STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	535 EGG HARBOR ROAD SEWELL, NJ 08080

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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: 08/21/23 Census: 90 Sample Size: 21 + 3 Complaint #: NJ00165706, NJ00166728 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		9/22/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/11/2023

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to provide privacy and promote dignity during resident assessment. This deficient practice was identified for 1 of 1 resident (Resident #24) reviewed for dignity. This deficient practice was evidenced by the following: On 08/07/23 at 12:53 PM, the surveyor entered	F 550	1. Resident #24 BIMS [redacted]/15, appears to have had no ill effects related to the interaction. The provider was in-serviced on resident rights and privacy immediately on 8/7/23. 2. Residents who were under the care of the identified Nurse Practitioner had the potential to be affected. 3. In order to prevent future occurrences, resident rights and privacy in-servicing	

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F 550	Continued From page 2 the dining room and observed the Nurse Practitioner ask Resident #24 several questions regarding his/her health and then bent down to examine Resident 24's feet. This was done in the dining room in the presence of other residents and staff and while Resident #24 was sitting at the table eating lunch directly across from another resident. The surveyor interviewed the Nurse Practitioner who confirmed that Resident #24 should not have been examined in the dining room and should have been seen in his/her room for privacy but the NP did not want to disturb his/her lunch. According to the Admission Record Resident #24 was admitted to the facility on EX Order 26 § 4b1 and review of Resident #24's Quarterly Minimum Data Set (MDS), an assessment tool revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident was EX Order 26 § 4b1 . On 08/07/23 at 12:56 PM, the surveyor interviewed the Unit Manager (UM) who stated that she was standing at the nurse's station and facing toward the dining room but did not observe the NP examining Resident #24. The UM confirmed that the NP should not see any resident or ask residents any questions in the dining room, residents should be seen in their room for privacy. At that same day at 12:59, the surveyor interviewed two Certified Nurse Assistants (CNA) who were in the dining room at the time of the observation. CNA #1 and CNA #2 both agreed that Resident #24 should have been removed to their room for privacy. CNA #1 did not feel	F 550	was provided to the identified provider, attending providers, consulting providers, healthcare partners, and facility staff. 4. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Director of Nursing or Designee will observe (2) two provider interactions. Results of observations will be forwarded to the quality assurance committee monthly for (3) months for review; revisions will be made as necessary.	

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F 550	Continued From page 3 comfortable saying anything because it was an NP but confirmed they should have offered to take Resident #24 to his/her room. CNA #2 stated they did not observe it but if they had then CNA #2 would have offered to move Resident #24 to his/her room. On 08/07/23 at 1:01 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Nurse Practitioner should have taken Resident #24 back to his/her room to ask any questions and to exam the resident because it was both a dignity and privacy issue and any staff that observed it should have offered to take Resident #24 to their room for privacy. Review of the facility policy titled, "Confidentiality of Information and Personal Privacy: (Reviewed/Revised 12/2018) revealed the following: Our facility will protect and safeguard resident confidentiality and personal privacy. 2. The facility will strive to protect the resident's privacy regarding his or her: a. accommodation, b. medical treatments, and d. personal care. NJAC 8:39 4.1(a) 12	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		9/22/23

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F 582	Continued From page 4	F 582		

for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's

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F 582	Continued From page 5 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the proper required Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN) for 2 of 3 residents (#107, #86) reviewed for facility change notifications. This deficient practice was evidenced by the following: On 08/04/23 at 1:24 PM, the Director of Nursing (DON) provided the surveyor with a list of residents who were discharged from the facility within the last six months and should have received Beneficiary Notices. The surveyor reviewed two of the residents (#107, #86) listed who were discharged from a Medicare Part A (helps cover skilled nursing facility care including rehabilitation services) stay at the facility and were documented as having a discontinuation of their Medicare Part A insurance payment to the facility. Resident #107 was admitted to the facility in [redacted]. The last documented day of coverage for Medicare Part A service was on [redacted]. The facility did not present the resident with the proper required SNFABN form to notify them of the termination of insurance. Resident #86 was admitted to the facility in [redacted]. The last documented day of coverage	F 582	1. Residents # 107 and #86 transferred internally from a Medicare A stay to a long-term stay and received a notice of Medicare non-coverage (NOMNC) but did not receive a skilled Nursing Advanced Beneficiary Notice of non-coverage (SNFABN). 2. One other resident had the potential to be affected; however, the resident was not impacted. Both the SNFABN and the NOMNC were issued. 3. In order to prevent future occurrences, Facility Social Workers were in-serviced on issuing the required SNFABN for Medicare A residents who anticipate being cut from Medicare A, transitioning internally to long-term care, and have remaining Medicare A days. Residents transferring to long-term care after a Medicare A stay who have Medicare A Days remaining will receive an SNFABN and a NOMNC when appropriate. 4. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Social Worker or Designee will audit the records of (3) three residents transferring internally to long-term care after a Medicare A stay who have Medicare Days	

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F 582	Continued From page 6 for Medicare Part A service was on EX Order 26 § 4b1. The facility did not present the resident with the proper required SNFABN form to notify them of the termination of insurance. On 08/09/23 at 12:24 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the DON that the facility did not provide the SNFABN to Resident #107 and Resident #86 after their Medicare Part A coverage had ceased and they were remaining in the facility. The Administrator and DON informed the surveyor that they were not aware that the SNFABN form had to be provided to these residents who continued their stay in the facility after their Medicare Part A insurance had ceased. Review of the facility policy "Medicare Denial Process" (Reviewed/Revised 02/2023) revealed the following: Medicare beneficiaries will be properly notified when it is determined that they do not meet the requirements for covered skilled services under the Medicare Program. ...SNF Advance Beneficiary Notice (CMS (The Centers for Medicare and Medicaid Services)-10055)-The facility designee will issue SNF Advance Beneficiary Notice in the following scenarios: ...The resident has Part A skilled benefit days remaining, and the Facility has determined that the resident no longer meets the skilled level of care and the resident will continue to live at the Facility. NJAC 8:39-5.4 (b) (c)	F 582	remaining to ensure an ABN has been issued when appropriate. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review; revisions will be made as necessary.	

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F 644	Continued From page 7	F 644		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASARR) level 1 assessment after a resident was newly diagnosed with a [redacted]. This deficient practice was identified in 1 of 2 residents reviewed for PASARRs (Resident #42) and was evidenced by the following: On 08/06/23 at 10:00 AM, the surveyor reviewed the resident's Preadmission Screening and Resident Review (PASARR) level 1 (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for	F 644	1. Resident #42 received a new diagnosis of [redacted]. This was addressed medically, but a PASARR Level II review was not initiated. Upon review, a PASARR Level II screen was not indicated. 2. Residents with a negative Level I pre-screen, who were later identified with newly evident or possible serious [redacted] or a related condition, had the potential to be affected. No other residents were affected. 3. In order to prevent future occurrences, Social Workers in-serviced were on	9/22/23

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F 644	Continued From page 8 long term care) which was negative, meaning the resident did not have any EX Order 26 § 4b1 diagnoses or changes. At the same time, the surveyor reviewed the admission Minimum Data Set, an assessment tool (MDS), dated 2021. Under the diagnoses section I, the surveyor noted that the resident did not have any EX Order 26 § 4b1 Resident #42 was admitted to the facility in EX Order 2 . Review of the resident's most recent MDS indicated the resident had medical diagnosis which included, but not limited to EX Order 26 § 4b1 The resident had a Brief Interview of Mental Status (BIMS) of EX Order 26 § 4b1 On 08/06/23 at 10:30 AM, the surveyor reviewed the residents' medications and one of the medications was NJ Exec. Order 26:4.b.1. The surveyor then reviewed the most recent MDS which was from June 2023 and under section I, diagnosis, the resident had diagnosis of EX Order 26 § 4b1 On 08/08/23 at 12:07 PM, the surveyor interviewed the Social Worker (SW) regarding completing PASARR. The SW told the surveyor "They were checked for completeness and diagnosis". The surveyor then asked the SW how she would identify residents with new EX Order 26 §4 and the SW responded, "It would be discussed at the morning meeting". On 08/09/23 at 2:00 PM, surveyor met with the SW again regarding the PASARR level one and two for Resident #42 and she did not provide any additional information.	F 644	PASARR Level II screening. Residents with newly evident or possible serious NJ Exec. Order 26:4.b.1-related conditions will be identified in a monthly review of new NJ Exec. Order 26:4.b.1 diagnoses with the NJ Exec. Order 26 4.b.1. Residents with newly evident or possible serious NJ Exec. Order 26:4.b.1 or related conditions will be assessed for screening for PASARR Level II. 4. As a quality assurance measure, on a weekly basis for (4) four weeks and a monthly basis for (2) two months, the Social Worker or Designee will audit (3) residents diagnosis reports and their referrals for PASARR screening when appropriate. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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F 644	Continued From page 9 On 08/10/23 09:52 AM, the SW met with the surveyor and said, "I'm not sure why the PASARR was not redone, it should have been, I was not the social worker at that time". On 08/18/23 at 1:30 PM, the surveyor reviewed the policy titled, "Admission Criteria", with a revision date of 1/2021. Number eight of the policy read "Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-admission Screening and Resident Review (PASARR) program to the extent practicable". NJAC 8:39-27.1 (a)	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		9/22/23

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F 657	Continued From page 10	F 657		

not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan. This deficient practice was identified for 1 of 22 residents reviewed for resident-centered care plans (Resident #69), and was evidenced by the following:

On 8/2/23 at 11:09 AM the surveyor observed Resident #69 in his/her room with the [redacted] Resident #69 asked where the [redacted] for his/her [redacted] was and stated the staff usually place it on the [redacted].

On 8/03/23 at 09:04 AM the surveyor observed Resident #69 with [redacted] Subsequent observations made on 8/4/23 at 11:14 AM, 8/7/23 at 12:47 AM, and 8/8/23 at 10:45 AM of Resident #69 with [redacted] on the [redacted].

The surveyor reviewed Resident #69's medical record which revealed that the resident was admitted to the facility with diagnoses that included but was not limited to [redacted]

The surveyor reviewed Resident #69's care plans

1. Resident #69 has a history of [redacted] The care plan was updated to reflect the current [redacted] use.

2.Resident #69 was reassessed by [redacted] department to evaluate continued need for [redacted]. The plan of care was updated per [redacted] recommendations

3. All Residents with discontinued [redacted] had the potential to be affected.

4. Resident #69 was affected by the deficient practice

5.No additional residents were affected.

6. In order to prevent future occurrences, residents with discontinued [redacted] will be discussed in the morning meeting. Care Plan will be reviewed in order to verify consistency with orders.

7. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the

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F 657	Continued From page 11 dated 1/29/20 which include that this resident has a EX Order 26 § 4b1 . The interventions include that this resident should utilize a EX Order 26 § 4b1 . The Annual Minimum Data Set (MDS) an assessment tool dated 7/31/23 indicated that Resident #69 was EX Order 26 § 4b1 and has functional ROM NJ Exec. Order 26 4.b.1 of NJ Exec EX Order 26 § and EX Order 26 § 4b1 . During an interview on 8/8/23 at 12:11 PM, the Certified Nursing Assistant stated that Resident #69 uses has a EX Order 26 § 4b1 but has not been using it lately. During an interview 0n 8/9/23 at 10:20 AM, the Unit 100 Nurse Manager (NM) stated that Resident # 69 does not wear a EX Order 26 § to NJ Exec. Order 26 anymore. She believes the Resident stopped wearing it in June. The NM stated this resident should not be getting the EX Order 26 §, but the care plan was not updated. During an interview on 8/09/23 at 12:06 PM, the Unit 100 NM confirmed that she should have updated the care plan. The facility provided policy titled Care Plans, Comprehensive, Person-Centered revised 12/2020 includes that assessments of residents are ongoing and care plans are revised as information about the resident's changes. NJAC 8:39-11.2(i)	F 657	Director of Nursing or Designee will review residents with orders to discontinue NJ Exec. Order 2 and compare the orders to the care plan to verify consistency. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		9/22/23

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F 658	Continued From page 12 §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 observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to follow professional standards of nursing practice by a.) not obtaining a physician's order for a negative EX Order 26 § 4b1 EX Order 26 § 4 therapy NJ Exec. Order 26-4.b machine setting prior to application. This deficient practice was identified for 1 of 1 residents (Resident #188) reviewed for EX Order conditions, b.) not clarifying physician orders for 1 of 4 residents reviewed for medication administration, (Resident # 56), and c.) not completing weekly EX Order assessments as ordered by the physician for 9 of 21 residents reviewed (Resident #38, #12, #8, #69, #78, #97, #68, #37, and #89) This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	1. A. Resident # 188 had a EX Order 26 § vac in place at EX Order 26 § 4b1. The admission order from EX Order 26 § 4b1 did not specify the EX Order 26 § 4b1 that was in place at the time of discharge from the EX Order 26 § 4b1. On 8/7/23, the order was clarified and updated to reflect the continued use of EX Order 26 § 4b1 of EX Order 26 § 4b1. 2. Resident #56 had an order for EX Order 26 § 4b written on 7/4/2023. This was a duplication of an order written on 3/27/23. Order clarified on 8/9/2023. EX Order 26 § 4b1, within normal limits. 3. Residents # 38, 12, 8, 68, 69, 78, 79, 37 EX Order assessments were not captured on the EX Order assessment tool. Once identified, EX Order assessments were completed on the EX Order assessment tool for Residents # 38, 12, 8, 68, 69, 78, 79, 37. 4. A. Residents with NJ Exec. Order 26 4.b.1 had the potential to be affected. No additional residents were affected. 5. Active residents receiving medications during the electronic medical record transition had the potential to be affected. No additional residents were affected.	

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F 658	Continued From page 13 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." a.On 08/02/23 at 10:48 AM, during the initial tour of the facility, the surveyor observed Resident #188 seated on the side of the bed with a [redacted] on the [redacted] When interviewed, the resident stated that the [redacted] resulted after the resident banged their leg at home and the [redacted] was used to aid in [redacted]. Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted] Review of Resident #188's Admission Minimum Data Set (MDS), an assessment tool, which remained in progress and revealed that the resident had a Brief Interview for Mental Status (BIMS) Score of [redacted] out of 15, which indicated that the resident was [redacted].	F 658	6. Active residents with orders for [redacted] assessments had the potential to be affected. Affected residents were assessed, and [redacted] assessments were documented on the [redacted] assessment tool. 7. Licensed Nurses in-serviced on Physician orders, medication order reviews, and [redacted] assessment/documentation. 8. To prevent future occurrences, residents requiring [redacted] will have orders reviewed within 48 hours of admission to verify orders are accurate and complete. 9. Residents in place at the time of transition had medical records reviewed to ensure no duplication of orders. 10. As per the performance improvement plan for [redacted] initiated on [redacted], [redacted] tools will continue to be reviewed to ensure compliance with completion on the scheduled date. A. As a quality assurance measure, on a weekly basis for four weeks, then a monthly basis for two months, the Director of Nursing or Designee will review (2) two residents requiring [redacted] to ensure complete, accurate orders. 1. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review and revisions will be made as necessary.	

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F 658	Continued From page 14 Review of the Order Summary Report (OSR) revealed an order dated 07/26/23 for EX Order 26 § 4b1 [redacted] change to be done every Monday-Wednesday-Friday in the evening for EX Order 26 § 4b1. The order failed to specify the rate at which the NJ Exec. Order 26 machine was required to be set at. On 08/07/23 at 1:12 PM, the surveyor observed Resident #188 seated on the side of the bed with the NJ Exec. Order 26 on the NJ Exec. Order 26:4.b.1. The surveyor asked the resident what the NJ Exec. Order 26 was set at? The resident showed the surveyor the digital display on the monitor which indicated that the machine was set at EX Order 26 § 4b1 [redacted] On 08/07/23 at 2:34 PM, the surveyor interviewed the Registered Nurse (RN) who stated that Resident #188's NJ Exec. Order 26 was set at EX Order 26 § 4b1 [redacted]. The RN stated that the settings were determined based on the physician's order. The surveyor asked the RN to review the orders in the electronic health record (EHR) and show the surveyor the order. The RN reviewed the orders and stated that she did not see an order for the NJ Exec. Order 26 settings. The RN explained that the resident was admitted at night and the night nurse must have seen the setting in the hospital records and set the EX Order 26 accordingly. The RN further stated that a physician's order should have been obtained and placed in the EHR when the nurse reviewed the admission orders with the physician. On 08/07/23 at 2:59 PM, the surveyor interviewed the Nurse Manager (NM) who stated that she worked at the facility for 20 years. The NM stated	F 658	2. As a quality assurance measure, on a weekly basis for four weeks, then a monthly basis for two months, the Director of Nursing or Designee will review (2) two resident records to ensure no duplication of orders. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review and revisions will be made as necessary. 3. As a quality assurance measure, on a weekly basis for four weeks, then a monthly basis for two months, the Director of Nursing or Designee will review the records of two (2) residents per unit to ensure compliance with completing EX Order assessment tools per order. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review; revisions will be made as necessary.	

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that the [NJ Exec. Order 26] setting should have come on the hospital transfer orders or was based on the recommendation of the facility physician or [EX Order 26:3.4] doctor. The NM further stated that an order was required for the established setting. The NM reviewed the OSR in the presence of the surveyor and stated that she did not see a physician's order that specified the [NJ Exec. Order 26] setting. The NM confirmed that there was no order for the [NJ Exec. Order 26] setting, but there should have been.

On 08/09/23 at 10:22 AM, the surveyor interviewed the Director of Nursing (DON) who stated that there were two nurses who were part of the admissions team who received information from the hospital prior to resident admission. The DON stated that the admissions nurse determined if the resident required specific equipment which was then ordered in accordance with the actual discharge orders from the hospital or further clarification was required. The DON stated that if an order was needed after the resident was admitted then it should be obtained as soon as possible. The DON further explained that the facility nurse liaison informed the Admission Coordinator verbally that a [NJ Exec. Order 2] was needed for Resident #188 but the [NJ Exec. Order 2] settings were not listed. At 10:55 AM, the DON provided the surveyor with Resident #188's After Visit Summary (AVS, hospital discharge instructions). Attached to the AVS was a hand written document which indicated that the resident had a NJ Exec. Order 26:4.b.1 . (continuous).

On 08/09/23 at 12:23 PM, the Licensed Nursing Home Administrator (LNHA), Assistant LNHA, DON, and Regional DON were informed that Resident #188 had a [NJ Exec. Order 26] in place set at [NJ Exec. Or]

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NJ Exec. Order 26:4.b.1 without a physician's order until after surveyor inquiry.

On 08/10/23 at 10:21 AM, the surveyor interviewed the Nurse Clinical Liaison and reviewed the undated Admission Notification form which indicated that a EX Order 26 § 4b1) was needed, but failed to specify the required settings. The Nurse Clinical Liaison explained that the hand written document that was attached to the Admission Notification was written by the facility nurse on the nursing unit who received verbal report from the hospital nursing staff regarding Resident #188's medical status prior to admission. The report was reviewed with the Nurse Clinical Liaison and it was confirmed that it included the NJ Exec. Order 2 settings NJ Exec. Order 26:4.b.1 [redacted] The Nurse Clinical Liaison confirmed that based on the documentation provided, the receiving facility nurse was aware of the NJ Exec. Order 26 settings prior to resident's arrival to the facility and could have obtained a physician's order for the NJ Exec. Order 2 settings prior to initiation.

Review of the facility policy 'EX Order 26 § 4b1 EX Order 26 § 4b1 " (Reviewed/Revised 12/2018) revealed the following:

The purpose of this procedure is to provide guidelines for establishing and maintaining EX Order 26 § 4b1 NJ Exec. Order 26:4 .

Verify that there is an order for this procedure.

.. EX Order 26 § 4b1 [redacted]

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b. On 8/09/23 at 9:00 AM, while observing LPN 3 prepare medication for administration to Resident #56, the surveyor observed an order in the electronic medication administration record [redacted]

When asked about the duplicate orders for [redacted], the LPN 3 stated she will speak to the nurse manager to clarify the [redacted] order. Resident #56 was observed taking [redacted] morning medication, [redacted] received only one dose of the [redacted] at that time.

The surveyor reviewed Resident #56's medical record which revealed that he/she was admitted to the facility and had diagnoses that included but were not limited to a [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 5/17/23 reflected that the resident was moderately [redacted].

A review of Resident #56's physician's orders (PO) reflected an order dated 7/4/23 for [redacted].

A review of the EMAR for July and August 2023 reflected that the medication nurse signed for the

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F 658	Continued From page 18 administration of both orders for EX Order 26 § 4b1. (The EMAR was signed to reflect the resident received EX Order 26 § 4b1 On 8/9/23 at 9:14 AM, the surveyor interviewed the Nurse Manager (NM) 2. At that time, the surveyor and the NM 2 reviewed the PO and EMAR for Resident # 56. The NM 2 stated that the order for the EX Order 26 § 4b1 is in the POs twice. She acknowledged that the duplicate orders for the EX Order 26 § 4b1 is incorrect. The NM 2 confirmed that the nurses were signing both orders as being administered in the EMAR. She stated she doesn't think the nurses would be giving two of the EX Order 26 § 4b1 tabs however they did sign them both out. She stated that she will call the doctor to clarify the order. On 8/09/23 at 10:26 AM, the NM 2 confirmed that there should have been only one order for the EX Order 26 § 4b1. A review of the Administering Medications Policy revised 12/2021 included that "if a dosage is believed to be excessive for a resident age, the person preparing/administering the medication shall contact the resident's attending physician or the facility's medical director to discuss the concerns."	F 658		

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C. 1) On 08/02/23 at 10:39 AM, during the initial tour of the facility Resident #38 told the surveyor he/she attended [redacted]. The surveyor observed the resident was on a low air loss mattress used for [redacted].

Review of the Admission Record indicated Resident #38 was admitted to the facility [redacted]. Medical diagnoses included but were not limited to [redacted]. Review of the most recent Minimum Data Set (MDS), dated July 2023 revealed the resident had a Brief Interview of Mental Status (BIMS) of [redacted], meaning the resident was [redacted]. Review of [redacted]

On 08/02/23 at 1:00 PM, the surveyor reviewed the physician orders for Resident #38. the orders showed the following order: Conduct [redacted] assessment weekly on (Saturday). Document findings in assessments [redacted]") every night shift every Saturday for [redacted] an active order dated 02/21/23.

On 08/09/23 at 10:15 AM, the surveyor reviewed the residents TAR for July and August 2023. Review of the July TAR showed that 07/29/23 was blank meaning the assessment was not completed by the staff. On 07/08/23, 07/15/22, and 07/22/23 they were signed by the nursing staff as completed. The surveyor then reviewed the August TAR and 08/05/23 and 08/12/23 were signed as completed by the nursing staff, meaning the [redacted] observation tools were completed. The surveyor then reviewed the assessment section of the EMR and there were no [redacted] observation tools to view.

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2) On 08/02/23 at 10:51 AM, during initial tour of the facility Resident #12 was in bed with eyes open. The resident was on a low air loss mattress (used to prevent EX Order 26 § 4b1).

On 08/03/23 at 09:30 AM, the surveyor observed Resident #12 in bed sipping on water.

Review of the admission record indicated that the resident was admitted to the facility EX Order 26 § 4b1 . Medical diagnoses included but was not limited to EX Order 26 § 4b1 Review of Resident #12 most recent quarterly Minimum Data Set (MDS), dated 6/2023 indicated the resident had a BMS of EX O , indicating the resident was EX Order 26 § 4b1 . Review of section M of the MDS which indicated the resident had a EX Order 26 § 4b1

On 08/09/23 at 11:00 AM, the surveyor reviewed Resident#12 physician orders in the Electronic Medical Record (EMR) which showed an order for the following: Conduct EX Order 26 § 4b1 assessment weekly on (Thursday). Document findings in assessments ("weekly EX Order2 observation tool") every night shift every Thursday for EX Order 26 § 4b1 . This was an active order dated 04/06/23.

On 08/09/23 at 12:40 PM, the surveyor reviewed the residents Treatment Administration Record (TAR) in the EMR which showed the order for the EX Order 26 § 4b1 assessments. The TAR was signed as completed by the nurse for EX Orde EX Order 2 assessments on 07/13/23, 07/20/23, 07/27/23, 08/3/23, and 08/10/23.

On 08/14/23 at 10:00 AM, the surveyor reviewed

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the assessments section of the EMR. The surveyor could not locate any EX Order observation tools.

3) On 08/02/23 at 11:53 AM, during the initial tour of the facility Resident #8 was receiving care from the Certified Nursing Assistant. The surveyor observed Resident #8 was on a EX Order 26 § 4b1 .

Resident#8 was admitted to the facility EX Order of EX Order 26. Medical diagnoses included but were not limited to EX Order 26 § 4b1 Review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 05/13/23 indicated the resident had a Brief Interview of Mental Status (BIMS) of EX Or, meaning the resident was EX Order 26 § 4b1. Review of EX Order 26 § 4b1 of the EX Order 26 revealed Resident #8 was at risk for EX Order 26 § 4b1.

On 08/09/23 at 11:30 AM, the surveyor reviewed the resident's physician orders and saw the following order: Conduct EX Order 26 § 4b1 assessment weekly on (Saturday). Document findings in assessments ("weekly EX Order observation tool") every night shift every Saturday for EX Order 26 § 4b1, an active order with an order date of 3/14/23.

On 08/09/23 at 11:45 AM, the surveyor reviewed the TAR for July and August 2023. Review of the July Treatment Administration Record (TAR) revealed the nursing staff signed the TAR for 7/11/23, 7/18/23, 7/25/23, 8/1/23, and 8/8/23 indicating that the EX Order assessments were completed by nursing and entered in the EX Order

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observation tool in the assessments section of the EMR.

On 08/09/23 at 12:10 AM, the surveyor reviewed the assessment section of the EMR and could not locate the [redacted] observation tools for those dates.

On 08/15/23 at 11:34 AM, the surveyor interviewed the Director of Nursing (DON) regarding the [redacted] observation tool in the assessments section of the EMR. The DON told the surveyor "Because it was a new system, the nurses thought when they signed initials in the TAR, it was automatically entered into the [redacted] observation tool in the assessment section of the EMR. The DON told the surveyor, "The staff do not understand how to enter the [redacted] assessment in the new system".

On 08/16/23 at 10:03 AM, the surveyor interviewed unit Licensed Practical Nurse #1 (LPN#1) regarding the physician orders for the [redacted] assessments weekly and document on the [redacted] assessment tool. The surveyor asked LPN#1 what signing the TAR actually meant for the [redacted] assessments. LPN#1 told the surveyor, "Well, we ask the Certified Nurse's Aide (CNA) to call us when they are providing care to a resident and then we go look at residents [redacted] to see if there are any issues that we didn't see before and then we sign it. LPN#1 continued, "We are just getting used to this system". The surveyor asked LPN#1 where she would document any changes if they had occurred and she said, "The progress notes". The surveyor asked LPN#1 if she knew where the [redacted] observation tools in the assessment section were in the EMR and she attempted but could not locate them. The surveyor asked LPN#1 if she had training, and

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she said they had one day of training prior to the new EMR and an extra training to learn how to modify orders. The surveyor asked if LPN#1if she had any training on documentation of [redacted] assessments since August and the LPN said "No".

4) On 08/02/23 at 11:09 AM, during the initial tour of the facility Resident #69 was observed in bed.

The surveyor reviewed Resident #69 ' s medical record which revealed that the resident was admitted to the facility with diagnoses that included but was not limited to [redacted]

The Annual Minimum Data Set (MDS) an assessment tool dated 7/31/23 indicated that Resident #69 was [redacted]. Review of section M, [redacted] conditions indicated the resident was at [redacted]

On 08/14/23 at 1:00 PM, the surveyor reviewed the physician orders (PO) for Resident #69. There is an order dated 3/4/23 to conduct full [redacted] assessment weekly on (Saturday). Document findings in assessments ("weekly [redacted] observation tool")

On 08/14/23 at 1:00 PM, the surveyor reviewed Resident #69's July 2023 TAR. The July TAR was signed off as the [redacted] assessment being completed on 07//08/23, 07/15/23, /0722/23, and 07/29/23. The August 2023 TAR was reviewed an signed off as the [redacted] assessment being completed on the 08/05/23 and 08/12/23. A

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review of the weekly [EX Order] observation tool revealed that no observation tool was completed for Resident #69 as for July of 2023 or on August 5, 2023 as ordered.

5) 08/02/23 at 10:28 AM during the initial tour the surveyor observed Resident #78 in [NJ Exec.] room sitting in a [EX Order 26 § 4b1].

The surveyor reviewed Resident #78 ' s medical record which revealed that the resident was admitted to the facility with diagnoses that included but was not limited to [EX Order 26 § 4b1]

The Quarterly Minimum Data Set (MDS) an assessment tool dated 06/10/23 indicated that Resident #78 was [EX Order 26 § 4b1]. Review of [EX Order 26 § 4b1] indicated the resident was at [EX Order 26 § 4b1]

On 08/15/23 at 12:21 PM, the surveyor reviewed the physician orders (PO) for Resident #78. There is an order dated 3/21/23 to conduct full [EX Order 26] assessment weekly on (Sunday). Document findings in assessments ("weekly [EX Order] observation tool").

On 08/14/23 at 1:00 PM, the surveyor reviewed Resident #78's July 2023 TAR. The July TAR was signed off as the [EX Order 26] assessment being completed on 07/09/23, 07/16/23, and 07/23/23. The August 2023 TAR was reviewed an signed off as the [EX Order 26] assessment being completed on the 08/06/23 and 08/13/23. A review of the weekly [EX Order] observation tool revealed that no observation tool was completed for Resident #78

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F 658	Continued From page 25 for July of 2023 or on August 6, 2023 as ordered. On 08/16/23 at 10:03 AM, the surveyor interviewed LPN # 2 regarding the order for EX Order checks. LPN#2 stated that a full EX Order 2 assessment should be completed every week and documented in the observation tool in the assessment tab. She ackowledged that from what she sees the EX Orde assessment were not completed as ordered for Resident #69 in July 2023 or on August 5, 2023. LPN#2 confirmed that EX Order assessments were not completed as ordered for Resident # 78 in July or on August 6, 2023. 9.) On 8/7/23 at 12:37 PM, the surveyor observed Resident #89 laying in the bed awake. On 8/14/23 at 11:42 AM, the surveyor again observed the resident laying in bed with their eyes closed and Resident #89 appeared to be asleep. A review of the Face Sheet reflected that the resident was admitted to the facility in EX Order 26 § 4b1 with diagnosis which included but not limited to EX Order 26 § 4b1 . A review of the most recent significant change EX Order 26 dated 5/5/23, reflected a BIMS score of EX which indicated the resident had EX Order 26 § 4b1 . A further review of section " EX Order 26 § 4b1 " reflected the resident was at risk for developing EX Order 26 § 4b1 .	F 658		

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A review of the resident's physician's orders (PO) an active order with a start date of 2/28/23 to "conduct full [EX Order 16] assessment weekly on (Tuesday). Document findings in assessments ("weekly [EX Order 3] observation tool") every night shift every Tuesday for [EX Order] check."

Review of the July TAR reflected that the July 4th TAR date was left blank and not signed by the nurse indicating that no full assessment was completed on that date. July 11th 2023 and July 18th 2023 were signed by the nurse but when the surveyor reviewed the assessment section of the EMR, there was no [EX Order] assessments for those dates. The DON was interviewed and confirmed there was no [EX Order] assessments available.

Review of August 2023 TAR reflected that the TAR for the [EX Order] assessments were signed by the nurses on August 1st and August 8th indicating that the [EX Order] assessments were completed by nursing and entered in the [EX Order] observation tool under the assessments section of the EMR on these dates.

The surveyor then reviewed the assessment section of the EMR and did not locate any [EX Order] assessments for these dates.

On 08/18/23 at 3:25 PM, the DON provided copies of [EX Order] assessments dated for August 2nd and August 9th which were different dates from the dates signed in the TAR of August 2nd and August 8th. The DON confirmed that the facility is now aware and will reeducate the nursing staff on how to properly document the [EX Order] assessments under the assessment tab.

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6.) On 8/2/23 at 10:35 AM, the surveyor observed Resident #97 in their room looking through a magazine. Present in the room was a visitor, who identified themselves as the resident's daughter. The daughter informed the surveyor that the resident was admitted to the facility recently due to frequent [redacted] in the [redacted].

A review of the Face Sheet (an admission summary) reflected that the resident was initially admitted to the facility in [redacted] diagnosis which included but not limited to [redacted].

A review of the most recent admission Minimum Data Set (MDS), an assessment tool, dated 7/31/23, under section "[redacted]" reflected the resident was at risk for developing [redacted].

A review of the resident's physician's orders (PO) included two active orders ordered on 7/25/23 to "conduct full [redacted] assessment weekly on Thursday. Document findings in assessments ("weekly [redacted] observation tool") in the morning every Thursday for [redacted] check."

A review of the resident's individualized resident-centered Care Plan included focused care areas initiated on 7/26/23 for [redacted] and [redacted]."

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Review of the July and August 2023 TAR reflected that the TAR was signed by the nurse for full EX Order 26 assessments order on 07/27/23, 08/3/23, and 08/10/23. indicating that the EX Order assessments were completed by nursing and entered in the EX Order observation tool in the assessments section of the EMR.

The surveyor then reviewed the assessment section of the EMR and could not locate the EX Order observation tools for these dates. The surveyor did observe a EX Order observation assessment dated 7/25/23, which was in progress and did not contain any documentation.

7.) On 8/2/23 at 10:57 AM, the surveyor observed Resident #68 in their room sitting in a EX Order 26 § 4b1 while being visited by a family member. The family member introduced themselves to the surveyor as the resident's daughter-in-law (family member) and informed the surveyor that they are the resident's caregiver at home prior to admission to this facility. They further informed the surveyor that the resident had an EX Order 2 "on (his/her) NJ Exec. Order 2."

On 8/3/23 at 12:12 PM, the surveyor observed Resident #68 being wheeled back to their room in a EX Order 26 § 4b1 by the family member. Once back in the resident's room, the family member informed the surveyor that the resident's EX Order 26 § is most likely a EX Order 26 § 4b1 but was unsure. They stated that the EX Order 26 § 4 was cared for by the EX Order 26 § 4 care nurse twice per week and had a NJ Exec. Order 26:4.b on the EX Order 26 § 4b1 seat as well as an air mattress (to help reduce further EX Order 26 § 4b1 complications).

A review of the Face Sheet reflected that the

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resident was admitted to the facility in EX Order 26 § [redacted] with diagnosis which included but not limited to EX Order 26 § 4b1 [redacted]

A review of the most recent admission MDS dated 7/12/2023, reflected a brief interview for mental status (BIMS) score of [redacted] which indicated the resident had EX Order 26 § 4b1. A further review of section EX Order 26 § 4b1 " reflected the resident EX Order 26 § 4b1 [redacted]

A review of the resident's PO included an active order started on 7/14/23 to 'EX Order 26 § 4b1 [redacted]

A review of the resident's individualized resident-centered Care Plan included a focused care area initiated on 7/7/2023 for impairment to EX Order 26 § 4b1 [redacted]

On 08/04/23 at 1:01 PM, the surveyor reviewed the TAR for July and August 2023. Review of the July TAR revealed the nursing staff signed the TAR for 7/14/23, 7/21/23, 7/28/23, and 8/4/23 indicating that the EX Order 26 § 4b1 [redacted]

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The surveyor then reviewed the assessment section of the EMR and could not locate the EX Order observation tools for 7/21/23 and 7/28/23.

8.) On 8/3/23 at 12:31 PM, the surveyor observed Resident #37 sitting in a EX Order 26 § 4b1

On 8/7/23 at 12:09 PM, the surveyor again observed the resident sitting in the EX Order 26 § 4b1 with their eyes closed in the dining/day room waiting for lunch to be served.

A review of the Face Sheet reflected that the resident was admitted to the facility in EX Order 26 § 4b1 with diagnosis which included but not limited to EX Order 26 § 4b1

A review of the most recent significant change MDS dated 5/5/23, reflected a BIMS score of EX Or which indicated the resident had EX Order 26 § 4b1 . A further review of section " EX Order 26 § 4b1 " reflected the resident was at risk for developing EX Order 26 § 4b1 .

A review of the resident's physician's orders (PO) an active order with an order date of 3/9/23 and a start date of 3/10/23 to "conduct full EX Order 26 assessment weekly on (Friday). Document findings in assessments EX Order 26 § 4b1 ") every night shift every Friday for EX Orde check."

Review of the July and August 2023 TAR reflected that the TAR was signed by the nurse for full EX Order 26 assessments order on 07/7/23,

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F 658	Continued From page 31 7/14/23, 7/21/23, 7/28/23, 8/4/23, and 8/11/23. indicating that the EX Order assessments were completed by nursing and entered in the EX Order observation tool in the assessments section of the EMR. The surveyor then reviewed the assessment section of the EMR and could not locate any EX Order observation tools for these dates. On 08/09/23 at 10:47 AM, the surveyor interviewed the Nurse Manager (NM #1) for the 400 and 500 nursing units, who stated nurses are used to documenting assessments in progress notes in the previous EMR software. On 08/09/23 at 12:34 PM, the surveyor interviewed the DON, who stated there was education provided to nursing staff approximately a week and a half ago about documenting in the assessment tab rather than in progress notes. On 08/10/23 at 10:07 AM, the surveyor interviewed Registered Nurse #1 (RN #1) who was confirmed by the facility to have signed the EX Order assessment order in the TAR on 7/28/23 for Resident #68 to have been completed. RN #1 informed the surveyor that she did not have an assessment documented in the EMR for that day and confirmed, "if it's not documented its not done." On 08/18/23 at 12:08 PM, the surveyor interviewed the DON who informed the surveyor that the administration team looked back at the identified residents without EX Order assessments documented and found "nurses were signing them off in the TAR, but the assessments were not documented."	F 658		

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F 658	Continued From page 32 NJAC 8:39-27.1 (a), 11.2 (b),	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed a.) to provide a EX Order 26 § 4b1 [redacted] This deficient practice was identified for 2 of 24 residents reviewed (Resident #188 and #89). This deficient practice was evidenced by the following: On 08/07/23 at 1:12 PM, the surveyor observed Resident #188 who was seated on the side of the bed. The resident voiced concern that there had been a delay in receipt of a [redacted] machine that was allegedly ordered upon the resident's admission to the facility.	F 695	1. Resident #188 had an order for a [redacted] written on 7/31/23. After obtaining settings and equipment, he started [redacted] on 8/7/23. 2. Resident # 89 was noted to be on [redacted] with an order for EX Order 26 § 4b1 [redacted]. Record review reveals [redacted] levels ranged from [redacted] signage was placed on 8/7/23. [redacted] delivery was adjusted to [redacted] per order. Residents receiving NJ Exec. Order 26:4.b.1 or supplemental [redacted] had the potential to be affected. 1. No additional residents were identified. 2. Licensed Nurses in-serviced on physician□s orders, EX Order 26 § 4b1 [redacted].	9/22/23

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F 695	Continued From page 33 Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility in EX Order 26 § 4b1 with diagnosis which included but were not limited to: EX Order 26 § 4b1 [redacted] Review of Resident #188's Admission Minimum Data Set (MDS), an assessment tool, which remained in progress and revealed that the resident had a Brief Interview for Mental Status (BIMS) Score of [redacted] out of 15, which indicated that the resident was EX Order 26 § 4b1 . Review of the Order Summary Report revealed an order dated 07/27/23 for EX Order 26 § 4b1 (hours of sleep) @ [redacted] at bedtime. Review of the Progress Notes revealed an entry dated 08/06/23 at 9:08 PM, entered by the Licensed Practical Nurse (LPN) which indicated that EX Order 26 § 4b1 at bed time was not available and was on order. Review of Resident #188's Care Plan revealed that on 08/08/23 an entry was added to reflect that the resident had altered EX Order 26 § 4b1 [redacted]. One of the interventions included: [redacted] as ordered. On 08/07/23 at 2:34 PM, the Registered Nurse (RN) stated that Resident #188 had brought it to her attention today that a [redacted] had not been provided by the facility and the resident did not	F 695	3. In order to prevent future occurrences, residents with newly ordered [redacted] will have the appropriate settings required to order and initiate EX Order 26 § 4b1 timely. B. Residents with supplemental [redacted] will have a sign placed on the entry door. [redacted] settings will be verified by the treating nurse each shift. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Director of Nursing or Designee will review up to three residents receiving EX Order 26 § 4b1 and three residents receiving supplemental [redacted] to verify timely receipt of equipment and accurate receipt and initiation of EX Order 26 § 4b1 [redacted] Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review; revisions will be made as necessary.	

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have anyone to bring their EX Order 26 § machine in from home. The RN reviewed the physician's orders in the presence of the surveyor and stated that an order was placed for the EX Order 26 § machine on 07/27/23. The RN stated that someone should have followed up when the EX Order 26 § order was placed to ensure that the resident received the EX Order 26 § as ordered.

On 08/07/23 at 2:59 PM, the surveyor interviewed the Nurse Manager (NM) who reportedly worked at the facility for 20 years. The NM stated that ordinarily, the facility attempted to obtain EX Order 26 § prior to resident arrival. The NM stated that she was surprised that Resident #188 had an order for EX Order 26 §4 and had not received it. The NM reviewed the August 2023 medication administration record (MAR) in the presence of the surveyor and stated that the nurses documented a code of E, which indicated that the drug was not available or a code of O, which indicated to see the progress notes (PN). The NM then reviewed the PN which failed to illustrate that the resident was ordered a EX Order 26 § machine that was not available for usage. The NM stated that the nurse should have called the doctor to let him/her know that a EX Order 26 § was ordered and was not available for further direction. The NM explained that management reviewed the PN daily and if nursing had documented that a EX Order 26 § was needed it would have been ordered upon identification. The NM stated that the lack of a EX Order 26 § machine should have resulted in closer resident monitoring and could have potentially resulted in an adverse medical problem.

Review of the PN revealed that on 08/08/23 at 3:54 AM, the Licensed Practical Nurse (LPN) documented Resident #188 used EX Order 26 § during

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this shift, tolerated well, and slept for the most part of the night.

On 08/08/23 at 1:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that if EX Order 26 § were ordered, then it should have been available within six hours. The DON stated that there was no policy that spoke to the process regarding the ordering of equipment such as EX Order 26 §.

On 08/09/23 at 10:22 AM, the surveyor interviewed the DON who stated that the Nurse Practitioner placed the order for EX Order 26 § on 07/27/23 and should have communicated the need for EX Order 26 § verbally to staff so that the order was promptly addressed. The DON stated that nursing should have also notified the management team that the EX Order 26 § was not available for resident use. The DON further stated that if nursing documented on the MAR that the reader should refer to the PN, then a note should have been documented in the PN to reflect that the resident was ordered a EX Order 26 § machine that was not available for use.

On 08/09/23 at 2:15 PM, the DON provided the surveyor with a Summary of Investigation dated 08/08/23, which revealed the following: Resident #188 had a delay in receiving their ordered EX Order 26 § device which did not result in any harm or negative impact. This delay was due to the unfamiliarity with the facilities new EMR (electronic medical record) system as well as new ordering procedure.

b.) On 08/07/23 at 12:37 PM, the surveyor observed Resident #89 who was laying in the bed awake with the EX Order 26 § 4b1 laying on the

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F 695	Continued From page 36	F 695		

left side of the bed. The surveyor observed the [redacted] machine running and was set at [redacted]. Upon exiting the room, the surveyor also observed that there was no sign posted outside of Resident #89's room door to show that there was [redacted] being utilized in the room.

Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility in [redacted] with diagnosis which included but were not limited to: elevated [redacted]

Review of Resident #89's Admission Minimum Data Set (MDS), an assessment tool, which remained in progress and revealed that the resident had a Brief Interview for Mental Status (BIMS) Score of [redacted] out of 15, which indicated that the resident was [redacted].

Review of the Order Summary Report revealed an order dated 07/25/23 for [redacted] continuously every shift.

Review of Resident #89's Care Plan revealed that on 08/02/23 an entry was added to reflect that the resident had [redacted] related to diagnosis of [redacted] One of the interventions included: [redacted]

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F 695	Continued From page 37 On 08/10/23 at 11:22 AM, the surveyor interviewed the Licensed Practical Nurse #2 (LPN) who confirmed the machine was on [EX Orde] and made the adjustments to [EX Orde] as per the PO. LPN #2 also removed the [EX Order 26 § 4b1] from the bed and placed it on resident #89's [EX Order 26 § 4b1]. On 08/14/23 at 12:46 AM, Interviewed the Director of Nursing (DON) regarding the [EX Orde] being set at [EX Or] when the PO is for [EX Or], and the [EX Orde] sign not being displayed outside the resident's room door. The DON confirmed that the nurses should be following the PO and if the order was written for [NJ Exec] then the [EX Orde] machine should be set at [EX Orde] and if there is [EX Orde] use in the resident's room, then there should be a sign on the door. Review of the facility policy, "Charting and Documentation" (Reviewed/Revised 01/2021) revealed the following: ...The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective ...complete, and accurate ...	F 695		
F 755 SS=D	NJAC 8:39-27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		9/22/23

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F 755	Continued From page 38 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint #NJ00166725 Based on record review and interview it was determined the facility failed to ensure that received medications were appropriately labeled and dated by the providing pharmacy and to check medication expiration dates prior to administering a medication. This deficient practice was identified in 1 of 1 resident reviewed for NJ Exec. Order 26:4.b.1 (Resident #288) and was evidenced by the following:	F 755	Resident #288 had an order for [NJ Exec. Ord] written on 8/11/23. 1. [NJ Exec. Ord] arrived on 8/11/23, and one bag was administered. Resident #288 had no ill effects. No other residents had the potential to be affected. 1. No other residents were receiving [NJ Exec. Ord] 2. Licensed nurses in-serviced on	

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F 755	Continued From page 39 On 08/18/23 at 10:04 AM, the surveyor reviewed Resident #288 Electronic Medical Record (EMR) which revealed Resident#288 was admitted to the facility on [EX Order 26 § 4b] at [EX Order 26 § 4b1] from an acute care facility. Review of the Physician Orders (POS) indicated the resident was ordered [NJ Exec. Order 26 4.b.1]) and had an order for NJ Exec. Order 26:4.b.1) which was total EX Order 26 § 4b1 , to be [EX Order 26 § 4b1] in the evening daily for until a total of [EX Order 26 § 4b1] was [EX Order 26 § 4b]. The [NJ Exec. Or] was ordered by the physician and sent to the outside pharmacy on 8/11/23 at 08:13 AM. On 8/11/23 at 7PM the facility had received the [NJ Exec. Or] and initiated administration to the resident. Review of the Admission Record indicated Resident #288 was admitted to the facility [EX Order 26 § 4b1]. Medical diagnoses included, but not limited to EX Order 26 § 4b1 . The surveyor attempted to view the most recent Minimum Data Set, an assessment tool but it was not completed due to the resident being a new admission. Review of the Social Worker Admission Assessment, it revealed the resident was EX Order 26 § 4b1 . On 08/18/23 at 10:17 AM, the surveyor interviewed the Director of Nursing (DON) regarding residents on [NJ Exec. Or]. The DON told the surveyor the facility used an outside contracted pharmacy for the EX Order 26 § 4b1 . The DON told the surveyor there was no pharmacist to mix [NJ Exec. Or] on weekends and if the facility did receive a [NJ Exec. Or] referral and there was no pharmacist available, "We wouldn't accept the resident."	F 755	medication administration policy. In order to prevent future occurrences, nursing supervisors will receive all [NJ Exec. Or] for (3) three months and audit the accuracy of the labels. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Director of Nursing or Designee will review up to three residents receiving [NJ Exec. Or] therapy to verify the accuracy of labeling. 1. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, revisions will be made as necessary.	

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On 08/18/23 at 10:45 AM, the surveyor met with the DON regarding Resident #288 and the [NJ Exec. Ord.]. The DON said the resident was admitted on [EX Order 26 § 4b1], and the Medical Doctor (MD) was aware the [NJ Exec. Ord.] would be administered to the resident on [EX Order 26 § 4b] for the [EX Order 26 § 4b1] and daily afterward.

On 08/18/23 at 10:54 AM, the surveyor spoke with contracted pharrmacy, the provider for Resident #288 [EX Order 2]. The pharmacy confirmed the [EX Order 2] for the resident was ordered on 08/11/23 and a four-day supply was delivered on 08/11/23 at 02:32 PM and signed for by the facility Resource Charge Nurse (RCN).

On 08/18/23 at 11:00 AM, the surveyor reviewed the progress notes which revealed that on 08/11/23 at 7 PM the resident received the [EX Order 2]. Further review of the progress notes and the Treatment Administration Record (TAR) revealed that on 08/12/23 and 08/13/23 the resident did not receive the [EX Order 2] as ordered by the physician. The physician was notified, and a substitute [NJ Exec. Order 26:4.b.1] was ordered until the [EX Order 2] arrived for the 08/14/23 dose.

On 08/18/23 at 11:10 AM, the surveyor interviewed the facility RCN who was the receiving nurse of the [EX Order 2] from the contracted pharmacy. During the interview the RCN told the surveyor he received the [EX Order 2] and told the surveyor, "I signed for it from the pharmacy, it came in on Friday the eleventh. I gave [NJ Exec. Order 26:4.b.1] to the nurse to administer; I received [NJ Exec. Order 26:4.b.1] total. The other [NJ Exec. Order 26:4.b.1] were placed in the refrigerator on the 400-unit. I put them on the bottom of refrigerator". The surveyor asked the

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RNC why the resident did not receive the [NJ Exec. Or] on 08/12/23 and 08/13/23 as documented in the progress notes. The RNC told the surveyor, "Saturday, there was an issue with expiration dates on the [EX Order 2] bags. The label said the [EX Order 2] expired 08/08/23 and we thought it expired so we discarded them and got an order for [EX Order 26 § 4b1] percent EX Order 26 § 4b1 per hour until new [EX Order 2] bags arrived".

The RNC told the surveyor, "I would not expect bags to be expired that were just received from the pharmacy". The surveyor asked if the bag that was administered to Resident #288 on 08/11/23 also had an expired date of 08/08/23 and the nurse said, "probably". The RCN was asked if the nurse should have checked the expiration date prior to administering the [EX Order 2] and the RCN said, "Yes".

On 08/18/23 at 11:55 AM, the surveyor spoke with the supervising Pharmacist from the contracted pharmacy regarding the residents [EX Order 2]. The supervisor told the surveyor the [EX Order 2] bags have a white and yellow label, each bag dispensed has a seven-day expiration. The pharmacist told the surveyor, "The date was not correct on the label and the facility disposed of the bags. All four bags were incorrectly labeled".

On 08/22/23 at 12:44 PM, the surveyor reviewed the policy titled, "Receipt of Routine Deliveries", an undated policy. The policy read that each facility has routine deliveries to meet the facility's needs and ensure timelines of medication availability. Number seven indicated that the facility designee inspects the packages for damage or errors and will notify the pharmacy

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F 755	Continued From page 42 immediately (24 hours) of any discrepancies. The surveyor then reviewed the policy titled, "Administering Medication", with a revision date of 12/2021. The policy statement was that medications shall be administered in a safe and timely manner, and as prescribed. Number nine of the policy indicated that the expiration/beyond use date on the medication label must be checked prior to administering. NJAC 8:39-29.2 (d), 29.6 (b.2)	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757		9/22/23

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F 757	Continued From page 43 by: Based on observation, interview, and review of facility documentation it was determined the facility failed to document behaviors on a resident receiving NJ Exec. Order 26:4.b.1. This deficient practice was observed for 1 of 2 residents reviewed for behaviors (Resident #42) and was evidenced by the following: On 08/02/23 at 1:00 PM, the surveyor observed Resident #42 sitting in the dayroom being assisted with lunch. On 08/07/23 at11:42 AM, the surveyor reviewed the physician orders which showed the resident was prescribed EX Order 26 § 4b1 [redacted] Resident #42 was admitted to the facility in [redacted]. Medical diagnoses included, but not limited to EX Order 26 § 4b1 [redacted]. Review of the most recent quarterly Minimum Data Set (MDS), an assessment tool revealed the resident had a Brief Interview of Mental Status of [redacted], meaning the resident NJ Exec. Order 26:4.b.1 to the [redacted] assessment questions. On 08/07/23 at 11:45 AM, the surveyor reviewed the most recent [redacted] note which showed the resident had two failed gradual dose reductions of [redacted] medications due to behaviors. On 08/07/23 at 12:20 PM, the surveyor reviewed the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 06/01/23, section I titled active diagnoses which indicated the resident had medical diagnoses of [redacted],	F 757	1. Resident #42 had several gradual dose reductions attempted and failed due to NJ Exec. Order 26:4.b.1. Behavior monitoring initiated. 2. Residents with behavior monitoring indicated had the potential to be affected. No additional residents were affected. 3. Licensed Nurses in-serviced on Behavior Assessment, Intervention, and Monitoring policy. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Director of Nursing or Designee will review (3) three residents with an indication for behavior monitoring. 1. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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NJ Exec. Order 26:4.b.1 .

On 08/07/23 at 12:26 PM, the surveyor reviewed an annual MDS dated 12/20/22, section I, titled active diagnoses revealed the resident did not have EX Order 26 § 4b1

On 08/07/23 at 12:43 PM, the surveyor observed Resident #42 in the day room being assisted by unit staff for lunch.

On 08/07/23 at 12:45 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) regarding documentation of behaviors in residents. LPN#1 told the surveyor, "Any residents with behaviors and who are on EX Order 26 § 4b1 medications are documented on the residents Medication Administration Records (MAR), if they have behavior, you write yes and if not, you write no". LPN#1 could not show the surveyor any documented behaviors for Resident #42.

On 08/07/23 at 01:25 PM, the surveyor requested Resident #42 documented behaviors. The Director of Nursing (DON) provided the surveyor with the behavioral health notes from the contracted company. The DON could not provide any behaviors documented by the nursing staff from the facility.

On 08/08/23 at 10:34 AM, the surveyor reviewed the active current care plan which showed a focus of EX Order 26 § 4. The care plan was initiated 04/05/21. Interventions included but were not limited to nursing staff will observe for signs and symptoms of NJ Exec. Order 26 and report observations to nurse for assessment: EX Order 26 § 4b1

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F 757	Continued From page 45 EX Order 26 § 4b1 Another care plan dated 03/23/23 and revised 08/04/23 had a focus of EX Order 26 § 4b1 . One of the EX Order 26 § 4b1 On 08/08/23 at 11:24 AM, the surveyor reviewed the quarterly MDS dated June 2023. Section E200 had documented EX Order 26 § 4b1 that the behavior occurred every1 to 3 days. On 08/10/23 at 10:42 AM, the surveyor interviewed LPN#1 who was caring for Resident #42 regarding EX Order 26 § 4b1. LPN#1 said that the resident EX Order 26 § 4b1 LPN#1 said the resident had not been EX Order 26 § 4b1 ". On 08/14/23 at 10:04 AM, the surveyor requested all monitoring of behaviors from nursing staff from the DON. The DON provided the surveyor with six progress notes of behavior monitoring, a total of 6 non-consecutive days by only one nurse. The surveyor asked if the behaviors were monitored every shift and the DON said, "I pulled the notes I could find". The surveyor asked if the progress notes by the one specific nurse were the only behaviors that were documented, and the DON said "It looks that way. but I'll keep searching". On 08/14/23 at 10:20 AM, the surveyor reviewed the Consultant Pharmacy note which stated the	F 757		

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F 757	Continued From page 46 staff were to monitor for specific and appropriate targeted behaviors for [NJ Exec. Order 26 4.b.1]. On 08/14/23 at 12:30 PM, the surveyor reviewed the Social Worker note dated 1/5/22 which indicated that behaviors were continuing to be monitored. On 08/17/23 at 10:45 AM, the surveyor reviewed the policy titled, "Behavior Assessment, Intervention and Monitoring", the policy had a revision date of 01/2022. Under the Assessment section of the policy, number two indicated that the nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition. Under the monitoring section of the policy, number four indicated that the nursing staff and the physician will monitor for side effects and complications related to psychoactive medications, for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. NJAC 8:39-27.1 (a)	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		9/22/23

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F 761	Continued From page 47 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined that the facility failed to a.) properly secure a EX Order 26 § 4b1 cart containing medications while unattended during EX Order 26 § 4b1 for 1 of 1 resident (Resident #68) reviewed for EX Order 26 § 4b1, and b.) store medications according to facility policy. This deficient practice was evidenced by the following: a. On 8/2/23 at 10:57 AM, the surveyor observed Resident #68 in their room sitting in a EX Order 26 § 4b1 while being visited by a family member. The family member introduced themselves to the surveyor as the resident's daughter-in-law (family member) and informed the surveyor that they are the resident's caregiver at home prior to admission to this facility. They further informed the surveyor that the resident had an EX Order 2 "on (his/her) NJ Exec. Order 26 ." On 8/3/23 at 12:12 PM, the surveyor observed Resident #68 being EX Order 26 § 4b1 back to their room in	F 761	1. No residents were affected. 2. Residents on the 200 unit and the 400 unit had the potential to be affected. No residents were affected. The treatment cart was locked, and unused medication was removed from the Manager□s Office and returned to the pharmacy. 3. Licensed Nurses will be in-serviced on medication storage procedures. 4. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Director of Nursing or Designee will check (5) five medication or treatment carts and one (1) manager□s office to ensure medications are securely stored. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be	

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F 761	Continued From page 48 a EX Order 26 § 4b1 by the family member. Once back in the resident's room, the family member informed the surveyor that the resident's EX Order 26 § [redacted] is most likely a NJ Exec. Order 26:4.b.1 but was unsure. They stated that the EX Order 26 § [redacted] was cared for by the EX Order 26 § 4b1 care nurse twice per week and had a EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in EX Order 26 § 4b1 with diagnosis which included EX Order 26 § 4b1 [redacted] A review of the most recent admission Minimum Data Set (MDS), an assessment tool, dated 7/12/2023, reflected a brief interview for mental status (BIMS) score of EX Or [redacted] which indicated the resident had EX Order 26 § 4b1. A further review of section "EX Order 26 § 4b1" reflected the resident was at risk for developing EX Order 26 § 4b1 [redacted] A review of the resident's individualized resident-centered Care Plan included a focused care area initiated on 7/7/2023 for EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 A review of the resident's physician's orders (PO)	F 761	made as necessary.	

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F 761	Continued From page 49 included an active order started on 7/12/2023 for EX Order 26 § 4b1 [redacted] On 8/9/2023 at 9:53 AM, the surveyor observed Registered Nurse #1 (RN #1) prepare to perform EX Order 26 § 4b1 for Resident #68 by bringing the EX Order 26 § 4b1 cart in the hallway, directly outside the resident's room door. At 10:03 AM, RN #1 donned (put on) disposable gloves, gathered a new plastic trash bag and a handful of disinfectant wipes from the unlocked cart drawers. RN #1 then left the cart unlocked and the third drawer slightly opened approximately two to three inches and went into the resident's room to disinfect the bedside tray table in preparation for the treatment supplies. After performing brief hand hygiene, RN #1 then returned to the unlocked treatment cart. At this time the surveyor interviewed the RN regarding the treatment cart being left unlocked with a drawer partially opened, and unattended, to which the RN confirmed it was left unlocked and opened and there are "some" prescribed medications in the cart, and she was "supposed to lock it." The RN further stated, "I thought I locked it." On 8/9/2023 at 10:47 AM, the surveyor interviewed the Registered Nurse/ Nurse Manager (RN/NM) for the facility's 400 and 500 units, who confirmed treatment carts are supposed to be locked when unattended. She	F 761		

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F 761	Continued From page 50	F 761		

further stated, "if left unlocked and unattended, the medication could get into the wrong hands like visitors or other patients."

A review of the "Storage of medication" policy provided by the facility with a revision date of 12/2018 included, "7. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others."

b. On 08/15/23 at 11:10 AM, the surveyors observed two (2) clear bags of medication bingo cards (a medication packaging system) under the desk in the open Unit 200 Nurse Manager's office. The medications included antibiotics, mood medications, heart medications, pain medications, heart burn medications, and supplements. There were no controlled medications observed. This room was not designated as a medication storage room.

On 08/16/23 10:45 AM, the Director of Nursing stated that the medications should not be stored in an unlocked office. She furthered that the office door is usually closed and locked.

08/18/23 01:13 PM, the Licensed Practical Nurse 1 stated that the medications should have been stored in a locked medication storage room.

The surveyor reviewed the facility provided policy revised on 2/7/2023. It reflects: #7. Compartments containing drugs and biologicals shall be locked when not in use.

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F 761	Continued From page 51 N.J.A.C. 8:39-29.4(h)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation, it was determined that the facility failed to store, label, and date potentially hazardous food, and maintain kitchen sanitation in a manner intended to limit the spread of food-borne illnesses. The deficient practice was evidenced by the following: On 08/02/23 at 9:50 AM, the surveyor entered the facility kitchen and toured with the Food Service Director (FSD). The surveyor observed 3 crates	F 812	1. No residents were affected. 2. Residents of the center with active diet orders had the potential to be affected. Undated milk is discarded immediately. Unlabeled dry goods, bread, and daily use items labeled. Wet substance under coffee machine was cleaned. Dishes were rerun through the dish machine at the appropriate temperature for cleaning and sanitation. Hot beverage temperatures were taken and logged.	9/22/23

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F 812	Continued From page 52 of milk that had no expiration dates printed on each milk. The FSD confirmed there were 75 milk cartons in each crate for a total of 225 milk cartons that had no expiration dates and confirmed the facility uses the "First in, First out" method and the dates should have been checked upon delivery before being stored in the refrigerator. On that same day at 10:16 AM, the surveyor observed 4 packs of bread on the countertop that were all unlabeled. The FSD stated the bread was brought out to be used today. There were 2 bags of partially used hamburger buns, 1 pack of partially used hot dog buns, and another bag was found on the bread rack unlabeled containing 2 hoagie rolls. The FSD confirmed the breads were not labeled and should have been labeled once the breads were opened. The surveyor also observed a wet substance under the coffee machine which appeared to be coffee. The FSD confirmed that the wet substance was coffee and added that the machine was used this morning for breakfast and the spill should have been wiped up. On 8/02/23 at 10:28 AM, the surveyor observed a rolling cart with various unlabeled items on the cart to include juices, a carton of milk, 2 bowls filled with butter and creamer, and 1 pack of balsamic dressing. The FSD stated the cart is used throughout the day and the items are taken from their labeled boxes and placed on the cart. The FSD then confirmed that once the items were not used, they should have been placed back in their labeled box or labeled. At that same date at 10:31 AM, the surveyor observed in the dry storage area 2 boxes of	F 812	3. The Food Service Director and Food and Nutrition staff in-serviced on food storage, preparation, distribution, and service in accordance with professional standards for food service safety. 4. As a quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Food Service Director or Designee will audit (5) five different inventory items to ensure appropriate storage, labeling, and dating. On a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Food Service Director or Designee will audit the storage and cleaning logs, the dish machine logs, and the hot beverage logs. On a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Food Service Director or Designee will observe the coffee machine after service to ensure the area is clean and sanitized. On a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Administrator or Designee will conduct a kitchen audit to ensure adherence to facility policy on documentation, labeling and storage, and sanitation. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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F 812	Continued From page 53	F 812		

premium Columbian coffee, 2 boxes of balsamic dressing, and 2 packs of tea bags that were not labeled and dated. There was also observations made of the rice bin and thickener bin not labeled or dated and the logs for both were not completed to show when the bins were filled or when they were cleaned. The logs were visible but both were blank. The FSD confirmed all the above items should have been labeled and the logs for the two bins should have been completed.

On 08/17/23 at 10:11 AM, the surveyor observed dish machine cycle and observed that the rinse cycle was at 140 degrees and not at the required 180 or above. The FSD confirmed the temperature was incorrect, shut down the machine, and stated that maintenance would be called.

The surveyor interviewed the dietary aide (DA) currently running the machine and the DA was unsure what the actual temperature should be for the rinse cycle. The FSD confirmed the DA was a new staff running the machine for the first time because they were short staffed but stated DA would get reeducated.

On that same date at 10:32 AM, the surveyor reviewed the coffee logs and found that the kitchen logs which included hot beverage testing were not completed on a daily basis and the logs stated the acceptable kitchen holding temp for hot beverage should be 170 to 180. Hot beverages for 7/9/23 and 7/10/23 were logged at 187, 7/11/23 was logged at 182, 7/13-7/30/23 these forms were all blank, none of the temperatures on any of the sections were completed for those days, and for 7/31/23 there was no temperature logged for hot beverage.

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F 812	Continued From page 54 For the month of August, 8/1/23 there was no log available, 8/2-8/12 no temperatures were done for hot beverage, 8/13- 8/15 was logged at 187 and 8/16/23 there was no temp and at the time of the check on 8/17/23 there were none noted for the 17th as well. A review of the facility's policy, "Food Storage and Labeling" reviewed/revised 02/2023, revealed food storage areas shall be maintained in a clean, safe, and sanitary manner. Policy interpretation and implementation 4. Food shall be rotated as delivered and used in a "First In, First Out" method. Items will be dated on receipt to facilitate this procedure. 6. Containers are clearly marked with the item name and use-by-date. 7. Label, date, and monitor refrigerated and non-refrigerated food items to ensure items are used, discarded or frozen (if applicable) by their use-by-dates. A review of the facility's policy, "Dish Machine" the Dietary Manager will train dish washing staff to monitor dish machine temperatures throughout the dishwashing process. NJAC 8:39-17.2(g)	F 812		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in	F 836		9/22/23

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F 836	Continued From page 55 compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider	F 836	1. No residents were affected. 2. No residents had the potential to be affected. All required paperwork for change in ownership/facility name submitted for review. 1. Facility signage is covered until the name change is approved. The administrator/Designee will monitor to ensure letterhead with new name will not	

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F 836	Continued From page 56 and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and	F 836	be used. 1. As a quality assurance measure, the status of the name change will be monitored by the QA committee monthly for six months.	

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physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:

(1) Within 30 days -
(i) A change of ownership;
(ii) Any adverse legal action; or
(iii) A change in practice location.

(2) All other changes in enrollment must be reported within 90 days."

On 08/02/2023 at 9:08 AM, upon arrival of the surveyors to the facility, the surveyor observed a facility entrance sign displayed on the street that had a name of "Center For Rehabilitation and Nursing at Washington Township" that did not correspond with the CMS (Center for Medicaid and Medicare Services) licensed, approved name and provider registered name "Jefferson Health Care Center."

As the surveyor entered the facility, there was a displayed sign with the same name "Center For Rehabilitation and Nursing at Washington Township" which was not the CMS licensed, approved and provider registered name, "Jefferson Health Care Center." The facility name displayed on the outside of the facility and in the lobby, "Center For Rehabilitation and Nursing at Washington Township" did not correspond with the CMS licensed and approved name of "Jefferson Health Care Center."

On 08/02/2023 at 10:50 AM, the State Surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) for the Entrance Conference. During

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entrance conference, the facility management confirmed that the facility's name was changed on 07/07/2023 at 7:00 AM.

That same day, at 01:11 PM, the surveyor reviewed various documents and facility policies that were provided by the Regional LNHA that presented with "Center For Rehabilitation and Nursing at Washington Township" demonstrated on the letterhead as the title. The documents provided showed that the facility name that was being used was not in accordance to the facility's licensed name and prior to CMS approved name/change of ownership approval.

On 08/03/2023 at 10:05 AM, the state surveyor met with the LNHA to clarify the facility's name. At this time, the surveyor discussed the facility's license displayed on the wall in the reception area which reflected that the CMS approved name of the facility, "Jefferson Health Care Center," which was different than the name displayed on all of the signs and document letterhead presented with "Center For Rehabilitation and Nursing at Washington Township."

During the meeting with the State Surveyor, the Regional LNHA provided a letter that the facility received from the State of New Jersey Department of Health (NJDOH), dated 05/19/2023. The letter referenced an application for transfer of ownership application received by the NJDOH that has been approved to proceed.

The letter establishes, "approving your request to proceed with the transfer of ownership interests of Jefferson Health Care Center." The letter continues to present, "The referenced application submitted is for the transfer of ownership of

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Jefferson Health Care Center" from the previous owner to the current owner. In addition, the letter establishes, "Simultaneously with the transfer of ownership, the Facility will be renamed Center For Rehabilitation and Nursing at Washington Township."

On page 2 of the NJDOH letter, "Although the new owner is authorized to operate the facility following the transaction, the Department will not issue the license under the new ownership until the items listed below are received and reviewed by staff from the Department." The letter continues to list a number of items that need to be submitted for the NJDOH to issue a new license for the new owners allowing them to change the name of the facility.

That same date at 11:35 AM, the State Surveyor interviewed the Regional LNHA who confirmed that the items listed on page 2, to complete the name change, was sent to the NJDOH but could not provide a copy of the final license.

Upon further review of the documents provided by the Regional LNHA, there was an email dated for 07/19/23 sent to NJDOH from the facility's attorney asking for the new license to be expedited to the facility. The State Surveyor met with the facility's LNHA to discuss the deficient practice of utilizing the facility name "Center For Rehabilitation and Nursing at Washington Township" without NJDOH Licensure approval.

No further information or documentation was provided to the survey team to refute these findings.

NJAC 8:39-5.1 (a)

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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) 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:	F 868		9/22/23

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F 868	Continued From page 61 Based on interview and document review, it was determined that the facility failed to provide documented evidence that Quality Assessment and Assurance (QAA) meetings were held with the required members in attendance for the past four quarters. On 08/04/23 at 1:45 PM, the surveyor requested all quarterly sign-in sheets for QAA meetings for the past four quarters. The Licensed Nursing Home Administrator (LNHA) stated that there were no sign-in sheets or proof of attendance as staff attended the meetings remotely via ZOOM (online platform). The LNHA further stated that since the facility recently changed ownership, she no longer had access to her emails and was unable to furnish the surveyor with documented evidence of staff meeting attendance or topics that were discussed. The LNHA stated that if the lack of documentation resulted in a deficient practice so be it, as she did not have access to any type of proof of QAA meeting attendance. On 08/14/23 at 10:07 AM, the surveyor interviewed the LNHA who stated that she began working at the facility in September of 2022. The LNHA stated that the facility held QAA Meetings on a quarterly basis in January, April, July and October. The LNHA showed the surveyor a copy of an e-mail dated 07/25/23, which she alleged demonstrated an invitation for a QAA Meeting. The surveyor reviewed the e-mail and noted that the Director of Nursing (DON) and Infection Preventionist were not listed on the e-mail as required participants. The LNHA stated that the Infection Preventionist was not in attendance, but the Administrator and Medical Director were present. The LNHA was unable to provide the surveyor with documented evidence that the	F 868	1. No residents were affected. 2. All residents are at risk to be affected by deficient practice. 3.The facility is unable to retroactively correct the deficient practice. Quality Assurance Performance Improvement (QAPI) meetings were held virtually each month. 4.The facility QAPI plan was reviewed and updated. QAPI team members educated on importance of attendance, including the infection preventionist and director of nursing. 3. Quality Assurance committee inserviced on QAPI guidelines. QAPI Meetings with the required members will be held in person on a quarterly basis, with a signature sheet circulated for documentation purposes. 4. As a quality assurance measure, on a quarterly basis for two quarters, the Regional Administrator or Designee will review up the Quality Assurance sign-in sheet and Minutes to ensure compliance. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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meeting was held with the required participants or designees in attendance.

On 08/17/23 at 12:09 PM, The LNHA presented the surveyor with a document titled, "Quarterly QA Meeting" invitation for meeting date of 07/25/23 at 10:30 AM. The LNHA stated that the document was in a different format than what she originally provided and rescinded. The LNHA stated that the Registered Nurse Unit Manager filled in for the DON in her absence at the QA Meeting. The LNHA confirmed that the Infection Preventionist was not present at the QA Meeting as required. Further review of the invitation revealed that the only required attendees included the Medical Director and the LNHA and all other employees listed on the invitation were noted to be optional attendees.

At that time, the LNHA further stated that the facility believed in quality assurance and their goal was to capture their documentation to support it. The LNHA further stated that she was confident that everyone was doing QA, but the facility needed a process to streamline it.

Review of the facility QAPI (Quality Assurance Performance Improvement) Plan (Established 07/25/23) revealed the following:

...Administrator Responsibilities: The Administrator is the chairperson of the QAPI committee and is responsible for ensuring the QAPI isplanned [sic.], developed, implemented, coordinated and ongoing in accordance with current rules, regulations, and guidelines that govern our facility ...

...The QAPI Committee Responsibilities: The

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F 868	Continued From page 63 QAA Committee will meet quarterly (or more often as necessary). QAPI activities and outcomes will be on the agenda of every staff meeting and shared with residents and family members. ...All department managers, the administrator, the director of nursing, infection control and prevention officer, medical director, consulting pharmacist, resident and/or family representatives (if appropriate), and additional staff will provide QAPI leadership by being on the QAA committee ... NJAC 8:39-33.1 (b)	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		9/22/23

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F 880	Continued From page 64 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. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 65 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility records it was determined that the facility failed to implement infection control protocols in a manner that would decrease the possibility of the spread of infection by a.) not performing hand hygiene in accordance with the Center for Disease Control and Prevention and facility policy during EX Order 26 § 4 care and b.) during the distribution of resident meal trays. This was observed for a.) 1 of 1 residents (Resident #68) reviewed for EX Order 26 § 4b care and b.) 5 of 7 nursing staff observed on 2 of 4 nursing units during resident meal pass. This deficient practice was evidenced by the following: a.) On 8/2/23 at 10:57 AM, the surveyor observed Resident #68 in their room sitting in a EX Order 26 § 4b1 while being visited by a family member. The family member introduced themselves to the surveyor as the resident's daughter-in-law (family member) and informed the surveyor that they are the resident's caregiver at home prior to admission to this facility. They further informed the surveyor that the resident had an NJ Exec. Order 26:4.b open EX Order 26 § 4b "on (his/her) NJ Exec. Order 26 ." On 8/3/23 at 12:12 PM, the surveyor observed Resident #68 being wheeled back to their room in a EX Order 26 § 4b1 by the family member. Once back in the resident's room, the family member informed the surveyor that the resident's EX Order 26 § is most likely a EX Order 26 § 4b1 but was unsure. They	F 880	1. No residents were affected. 2. Resident #68 and Residents on the 100 and 400 units had the potential to be affected. No residents were identified as affected. RN #1 and CNA #2 immediately in-serviced on Infection Control Guidelines for Nursing Procedures and Handwashing/Hand Hygiene. 3. Staff will be in-serviced on hand hygiene and observations completed by the Infection Preventionist. As quality assurance measure, on a weekly basis for (4) four weeks, then a monthly basis for (2) two months, the Infection Preventionist or Designee will observe (1) one resident meal service and hand hygiene for (2) two staff members to ensure appropriate technique. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review; revisions will be made as necessary.	

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stated that the [redacted] was cared for by the [redacted] nurse twice per week and had a [redacted] EX Order 26 § 4b1 [redacted]

A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnosis which included EX Order 26 § 4b1 [redacted]

A review of the most recent admission Minimum Data Set (MDS), an assessment tool, dated 7/12/2023, reflected a brief interview for mental status (BIMS) score of [redacted] which indicated the resident had EX Order 26 § 4b1 A further review of section EX Order 26 § 4b1 " reflected the resident was at risk for [redacted]

A review of the resident's individualized resident-centered Care Plan included a focused care area initiated on 7/7/2023 for EX Order 26 § 4b1 [redacted]

A review of the resident's physician's orders (PO) included an active order started on 7/12/2023 for EX Order 26 § 4b1 [redacted]

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EX Order 26 § 4b1 [redacted]

On 8/9/2023 at 9:53 AM, the surveyor observed Registered Nurse #1 (RN #1) prepare to perform EX Order 26 § 4 care for Resident #68. RN #1 began at the treatment cart near the nurse's station by donning (putting on) disposable gloves and using a disinfectant wipe to wipe the cart surface. The RN then doffed (took off) the gloves and disposed of them along with the wipes and proceeded to wash her hands at the sink in the hallway. The surveyor, while using a digital stopwatch timed the nurse while she lathered her hands with soap to be eight (8) seconds before she rinsed and dried her hands. The nurse then went to Resident #68's room to check if they were ready for the treatment, at which point the resident's daughter-in-law, who was assisting the resident with morning care, stated they are almost ready. At 10:03 AM, the resident was ready for the EX Order 26 § 4 care treatment. RN #1 informed the Licensed Practical Nurse orientee (LPN/o) who was following her for the day that they are about to start treatment and brought the EX Order 26 § 4 care treatment cart in the hallway, directly outside the resident's room door. The LPN/o entered the resident's room while RN #1 donned gloves, entered the room to identify the resident and assess the EX Order 26 § 4 to be treated. Once completed, the RN then doffed her gloves and washed her hands at the sink in the resident's room. The surveyor timed the RN's hand washing to be six (6) seconds prior to rinsing the soap off her hands. RN #1 then went to the cart, donned disposable gloves, gathered a new plastic trash

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bag and a handful of disinfectant wipes from the unlocked cart drawers, left the cart unlocked and the third drawer slightly opened approximately two to three inches and went into the resident's room to disinfect the bedside tray table in preparation for the treatment supplies. The RN then disposed of the used wipes, doffed her gloves, and washed her hands at the same sink, this time for approximately two (2) seconds. RN #1 then returned to the unlocked treatment cart; at this time the surveyor interviewed the RN regarding the treatment cart being left unlocked with a drawer partially opened, and unattended, to which the RN confirmed it was left unlocked and opened and there are "some" prescribed medications in the cart, and she was "supposed to lock it." The RN further stated, "I thought I locked it." The RN then donned new gloves and prepared all the medication and supplies needed for the treatment as ordered by the physician.

At 10:13 AM, the RN brought in the treatment supplies into the room, placed a clean barrier pad down on the table and placed her supplies. She then assessed the [redacted] once more, doffed her gloves and washed her hands, this time four (4) seconds before rinsing the soap. She donned new gloves used clean 4x4 gauze which was prepared with sterile saline to pat the [redacted] clean. She then stated "usually there would be a dressing on that we would remove and then change gloves, but there is no dressing on" to which the resident's daughter-in-law stated it came off when the resident was getting ready earlier. RN #1 then patted the [redacted] dry with clean 4x4 gauze, applied the ordered [redacted] and covered the [redacted] with an ABD pad as ordered. The RN then disposed of used supplies in the trash bag, disposed of the bag in

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the trash bin, doffed her gloves and washed her hands for three (3) seconds.

At 10:19 AM, RN #1 and the surveyor returned to the treatment cart and the surveyor interviewed the RN regarding hand washing technique. RN #1 stated she was "supposed to wash hands for 20 seconds," and acknowledged that she "did not wash hands for 20 seconds this time." The RN stated that she normally does not keep track of hand washing time with a clock or timer, rather by "singing happy birthday song."

On 8/9/2023 at 10:47 AM, the surveyor interviewed the Registered Nurse/ Nurse Manager (RN/NM) for the facility's 400 and 500 units, who stated hand washing "should be for 20 seconds, if proper hand hygiene is not performed it could compromise infection control."

On 8/10/2023 at 12:41 PM, the surveyor interviewed the facility's full time Infection Preventionist Registered Nurse (IP) who stated staff need to lather their hands for 20 seconds with soap when washing their hands. She further stated, "if not, it can transfer bacteria to another patient or staff member, could cause a breech in infection control."

On 8/14/2023 at 11:32 AM, the surveyor interviewed the facility's Director of Nursing (DON) who stated, "during EX Order 26.3.4 care we expect staff to follow hand washing policy when soap and water is appropriate and when alcohol-based hand rub (ABHR) is appropriate and expect that the policy be followed. Our policy states 15 seconds or greater, so if less than that then it's not appropriate. Potential effects of poor hand hygiene would increase risk of infection."

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b.) On 8/3/2023 at 11:43 AM, the surveyor observed Certified Nursing Assistant #1 (CNA #1) delivering meal trays to residents on the facility's "400" nursing unit. The CNA delivered a meal tray to the resident in room 408, he then returned to the meal cart and obtained another meal tray. At 11:46 AM, the CNA delivered the tray to room 407 bed A and set it down on the tray table. He then went to bed B of room 407, and without gloves, assisted the resident to position themselves in bed, by pulling them to sit upright for their meal. He then, without performing hand hygiene, returned to the meal cart in the hallway and grabbed another tray and delivered it to the resident in room 401 bed A. not having performed hand hygiene, at 11:49 AM the CNA grabbed another meal tray and delivered to 407-B. The CNA stayed in the room and, without gloves, adjusted the resident's tray table, set up the meal tray for the resident, took any trash from the meal tray setup and disposed of it in the trash, did not perform hand hygiene and went to the meal cart to grab and deliver a meal tray to room 405.

On 8/8/2023 at 12:20 PM, the surveyor observed meal tray pass on the "100" nursing unit. At 12:23 PM, CNA #2 delivered a meal to the resident in room 102 bed A, without gloves on, assisted with tray setup and remained in the room a talking to the resident while holding to the footboard of the resident's bed. CNA #2 then proceeded back to the meal cart, did not perform hand hygiene, and took another tray out of the cart and delivered it to room 106 bed B.

On 8/8/23 at 12:30 PM, on the surveyor observed CNA #3 on nursing unit 100 deliver a meal to the resident in room 109 bed A. CNA #3 then donned

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gloves and with the assistance of another CNA repositioned the resident in bed, doffed her gloves, did not perform hand hygiene, went to the meal cart, and grabbed another meal tray and delivered it to room 107 bed A.

On 8/14/2023 at 11:51 AM, the surveyor observed meal pass on the "400" nursing unit. LPN #1, took a meal tray from the meal cart, delivered it to room 409 bed A, placed it on the tray table, and without gloves, adjusted the table for the resident. She then without performing hand hygiene, returned to the meal cart, took another tray, and delivered to room 413 bed B. With no hand hygiene returned to the cart, took a tray, and went to room 414 bed B where she placed the tray on the table, without gloves used the controls on the footboard of the bed to adjust the bed position for the resident, did not perform hand hygiene, and went to the cart to take a tray to room 413 bed A.

At 12:00 PM, the surveyor observed CNA #4 come out of room 408 after delivering a meal tray to bed A, go to the meal cart and obtain eating utensils, delivered them to 408-A, picked up another meal tray from the resident's room and brought it back to the meal cart and placed it into the cart with undelivered meals.

On 8/10/2023 at 12:41 PM, the surveyor interviewed the IP who stated hand hygiene should be performed "prior to handling a resident's meal tray, between each tray, assist residents if needed with hand hygiene, and perform proper hand hygiene if having provided any care to a resident or had any contact with the resident's environment prior to grabbing another resident's meal tray."

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	315231	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	535 EGG HARBOR ROAD SEWELL, NJ 08080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 72	F 880		

On 8/14/2023 at 12:12 PM, the surveyor interviewed LPN #1 who stated she was an agency nurse working at the facility. The LPN stated the was "not sure if it is protocol here to wash hands in between touching meal trays if in contact with resident's environment." The LPN also stated she was not told to wipe tray tables with a disinfectant wipe prior to setting the meal down, "just declutter" the table.

On 8/14/2023 at 12:35 PM, the surveyor interviewed CNA #4 who stated that "if touching resident environment or helping adjust a resident in bed, you place the tray down, put gloves on, help the resident, then perform hand hygiene before going to touch another resident's tray."

On 8/16/2023 at 11:11 AM, the surveyor interviewed CNA #1 who stated hand hygiene is supposed to be performed in between delivering meal trays to each resident. He stated "the purpose is for infection control. If you don't you could spread germs or whatever is around." The surveyor informed the CNA of the observation on 8/3/2023 of CNA #1 while delivering meal trays and assisting residents, to which the CNA stated "I should have done that" referring to hand hygiene.

On 8/16/2023 at 11:50 AM, the surveyor interviewed the DON regarding hand hygiene during meal tray distribution. The DON informed that facility policy is that if staff are in contact with the resident's environment, the are expected to perform hand hygiene otherwise it risks breaking infection control. The DON also confirmed that any agency staff in the facility are expected to abide by these precautions and the agency for which they work are given the facility's hand

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F 880	Continued From page 73	F 880		

hygiene policy.

A review of the "Infection Control Guidelines for All Nursing Procedures" policy provided by the facility with a revision date of 01/2021 included, "Policy: it is the policy of our facility to adhere to infection control guidelines to limit or prevent the spread of infection between residents and/or staff. Purpose to provide guidelines for general infection control while caring for residents ...7. Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions ... a. before and after direct contact with residents ... d. after removing gloves ... after handling items potentially contaminated with blood, body fluids, or secretions ... 8. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-90% ethanol or isopropanol for all the following situations: a. before and after direct contact with residents ...e. before handling clean or soiled dressings, gauze pads, etc ... g. after contact with a resident's intact skin ... i. after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, and j. after removing gloves."

A review of the "Handwashing/Hand Hygiene" policy provided by the facility with a revision date of 01/2021 included " ...7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...l. after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, m. after removing gloves; o. before and after eating or handling food. p. before and

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	315231	A. BUILDING _____ B. WING _____	C 08/21/2023

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F 880	Continued From page 74 after assisting a resident with meals ..." Under the section labeled "procedure" and "washing hands" it includes "1. Wet hands with water and apply cleaning product to hands. 2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 15 seconds (or longer, covering all surfaces of hands and fingers. 3. Rinse hands thoroughly under running water. Hold hands lower than wrists. To not touch fingertips to inside of sink. 4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. 5. Discard towels into trash ... N.J.A.C. 8:39-19.4(m)(n)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060806	A. BUILDING: _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: NJ 00165706 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for 1.) the complaint weeks of 07/02/ 23 through 07/15/23 and 2.) the standard survey weeks of 07/16/23 through 07/29/23. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. No residents were affected. 2. Active residents in the center had the potential to be affected. 3. In order to prevent future occurrences, a new staffing agency has been engaged, sign-on and referral bonuses implemented, a new staffing system implemented, and ongoing recruitment and retention efforts will be continued. Efforts will be made to replace callouts. Licensed Nurses and Nurse Managers will assist with covering open shifts and providing direct care. Staffing ratios will be reviewed daily.	9/22/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 07/02/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -07/02/23 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/05/23 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/08/23 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/10/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/12/23 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -07/15/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of staffing prior to survey from 07/16/2023 to 07/29/2023, the facility was	S 560	1. As a quality assurance measure, on a weekly basis for four weeks, then a monthly basis for 2 months, the Director of Nursing or Designee will review past week, current week, and future week staffing levels to confirm compliance. Recruitment, hiring, and retention efforts will be documented, tracked, and trended. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -07/16/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/17/23 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/21/23 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/22/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -07/23/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. On 08/17/23 at 11:15 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding the staffing guidelines, recruiting, and retention. The SC was aware of standing rations and able to verbalize all shifts. The SC told the surveyor that, "Somedays we meet the ratios and the majority of the time we do try to have the adequate staff day to day". The SC told the surveyor, "If no adequate staff, we have on call supervisors that would come in and work on floor, we are all hands on deck".	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315231	A. Building B. Wing	10/2/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	535 EGG HARBOR ROAD SEWELL, NJ 08080

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 F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 09/22/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
8/21/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315231 Y1	A. Building B. Wing Y2	10/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	535 EGG HARBOR ROAD SEWELL, NJ 08080

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0644	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	09/22/2023	LSC	09/22/2023	LSC	09/22/2023
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	09/22/2023	LSC	09/22/2023	LSC	09/22/2023
ID Prefix F0757	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(d)(1)-(6)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	09/22/2023	LSC	09/22/2023	LSC	09/22/2023
ID Prefix F0836	Correction	ID Prefix F0868	Correction	ID Prefix F0880	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	09/22/2023	LSC	09/22/2023	LSC	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/21/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060806 Y1	A. Building B. Wing Y2	10/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	535 EGG HARBOR ROAD SEWELL, NJ 08080

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/22/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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8/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060806	A. Building B. Wing	10/2/2023

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FOLLOWUP TO SURVEY COMPLETED ON	
8/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING **01** B. WING _____	C **08/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/14/2023 and 08/15/2023 and Jefferson Health Care Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Jefferson Health Care Center is a 2-story building that was built in the January 1988. It is composed of Type II Protected construction. The facility is divided into 12 smoke zones.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		9/22/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/11/2023

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K 222	Continued From page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	**535 EGG HARBOR ROAD** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/14/2023 and 08/15/2023, it was determined that the facility failed to provide 1 of 14 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 08/14/2023 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with fourteen (14) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff, and Visitors would use in the event of an emergency to exit the building. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility DBS, a tour of the building was conducted. During the two (2) day building tour of the facility, the surveyor inspected fourteen (14) designated exit discharge doors with the following results:	K 222	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected. 3. Thumb turn lock and fastening devices were removed from the internal set of doors in the main entrance set of exit discharge doors. Facilities staff in-serviced on the requirement for means of egress to remain readily accessible and free from obstruction. Thumb turn lock and fastening devices will not be utilized. 4. As a quality assurance measure, on a monthly basis for (3) months the Facilities Manager or Designee will observe exit discharge doors to ensure no presence of thumb turn lock and fastening devices or other obstruction of exit door egress. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary	

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K 222	Continued From page 3 On 08/15/2023 (day two of survey) at approximately 8:58 AM, the surveyor observed the main entrance one set of exit discharge doors (internal set of doors) revealed thumb turn lock on the egress side of the doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The doors had a sign that read, Push here in the event of an emergency. Thumb turn lock and fastening device on the door could restrict emergency use of the exit. The DBS confirmed the findings at the time of observations. On 08/15/2023 at approximately 12:40 AM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/14/2023 and 08/15/2023 in the presence of facility management, it was determined that the facility failed to provide a battery backup emergency lights above two (2) of two (2) emergency generator's transfer switch locations,	K 291	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected.	9/22/23

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K 291	Continued From page 4 independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 08/14/2023 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A request was made to the DBS if the facility had an Emergency Generator. The DBS told the surveyor, yes we a Generator. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility DBS, a tour of the building was conducted. During the two (2) day building tour, of the facility the surveyor observed the following: 1) On 08/14/2023 at approximately 11:28 AM, an inspection in the basement level Main electrical room, the surveyor observed no evidence of a battery back up emergency light for the 600 amp and 200 amp automatic transfer switches for the generator. 2) On 08/14/2023 at approximately 12:45 PM, an inspection inside a mechanical room, the surveyor observed no evidence of a battery back up emergency light for the Onan and Cummings automatic transfer switches for the generator.	K 291	3. Battery Backup emergency light installed for the 600 amp and 200 amp automatic switches for the generator. Battery Backup emergency light installed for the Onan and Cummings automatic transfer switches for the generator. Facilities staff in-serviced on Emergency Lighting requirements for 1.5 hours of lighting independent of the facility□s electrical system and emergency generator. 1. As a quality assurance measure, on a monthly basis x (3) three months, the Facilities Manager or Designee will inspect battery operated emergency light operation. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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K 291	Continued From page 5 The DBS confirmed the findings at the time of observations. On 08/15/2023 at approximately 12:40 AM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/14/2023 and 08/15/2023 in the presence of facility management, it was determined that the facility failed to provide four (4) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by	K 293	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected. 3. Two illuminated exit signs were installed in the enclosed outside courtyard (near the food storage room) #1 and the enclosed outside courtyard (near the Resident dining room) #2. Facilities staff in-serviced on the requirement for access exits to be marked by approved, readily visible signs.	9/22/23

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K 293	Continued From page 6 approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 08/14/2023 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a	K 293	4. As a quality assurance measure, on a monthly basis X (3) three months, the Facilities Manager or Designee will observe exit signs to ensure illuminated signs are present at exit doors. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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K 293	Continued From page 7 copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with two (2) enclosed (surrounded by the building) outside courtyards that Resident, Staff, and Visitors could use. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility DBS, a tour of the building was conducted. During the two (2) day building tour of the facility, the surveyor observed four (4) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations: On 08/15/2023, 1) At approximately 10:16 AM, the surveyor observed in the enclosed outside courtyard (near the food storage room) #1, that the facility failed to have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. 2) At approximately 10:27 AM, the surveyor observed in the enclosed outside courtyard (near the Resident dining room) #2 that the facility failed to have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. The DBS confirmed the findings at the time of	K 293		

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K 293	Continued From page 8 observations. On 08/15/2023 at approximately 12:40 AM during the survey exit, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		9/22/23

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K 321	Continued From page 9 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/14/2023 and 08/15/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 08/14/2023 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as a two-story building with 124 Resident sleeping rooms and various common areas. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility DBS, a tour of the building	K 321	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected. 3. Laundry Room door adjusted to facilitate secure closure. Facilities staff inserviced on the requirement to ensure that fire rated doors to hazardous areas are separated by smoke resistant partitions and securely close. 4. As quality assurance measure, on a monthly basis x (3) months the Facilities Manager or Designee will observe (3) three fire rated doors to hazardous areas to ensure secure closure. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review and revisions will be made as necessary.	

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K 321	Continued From page 10 was conducted. During the two (2) day building tour of the facility, the surveyor observed the following hazardous area that failed to have smoke resisting doors. 1) On 08/15/2023 at approximately 10:05 AM, an inspection of the Commercial Laundry room was performed. During a closure test of the corridor door leading into the Commercial Laundry room, the door did not close all the way into its frame. The surveyor observed and recorded the opening between the door and frame was 3/4 of an inch. This closure test was repeated two additional times with the same results. The commercial Laundry room was larger than 50 square feet. With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Commercial Laundry is the primary and/ or secondary egress route in the event of a fire. The DBS confirmed the finding at the time of observation. On 08/15/2023 at approximately 12:40 PM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		9/22/23

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K 341	Continued From page 11 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 08/14/2023 and 08/15/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 outside second floor patio area in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 08/14/2023 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a	K 341	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected. 3. Audio and visual alarm horn strobe installed in second-floor patio and tied into building□s fire alarm system. Facilities staff in-serviced on the necessity for the second-floor outdoor patio to be equipped with a dedicated, effective fire warning system by way of an audio and visual alarm tied into the facility□s fire alarm system. As a quality assurance measure, on a monthly basis x (3) three months, the Facilities Manager or Designee will test	

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K 341	Continued From page 12 copy of the facility lay-out which identifies the various rooms in the facility. A review of the facility provided lay-out identified the facility is made up of two buildings the are connected. The Rehabilitation building is a two-story building and the Nursing Home is a single-story building. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility DBS, a tour of both building's was conducted. On 08/14/2023 (day one of survey) at approximately 10:16 AM, an inspection of the Rehabilitation building's second floor outside patio area was performed. The surveyor observed that the facility failed to have an audio and visual alarm to notify Resident, Staff and Visitors of an activation of the building's fire alarm system. At this time, the surveyor asked the DBS, Do you have an audio and visual alarm tied into the building's fire alarm system. The DBS looked around and told the surveyor, no. The DBS confirmed the findings at the time of observations. On 08/15/2023 at approximately 12:40 PM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	audio and visual alarm for functionality. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

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K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/14/2023 and 08/15/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 08/14/2023 (day one of survey) during the	K 351	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected. 3. An orange plastic cap covering the frangible glass head on one sprinkler in the rehab center□s first-floor electrical room was removed immediately. Escheon cap installed in the employee lounge. Activities closet drop ceiling installed. Escheon Cap installed in the classroom. Escheon Cap installed in the Soiled Linen room.	9/22/23

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THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	**535 EGG HARBOR ROAD** **SEWELL, NJ 08080**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 14 survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms in the facility. A review of the facility provided lay-out identified the facility is made up of two buildings the are connected. The Rehabilitation building is a two-story building and the Nursing Home is a single-story building. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility's DBS, a tour of the facility was conducted. Along the two (2) day tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 08/14/2023: 1) At approximately `10:41 AM, inside the Rehabilitation building's first floor Electrical room, the surveyor observed the fire sprinkler inside the room had an orange plastic cap covering the frangible glass head. This would not allow the sprinkler to function properly in the event of a fire. On 08/15/2023: 2) At approximately 10:16 AM, the surveyor observed inside the Nursing Home Employee lounge closet one sprinkler in the drop ceiling that was missing an escheon cap. This left an approximately one inch gap in the ceiling tile. In the event of a fire this would allow the heat to by-pass the fire sprinkler and take longer to	K 351	Facilities staff inserviced on NFPA requirements for sprinkler installation and coverage. 1. As a quality assurance measure, on a monthly basis for (3) three months, the Facilities Manager will review two sprinkler heads for penetrations and/or obstructions. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING **01** B. WING _____	C **08/21/2023**

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K 351	Continued From page 15 activate. 3) At approximately 10:27 AM, the surveyor observed inside the Activities room's closet one (1) down pendent sprinkler thirty-nine (39) inches down from the closet's ceiling. Code requires an up-rite sprinkler to be located with-in twelve (12) inches of the ceiling. 4) At approximately 11:12 AM, the surveyor observed inside the Classroom one sprinkler in the drop ceiling that was missing an escheon cap. This left an approximately one (1) inch gap in the ceiling tile. In the event of a fire this would allow the heat to by-pass the fire sprinkler and take longer to activate. 5) At approximately 11:17 AM, the surveyor observed inside the Soiled Linen one sprinkler in the drop ceiling that was missing an escheon cap. This left an approximately three-quarters (3/4) inch gap in the ceiling tile. In the event of a fire, this would allow the heat to by-pass the fire sprinkler and take longer to activate. The DBS confirmed the findings at the time of observations. On 08/15/2023 at approximately 12:40 AM during the survey exit, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101	K 911		9/22/23

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	315231	A. BUILDING **01** B. WING _____	C **08/21/2023**

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K 911	Continued From page 16 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 08/14/2023 and 08/15/2023, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 12 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location.	K 911	1. No residents were affected. 2. Residents of the center had the potential to be affected. No residents were affected. 3. GFCI was installed for the electrical outlets within 6 feet of a sink in the salon and Unit 300 Electrical Room. Facilities staff in-serviced on the requirement for GFCI outlets in locations within 6 feet of a water source. 4. As a quality assurance measure, on a monthly basis for (3) three months, the Facilities Manager or Designee will monitor and assess locations that may necessitate GFCI outlets. Results of audits will be forwarded to the quality assurance committee monthly for (3) months for review, and revisions will be made as necessary.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING **01** B. WING _____	C **08/21/2023**

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K 911	Continued From page 17 (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 08/14/2023 (day one of survey) during the survey entrance at approximately 9:38 AM, a request was made to the Administrator and Director of Building Services (DBS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as a two-story building with 123 Resident sleeping rooms. Starting at approximately 10:11 AM on 08/14/2023 and continued on 08/15/2023 in the presence of the facility's DBS, a tour of the building was conducted. During the two (2) day building tour of the facility, the surveyor observed and tested twelve (12) electrical outlets in wet (with-in 6 feet of a sink) locations that failed to de-energize when tested in the following locations. On 08/15/2023: 1. At approximately 10:40 AM, inside the Resident's Salon, one Duplex electrical outlet located thirty-six (36) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code.	K 911		

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K 911	Continued From page 18 2. At approximately 10:58 AM, inside the #300 Electrical room, one Duplex electrical outlet located thirty-nine (39) inches to the right of the sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The DBS confirmed the findings at the time of observations. On 08/15/2023 at approximately 12:40 AM during the survey exit, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315231 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTER FOR REHAB & NURSING WASHINGTON TOWNSHIP	535 EGG HARBOR ROAD SEWELL, NJ 08080

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	09/22/2023	LSC K0291	09/22/2023	LSC K0293	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	09/22/2023	LSC K0341	09/22/2023	LSC K0351	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	09/22/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
8/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO