s policy and procedures on accidents/incident and proper use of siderails c) The [redacted] checklist will be reviewed and audited by the Director of Nursing every quarter. IV: Quality Assurance Concern A a) Audits will be conducted by the Director of Nursing on all accidents/incidents to ensure completion of the falls checklist and that all assessments are done, appropriate interventions are put in place and causal factors identified after every fall weekly x 4, monthly x 2, and quarterly x 4. b) All negative findings will be brought to the Director of Nursing and Administrator for immediate correction. c) Results of all audits will be brought to QAPI committee x 4 quarters. V. Person responsible: Director of Nursing	

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Resident was not able to say what had happened due to [redacted] status of the resident. Resident was last seen at 2:30 AM in bed, call light was within reach.

On 11/15/22 at 9:40 AM, a second surveyor (Surveyor #2) observed Resident #119 was sitting at the nursing station in a wheelchair. Surveyor #2 interviewed the resident in his/her [redacted]. The resident stated he/she had [redacted] because of [redacted] Surveyor #2 conducted telephone interview with an emergency contact (EC) of Resident #119. The EC stated she knew the resident had [redacted], and there were concerns that the resident had not always been changed timely.

On 11/16/22 at 7:56 AM, the surveyor observed Resident #119 sleeping in a bed in the low position, and the leg portion of the bed was elevated, and the head portion was down with both one-half side rails in place. The surveyor did not see a call bell attached to the wall. At that time, the resident's assigned CNA #2 was in the room. The surveyor interviewed CNA #2 about the bed position for Resident #119 and CNA #2 stated that Resident #119 liked to get up out of bed and that the resident's bed was usually left like that from the overnight shift. The CNA stated the resident has had a few [redacted] At that time, the surveyor inquired to CNA #2 if the Resident #119 had a call bell and CNA #2 looked for the call bell and stated, "I don't see a call light plugged in".

On 11/16/22 at 8:22 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who was overseeing the unit at that time, and asked that she accompany the surveyor to Resident #119's room to observe the positioning of

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F 689	Continued From page 68 Resident #119 in bed. During the observation, the surveyor inquired to the ADON if Resident #119 was supposed to have the bed positioning the feet elevated and the head position lowered while in bed, with the half side rails elevated. The ADON stated "no", and stated the bed was supposed to be flat with the head of the bed also flat, and the side rails were used to [redacted] On 11/16/22 at 8:51 AM, the surveyor reviewed the EMR for Resident #119 which revealed: Resident #119 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed a Brief Interview for Mental Status score of [redacted] which indicated a [redacted] status revealed the resident required a [redacted] The MDS revealed the resident was [redacted] t, and only able to stabilize with staff assistance. Three questions in the [redacted] History on Admission/Entry or Reentry section were left blank and No, Yes or Unable to Determine were not coded. The three questions identified if the resident had a [redacted] in the last month prior to admission /entry or reentry, if the resident had a fall any time in the last 2-6 months prior to admission/entry or reentry, and did the resident have any fracture related to a [redacted] in the six months prior to admission/entry or reentry. Resident #119's Care Plan (CP) revealed a Focus: Resident is at risk for [redacted] [result to] history of [redacted] with Date Initiated: [redacted] and	F 689		

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Revision on: [redacted] and [redacted] resident had incident of [redacted] resident tried to transfer him/herself from [wheelchair] to bed, no injury noted, [redacted] had incident of [redacted] resident found on floor facing the bathroom no injury noted. The goal was for Resident #119 to not sustain serious injury through the review date, Date Initiated [redacted] Revision Date: [redacted] Target Date: [redacted] and Resident #119 will have no incident of [redacted] [until] next review date, Dated Initiated: [redacted], Revision: [redacted]2, Target Date: [redacted]. The CP Interventions: Date Initiated: [redacted] included: Anticipate and meet needs, Anticipate toileting needs, Be sure call light is within reach and encourage to use it for assistance as needed, Provide prompt response to all requests for assistance, and Monitor side effects of medication. The CP interventions: Dated Initiated: [redacted] included the following: Keep resident in common areas for increased observation and placed resident in front of the nurse's station wherein staff can view resident whereabouts (The surveyor's observation of a missing call bell for Resident #119, on [redacted] at 7:56 AM, was inconsistent with the documented CP interventions to prevent falls for Resident #119, and the [redacted] were not a documented intervention used to prevent falls while the resident was sleeping in bed).

A review of Resident #119's Order Summary Report for [redacted] revealed an order for "Apply [redacted] to bed for mobility", dated [redacted] (This order did not indicate to utilize to prevent [redacted]), and an order dated [redacted] for "Bed in lowest position every shift" (This order was not indicated on the CP for [redacted] prevention).

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F 689	Continued From page 70 On 11/16/22 at 12:57 PM, the Director of Nursing (DON) provided the surveyor with the facility investigations, as requested, for the prior six months and the documents revealed four "[redacted] Investigation Tool" documents for Resident #119: The [redacted] Investigation Tool dated [redacted] revealed: Date of fall: [redacted], at 12:50 PM, Was the patient [redacted]" prior to [redacted] "Yes", Based on your investigation and assessment what was the causative factor/s: [redacted] There were no statements attached to the investigation. The [redacted] Investigation Tool dated [redacted], revealed date and time of [redacted] was [redacted] at 11:00 AM. Based on your investigation and assessment what was the causative factor/s: "Being [redacted] is one of causative factors for [redacted] The nursing description revealed 11:00 AM resident noted seated on side of bed with assigned CNA who reported to writer [redacted]) seen during AM care. One statement was attached from a CNA and was undated. The [redacted] Investigation Tool dated [redacted] revealed at [redacted] 2 at 2:45 PM was the time and date of [redacted]. Based on your investigation and assessment what was the causative factor/s: Resident is having the behavior on and off get up from wheelchair, is [redacted] of [redacted], resident unable to follow staff direction, noted most of the times [redacted] and can sit still in [wheelchair]. It is the reasons	F 689		

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that resident had [redacted]. The Immediate Action Taken ... "Resident was educated to call for assistant [sic.] when getting out of bed" One statement was attached from a CNA and dated [redacted]

The [redacted] Investigation Tool dated 1[redacted] revealed Time of [redacted] (AM and PM were circled), Based on your investigation and assessment what was the causative factor/s: "Resident is [redacted] to follow [redacted]. Having [history] of frequent [redacted]." There were no statements attached.

On 11/18/22 11:59 AM, the surveyor interviewed the DON regarding what process was after a resident sustained a [redacted] The DON stated there should be a full risk assessment completed, and incident report with statements from the staff, and investigation should be completed. After the completion of the investigation, the DON stated the possible causal factors would be identified and new interventions to prevent [redacted] would be implemented after every [redacted] The surveyor asked the DON was it ever acceptable to keep a resident's head of bed low, feet up and half side rails up to prevent falls, and she stated 'No".

On 11/22/22 11:38 AM, the DON confirmed that there were no [redacted] assessments completed after the [redacted] sustained by Resident #119.

A review of the Accidents: Assessment, Prevention, and Interventions Policy, Effective 7/1/21 revealed: 1. It is the policy of the facility to complete a fall risk assessment for all residents ..., "after every f[redacted]" ..., Purpose: To ensure that all residents are properly assessed, and appropriate interventions are put in place to

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F 689	Continued From page 72 prevent falls. Responsibility: The licensed practical nurse completes the [redacted] risk assessment ...after every [redacted] ...,6. Nursing Staff Initiates and documents following safety measures and initiates [redacted] care plan, Licensed Nurse 7. If resident [redacted] or attempt to get up without assistance, assesses resident's needs to determine the cause of the behavior ... Licensed Nurse 9. All interventions must be indicated on the [redacted] care plan, 10. Must ensure that all interventions are in place and functioning if applicable. A review of the Comprehensive Care Planning Policy, effective 05/29/20, revealed a Purpose: To indicate the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being ..., Procedure: Interdisciplinary Team, 4. Updates are plan as need with changes in treatment, needs and condition.	F 689		
F 725 SS=E	NJAC 8:39-27.1 (a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		1/19/23

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F 725	Continued From page 73 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure a.) resident with a [redacted], who was at risk for [redacted] with an [redacted] r, was identified and interventions put in place to prevent [redacted] risk assessment was done [redacted] to identify causal factors and put interventions in place (Resident #119), c.) appropriate activities of daily living (ADL) care was provided (Resident #49, #34, #101, #114) and d.) a resident's known behaviors were documented and addressed (Resident #19). This deficient practice was evidenced by the following: Refer to: F 686, F 689, F 677, and F 742 a.) Resident #49 was observed on 11/07/22 in bed on his/her back. The surveyor observed that the lunch cart arrived at 11:50 AM. The surveyor	F 725	I. Immediate Action 1. Staff assigned to resident #49 were updated on resident□s status and educated on eating, bed mobility, need to provide frequent [redacted] checks and timely changes, turning and positioning and application [redacted] at all times while in bed. 2. Resident #119□s [redacted] evaluation was conducted and new interventions were put into place. 3. Residents #49, #34, #101 and #114□s [redacted] were cleaned, [redacted] and [redacted] a) An interdisciplinary team meeting will be held to discuss and address resident□s #19 behaviors to identify target behaviors, non-pharmacological interventions and develop care plan to manage resident□s behavior. 4. The facility is in constant contact with multiple staffing agencies to meet the	

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F 725	Continued From page 74 returned to Resident's #49's room at 12:05 PM to find the resident still sleeping. At 12:15 PM, the resident's lunch tray was observed on the bedside table untouched and out of the resident's reach. The Certified Nursing Assistant (CNA) arrived at 12:49 PM to assist the resident who only ate [redacted] Resident #49 was dependent on staff and had not been assisted in eating until [redacted] minutes after the tray arrived. On 11/14/22, the surveyor observed Resident #49 laying on their back in bed from 9:02 AM to 11:30 AM. The surveyor asked the CNA about Resident #49, and the CNA informed the surveyor that she did not provide morning care to the resident yet. The surveyor and CNA both observed that Resident #49's [redacted] had been [redacted]. Resident #49 had not been assisted in repositioning for over [redacted] hours and had not been assisted with [redacted] care. Record review revealed an entry by [redacted] care dated [redacted] that Resident #49 had a [redacted]. There were no new interventions in the Care Plan. A review of the progress notes up to [redacted] revealed the physician or dietitian had not been made aware as per policy, and no interventions were implemented. On 11/21/22 at 8:42 AM, the dietitian still had not formulated a plan regarding the resident's [redacted]. The resident was also weighed by the dietitian in the presence of the surveyor and weighed [redacted] pounds. Resident #49 had	F 725	staffing needs of the facility. 5. The facility continues to offer referral bonuses and incentives, advertised on social media, posted flyers in various community establishment, colleges and schools, partnered with CNA schools, banners along the facility property and word of mouth to employees and community. 6. The facility added a recruiter who specifically works on recruiting nurse and CNAs via an applicant tracking system, outside recruitment companies, posting of open positions and job fairs in the facility. 7. The Assistant Director of Nursing/Designee will continue to conduct weekly [redacted] rounds and update weekly [redacted] tracker. 8. Staff will be reinserviced by the Assistant Director of Nursing/Designee on identifying and reporting changes in wound condition 9. The Dietician will continue to audit weights II. Identification of Others: 1. The facility respectfully submits that all residents may be affected by this practice. III. System Changes 1. Policy and Procedure for Minimal Staffing was reviewed and the staffing coordinator was reeducated. 2. Policy and Procedure for [redacted] were reviewed by the Director of Nursing and Administrator and no revision necessary.	

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F 725	Continued From page 75 weighed [redacted] pounds on [redacted]. The dietitian was not aware Resident #49 was [redacted] himself/herself. The dietitian had not formulated a plan until three days after being made aware. Resident #49 had a [redacted] pounds in [redacted] days. b.) On 11/14/22 at 11:45 AM, the surveyor interviewed Resident #119's CNA who stated that Resident had not had any [redacted] The same day, the surveyor reviewed the resident's electronic medical records and discovered four documented [redacted] or incidents between [redacted] through [redacted]. Further review of the incidents revealed incomplete [redacted] risk assessments and incident reports. The direct care CNA was unaware of actual [redacted] for Resident #119. On 11/15/22 at 9:40 AM, during an interviewed with the surveyor, the resident in his/her [redacted] stated that he/she had [redacted] because of [redacted]. The surveyor conducted a telephone interview with an emergency contact (EC) of Resident #119. The EC stated she knew the resident had [redacted], and there were concerns that the resident had not always been changed timely. On 11/16/22 at 7:56 AM, the surveyor observed Resident #119 sleeping in a bed in the low position, and the leg portion of the bed was elevated, and the head portion was down with both one-half side rails in place. The surveyor did not see a call bell attached to the wall. At that time, the resident's assigned CNA #2 was in the room. The surveyor interviewed CNA #2 about the bed position for Resident #119 and CNA #2 stated that Resident #119 liked to get up out of	F 725	3. Policy and Procedure for Tray passing Plan was reviewed and will be revised by the Dietician to include tray passing and feeding of patients on a timely manner. 4. Policy and procedure for [redacted] was reviewed by the dietician, Director of Nursing and Assistant Director of Nursing and no revision was necessary. III. Quality Assurance 1. The facility Administrator and Human resource personnel will continue to track all recruitment efforts, referrals, applicants and hired employees on a monthly basis and the Administrator will report findings to the quality assurance and corporate team quarterly. 2. The Dietician will audit all identified weight loss weekly x 4 weeks, monthly x 2 months and quarterly x 3. 3. All negative findings will be brought to the Administrator immediately. 4. The results of all audits will be brought to the QAPI meeting quarterly x 4 quarters. 5. The Assistant Director of Nursing will conduct an audit will be conducted on identifying resident at are at risk for developing worsening of pressure ulcers weekly x 4 weeks, then monthly x 2 months and quarterly x 3 quarters. 6. All negative findings will be brought to	

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F 725	Continued From page 76 bed and that the resident's bed was usually left like that from the overnight shift. The CNA stated the resident has had a few [redacted] At that time, the surveyor inquired to CNA #2 if the Resident #119 had a call bell and CNA #2 looked for the call bell and stated, "I don't see a call light plugged in". On 11/16/22 at 8:22 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who was overseeing the unit at that time, and asked that she accompany the surveyor to Resident #119's room to observe the positioning of Resident #119 in bed. During the observation, the surveyor inquired to the ADON if Resident #119 was supposed to have the bed positioning the feet elevated and the head position lowered while in bed, with the half side rails elevated. The ADON stated "no", and stated the bed was supposed to be flat with the head of the bed also flat, and the side rails were used to prevent[redacted]. On 11/18/22 11:59 AM, the surveyor interviewed the DON who stated that after a resident [redacted] there should be a full risk assessment completed, and incident report with statements from the staff, and investigation should be completed. After the completion of the investigation, the DON stated the possible causal factors would be identified and new interventions to prevent [redacted] would be implemented after every[redacted] On 11/22/22 at 11:38 AM, the DON confirmed there were incomplete assessments and reports on Resident #119's [redacted]. The staff did not complete the assessments needed to develop and implement interventions for the resident. The resident did not have a call bell available. The resident's emergency contact	F 725	the Administrator immediately 7. The results of all audits will go to the QAPI meeting quarterly x 4 quarters. IV. Responsibility 1. Director of Nursing 2. Dietician 3. Administrator 4. Assistant Director of Nursing	

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had concerns about the resident being toileted enough.

c.) During facility tour on 11/07/22, surveyors observed dependent residents being reviewed for ADL care. Resident #49 was observed with [redacted] with a [redacted] under all the [redacted]. Resident #34 was observed with [redacted] with a [redacted] under the [redacted]. Resident #101 was noted with [redacted] with a [redacted] under the [redacted]

On 11/10/22 at 11:10 AM, the surveyor interviewed the Licensed Practical Nurse /Unit Manager regarding ADL care for dependent residents. The UM stated she knew the staff and she "trusted them." [to complete [redacted] care]. The surveyor then accompanied the UM to Resident #49, #34 and 101's Room, where we both the surveyor and UM observed that [redacted] care had not been provided. The resident's [redacted] were [redacted] and had a [redacted] from [redacted] underneath the [redacted]

On 11/16/22 at 7:56 AM, Resident #114 was observed awake in bed. The surveyor observed no call bell in the area. The CNA entered the room and confirmed there was no call bell for Resident #114 or his/her roommate. Resident #114 stated that he/she believed there were [redacted] on him/her. In the presence of the surveyor, the CNA checked and confirmed that Resident #114 had [redacted] on. The Assistant Director of Nursing (ADON) was present and stated, "I know the night staff is doing it."

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F 725	Continued From page 78 On 11/22/22 at 1:30 PM, the DON stated it was her expectation that dependent residents be provided with ADL care. d.) On 11/7 at 11:15 AM, the surveyor observed Resident #19 [redacted] into other resident rooms and talking loudly while in the hallway. The surveyor observed that staff attempted to redirect the resident but were unsuccessful. At 11:50 AM, two residents expressed concern regarding Resident#19 entering their room. The residents stated they were not afraid, but Resident #19 would take snacks of theirs. The surveyor had multiple observations of Resident #19 [redacted] the halls and in or out of other resident rooms. (11/17/22 at 10:37 AM, 11:15 AM, and 2:22 PM; 11/9/22 at 10:29 AM; 11/15/22 at 9:15 AM, 11/16/22 at 12:20 PM; and 11/18/22 at 10:54 AM) On 11/09/22 at 10:29 AM, the surveyor observed Resident #19 entering Room [redacted] There was no staff nearby to redirect. On 11/16 at 12:15 PM, the medication nurse could not provide behavior documentation on the behavior monitoring form. The nurse stated she was not familiar with the episodic charting. The staff could not provide documentation of the prevalence and frequency of Resident #19's behaviors. A review of medical records revealed that Resident #19 had a diagnosis which included [redacted]. The Care Plan noted the behaviors for Resident #19 and included that the staff should document behaviors and resident	F 725		

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F 725	Continued From page 79 response to interventions. The staff informed the surveyor that Resident #19 [redacted] daily, all the time, and all over the unit. The staff further stated that the resident could be [redacted], and difficult [redacted] Direct care staff had reported that Resident #19 [redacted] daily into other resident rooms, but there was no data documented to validate the [redacted]r. The monthly summaries provided by the facility also failed to capture the [redacted]. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 2/01/21: 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.	F 725		

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The surveyor requested staffing for the weeks of 10/23/2022 to 10/29/2022 and 10/30/2022 to 11/5/2022.

Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:

-10/23/22 had 13 CNAs for 125 residents on the day shift, required 16 CNAs.

-10/24/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.

-10/25/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.

-10/26/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.

-10/27/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.

-10/29/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.

-10/30/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs.

-10/31/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs.

-11/01/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs.

-11/02/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

(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 725	Continued From page 81 NJAC 8:39-5.1(a)	F 725		
F 732 SS=C	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. (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	F 732		1/19/23

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F 732	Continued From page 82 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 observations, interviews, and record review, it was determined that the facility failed to ensure that the 24-hour staffing information was posted and displayed in a place that was readily accessible to residents, family members, and the public. This deficient practice was evidenced by the following: The surveyor did not observe the 24-hour staffing information posted in a prominent area that was readily accessible to the public, residents or visitors on 11/9/22, 11/10/22, 11/14/22, 11/15/22, 11/16/22, and 11/18/22. This deficient practice was evidenced by the following: On 11/9/22 at 8:40 AM, 11/10/22 at 8:42 AM, 11/14/22 at 8:45 AM, 11/15/22 at 8:30 AM, and 11/18/22 at 8:33 AM, the surveyor observed the facility's "Alliance Staffing Sheet" in a clear plastic sleeve at the receptionist desk. The staffing sheet listed the date, name of the facility, day shift, evening shift, and night shift. It did not include the total number and the actual hours worked by the licensed and/or unlicensed personnel. On 11/16/22 at 10:23 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated she posted the staffing at the time clock, the front desk, the door of nursing office and on the nursing office clipboard. The Staffing coordinator showed the surveyor the facility's "Alliance Staffing Sheet" that was on the	F 732	I. Immediate Action 1. Upon identification of the concern, nursing staffing hours were posted at the front desk as per guidelines clearly visible to residents, visitors and staff. For residents that don't go down to the reception desk and requested staffing information, 24 hour Staffing information are posted in the lobby and will be provided to any residents, family and anyone that requested for it. 2. Education was provided to the staffing coordinator, nursing supervisors, and unit managers on nursing staffing data posting requirements and they verbalized understanding II. Identification of others: The facility respectfully submits that all residents may be affected by this practice. III. System Changes 1. The policy and procedure for posting nursing staffing data was shared with the Staffing Coordinator. 2. Reeducation will be given to staffing coordinator, nursing supervisors and unit managers on posting requirements. IV: Quality Assurance 1. Daily staffing posting will be checked by Human Resource Director for appropriate posting and report findings to	

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F 732	Continued From page 83 clipboard. The SC stated that they do not post the actual number or hours worked by the licensed/unlicensed staff. On 11/16/22 at 1:15 PM, during a follow up interview with the SC, she stated "I have the staff reporting sheet that I report to the state". She provided the surveyor with copies of the "New Jersey Department of Health (NJDOH)Nursing home Resident Care Staffing Report" for the day shift, the evening shift and the night shift for 11/16/22. This report listed the date, the census, the facility name, the number of staff and total hours worked. The SC stated that these reports are also in a binder that is kept at the receptionist desk. On 11/16/22 at 01:26 PM the surveyor observed a black "Staff Posting" binder behind the receptionist's desk. A review of the binder revealed the NJDOH Nursing home Resident Care Staffing Reports. On 11/18/22 at 08:59 AM, during an interview with the Director of Nursing (DON), the surveyor asked if the actual hours per shift of the licensed and unlicensed staff responsible for resident care was posted in a highly visible area that also includes the facilities name date and census. The DON stated, "I know staffing was posted but I don't think the hours were". A review of the facility policy titled, "Staffing Policy" reviewed 5/12/22, revealed Policy: As per federal requirements, Alliance Care Rehabilitation and Nursing Center will post nurse staffing information and census information in a prominent place readily accessible to residents and visitors. The information will be updated	F 732	the Administrator and Director of Nursing. 2. Audits will be conducted by Director of Nursing/Administrator/Designee on staffing postings to ensure completion weekly x4, monthly x2, and quarterly x4. 3. All negative findings will be brought to the Administrator/Director of Nursing for immediate correction. 4. Results of all audits will be brought to Quality Assurance and Performance Improvement committee quarterly x 4 quarters. V. Person responsible: Director of Nursing, Human Resources Director	

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F 732	Continued From page 84 every shift by the nurse supervisor. Information required is as follows: Facility name, Current date, Total number and actual hours worked, according to categories, for RN, LPN, and Nurse Aides, Resident census. NJAC 8:39-41.2(a)(d)	F 732		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, it was determined that the facility failed to: a.) document target behaviors for residents who are receiving [redacted] medications, b.) implement nonpharmacological interventions, and c.) develop care plan interventions to manage the behaviors of residents who displayed [redacted] behavior and [redacted] that was [redacted] This deficient practice was identified for Resident #19, one of 2 residents reviewed for behavior, and was evidenced by the following: During the initial tour on 11/07/22 at 10:37 AM,	F 742	I. Immediate Action a) An interdisciplinary team meeting will be held to discuss and address resident□s #19 behaviors to identify target behaviors, non-pharmacological interventions and develop care plan to manage resident□s behavior. b) Staff will be reinserviced on behavior management and documentation. II. Identification of others: a) An audit will be conducted by the Director of Nursing/Designee for all residents on [redacted] medications and known behaviors to ensure	1/19/23

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F 742	Continued From page 85 the surveyor observed a resident entering and exiting other residents' rooms. The resident was identified as Resident #19. On 11/07/22 at 10:40 AM, the surveyor asked the Unit Manager about challenging residents on the unit, she stated there were none. On 11/07/22 at 11:15 AM, the surveyor observed Resident #19 [redacted] in other resident's room. Resident #19 was talking out loud while ambulating in the hallway. A Certified Nursing Assistant (CNA) attempted to redirect Resident #19 to their room but was unsuccessful. On 11/07/22 at 11:50 AM, two residents (Resident #5 and #88) stated a resident would [redacted] into their room at night looking for a snack. Both residents stated they did not fear the resident, but they would like the behavior to be addressed. On 11/07/22 at 2:22 PM, the surveyor observed Resident #19 exiting room [redacted]. Resident #19 was talking out loud. On 11/09/22 at 10:29 AM, the surveyor observed Resident #19 entering Room [redacted]. There was no staff nearby to redirect. On 11/09/22 at 11:30 AM, the surveyor reviewed Resident #19's electronic medical record (EMR). The Admission Face Sheet reflected that Resident #19 was admitted to the facility with diagnoses which included but were not limited to [redacted] The Quarterly Minimum Data Set (MDS) dated	F 742	appropriate documentation and interventions for the behaviors are in place. b) All negative finding will be reported to the Director of Nursing and Primary Care Physician for immediate correction III. System Changes a) The policy and procedure for Behavior Management was reviewed by the Director of Nursing and no revision needed. b) Staff will be reinserviced on appropriately documenting target behaviors for residents who are receiving [redacted] medications which includes but not limited to episodic behaviors and monthly behavior notes, implement nonpharmacological interventions to manage the behaviors of residents who displayed [redacted] behavior and [redacted] to [redacted] behavior that was [redacted] IV: Quality Assurance a) Audits will be conducted by the Director of Nursing/Designee on all residents on [redacted] medications and known behaviors to ensure appropriate interventions and documentation are in place weekly x 4, monthly x 2, and quarterly x 4. b) All negative findings will be brought to the Director of Nursing and Administrator for immediate correction. c) Results of all audits will be brought to Quality Assurance and Performance Improvement (QAPI) committee quarterly x 4	

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F 742	Continued From page 86 [redacted] revealed that Resident #19 as [redacted]. Resident #19 did not have a score on the Brief Interview for Mental Status. [redacted] of the MDS which addressed behavior was coded as [redacted] indicative of no [redacted] received a "[redacted]o" value for the presence and frequency of behavior. [redacted] which addressed rejection of care received also a [redacted] value indicative of no behavior. Section E [redacted] which addressed wandering received a [redacted] value. Review of an Order Summary Report, with active orders as of [redacted] revealed that Resident #19 was prescribed the following medications: [redacted] milligrams (mg) every [redacted] hours orally for [redacted] (an [redacted] medication [redacted] mg [redacted] tablet [redacted] times a day orally for [redacted] (an [redacted] medication) [redacted] mg [redacted] tablet orally every [redacted] hours for [redacted]. [redacted]) [redacted] mg orally for [redacted]. The Behaviors to be monitored were: [redacted]. On 11/09/22 at 1:30 PM, the surveyor further reviewed the EMR, and the following entries were noted: [redacted], revealed that Resident #19 was involved in a [redacted] with another resident. [redacted], Observed in room, shirt stained, per staff uncooperative with care...	F 742	V. Person responsible: Director of Nursing	

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[redacted], Resident is [redacted]. Respiration easy and unlabored. Resident mostly quiet during day time, but other residents complaint that he went to their room at night time. Sometimes is he is very loud in the afternoon [redacted] when approach, unable to redirect at time. Due medications given as ordered. Seen by [redacted] meds increase, but behavior is the same. Called [redacted] again regarding resident behavior [redacted] to other resident room at night left message.

[redacted] Resident is uncooperative with taken med at Time [redacted] with care, [redacted] on the floor, in the closet, take other resident personal snacks, [redacted] precaution maintained. continue to walk around unit and [redacted] out sometime, redirect by staff and encourage to stay calm, snack offer and taken well resident vital signs are stable. Will continue monitor resident.

On the medication administration record, the nurses were to document the behaviors and indicated with a yes or no for the absence/ presence of the behaviors. The nurses documented [redacted] indicated no to a behavior. However, staff revealed that Resident #19 [redacted] daily, was uncooperative with care and other residents had expressed concerns over the behavior.

10/24/22, Resident is uncooperative with taking meds at time, non-compliant with care, [redacted] on the floor, in the closet, take other resident personal snacks, [redacted] precaution maintained. Continued to walk around unit and [redacted] out sometime, redirected by staff and encouraged to stay calm, snack offer and taken

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F 742	Continued From page 88 well resident vital signs are stable. Will continue monitor resident. On [redacted] at 10:11 AM, the surveyor interviewed the CNA who cared for Resident #19. The CNA stated that Resident #19 had behavior of being [redacted] and [redacted] other resident's room. The CNA further stated that Resident #19 would take other resident's snacks, could be very [redacted] all the time and all over the unit. On [redacted] at 12:15 PM, an interview with the lead CNA confirmed that Resident #19 was [redacted] toward staff [redacted] around the unit, displayed [redacted] behavior and was difficult to redirect. On [redacted] at 1:30 PM, the surveyor interviewed the UM who confirmed that Resident #19 [redacted] into other residents' rooms. The UM stated that Resident #19 was ordered medications for the [redacted]. When asked about other approaches used to curtail the [redacted] UM stated redirection helped at times. On [redacted] at 9:15 AM, the surveyor observed Resident #19 [redacted] in the hallway, clothing [redacted], [redacted]. On [redacted] at 12:20 PM, the surveyor Observed in the hallway [redacted] with [redacted]. The CNA stated she attempted earlier to provide care to Resident #19 but [redacted]. On [redacted] at 09:30 AM, the surveyor observed Resident #19 in the hallway, [redacted] and [redacted].	F 742		

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F 742	Continued From page 89	F 742		

On [redacted] at 10:54 AM, the surveyor interviewed the CNA assigned to Resident #19. The CNA stated that she offered shower to Resident #19 even on days that Resident #19 was not scheduled for shower but Resident #19 refused. The CNA stated when Resident #19 refused shower she would inform the UM and document in the shower log. The surveyor reviewed the shower log and could not find any documentation regarding refusal of care.

On [redacted] at 12:41 PM, the surveyor interviewed the MDS Coordinator regarding the coding on the MDS. The MDS Coordinator stated to complete the MDS she retrieved data from the EMR, interviewed the staff and the resident if the resident could be interviewed. The MDS Coordinator stated that Social Services staff were responsible to complete[redacted] of the MDS which addressed behavior.

On [redacted] at 12:55 PM, the surveyor interviewed the Social Worker (SW) who confirmed that she was aware of some of the [redacted], but she could not comment why the [redacted] was not coded on the MDS.

On [redacted] at 2:24 PM, the SW informed the surveyor that the behavior was not coded because the look back period had to be within 7 days. The SW provided the "Coding Instructions Sheet" to the surveyor. Under " Steps for Assessment, the following were to be fulfilled:
1. Review the resident's medical record for the 7-day look-back period.
2. Interview staff members and others who have had the opportunity to observe the resident in a variety of situation during the 7-day look-back

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period.
3. Observe the resident during conversations and the structured interviews in other assessments sections and listen for statements indicating an experience of [redacted]).
4. Clarify [redacted].

The SW did not have any input from the staff. During the interview the SW stated that she was aware of the [redacted] but did not elaborate further on actions taken to thoroughly complete the assessment.

On 11/16/22 at 12:15 PM, the surveyor interviewed the nurse on the medication cart, regarding monitoring for residents receiving [redacted] medication. The nurse could not provide the documentation. The behavior was not entered on the monitoring form. The nurse was not familiar with that type of charting.

The Care plan Resident #19 had a focus for [redacted] therapy for [redacted] medication). The goal was for Resident #19 to have fewer episode of [redacted], [redacted] interfering with ADLs. The interventions included: [redacted]. Approach in a [redacted] r. Assist to develop more appropriate methods of [redacted]. Encourage to [redacted] y. Document behaviors and resident's response to interventions.

The behavior of [redacted] observed by the surveyor, reported by the residents and staff was not documented in the monthly behavior summary. The behavior was not triggered on the

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F 742	Continued From page 91 MDS. A care plan that addressed the [redacted] behavior was implemented on [redacted], after surveyor inquiry. The care plan for [redacted] Drug use was not specific and failed to address any non-pharmacological interventions that were utilized by direct care staff to curtail the [redacted] The above concerns were discussed with the administrative staff on 11/22/22. On 11/22/22 at 12:36 PM, the DON provided a policy titled, " Managing/ Documenting Resident Behaviors dated [redacted] last revised [redacted]. The policy revealed: It is the policy of the facility to monitor residents' behavior and document behaviors in the medical record. Purpose: To provide a method of addressing resident behaviors, documenting behaviors. Procedure: Registered Nurse: Assesses resident for history of behaviors, how behaviors have been managed in the past, what triggers the behaviors, and what pharmacological and non-pharmacological interventions have been successful. Licensed Nurse: Documents episodically in medical record to include where possible, cause, or trigger, all interventions attempted, disruption to others and duration of episode. The monthly summaries provided failed to capture the behaviors. There was no documentation in the Interdisciplinary Progress Notes (IDCPN) regarding what staff's interventions will be utilized to reduce the episodes. The policy was not being followed. NJAC 8:39- 28.1 (c)	F 742		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		1/19/23

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F 812	Continued From page 92 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to maintain the kitchen, and pantry areas, in a clean and sanitary manner to limit the spread of infection and potential food borne illness by failing to ensure: a.) the environment and kitchen equipment was maintained in a manner to limit the potential for microbial growth, b.) the dish machine was operated within appropriate temperature specifications per the policy, c.) the [redacted] test strips were used per manufacturer's directions, and d.) resident food stored in unit refrigerators was labeled and dated. The deficient practice occurred was observed in the main kitchen, and in the [redacted] and [redacted] floor resident pantry, and was evidenced by the following:	F 812	I. Immediate Attention 1) The can opener affixed to the metal table and the cutting board was replaced immediately. 2) The walls behind the floor, beneath and the sides and front of the entire cooking equipment area, located under the hood, including the stove, fryer and ovens were cleaned, the area was power washed and re-painted. 3) Gaskets for all refrigerators were replaced 4) The exterior of the ice machine holder soiled with debris: ice machine holder was immediately cleaned 5) The dry storage room was cleaned of all debris and all storage containers and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 93 Reference: U.S. Food & Drug Administration, 2017 Food Code, 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49 degrees C (120 degrees F). On 11/07/22 at from 8:58 AM to 9:26 AM, the surveyor conducted an initial tour of the kitchen with the food Service Director (FSD), and Registered Dietitian (RD) and observed the following: 1. The can opener affixed to the metal table was visibly soiled with dark caked on debris on the blade and the blue insert. 2. The walls behind, the floor beneath and the sides and front of the entire cooking equipment area located under the hood, which included the stove, fryer, and ovens was visible soiled with copious amounts of food and dark colored grease like debris. The debris included what appeared to be a burnt potato on the on the floor, and various other debris. The RD acknowledged the area was not clean. 3. The reach in refrigeration units located near the cooking area (Box # 3 and #4) had ripped door gaskets with embedded dark debris. 4. The exterior of the ice machine holder was soiled with debris and when the surveyor asked the FSD how often it was cleaned, the FSD stated weekly. The surveyor inquired to the FSD how often cleaning was completed for the kitchen, and she stated it was not cleaned daily.	F 812	lids were cleaned and sanitized 6) The floor underneath the racks in the dry storage room was immediately cleaned 7) The small handwashing sink, handles and darkened areas was immediately cleaned 8) The 4th floor pantry refrigerator was cleaned and all unlabeled and undated food items were discarded 9) The [redacted] floor pantry counter and ice machine baffle were cleaned 10) The [redacted] floor pantry floor and sink areas were cleaned 11) A low temp chemical sanitizer was used in the dish machine and checked to ensure staff follow manufacturer's direction as printed on the [redacted] strip color chart which states "dip and remove quickly. Blot immediately with paper towel. Compare to color chart at once." 12) The kitchen cleaning schedule was posted visible to all dietary staff and all were reinserviced. II. Identification of others a) The Certified Dietary Manager (CDM) performed an audit of all areas identified with issues and no additional findings were noted. III. Systemic Changes a) The Policy and Procedure titled Dating and Labeling all items was reviewed by the Administrator and CDM and found to be in compliance. b) The Policy and Procedure titled Receivable and Storage Policy was reviewed by the Administrator and CDM	

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F 812	Continued From page 94 The surveyor asked to provide a copy of a cleaning schedule and the FSD provided a copy of a cleaning schedule dated 11/01/22 and titled "Cleaning list to be done daily by dietary employee". The FSD stated she could not locate a recent daily cleaning schedule and stated the list was completed weekly. At that time the FSD stated she did not have a currently completed cleaning schedule and provided the surveyor with the copy of the most recently completed schedule, dated 11/01/22, which revealed: 1. Clean the two ice cream boxes, 2. Clean the two milk boxes, 3. Clean the oven, 4. Clean the storage room and label everything, 5. Clean the walking in fridge and freezer, 6. Clean the drain waste and sink (meat washer), 7. Clean and remove pots then put back in place, 8. Clean top counter, 9. Clean the two fridge and label the food as well, 10. Clean the vegetables freezer, 11. Clean and remove dishwasher rack to clean the bottom floor,12. Clean all the carts. The FSD also provided the surveyor with a blank copy of the "Daily Cleaning schedule four our Dietary Dept [Department]" which revealed: Clean legs and wheels for all the carts, Clean behind the kitchen equipment, Clean dollies, Clean all food carts and lids, Clean all garbage cans, Wipe all walls, Coffee urns/ inside out, Stoves, steam tables, steamers, sinks, drains, Broom room, Sweep and mop after each meal, Dish machine is cleaned after each meal, Coffee mugs are cleaned every Thursdays, Milk boxes as needed, Walking refrigerator and freezer as needed, Ice maker once a month is emptied out and cleaned (Usually first week of the month), Power wash floors, Take stove burners top holding parts apart once a week and clean inside. 5. The dry storage room had debris and soiled	F 812	and found to be in compliance. c) The Policy and Procedure titled Sanitizing Food Surfaces was reviewed by the Administrator and CDM and found to be in compliance. d) The Policy and Procedure titled Ice Machine Sanitation Policy was reviewed by the Administrator and CDM and found to be in compliance. e) The Policy and Procedure titled Kitchen Equipment/ General Cleaning was reviewed by the Administrator and CDM and found to be in compliance. f) The Policy and Procedure titled Pantry Cleaning Policy was reviewed by the Administrator and CDM and found to be in compliance. g) The Policy and Procedure titled Pantry Refrigerator Policy was reviewed by the Administrator and CDM and found to be in compliance. h) The Policy and Procedure titled Pot Washing Policy was reviewed by the Administrator and CDM and found to be in compliance. i) All kitchen staff will be reeducated by the Certified Dietary Manager on the following topics. a. Dating and Labeling of Food Items procedure b. Receivable and Storing procedures c. Sanitizing Surfaces procedures d. Ice Machine Sanitation Procedures e. Kitchen Equipment General Cleaning procedures f. Refrigerator Cleaning procedure g. Dish Machine Policy h. Pot washing procedure	

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F 812	Continued From page 95 areas on the container lids that covered the individual ketchup and mustard packets. The surveyor asked the FSD if the lids were cleaned, and she stated "weekly". 6. The floor underneath the racks in the dry storage room were soiled with debris and crumbs. 7. The small handwashing sink was soiled with splatters on the sink, debris by the handles and darkened areas in the basin. On 11/07/22 at 1:20 PM, the Licensed Nursing Home Administrator provided the surveyor with a Certificate in Safe Food Handling from the Township of [name] Health Department dated 06/09/22 with the FSD's name. 8. On 11/10/22 at 10:56 Am, the surveyor toured the [redacted] floor pantry with the Licensed Practical Nurse Charge Nurse (LPNCN #1). The refrigerator contained an unlabeled food item in a bag. The LPNCN #1 picked the item up and stated, "it feels like a burrito or something", and confirmed there was no date on the bag. Another item was labeled with Resident #119's name, and the LPNCN #1 confirmed the item was not dated and usually things were brought in by Resident #119's spouse. 9. On 11/10/22 at 11:24 AM, the surveyor toured the [redacted] floor pantry with a Certified Nurse Aide (CNA). The surveyor observed food splatters on counter and ice machine baffle. 10. On 11/10/22 at 11:30 PM, the surveyor toured the [redacted] floor pantry with the Licensed Practical Nurse, Charge Nurse (LPNCN #2) and observed	F 812	IV. Quality Assurance 1. An audit tool was developed by the CDM to conduct audits on all areas of the kitchen including but not limited to dating and labeling of food, receivables and storage of food items, sanitizing food services, ice machine maintenance and cleaning, general kitchen cleaning, dry storage room cleaning, lead cleaning, floor cleaning, handwashing sink cleaning, pot washing, pantry cleaning dish machine cleaning. 2. The pantry refrigerators will be audited by the Dietician for unlabeled and undated food items weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. 3. Audits will be done by the CDM/Food Service Supervisor weekly x 4 weeks, monthly x 2 months, quarterly x 3 quarters. 4. Any negative findings will be brought to the Administrator immediately. 5. The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. V. Person Responsible: Certified Dietary Manager (CDM)	

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F 812	Continued From page 96 the floor area and sink area was soiled with debris. 11. On 11/14/22 at 9:33 AM, the surveyor conducted a follow-up tour of the kitchen, in the presence of the Corporate Food Service Director CFSD) and FSD, and observed the dish machine in operation, and the food service staff was removing insulated lids and bowls in racks from the clean side of the machine. At that time the surveyor asked the food service worker (FSW) who was loading the dish machine what the temperature should be for the machine to work properly. At that time the CFSD stated the temperature should be 120 for the wash which was the gauge on the left and 140 degrees farenheight (f) for the rinse, which was the gauge on the right, and the machine was a low temperature machine. The surveyor observed multiple racks being sent through the machine and observed that the wash and rinse temperature was less than 90 f and continued to vary as dish racks were sent through the machine. The surveyor's observations continued, and the rinse did not rise above 130 f. When asked the CFSD if the temperature was acceptable, he stated, "we have to wait, it takes time and it will get hot." When asked if the machine had a booster (helps water temperature rise), the CFSD stated the machine had a booster and it was working. The surveyor asked the CFSD if the items sent through the machine should be used if it is not the appropriate temperature, and he stated "no", and had the staff bring back the bowls and lids. The CFSD stated that the machine has a chemical sanitizer and when asked how you would know if the sanitizer was working, he proceeded to remove a piece of test strip from a [redacted] test strip reel	F 812		

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F 812	Continued From page 97	F 812		

and placed it directly in the water stream that was exiting the dish machine and proceeded to hold up the strip and show the surveyor the color chart as compared next to the strip. The surveyor observed that the strip was black when the CFSD held it up, and the FSD stated it was 100 (parts per million) and stated it "was okay." The surveyor then observed the printed manufacture's directions printed on the chlorine strip color chart which revealed "Dip and remove quickly. Blot immediately with paper towel. Compare to Color Chart at Once." (The CFSD did not follow the directions printed on the label). The surveyor then observed the dish machine in operation with empty racks being sent through and the temperature was monitored, with varied temperatures between 110-115 f wash and 118 f to 125 f rinse. At that time the FSD stated "stop washing it is going down [temperature]".

On 11/14/22 at 10:11 AM, the surveyor requested the dish machine policy and manufacture's specifications for the dish machine and policy from the CFSD.

On 11/14/22 at 11:45 AM, the Regional Administrator (RA) provided a Dish Machine Policy, dated 10/20/21, which was signed by the CFSD. The Policy revealed Low Temp [temperature] Machine = 120F (or Manufacture's or state Requirement), Policy Statement, Dishes are placed on rack and spray before entering dish machine, Wash and Rinse temperature should be 120F or above while sanitizer should be used at all times ...The [brand name] Chlorine test kit can be used to determine the concentration of chlorine solution. The color chart match should be at a minimum 50 to 100 PPM (parts per million to assure sanitation).

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F 812	Continued From page 98 On 10/14/22 at 12:35 PM, the RD provided the surveyor with the Policy for checking dish machine test strip, dated 10/20/21 and signed by the CFSD. ...Dip test strip in sanitizing solution for 10 seconds, [redacted] test kit) compared to chart. The color chart match should be the minimum 50 to 100 parts per million to assure sanitation. On 11/15/22 at 12:50 PM, the CFSD provided another Policy for checking dish Machine/Pot Test Strips dated 10/20/21 and signed by the CFSD. The Policy revealed Dip Test Strip in sanitizing solution for ten seconds, ([redacted] test kit) compared to chart. The color chart match [sic.], should be the minimum 50 to 100 PPM to assure sanitation. Record result in book. Immerse all items in solution for 60 seconds or longer. Testing is done at the end of the washing cycle for dish machine, for pots washing testing should be done before. The policy did not match the label of the chloring test strips and did not specify if the strip should be placed in the water exiting the dish machine. On 11/15/22 at 11:37 AM, the surveyor conducted a follow-up observation during the lunch meal service and observed the tray line process and in the presence of the CFSD. The surveyor observed a carboard box of plastic wrap on the table adjacent to the tray line which had a soiled and stained box. There were two plastic lids on the top of the tray line, both lids were upside down and being used to hold individual sauces and breakfast syrup and were stained with visible debris affixed to the lids. The surveyor showed the CFSD the lids and he proceeded to use his finger to wipe the debris from one of the lids.	F 812		

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F 812	Continued From page 99 On 11/18/22 at 1:00 PM, the RA provided the surveyor with the manufacture's Specification Sheet for the chlorine test strips. The Directions revealed "Dip the strip into the chlorine sanitizing solution, blot with paper towel, and then instantly compare the resulting color with the enclosed color chart ...". The Kitchen Cleaning Policy dated 08/21/21 and signed by the LNHA revealed: It is the policy of the [facility] to keep the kitchen clean at all times. Procedure: 1. Staff members must "clean as you go" at all times, 2. The kitchen must be swept and mopped after each meal, all food trucks after each use, 3. The kitchen walls must be cleaned weekly and as needed, 4. Carts, tables, shelves, containers under and behind equipment as needed. Refrigerators and freezers as needed. The Pantry Cleaning-Housekeeping Policy, dated 11/01/18 and signed by the LNHA revealed: It is the policy of the [facility] to ensure that unit pantries are maintained in a clean and functional order. Purpose: To maintain the cleanliness of areas involving food storage/handling. The Food from Outside: Safe Handling policy, dated 06/27/22 and signed by the LNHA revealed: It is the policy of [the facility] to store any personal resident food items that require refrigeration in the unit refrigerator under safe handling guidelines. Procedure: ...3. Writes name/room number and date/time on bag/container. 8. Discards all food remaining in refrigerator after 72 hours. NJAC 8:39-17.2(g)	F 812		
F 838 SS=F	Facility Assessment	F 838		1/19/23

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F 838	Continued From page 100 CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to,	F 838		

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F 838	Continued From page 101 (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that facility wide assessment included the resources required to establish policies and procedures for management of on-going outbreak [redacted] which dated back to [redacted] on the [redacted] Unit. This deficient practice was identified by the following. Reference F880, F882 On 11/07/22 at 10:53 AM, during entrance conference, the facility Licensed Nursing Home	F 838	I. Immediate Action a) The Facility Assessment will be revised by the Administrator to include the resources required to establish policies and procedures for management of ongoing outbreak of [redacted]. II. Identification of Others: a) The Infection Preventionist will perform an audit of all current residents that are diagnosed with [redacted] and ensure there is an appropriate plan of care are in place to protect other residents. III. System Changes:	

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F 838	Continued From page 102 Administrator (LNHA) informed the survey team that the facility was currently in an [redacted]. The survey team was informed that there were currently nine cases in the facility and the residents resided on the [redacted] unit. The LNHA stated the facility Infection Preventionist, communicated with the Department of Health and there was a line listing for the C. Auris cases. On 11/09/22 at 11:16 AM, during an interview with the survey team, the facility regional Registered Nurse (RRN) stated that the facility did not have a C. Auris line list, so he created one. The RRN stated that he had created the list without conferring first with the facility's uncertified Assistant Director of Nursing Infection Preventionist (ADON/IP). On 11/09/22 at 11:44 AM, the ADON/IP stated the nursing staff would test the [redacted] and [redacted]. [redacted] every [redacted] months. She stated that the UM also included other residents on the unit for testing. There were more than [redacted] residents on the unit during the last test period, but only [redacted] were tested. The ADON/IP further stated that the results were placed on the resident's chart in the EHR from the lab report. She stated that she was in contact with the local health department. The ADON/IP staff that staff were educated on the proper Personal Protective Equipment (PPE) to use which included gown, goggles, N95 and if serving meals or administering medications, doff (remove) full PPE and except the face shield which could be cleaned and reused. She stated that the cleaning product used in the resident rooms with [redacted], was [redacted] On 11/15/22 at 1:16 PM, the surveyor interviewed	F 838	a) The Policy and Procedure titled Facility Assessment was reviewed and revised to include Identification of patients diagnosed with [redacted] prior to admission. b) Education will be provided by the Infection Preventionist to all Admission Personnel on screening for [redacted] patients for all potential residents prior to admission and discussing with Administrator/Director of Nursing to determine if the facility can ensure the safety of others if admitted. c) Education will be provided to all staff by the Infection Preventionist/Staff Educator regarding following proper protocols when caring for patients with [redacted]. d) The Infection Preventionist will perform staff competencies on new hires and all staff annually and as needed on how to care for patients with [redacted] IV. Quality Assurance a) Audits on [redacted] patients charts will be done by the Infection Preventionist to ensure appropriate plan of care is in place weekly x 4 weeks, monthly x 2 months and Quarterly x 3 quarters. b) Any negative findings will be brought to the Administrator. c) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. V. Person Responsible: Administrator	

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F 838	Continued From page 103	F 838		

the Manager of Housekeeping (MH) in the presence of the survey team. The MH stated that the facility used [redacted] Wipes and [redacted] for cleaning. The MH confirmed [redacted] did not kill [redacted] but that [redacted] did.

On 11/18/22 at 10:23 AM, the surveyor requested a copy of the Facility Assessment (Intent, for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require). Review of the Facility Assessment revealed that the facility, "may accept residents with, or residents may develop, the following common diseases, conditions, physical and cognitive disabilities. .. ....We are always working to educate our staff to expand diseases/ conditions, physical, and cognitive disabilities we can care for to expand our service to greater numbers of our community." The facility failed to list [redacted] under the Infectious Disease section. The Facility Assessment revealed that Infection Prevention and Control were provided directly by the facility staff and not by contracted services. The Facility Assessments further revealed that when a resident develops a new diagnosis, condition, or symptom, the Director of Nursing (DON) and the facility educator would ensure staff competency to care for the resident. The facility must update the assessment as needed or at least annually.

On 11/22/22 at 12:54 PM, a surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA) in the presence of the survey team who stated that the purpose of the Facility Assessment was to communicate the needs of the facility and it was required to be updated yearly. Review of the Facility

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F 838	Continued From page 104 Assessment indicated that it was updated in [redacted] the month and day were not specified. When the surveyor asked if [redacted] should have been included in the Facility Assessment, the RLNHA replied that all of the needs of the facility that are required to provide care for the residents should have been included in the Facility Assessment. The facility had been in [redacted] outbreak since [redacted] per facility interviews. The facility revealed the last review of the Facility Assessment had been in [redacted] (no specific date). The [redacted] had not been identified or addressed. Facility staff interviews revealed either discrepancies in how to mitigate the spread of [redacted], or lack of information. NJAC 8:39-19.1 (a)(b)	F 838		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §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)	F 868		12/23/22

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F 868	Continued From page 105 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 interview and record review, it was determined that the facility failed to provide documentation that the Quality Assurance Performance Improvement (QAPI) committee met at least quarterly. This deficient practice was identified for 2 of 4 meetings for the year 2022, and was evidenced by the following: On 11/07/22 at 10:47 AM during the entrance conference meeting, the Licensed Nursing Home Administrator (LNHA) stated the facility held quarterly QAPI meetings. On 11/14/22 at 10:45 AM, Surveyor #2 interviewed the Infectious Disease Doctor (IDD) via speaker phone (with permission) in the presence of the survey team. The IDD stated that his role has been mainly for education and	F 868	F868 QAA Committee Assessment Level E I. Immediate Action a) All future QAA meetings will be scheduled at a time that all required members can attend. This includes the Medical Director, Administrator, Director of Social Work, Director of Nursing and the individual designated as the Infection Preventionist, must be a member of the facility's Quality Assurance and Performance Improvement (QAPI) committee. II. Identification of others a) The facility respectfully submits that all mandatory attendees will be in attendance for all future Quality	

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F 868	Continued From page 106 antibiotic stewardship. The IDD stated that he was not aware that the facility had consistent cases of [redacted]. The IDD stated, "That is a new one." He further stated, "I did not realize there was an outbreak of [redacted] at the facility, and if I knew I would have helped them to address it." The IDD stated that he was unaware that here had been cases of [redacted] at the facility since [redacted]. The IDD stated that he did not know who had the [redacted] but would address it and help them out but needed to know what the underlying problem or cause was to do so. He further stated that contributing factors may have been related to environmental cleaning or improper personal protective equipment (PPE, equipment or clothing worn to protect the body from infection) adherence. On 11/22/22 at 10:13 AM, Surveyor #2 interviewed the primary Medical Director (MD) via speaker phone (with permission) in the presence of the survey team. The MD stated that he attended Quality Assurance (QA) Meetings every three months and was unsure who the facility IDD was. The MD stated that he would not know if [redacted] had been discussed during QA. On 11/23/22 the surveyor requested the QAPI sign in sheets for review. At 8:53 AM, the Director of Nursing (DON) provided the surveyor with sign-in sheets from "Quarterly QAPI Meeting" dated 07/13/22 and 10/17/22. On 11/23/22 at 9:27 AM, during an interview with Surveyor #1, the LNHA stated that there was a QAPI committee. The LNHA stated that there was a "full" meeting every three months [quarterly] which included staff such as the Infection Preventionist (IP), DON, the department heads,	F 868	Assurance and Performance Improvement committee (QAPI) meetings. III. System Changes a) The Policy and Procedure for Quality Assurance Performance Improvement (QAPI) was reviewed and revised by the Administrator, Medical Director and Director of Nursing to include scheduling of QAPI meetings in advance to ensure all required members can attend. Completion Date 12/23/2022 b) Education of all Department Heads, Director of Nursing, Administrator and Medical Director of the importance of Quality Assurance and Performance Improvement (QAPI) in identifying quality issues and their participation and attendance is vital to the success of the program. Completion date 12/23/2022 IV. Quality Assurance a) Audits will be done of each Quality Assurance and Performance Improvement (QAPI) meeting by the Administrator to ensure the required members were in attendance. b) Audits will be done Quarterly and for any additional QAPI meetings that were scheduled. V. Person Responsible: Administrator	

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F 868	Continued From page 107 vendors, Medical Director (MD), and nurses from all units. The LNHA stated the committee would address any issues that were discovered by staff or supervisors, or that were discovered via reports and information or education she had obtained and thought should be included. The LNHA stated the committee would perform a risk analysis to ensure the interventions for the concerns were implemented and if there were revisions to be made. On 11/23/22 at 9:36 AM, surveyor #1 asked the LNHA if the on-going Candid Auris concern had been addressed in QAPI. The LNHA stated she had not been aware of the problem of [redacted] because of the change of the Infection Preventionist. The LNHA stated that [redacted] would be the goal of QAPI now. The surveyor requested the missing two QAPI Meeting sign-in sheets for the year [redacted]. The LNHA stated that she had started at the facility in [redacted] and was unable to locate documentation for any prior QAPI meetings. A review of the facility provided, "Infection Prevention and Control Program" dated 06/27/22, included but was not limited to responsibilities: infection prevention oversight committee Quality Assurance (QA) committee has ultimate responsibility for overseeing and implementing the infection prevention/control program is delegated to the QA committee. The QA committee shall meet no less than quarterly and maintain written minutes with documentation of agenda items, discussion and actions/recommendations. Responsibilities include but may not be limited to review of findings related to facility-associated infections,	F 868		

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F 868	Continued From page 108 outbreak investigations. A review of the facility provided, "QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI)" reviewed 07/12/22, included but was not limited to Policy: ....to create a homelike environment where the needs of residents will be addressed by competent, highly skilled and compassionate staff. The staff [redacted] are committed to enhancing the quality of life of each resident in order to achieve their optimal level of wellness. Purpose: to study, plan, analyze, and validate specific areas of improvement for positive resident care outcomes. Guiding Principles: 3. we will use QAPI to make decisions to guide our day-to-day operations. 4. we will set goals for performance and measure progress towards those goals. 6. we will research best practices and standards of care, to ensure we are delivering the highest quality of care and services to our residents. Reference: "Title 42 - Public Health CHAPTER IV - CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER G - STANDARDS AND CERTIFICATION PART 483 - REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES Subpart B - Requirements for Long Term Care Facilities § 483.75 Quality assurance and performance improvement" last amended 11/23/22, included but was not limited to: each LTC (Long Term Care) facility ... .must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must "(1) Maintain documentation and demonstrate evidence of its ongoing QAPI	F 868		

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F 868	Continued From page 109 program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;" and "Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program." The facility failed to maintain documents and evidence of the ongoing quarterly QAPI program meetings. NJAC 8:39-33.1(b)	F 868		
F 880 SS=F	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		1/12/23

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F 880	Continued From page 110	F 880		

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 111 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: Complaint #NJ00158982 Refer to F882 Based on observations, interviews, medical record review, and review of other facility documentation, it was determined that the facility failed to minimize the spread of infection during a [redacted]) Outbreak by failing to ensure: a) staff donned (put on) the required Personal Protective Equipment (PPE, garments or equipment used to protect the body from infection) prior to room entry of residents on transmission based precautions (isolation protocol) and performed hand hygiene when indicated b) housekeeping staff utilized cleaning products that were effective against [redacted] c) maintained ongoing communication with the on-site [redacted] center regarding the status of residents who required transmission based precautions (isolation) during dialysis treatment due to [redacted] d) the facility assessment was updated to include staff roles and responsibilities related to the care of residents diagnosed with [redacted] at the facility. This deficient practice was identified for (three) 3 of 5 (five) residents (Residents #113, #115 and an unsampled resident) reviewed for transmission	F 880	I. Immediate Action 1. Resident #113 a) CNA and unit staff members who failed to practice hand washing and proper donning and doffing of PPE were reinserviced and individually counseled by Assistant Director of Nursing on standards of infection control practices with return demonstration. b) All staff were reinserviced on the proper procedures for donning and doffing PPE when caring for [redacted] residents and on hand washing. Resident #115 a) Housekeeping staff was reinserviced on proper donning and doffing of PPE, proper hand washing and proper use of ABHR prior to entering and exiting a room of a resident with [redacted]. b) All housekeeping staff reinserviced on utilization of facility provided hand sanitizer and were educated on appropriate cleaning products to use to prevent the spread of [redacted] 2. Resident #113 and #115 a) An audit of all communication with the [redacted] center was performed for residents #113 and #115 and it was determined that the [redacted] center was	

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F 880	Continued From page 112 based precautions on 1 of 1 nursing unit, [redacted] Floor[redacted] and [redacted] Unit, in accordance with acceptable standards of infection control practice and was evidenced by the following: Surveyor A 1. On 11/10/22 at 10:53 AM, the surveyor observed Resident #113 lying in bed talking on the telephone. There was signage on the outside of the resident's door which indicated that the resident was on transmission based precautions (TBP) and droplet precautions were in place and instructed that everyone who entered must: Clean their hands, including before entering and when leaving the room, make sure their eyes, nose and mouth are fully covered before room entry, remove face protection before room exit. A second sign cautioned that Contact Precautions were also in place and everyone must: Clean their hands, including before and after entering the room. It further instructed providers and staff to: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit... On 11/10/22 at 12:16 PM, the surveyor observed the Certified Nursing Assistant (CNA) who wore only a surgical mask and did not perform hand hygiene with the alcohol based hand rub (ABHR) that was present on top of the fully stocked PPE cart that was outside of the resident's room as she prepared to don her PPE. The CNA donned a gown and did not don gloves prior to entering Resident #113's room before she picked up the resident's meal tray with her bare hands and carried it out to the food cart that was outside of the resident's room. The CNA then proceeded to	F 880	appropriately notified of the resident□s [redacted] status prior to the residents starting treatment. b) [redacted] Communication Log was revised to include residents□ isolation requirements and diagnosis to ensure enhanced communication with the [redacted] center. c) The facility updated the [redacted] line list and reinserviced the unit staff 3. The facility Assessment was updated to include [redacted]. 4. Resident #92 a) The LPN was reinserviced on the proper procedures for Donning and Doffing PPE when caring for [redacted] residents and on hand washing. II. Identification of others: The facility respectfully submits that all residents can potentially be affected by this deficient practice. III. System Changes a) The Policies and Procedures on Infection Control for [redacted] were reviewed and will be revised by the Administrator, Director of Nursing, and Medical Director to include enhanced communication with the [redacted] center and revision of the [redacted] communication log, all residents on the [redacted] floor who are negative for [redacted] will continue to be tested every 4 weeks as per DOH guidelines, and a line list will be provided to the [redacted] center and the facility□s DOH contact person after testing every	

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F 880	Continued From page 113 doff her gown and surgical mask and placed it in the trash can inside the resident's room. The CNA came out of the resident's room, obtained a new surgical mask which she donned without first performing hand hygiene. When interviewed, the CNA stated that Resident #113 had [redacted] and was on contact isolation. The CNA stated that gloves, eye protection and hand hygiene were not required if direct care was not provided to the resident. The CNA acknowledged that she failed to perform hand hygiene after she doffed her gown and surgical mask and exited the resident's room. The CNA stated that she also failed to perform hand hygiene before she obtained a new surgical mask from the PPE cart and donned it, because the surveyor wanted to speak with her. The CNA stated that she received an in-service related to [redacted] precautions which required that she must wear full PE as indicated on the signage to enter the room, doff the PPE in the room and wash her hands when she came out of the room. Review of Resident #113's Admission Record, an admission summary, revealed that the resident was admitted to the facility in [redacted] with diagnoses which included but were not limited to: [redacted]. Review of Resident #113's quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] which indicated that the resident was [redacted]. Further review of the	F 880	month. b) Reeducation will be given to all staff members by Staff Educator on proper infection control guideline for [redacted]. c) The Policy and Procedure for Donning and Doffing of PPE and Hand Washing was reviewed and found to be in compliance. Completion date IV: Quality Assurance 1. Donning and doffing of PPE and hand washing will audits will be done by the Assistant Director of Nursing/Infection Preventionist/Designee for at least 3 staff members weekly x 4 weeks, monthly x 2 weeks and quarterly x 4 quarters. 2. An audit will be conducted by the Housekeeping Director on the appropriate use of cleaning products to use for disinfection for resident□s rooms with [redacted] weekly x 4 weeks, monthly x 2 weeks and quarterly x 4 quarters. 3. Audits will be conducted by the Director of Nursing/Infection Preventionist/Designee on all [redacted] residents that are positive for [redacted] to ensure continuous communication of [redacted] status through the [redacted] communication log weekly x4, monthly x2, and quarterly x4 quarters. 4. The Housekeeping Director will conduct an audit to ensure housekeeping staff are utilizing the correct cleaning products for room of residents with [redacted] weekly x 4 weeks, monthly x 2, quarterly x	

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F 880	Continued From page 114 assessment revealed that the resident required total dependence of [redacted] persons for bed mobility and transfers to the wheelchair and required limited assistance of one person for eating. Active diagnoses included [redacted]. On 11/10/22 at 12:33 PM, the surveyor interviewed the Assistant Director of Nursing Uncertified Appointed Infection Preventionist (ADONUAIP) in the presence of the survey team, who stated that the staff on the [redacted] Unit were in-serviced and informed that a gown, N95 mask (respirator that filters 95% of particles), gloves and face shield were required to be worn to enter resident rooms who had [redacted] and hand hygiene was required to be performed both before entry and prior to exiting the room. The ADONUAIP stated that ABHR was preferred over handwashing. When the surveyor informed the ADONUAIP of the observation of the CNA who entered Resident #113's room she stated, "That was a big No, No for the aides to go into the isolation rooms without gloves on and a failure to perform hand hygiene." The ADONUAIP stated, "She did not know if the staff did not understand or if they just did not want to listen to us." The ADONUAIP explained that an N95 was required to enter the resident's room, though she did not know why, as that was what she had learned. The ADONUAIP further stated, staff may wear a surgical mask in the hallway and when they entered the resident's room they must then wear full PPE as directed to prevent the further spread of infection. On 11/10/22 at 10:23 AM, the surveyor interviewed the Director of Respiratory Therapy (DORT) who stated that Resident #115 was on both Contact and Droplet Precautions due to [redacted]	F 880	4 quarters. 5.All negative findings will be brought to the Administrator and Director of Nursing and Administrator for immediate correction. 6. All findings will be presented to Quality Assurance and Performance Improvement committee for 4 quarters. V.DPOC a) A root cause analysis was completed and determined the facility failed to minimize the spread of infection of [redacted] that presents serious health risk by failing to ensure: a) staff donned (put on) the required PPE prior to room entry of residents on transmission based precautions and performed hand hygiene when indicated b) housekeeping staff utilized cleaning products that were effective against [redacted] c) maintained ongoing communication with the on-site [redacted] treatment center due to [redacted] d) the facility assessment was updated to include staff roles and responsibilities related to the care pf residents diagnosed with [redacted] at the facility. b) The Infection Preventionist will complete the CDC□s Infection Preventionist training in order to help facilitate enhanced compliance with infection control and prevention. c) The Infection Preventionist and Director of Nursing/Designee and other nursing leadership will conduct rounds throughout the facility to ensure all staff is	

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F 880	Continued From page 115 [redacted] and indicated that full PPE which included an N95 respirator mask was required in order to enter the resident's room. There was signage posted on the outside of the resident's room which provided full instruction for PPE usage and hand hygiene. At 10:25 AM, the surveyor entered Resident #115's room and observed that the resident was ventilator dependent and was [redacted] due to [redacted]. The resident was able to make his/her needs known by silently mouthing words. Review of Resident #115's Admission Record revealed that the resident was admitted to the facility in [redacted] with diagnoses which included but were not limited to: [redacted] Review of Resident #115's quarterly MDS, dated [redacted], revealed that the resident's BIMS score was [redacted] which indicated that the resident was [redacted] Further review of the MDS revealed that the resident required total dependence of [redacted] for bed mobility and transfers. Active diagnoses included [redacted], and [redacted]. On 11/15/22 at 12:27 PM, the surveyor observed the Housekeeper (HK) outside of Resident #115's room. When interviewed, the HK stated she had worked at the facility for one month and filled in for the full-time HK who was off that day and did not normally work on the unit. The HK stated that	F 880	exercising appropriate use of PPE and to ensure infection control procedures are being followed. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. d) The Infection Preventionists or Director of Nursing/Designee will monitor the [redacted] Communication Binders containing the [redacted] Communication Logs to ensure that the facility the [redacted] center of residents requiring ongoing transmission-based precautions. e) The Housekeeping Manager will conduct rounds throughout the facility to ensure that housekeeping staff are utilizing the correct cleaning products. Ad hoc education will be provided to persons who are not utilizing the correct cleaning products. f) The facility shall provide inservice training to appropriate staff as follows: " Nursing Home Infection Preventionist Training Course Module 1 Infection Prevention & Control Program https: //www. train.org/main/course/1081350 Provide the training to: Topline staff and infection preventionist " CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https ://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff	

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F 880	Continued From page 116 she used [redacted] wipes to wipe the mop and broom handles and used [redacted] to wipe down all other room surfaces, and [redacted] to mop the floors. On 11/15/22 at 12:42 PM, the surveyor observed the HK as she prepared to enter Resident #115's room. When interviewed, she stated that a face mask, goggles, gown and gloves were required to enter the resident's room. The HK then proceeded to don gloves, then donned a gown and left the gown untied in the back and the arms of the gown hung down past her gloved hands. The HK then doffed (removed) her surgical mask and donned an N95 mask and face shield. The HK entered the resident's room and emptied the resident's trash and swept up a glove that was on the resident's floor into a dust pan. The HK then doffed her gown and gloves and lifted the lid of the trash can with her bare hands in order to dispose of her gown and gloves. The HK then doffed her N95 mask and lifted the lid of the trash can a second time with her bare hands and disposed of the N95 mask. The CNA then came out of the room and failed to perform hand hygiene before she accessed the PPE bin and obtained a new surgical mask which she donned beneath her face shield. When interviewed, the HK stated that she forgot to tie her gown in the back and was unsure of the order that she was supposed to don her PPE and whether her gloves or gown were to be donned first. The HK stated that she put her gown on first which left the gown to hang down over her hands. The HK stated that when she touched the lid to the trash can with her bare hands and then doffed her N95 mask without first performing hand hygiene there was a chance that she was exposed to "germs." When asked why she did not use the ABHR that was on	F 880	" CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces https: //youtu.be/t70H80Rr51g Provide the training to: Frontline staff " CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https: //youtu. be/xmYMU1y7qiE Provide the training to: Frontline staff " CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https: //youtu. be/YxT¿Tw9yav4 Provide the training to: Frontline staff " Nursing Home Infection Preventionist Training Course Module 5 Outbreaks https: //www. train. org/cdctrain/course/10818 03/ Provide the training to: Topline staff and infection preventionist " Nursing Home Infection Preventionist Training Course Module 11B □ Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ Provide the training to: All staff including topline staff and infection preventionist " Nursing Home Infection Preventionist Training Course Module 7 □ Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist " Nursing Home Infection Preventionist Training Course Module 6¿ □ principles of Standard Precautions	

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F 880	Continued From page 117 top of the PPE bin the HK stated that she normally carried her own personal hand sanitizer in her pocket but she forgot it today. The surveyor noted that there was a reference guide posted on the wall outside of the room which provided instruction for the sequence to don PPE. The HK then proceeded to review the signage that she reportedly had not noticed prior to the observation. On 11/15/22 at 1:16 PM, the surveyor interviewed the Manager of Housekeeping (MOH) in the presence of the survey team. The MOH stated that the facility used [redacted] Wipes and [redacted] for cleaning. The MOH confirmed that [redacted] did not [redacted], but that [redacted] did. The MOH stated that [redacted] wipes were required to clean room surfaces and [redacted] was required to be used to mop the floors in order to be effective against [redacted]. The MOH stated that staff were required to wear PPE according to the signage posted outside of the resident's room. The MOH stated that if the HK donned her gloves first the band of the gown would be opened. The MOH stated that if you donned the gown first and then the gloves, the band of the gown would remain closed to protect clothing. The MOH stated that the gown should have been tied in the back so that nothing gets on your clothes. The MOH stated if the gown were left open, that would be an infection control problem. The MOH stated it was also an infection control problem if the HK did not perform hand hygiene after she doffed her PPE, touched the trash can lid and before she donned a new surgical mask. The MOH stated that the HK staff should not have used her own hand sanitizer as staff were required to use the hand sanitizer that	F 880	https://www.train.org/main/course/1081804/ Provide the training to: All staff including topline staff and infection preventionist " Nursing Home Infection Preventionist Training Course Module 6B □ Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist VI. Person responsible: Administrator/Director of Nursing/Infection Preventionist	

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F 880	Continued From page 118 was provided on their housekeeping carts. The MOH explained that the HK staff did an AM tour, spot cleaned the floors and cleaned the [redacted] rooms last after their AM tour, so the room was already cleaned this morning prior to the surveyor's observation. The MOH stated that she would provide the HK with an in-service right now because they should not have cleaned [redacted] or [redacted] and should have donned/doffed PPE correctly to prevent the further spread of [redacted]. 2. On 11/10/22 at 11:15 AM, the surveyor reviewed both Resident #113's and Resident #115's [redacted] Communication Binders which contained [redacted] Communication Logs [redacted]) that were dated [redacted], and [redacted] and failed to contain documented evidence that the residents required ongoing transmission based precautions due to a diagnosis [redacted]. On 11/14/22 at 11:50 AM, the surveyor reviewed both Resident #113's and Resident #115's [redacted]s and noted that on [redacted], the [redacted]L failed to inform the receiving dialysis center that both residents had [redacted] and required transmission based precautions. On 11/14/22 at 12:36 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to the [redacted] Floor [redacted] Unit regarding Resident #113's and Resident #115's [redacted]. The LPN stated that the [redacted] center was informed verbally in report that the residents were [redacted] for [redacted] prior to [redacted] treatment. The LPN stated that the [redacted] center had a list of residents who were positive for [redacted] and also had access to the facility's electronic health record (EHR). The LPN stated that the [redacted] were completed by the	F 880		

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sending facility nurse and communicated the resident's medications and vital signs but maintained that the diagnosis of [redacted] was not required to be documented on the forms because it was in the EHR. The LPN stated that she did not document that she provided verbal report to the receiving [redacted] center in the nursing progress notes contained within the EHR.

On 11/14/22 at 1:02 PM, the surveyor interviewed the ADONUAIP in the presence of the survey team, who reported that she had filled in for the facility Infection Preventionist Nurse who was on vacation since the middle of October and was unsure when she would return. The ADONUAIP stated that before a resident was scheduled for dialysis treatment, the diagnosis of [redacted] was communicated so that staff were fully aware. The ADONUAIP explained that nursing called the dialysis center over the phone and she would have expected that nursing would have documented a diagnoses of [redacted] on the [redacted] as well. The ADONUAIP stated that she was unsure if the [redacted] center had access to the facility's EHR. The surveyor showed the ADONUAIP both Resident #113's and Resident #115's [redacted] and the ADONUAIP stated that she did not see that [redacted] status written on the forms as required. The ADONUAIP stated that, "We are going to start doing that." The ADONUAIP stated that she would emphasize that this was a [redacted] resident. The ADONUAIP provided the surveyor with the contact information for the Nurse Manager (NM) at the [redacted] center. The surveyor phoned the NM at 1:20 PM, and provided direct contact information on the voicemail to return the surveyor's phone call.

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F 880	Continued From page 120 On 11/16/22 at 12:13 PM, the surveyor interviewed the NM at the on-site, non-affiliated [redacted] center, who stated that there was an endorsement [redacted] Communication Log that listed several residents who were [redacted]. [redacted]s. The NM stated that the LPN from the long term care facility came to the [redacted] center today and informed her verbally that Resident #113 was positive for [redacted] The NM stated that the dialysis was not notified via the [redacted] and was not made aware prior to today. The NM stated that she learned of other [redacted] cases [redacted] at the facility via review of the hospital discharge summary. The NM maintained that Resident #113 was the only resident who was positive for [redacted] that the [redacted] center was unaware of. The NM stated that the sending facility nurse should have told the [redacted] staff the resident had [redacted]. The NM further stated that the dialysis nurses wore a gown, face shield, mask and gloves during the care of the resident who received [redacted] treatments. The NM further stated that since the resident was not on isolation to our knowledge, the nurse would have worn the same gown to treat all assigned residents and only changed his/her gloves between residents. The NM stated that if isolation was required the resident would have been put on the [redacted] machine at the end of the room and double disinfected and cleaned the [redacted] machines and chairs more thoroughly with [redacted]. The NM stated that the [redacted] center was unable to assign designated staff due to short staffing. The NM stated that the nursing staff were also told not to wear the same gown to care for other residents that they have worn to care for a resident known to have [redacted] to prevent transmission. The	F 880		

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surveyor asked the NM to provide a list of all residents at the long-term care facility who received [redacted] at the center and were known to have a diagnoses of [redacted].

11/16/22 12:49 PM, the surveyor interviewed the LPN who stated that she did not speak to anyone at the [redacted] center about Resident #113. The LPN stated that she was informed by the facility after she spoke with the surveyor, that the diagnoses of [redacted] was required to have been documented on the [redacted]. The LPN maintained that the dialysis center had the same EHR and the [redacted] center staff should have reviewed the computer system to confirm that the resident did not have [redacted] prior to treatments. The LPN further stated that she informed the NM of Resident #113's diagnoses of [redacted] along with several others. The surveyor noted that Resident #115 was not identified in the list that the LPN provided orally to the surveyor. The LPN stated that, "Some of the residents at the facility were not admitted with a confirmed diagnoses of [redacted]. [redacted] and developed it here because we test the residents monthly." The LPN stated that if she had a new resident, she would not jump to provide care and would instead review the resident's history first to see if the resident had an infection or not. The LPN stated that we do not document that the resident had [redacted] on the [redacted] and if it were not documented, it was not done. The LPN further stated that the spread of infection were a problem if the [redacted] center was not informed of the resident's diagnoses of [redacted] Auris prior to treatment due to the need to isolate the resident. The LPN stated that the NM asked her today which residents had [redacted], and she insisted that they did not have a conversation about it.

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F 880	Continued From page 122 On 11/16/22 at 1:29 PM, two surveyors went to the [redacted] center and interviewed the NM who stated that she was unable to demonstrate her view of the facility's EHR, "because it was not working right now." The NM instead referred the surveyors to the [redacted] Dietician ([redacted]) who demonstrated the EHR view for Resident #113's EHR and stated that they probably forgot to write it on the [redacted] Communication Record. The RD reviewed the Progress Notes and Medical Diagnoses sections with the surveyors. The NM stated that someone should have endorsed the resident's diagnoses of [redacted] to her. The NM stated, " I do not remember seeing isolation in the EHR." The RD replied, "That is because you do not have access to the EHR." The NM then proceeded to provide the surveyor with a list of residents at the facility for whom she had a confirmed diagnoses of [redacted] that was provided by the facility LPN. The surveyor reviewed the list and noted that Resident #115 was not on the list. When the surveyor asked why the resident was not on the list she stated. "Nobody told us that Resident #115 had [redacted] The NM stated when we received the list today, resident #115 had already had a treatment done earlier that morning. The NM confirmed that there was only one isolation room in the [redacted] center and it was not equipped for [redacted] residents. So the ventilator residents who have isolation needs were placed at the end of the [redacted] unit. On 11/16/22 at 1:39 PM, the NM took the two surveyors to the [redacted] unit and the surveyors observed that Resident #113 was in the only available isolation room. The NM stated that the nurse who was assigned to her was at lunch and was unable to be interviewed. The NM stated that	F 880		

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F 880	Continued From page 123 the [redacted] nurses only changed their gowns between residents if a resident was known to be on isolation. Otherwise the same gown was worn between residents. The NM stated that a 1:100 [redacted] concentration was used to disinfect the [redacted] which are passed into [redacted] and chairs for non-isolation residents and a [redacted] concentration was used to disinfect the [redacted] and chairs for known isolation residents. On 11/16/17 at 1:47 PM, in a later interview with the NM she stated, "Moving forward Resident #115 would now need to be isolated now that we know the resident has [redacted]." On 11/16/22 at 3:06 PM, the surveyor interviewed the LNHA who stated that the facility liaison provided the [redacted] center NM with an electronic referral prior to admission for approval of [redacted] insurance coverage etc. The LNHA stated that the clinical paper was reviewed by the facility and it was determined that the facility had indeed informed the facility prior to acceptance that Resident #113 did have a diagnoses of [redacted] The LNHA also maintained that the NM also had access to the EHR and could have reviewed the system and determined that the resident was on isolation precautions. The LNHA stated that she could not speak to why the facility nurses had not documented that Resident #113 and #115 had a diagnoses of [redacted] on their DCLs to maintain ongoing communication with the [redacted] center as required. The LNHA stated that we told them verbally. The LNHA acknowledged that, "If you did not document it, you did not do it." The LNHA stated that the NM did not tell her that she was not aware that	F 880		

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F 880	Continued From page 124 Resident #115 had [redacted]. On 11/16/22 at 3:34 PM, the LNHA and the DON were called to the conference room to join the survey team and were informed of the findings that were a public health concern related to the critical information regarding [redacted] that there was not an ongoing communication between the facility and the [redacted] center to ensure that the residents were properly placed on TBP. On 11/18/22 at 11:29 AM, two surveyors interviewed the NM and the Regional Coordinator (RC). The RC stated that we received referrals from the sending facility and the NM printed it out and reviewed it. The NM stated she checked [redacted], history and physical (H & P), and a [redacted] result within the past 30 days. The NM stated that she also reviewed the diagnoses and prescription of the [redacted] treatment. The NM stated that the diagnoses of a [redacted] was not in those records. The NM stated that she provided the facility with a statement that she received the clinical record and it was an oversight on her part because when she reviewed the Progress Notes and H & P and the present assessment she did not see the diagnoses. The NM further stated that she had not realized that she had forgotten to date the statement. The NM acknowledged that she only learned of Resident #115's need for isolation precautions last [redacted] based on surveyor inquiry. The NM further stated that she overlooked the isolation status in the initial clinical referrals sent by the facility for both Residents #113 and 115. The NM stated that she never spoke to the nurses at the facility prior to	F 880		

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treatments as oral report was not given. The NM stated that the Charge Nurse was off and could not be reached. The NM stated that the Charge Nurse did not document having received oral report from the facility prior to resident transfer. The NM stated they just brought the residents over and provided the [redacted] Communication Book for review. The NM stated that the facility Nurse and CNA accompany the [redacted] staff to hook up the resident to the [redacted] for treatment. The RC stated that if there were a new case of [redacted] it should have been documented in the [redacted] Communication Book. The RC stated that the staff reviewed the DCSs to ensure the resident was stable prior to treatment.

3. On 11/18/22 at 12:23 PM, the surveyor interviewed the ADONUAIP and the DON in the presence of the survey team regarding the status of the residents on the [redacted] Unit with diagnoses of [redacted] On 11/10/22, the LNHA provided the surveyor with a list of ten residents who were diagnosed with [redacted]. The DON stated that it was her understanding that there was no indication that the residents tested [redacted] at the facility and agreed to provide the survey team with data to demonstrate that. At that time, the ADONUAIP stated that if a resident were tested [redacted] with [redacted], it meant that the resident was already tested and treated with [redacted]. The ADONUAIP stated that though she had no formalized training in infection control, she had covered for the IP since she was out. The ADONUAIP stated that the Department of Health (DOH) had just issued an [redacted] for

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a confirmed outbreak) to the facility which indicated that the facility had an active outbreak related to [redacted]. The ADONUAIP stated that she completed case reports for [redacted] residents who had [redacted], and that two of the ten residents who were on the list provided to the surveyor on 11/10/22, were hospitalized and she only scanned [redacted] of the case reports to the DOH for review. The ADONUAIP stated she conferred with the resident's regular physicians when she had questions related to [redacted], as she, "Just found out last month that there was an Infectious Disease Doctor (IDD) on staff at the facility."

On 11/21/22 at 12:46 PM, the surveyor interviewed the ADONUAIP in the presence of the survey team as she reviewed hospital records provided by the Regional Nurse (RN) in the presence of the survey team. The ADONUAIP stated when the residents [redacted] in the hospital we have to accept them and isolate them for 10 days because we do the swabbing here at the facility. The ADONUAIP stated that if the resident was [redacted] for [redacted] upon transfer from the hospital, we tested the resident here and notified the DOH of the result. The ADONUAIP acknowledged that an unsampled resident may have gotten [redacted] here at the facility. The ADONUAIP stated that since we tested the resident here, the positive test result was attributed to our facility. The ADONUAIP stated that her submission of testing to the DOH was sometimes delayed because of the start of the onset of [redacted], so she did not send the case reports until she had all of the information.

On 11/22/22 at 9:33 AM, the DON and the RN presented the surveyor with [redacted] Case

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Report Forms for four unsampled residents that were completed and returned to the DOH, and lab specimen results for a [redacted] unsampled resident. The RN stated that [redacted] case reports were sent for [redacted] unsampled residents. The surveyor asked why a Case Report was not completed for the [redacted] unsampled resident and she responded because the resident was only here at the facility for a couple of days and was not determined to have tested [redacted] at the facility. The DON maintained that upon receipt of the case studies the DOH issued an E# over the phone verbally. The DON maintained that, "While the E# was issued by the DOH, there was no determination that the [redacted] infections for those five unsampled residents originated at the facility and it was still under investigation."

On 11/22/22 at 10:13 AM, the surveyor phoned the Medical Director (MD) in the presence of the survey team via speakerphone (with permission) who stated that he had been the MD for a year or so. The MD stated that if a resident were to be determined to have been [redacted] with [redacted] it was an infection, and was not treated. The MD stated that some of the residents who were diagnosed with [redacted] may have been positive prior to admission to the hospital. The MD stated that once [redacted] was detected via lab specimen the resident was required to be placed on isolation. The MD stated that he would not know if [redacted] was discussed at the Quality Assurance Meetings that he attended every three months. The MD stated that he did not know who the IDD was or the IP at the facility was as they changed sometimes. The MD stated that there was now PPE located outside of isolation rooms and he felt that the staff were doing more about [redacted] than

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F 880	Continued From page 128 they used to. On 11/18/22 at 10:23 AM, the surveyor requested a copy of the Facility Assessment (Intent, For the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require) and the IP's employee file and proof of her last day worked. Review of the Facility Assessment revealed that it failed to contain any mention of [redacted] under the Infectious Disease section. Further review of the Facility Assessment revealed that Infection Prevention and Control were provided directly by the facility and was not a contracted services. Also contained within the Facility Assessment was the contact information for the Infection Control Medical Doctor who was assigned to the facility. On 11/22/22 at 12:54 PM, the surveyor interviewed the RLNHA in the presence of the survey team who stated that the purpose of the Facility Assessment was to communicate the needs of the facility and it was required to be updated yearly. Review of the Facility Assessment indicated that it was updated in 2022, the month and day were not specified. When the surveyor asked the RLNHA if [redacted] should have been included in the Facility Assessment the RLNHA stated that all of the needs of the facility should have been in the Facility Assessment as we have to care for the residents. The facility failed to provide the surveyor with the employee file or time card punches to validate the last day the Infection Preventionist worked at the facility. Surveyor B	F 880		

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4. On 11/10/22 at 11:39 AM, the surveyor observed a staff member (who was later identified as a Licensed Practical Nurse Apprentice (LPNA)) wearing an N95 mask, glasses (not protective goggles or face shield) and gloves, deliver a lunch tray to Resident #92. She placed the lunch tray on the bed side table and moved the table over to the side of the resident's bed. The LPNA removed her gloves and exited the room. She then used hand sanitizer donned a gown and gloves and went back into room and assisted the resident with his/her meal.

The surveyor observed signage on the outside of the resident's room: a STOP, Must See Nurse sign, a Droplet Precautions Everyone Must: ...Make sure their eyes, nose and mouth are fully covered before room entry sign, and a Contact Precautions Everyone Must: ...Put on gown before room entry. Discard gown before room exit sign. There was a stocked PPE bin located outside of the room which contained hand sanitizer, gloves, gowns, and masks.

A review of the Admission Record revealed Resident #92 was admitted to the facility with diagnoses that included, but were not limited to;

[redacted]

Review of Resident #92's Physician Orders revealed two active orders for "Contact Precautions for [redacted] on [redacted], dated [redacted] and [redacted]

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F 880	Continued From page 130 On 11/10/22 at 11:47 AM, the surveyor interviewed the LPNA when she exited the room. The surveyor pointed to the signs and asked the LPNA what the signage for droplet and contact precautions meant. She stated that before entering the room you must follow the signage requirements. She stated, "I did not put on a gown before I dropped the tray, but I shouldn't of gone in the room without a gown". The surveyor asked her about the glasses she was wearing, she stated she was wearing eye glasses and that it was "not OK to go in the room without eye protection". She further stated that she should have found a face shield before entering the room. The LPNA stated the resident had [redacted], which was contagious, and she should have had a gown on to prevent getting into contact with anything in the room because it was an infection barrier, to protect you and the resident. On 11/10/22 at 11:52 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN), assigned to Resident #92, reviewed the Contact and Droplet Precaution signage outside of the resident's room. She stated "you must wear a gown, gloves, a N95 mask, and goggles before entering the room and then remove them when exiting the room. The LPN stated the resident was on Contact Precautions because of [redacted] but she was "not sure why the resident was on Droplet Precautions". On 11/10/22 at 11:57 AM, during an interview with the Infection Preventionist (IP), the surveyor reviewed the signage on Resident #92's door. She stated that when serving lunch, the proper gown, N95 mask, gloves and goggles should be worn before entering the room. She stated the	F 880		

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purpose of the gown was to prevent the spread of [redacted] and that the purpose of the goggles was to protect the eyes from droplets. The surveyor reviewed what she observed when the LPNA was delivering the lunch tray. The IP stated the staff had just been in serviced on following the signage and donning the proper PPE when delivering the meal trays. The surveyor asked if it was ok for the LPNA to deliver the lunch tray without donning a gown, the IP stated, "no it was not".

On 11/10/22 at 12:30 PM, review of the facility provided in service sign in sheet dated [redacted] revealed the LPNA was in serviced on "3...donning and doffing PPE re-meal pass".

On 11/10/22 at 1:18 PM, the surveyor interviewed the Director of Nursing (DON) on process for PPE during meal delivery. She stated that staff must "gown up" when delivering the trays and doff (remove) the gown prior to exiting the room. She further stated staff "must wear a face shield/goggles for droplet precautions". The DON stated that the IP had made her aware of the above and that the LPNA had been in serviced on the proper PPE.

A review of facility policy "Infection Control: Prevention and Control of [redacted] reviewed on 7/26/22, revealed Policy: It is the policy of Alliance Care Rehabilitation and Nursing Center to adhere to the infection control guidelines to limit or prevent residents and staff from the onset of [redacted]; General Information: ...both Standard and Contact Precautions ...healthcare personnel should still use gowns and gloves when performing tasks that put them at higher risk of contaminating their

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clothing.

A review of facility policy "Transmission Based Precautions" reviewed on 6/12/22, revealed
Policy: It is the policy of Alliance Care Center to adhere to the basic infection control guidelines to limit or prevent residents and staff from the onset of spread of microorganisms. Transmission Based Tracer: Signs indicating a resident is on transmission based precautions are clear and visible. Staff are able to successfully verbalize the transmission based precautions required before entering the room
...Glove and gowns are donned upon entry into the environment (i.e..Room or cubicle of resident on contact precautions).

A review of facility policy, "Infection Control: Prevention and Control of [redacted] reviewed on 7/26/22, revealed: If residents with [redacted] receives physical therapy or occupation therapy or other shared services (recreation therapy), staff should not work with other residents while working with the affected patient. They should use a gown and gloves when they anticipate touching patient or potentially contaminated equipment. The resident should be the last patient to receive therapy for the day. Shared equipment should be thoroughly cleaned and disinfected after use.
Hand Hygiene: Increased emphasis on hand hygiene is needed on the unit where a patient with [redacted] resides. When caring for a resident with [redacted], healthcare personnel should follow standard hand hygiene practices which include alcohol-based hand sanitizer...
As part of contact precautions, health care personnel should: Always wear gloves to reduce hand contamination, Avoid touching surfaces

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F 880	Continued From page 133 outside the immediate patient care environment while wearing gloves, Perform hand hygiene before donning gloves and following the removal of gloves. Environmental Disinfection: [redacted] can persist on surfaces on health surfaces in health care environments. Quaternary ammonia products that are routinely used for disinfection may not be effective against[redacted]. Until further information is available, CDC recommends use of Environmental Protection Agency registered hospital grade disinfection against[redacted] Thorough daily cleaning and terminal cleaning and disinfections of patient's rooms and cleaning and disinfecting areas outside of their rooms where they receive care (therapy, activities) is necessary. Shared equipment should be cleaned and disinfected before being used by another resident. Screening Close Contacts: Prior to detection someone may have become affected. Therefore, identification of patient's prior healthcare exposures and contacts is necessary. Identify Prior Healthcare Exposures: Patient's current facility, Facilities at which the index patient stayed for more than 7 days in the prior three months. Facilities with longer length of stay (LTC facilities, nursing homes). A review of facility policy, [redacted] (approved 08/16/22) revealed the following: Procedure: Individual Responsibility of the Charge Nurse/Licensed Nurse to ensure all pertinent information relating to resident care is communicated with the [redacted] center, including but not limited to presence of contagious infections (e.g.[redacted])...	F 880		

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F 880	Continued From page 134 A review of facility policy, "Infection Control: Donning and Doffing of PPES Purpose: To prevent the spread of infection. Wash hands using the proper hand hygiene procedure, Don gown first, Ensure the gown opening is in the back..., Gown cuffs are pulled down to cover the wrist, Don a mask, Apply goggles or face shields, Place over face and eyes and adjust to fit. Don gloves extend to cover the wrist of the isolation gown, Cuff of gloves cover the wrist and are placed over the gown cuffs ...Perform hand hygiene between removal and donning new gloves ...Wash hands or use alcohol-based hand sanitizer immediately after removing all PPE. NJAC 8:39-19.4(a) (1,2)(c)(d)(e)(f)	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized	F 882		1/12/23

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F 882	Continued From page 135 training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Complaint #NJ00158982 Based on facility staff interviews and review of other pertinent facility documentation, it was determined that the facility failed to ensure that the designated Infection Preventionist (IP) had completed specialized training in infection prevention and control and was qualified by certification and experience for 1 of 1 staff member reviewed in accordance with Center for Medicare and Medicaid Services (CMS) and New Jersey State guidelines. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A Physician who has completed an infectious	F 882	I. Immediate Action a) The facility will ensure that the individual designated to cover as the Infection Preventionist, has completed specialized training and certification in Infection Prevention and Control. II. Identification of others a) The facility will have more than one individual with training in Infection Prevention and control Program. III. System Changes a) The job description of full-time Infection Preventionist was reviewed revised by the Administrator, Medical Director, Infectious Disease MD and Director of Nursing. b) The facility hired a new Certified Infection Preventionist and facilitated the completion of training for the individual designated to cover the infection preventionist to ensure that the infection preventionist position is covered at all times. IV. Quality Assurance 1. The Director of Nursing will report to the QAPI Committee the individual designated to cover as the Infection Preventionist has completed and sustained their required training for Nursing Home Infection Preventionist Training and Certification quarterly.	

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F 882	Continued From page 136 disease fellowship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. iv. Facilities with 100 or more beds or on-site hemodialysis services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021. On 11/07/22 at 9:36 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the facility had a Registered Nurse (RN) who served in the role of Infection Preventionist Nurse (IPN) who possessed an Infection Prevention Certification. The LNHA stated that the IPN's job duties included management of residents with [redacted] t) infections on the [redacted] -floor [redacted] and [redacted]) unit. The LNHA further stated that the IPN managed the infection with monthly testing in collaboration with the Department of Health (DOH). At 10:53 AM, in a later interview with the LNHA during the entrance conference, the LNHA stated that the IPN's "only" job responsibility was Infection Prevention which included related education and fit testing for N95 (respirator mask that filters out 95% of particles) mask usage.	F 882	V. Person Responsible: Administrator/Director of Nursing	

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F 882	Continued From page 137 At 1:33 PM, in a later interview with the LNHA, the LNHA stated that the Assistant Director of Nursing (ADON) covered for the IPN temporarily while the IPN was out on leave for an undisclosed amount of time. The surveyor requested to view the ADON's certifications and or training records and requested to view timecard punch logs for both the IPN and the covering ADON/IP. At 2:16 PM, the LNHA clarified that the ADON did not possess any type of infection control training or certification. The LNHA failed to provide timecard punch logs for either the IPN or the ADON/IP who served as the acting IPN as previously requested. On 11/14/22 at 10:33 AM, the surveyor observed the ADON/IP working in a clinical role, administering medications, on the fourth floor of the facility. On 11/14/22 at 8:59 AM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA) who stated that the former Director of Nursing (DON) resigned in [redacted] (date not specified) and the current DON started working at the facility in the [redacted] week of [redacted]. The RLNHA stated that when the IPN went out on leave in October, the ADON had covered the position since that time. On 11/14/22 at 9:48 AM, the surveyor interviewed the LNHA who stated that she served in the role since [redacted]. The LNHA stated that one of the two Medical Directors who served in the shared role, was also an Infectious Disease Doctor (IDD). The LNHA further stated that while the IDD provided education to the facility related to COVID-19, she did not recall that the IDD had	F 882		

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provided the facility staff with any education or information related to [redacted]. The LNHA stated that the building had been in outbreak and accepted residents who previously tested positive with [redacted]. The LNHA further stated that most [redacted] residents were at risk for [redacted] so it was not like an actual outbreak. The LNHA further stated that she did not recall any widespread infection as only [redacted] residents had resided on the unit since she began working at the facility.

On 11/14/22 at 10:45 AM, the surveyor interviewed the IDD via speakerphone (with permission) in the presence of the survey team. The IDD stated that he had been with the facility for a while but due to the pandemic had only been on-site for the past year. The IDD stated that his role has been mainly for education and [redacted] stewardship. The IDD stated that he was not aware that the facility had consistent cases of [redacted]. The IDD stated, "That is a new one." He further stated, "I did not realize there was an outbreak of [redacted] at the facility, and if I knew I would have helped them to address it." The IDD stated that he was unaware that there had been cases of [redacted] at the facility since [redacted]. The IDD stated that he did not know who had the [redacted] but would address it and help them out but needed to know what the underlying problem or cause was to do so. The IDD further stated that contributing factors may have been related to environmental cleaning or improper personal protective equipment (PPE, equipment or clothing worn to protect the body from infection) adherence.

On 11/14/22 at 1:02 PM, the surveyor interviewed the ADON/IP in the presence of the survey team.

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F 882	Continued From page 139	F 882		

The ADON/IP stated that the IP was on vacation since the middle of October, and she filled in for the position. The ADON/IP further stated that when the former DON resigned and the Unit Manager (UM) resigned, she also filled in for both positions. The ADON/IP stated that the IP was expected to return, though she was not sure when. The ADON/IP stated that she conferred with the Regional Nurse (RN) with infection control questions related to [redacted] but was unsure if the RN had any Infection Control certification or specialized training. The ADON/IP further stated that the newly hired ADON #2 had specialized IP training.

On 11/18/22 at 12:26 PM, the surveyor interviewed the ADON/IP who confirmed that she had no specialized training to fill in for the role of IP while the IP was on a leave of absence. The ADON/IP stated that she consulted with the resident's attending physician's when she had infection control related questions. The ADON/IP clarified that the attending physicians were "regular physicians" and were not IDDs. The ADON/IP stated that she only just recently found out that the facility had an IDD when he visited the facility last month and did an in-service related to COVID-19. The ADON/IP confirmed that she did not know of the IDD prior to that. The ADON/IP clarified that the newly hired ADON #2 also did not have specialized infection control training as she previously stated. The ADON/IP confirmed that her responsibilities included: employee health services for new hires, and [redacted] rounds in addition to ADON/IP. The DON who was present, stated that she was hired on [redacted], and the ADON #2 was hired on [redacted]. The DON stated that she now attended wound rounds since the ADON #2 was hired. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315359	A. BUILDING _____ B. WING _____	C 11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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F 882	Continued From page 140	F 882		

DON stated that when the ADON/IP was observed passing medications the other day, she did so due to a need for temporary nursing coverage.

On 11/22/22 at 10:13 AM, the surveyor interviewed the primary Medical Director (MD) via speakerphone (with permission) in the presence of the survey team. The MD stated that he attended Quality Assurance (QA) Meetings every three months and was unsure who the facility IDD was. The MD stated that he would not know if Candida Auris had been discussed during QA. The MD stated that the IP position changed sometimes, and he did not know who was currently responsible for the role. The MD stated that he observed PPE outside of resident rooms who were isolated for [redacted] and felt the facility was doing more about it than they used to.

On 11/22/22 at 10:23 AM, the surveyor interviewed the DON and requested to see the IP's employee file and proof of the last day worked. The facility failed to provide the information as requested upon the second request.

On 11/22/22 at 1:13 PM, the surveyor interviewed the ADON #2, who stated that he did not really have any previous experience in infection control. The DON stated that the ADON #2 would assist the ADON/IP in the role of IP and maintain the line listing reported to the DOH as a group effort and specified that he would not take over the IP role. The DON further stated that the ADON/IP would do that.

Review of the undated facility policy, "Infection Control Nurse Job Description" revealed the

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	315359	A. BUILDING _____ B. WING _____	C 11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 882	Continued From page 141	F 882		

following:

Education: Must possess valid unencumbered state license.

Experience: Two (2) years of experience preferred as a supervisor in a hospital, nursing care facility, or other related health care Facility. Must have, as a minimum of six (6) months experience in rehabilitative and restorative nursing practices.

Duties and Responsibilities included but were not limited to: Assist the Director of Nursing and Associate Director of Nursing in planning, developing, organizing, implementing, evaluating, and directing the day-to-day functions of the Nursing department, in accordance with current rules, regulations, and guidelines that govern the Facility.

...Provide direct nursing care, as necessary.

...Develops and coordinates the infection prevention and control program throughout the facility.

Implements the program by formulating, establishing and evaluating policies and procedures relating to patient care infection control measures throughout the facility.

Performs annual assessment and develops action plans from the prior year activities ...

Specific Requirements:

...Must be knowledgeable of nursing and medical practices and procedures, as well as laws,

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F 882	Continued From page 142 regulations, and guidelines that pertain to nursing care facilities. Must possess leadership and supervisory ability and the willingness to work harmoniously with and supervise other personnel .... Acknowledgement: ...Unit Manager Infection Control Nurse The policy failed to contain the required elements of the Infection Control Practitioner as outlined in Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020.	F 882		
F 919 SS=D	NJAC 8:39-20.2 Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to have call bell system in place for two resident (Resident #114 and #119) and on 1 of 4 Resident units. The deficient practice was evidenced by the following: On 11/07/22 at 11:45 AM, the surveyor	F 919	F919 Resident Call System SS=D I. Immediate Action Concern A a) Missing call bells for residents #114 and #119 were immediately replaced by maintenance	1/19/23

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F 919	Continued From page 143 interviewed Resident #114 while the resident was in a wheelchair in the room. The surveyor did not observe a call bell located near the resident and the inquired to the resident about the call bell. Resident #114 stated "I don't even know if it works, and when they come, they come, and I cannot say on time". On 11/16/22 at 7:59 AM, the surveyor observed Resident #114 awake in bed, and there was no call bell attached to the wall, or by the resident. The Certified Nurse Aide (CNA) assigned to Resident #114 was in the room and the surveyor asked about the call bell for Resident #114, and he stated, "it is not there". At that time, the surveyor observed the roommate, Resident #119 sleeping in bed and there was no call bell attached to the wall and accessible to the resident. The surveyor inquired to the CNA if he could show the surveyor the call bell for Resident #119, and he stated he was looking and "I don't see no call light plugged in". On 11/16/22 at 8:22 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who was overseeing the unit at that time, and had the ADON accompany the surveyor to Resident #114 and #119's room. The surveyor inquired if both resident's had call lights. The ADON looked at the wall, where the call bell would be attached and next to both residents beds, and stated, "oh yeah", and confirmed there was no call light attached to the wall for either resident. NJAC 8:39-31.8(9)	F 919	b) All staff in-serviced on policy and procedure for call bells, and on what to do when the call bell is missing or not working II. Identification of others: a) A house-wide audit was conducted by the Maintenance Director to ensure that all call bells were in place and functioning properly b) All negative findings will be reported to the Administrator and maintenance director for immediate correction c) An immediate reeducation will be given to any staff member who did not immediately report a broken/missing call bell. III. System Changes a) The Policies and Procedures on call bell system was reviewed by the Administrator, Maintenance director, and Director of Nursing and no revision was necessary. b) Reeducation will be given to staff members by Staff Educator on policy and procedure for call bells and on what to do when the call bell is missing or not working. IV: Quality Assurance Concern A a) Audits will be conducted by the Maintenance Director/Designee on all call bells to ensure proper functioning weekly x4, monthly x2, and quarterly x4 quarters. b) All negative findings will be brought to the Director of Nursing, Maintenance Director and Administrator for immediate	

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F 919	Continued From page 144	F 919	correction. c) Results of all audits will be brought to Quality Assurance and Performance Improvement (QAPI) committee x4 quarters V. Person responsible: Maintenance Director, Administrator, Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060736	A. BUILDING: _____ B. WING _____	C 11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CE	155 40TH STREET IRVINGTON, NJ 07111

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 10 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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	S 560	F560 I. Immediate Action: 1. The Administrator and Director of Nursing met with the Staffing Coordinator to determine current staffing vacancies in the nursing department to ensure accuracy of facility needs. 2. The facility has reviewed current salaries in comparison to other facilities in the immediate area to ensure salary competitiveness within the community. 3. The facility contacted the current agencies utilized by the facility to emphasize the facility's immediate needs. 4. The facility maintains daily contact with these agencies to assist in meeting	12/23/22

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

Electronically Signed | 12/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: 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. The surveyor requested staffing for the weeks of 10/23/2022 to 10/29/2022 and 10/30/2022 to 11/5/2022. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -10/23/22 had 13 CNAs for 125 residents on the day shift, required 16 CNAs. -10/24/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. -10/25/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. -10/26/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.	S 560	the needs of the facility. (Ongoing) 5. Nursing Administration is available for interviews, hiring and training as needed to ensure all potential candidates are interviewed, evaluated and offered positions if appropriate. (Ongoing) 6. The facility continues to offer incentives including referral bonuses and other incentives. 7. The facility advertises on various platforms such as social media, posted flyers in various community establishments, colleges and schools. We have partnered with C.N.A. schools, hung banners across facility proper to enhance our recruitment efforts. We have encouraged word of mouth referrals to employees and the community. (Ongoing) 8. The facility works with a full-time recruiter whose sole responsibility is to recruit nurses and C.N.A.s. II. Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III. Systemic Changes 1. The Administrator, Director of Nursing, Human Resource Director have reviewed the state staffing ratios with the Staffing Coordinator to ensure meeting the state required ratios is the primary focus for staffing the facility. 2. The Staffing Coordinator was instructed to notify the Director of Nursing and/or the Administrator when staffing ratios are not being met so they can lend assistance in fulfilling those ratios. 3. Human Resource Director will complete exit interviews for all nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060736	A. BUILDING: _____ B. WING _____	C 11/23/2022

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S 560	Continued From page 2 -10/27/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. -10/29/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. -10/30/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. -10/31/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. -11/01/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs. -11/02/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs. On 11/16/22 at 10:23 AM, during an interview with the surveyor, the staffing coordinator stated she was aware of the state staffing ratios and that the facility usually meets the ratios unless there had been call outs. On 11/18/22 at 8:59 AM, during an interview with the Director of Nursing stated she was aware of the state staffing ratios, but "the staffing coordinator would be the one to ask if the facility was meeting the ratios".	S 560	employees who have vacated their positions in an attempt to address any issues which could be affecting retention of employees. (Ongoing) 4. Orientation frequency will be increased to ensure that all potential candidates for employment will have opportunities to complete the orientation as soon after accepting a facility offer. (Ongoing) IV. Quality Assurance 1. A tracking log will be maintained of all communication with agencies, referrals, applicants, interviews, newly hired, orientation completion and success of recruitment efforts and will be reviewed monthly by Director of Nursing, Administrator and Human Resource Director. 2. All findings will be reviewed by the Quality Assurance Team at least quarterly and changes made as needed to improve facility ratios. V. Responsibility: Administrator, Director of Nursing and Human Resource Director	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060736 Y1	A. Building B. Wing Y2	1/30/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/23/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/23/2022	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315359		1/30/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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 F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/12/2023	ID Prefix F0882 Reg. # 483.80(b)(1)-(4) LSC	Correction Completed 01/12/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
11/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO