STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING _____ B. WING _____	11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WEST DEPTFORD)	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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:11/1/2022 Census:129 Sample: 31 + 2 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		12/13/22

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

Electronically Signed | 11/16/2022

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

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to maintain an orderly environment when wallpaper was observed peeling from the wall, a closet was off the hinges, and various dried, liquid stains were observed on the floor. The observations were made in 5 resident rooms. On 10/26/22 at 08:51 AM, inside room [redacted], surveyor #1 observed the wall paper peeling at the seams in at least five different areas. The surveyor further observed dried brown liquid on the floor.	F 584	It is the intent of this facility to maintain a safe, clean, comfortable, and home like environment. A. Identified peeling wallpaper in Rooms NJ EX Order: 264b1 were corrected on 10/31/22. B. Current residents have the potential to be affected by this practice. C. Nursing Home Administrator will re-educate Maintenance Director on ensuring peeling wallpaper is corrected.	

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F 584	Continued From page 2 On the same date at 09:17 AM inside room [redacted] surveyor #1 observed wallpaper peeling from the wall. The area peeling was approximately 48 inches long. On the same date at 09:20 AM inside room [redacted], surveyor #1 observed wallpaper peeling from the wall in three areas. Each peeling area was approximately 24 inches long. On the same date at 11:05 AM inside room [redacted] surveyor #2 observed wallpaper peeling from the wall near the room entrance. The surface behind the wallpaper revealed a dark substance. On the same date and approximate time inside room [redacted], surveyor #2 observed the closet door off the hinges and peeled wallpaper near the base board. On 10/31/2022 at 1:01 PM, during an interview with surveyor #1, the Licensed Nursing Home Administrator stated that wallpaper is replaced or maintained as needed when it is identified. The facility did not present a policy referencing wallpaper. N.J.A.C. 8:39-31.3	F 584	D. Nursing Home Administrator or designee will perform random audit of 5 resident rooms weekly x 4 and monthly x 2 to ensure wallpaper is not peeling, and if so corrected. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		12/13/22

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F 641	Continued From page 3 Based on interview and medical record review, it was determined that the facility failed to complete a resident assessment that accurately reflected the resident's status/behaviors. This was identified during a review of the Minimum Data Set (MDS), an assessment tool, for 1 of 31 residents reviewed (Resident #51). This deficient practice was evidenced by the following: On 10/24/2022 at 10:29 a.m. the surveyor reviewed an Admission MDS Assessment that had a reference date of NJ EX Order. 264b1 According to NJ EX Order. 264b1 Resident #51 scored a 3 on a Brief Interview for Mental Status which indicated that the resident was NJ EX Order. 264b1 NJ EX Order. 264b1 Review of NJ EX Order. 264b1 revealed that the resident had not displayed any physical, verbal, or other behavioral symptoms. Review of section NJ EX Order. 2 revealed that Resident#51 did not reject care and section NJ EX Order. 2 revealed that resident had not NJ EX Order. 264b1 The MDS further indicated in Section I that Resident #51's diagnoses included NJ EX Order. 264b1 On 10/24/2022 at 10:29 AM the surveyor reviewed a Progress Note (PN) dated NJ EX Order. 264b1 at 4:19 AM in which a facility nurse documented that Resident # 51 was found NJ EX Order. 264b1 in the hallway and was constantly asking to go home. The resident complained of a NJ EX Order. 264b1 but refused to take prn NJ EX Order. 264b1 medicine as per patient she doesn't trust the nurse. The resident behaviors that were described in the PN were not documented in the Admission MDS Assessment dated NJ EX Order. 264b1 as required.	F 641	It is the intent of this facility to have the assessment accurately reflect the resident's status. A. Significant correction of prior comprehensive assessment with an assessment reference date of 10/26/22 was completed and submitted. B. Current residents have the potential to be affected by this practice. C. Resident Nurse Assessment Coordinator re-educated Social Worker to review progress notes up to assessment reference date and code the presence of behavior symptoms in NJ EX Order. 264b1 of Minimum Data Set. D. Resident Nurse Assessment Coordinator or designee will perform random weekly audit x4 and monthly x 2 to ensure behavior symptoms are coded in NJ EX Order. 264b1 Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

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F 641	Continued From page 4	F 641		

A PN dated NJ EX Order. 264b1 at 5:49 AM documented that Resident #51 refused to take NJ EX O medicine. The resident behaviors that were described in the PN were not documented in the Admission MDS Assessment dated NJ EX Order. 264b1 as required.

A PN dated 8/20/22 at 2:39 AM documented that Resident #51 wanted to leave and wanted to go to a door to leave. Another PN on that same day at 1:42 AM documented that Resident #51 had been going NJ EX Order. 264b1 of other patient rooms and was NJ EX Order. 264b1. The resident behaviors that were described in the PN were not documented in the Admission MDS Assessment dated NJ EX Order. 264b1 as required.

A PN dated NJ EX Order. 264b1 at 6:30 documented that Resident #51 was NJ EX Order. 264b1 during the night, NJ EX Order. 264b1 through the unit, and was looking tired. The resident behaviors that were described in the PN were not documented in the Admission MDS Assessment dated NJ EX Order. 264b1 as required.

A PN dated 8/23/2022 at 4:12 AM documented that Resident #51 was walking into other resident rooms and NJ EX Order. 264b1 NJ EX Order. 264b1 that he/she has to get out and go home. The resident behaviors that were described in the PN were not documented in the Admission MDS Assessment dated NJ EX Order. 264b1 as required.

A PN dated 8/25/2022 at 9:50 PM documented that Resident #51 was NJ EX Order. 264b1 through the

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F 641	Continued From page 5 unit, seeking the exit door to the [NJ EX Order. 264b1]. The resident behaviors that were described in the PN were not documented in the Admission MDS Assessment dated [NJ EX Order. 264b1] as required. On 10/26/2022 at 12:07 PM the MDS Coordinator confirmed that Resident #51 had exhibited behaviors during the look back period. He stated that NJ EX Order. 264b1 of care, and other behavioral symptoms should have been coded in the Admission MDS dated [NJ EX Order. 264b1] as required.	F 641		
F 689 SS=D	NJAC 8.39-11.1 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations on 10/31/2022 in the presence of facility management, it was determined the facility failed to provide a safe environment for the residents. This deficient practice was indentified for 1 of 3 shower rooms, 2nd floor. This deficient practice was evidenced by the following:	F 689	It is the intent of the facility to maintain and environment free of accidents and hazards as possible. A. Razors and nail clipper were immediately disposed of in a sharp's container. Sharps container was replaced into locked cabinet. B. Current residents have the potential to	12/13/22

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F 689	Continued From page 6 During the tour of the facility in the presence of the facility's Maintenance Director (MD) at 10:56 AM,an inspection inside the [redacted] floor Resident shower room was performed. The corridor door had a passage (no means to lock) door knob installed on the door. The surveyor observed inside the shower room a sharps container cabinet that was mounted to a wall with no evidence of the inner puncture proof sharps container with a one way drop down tray. Further inspection identified that the cabinet door was unlocked and the cabinet contained approximately 35 razors and a nail clipper. The shower room was accessible to Residents. The MD confirmed the findings at the time of observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:32 PM on 11/01/2022. NJAC 8:39-31.2(e)	F 689	be affected by this practice. Environmental Services Director audited remaining shower rooms to ensure sharps container was present in locked cabinet. C. Nursing Home Administrator re-educated Environmental Services Director on replacing and securing a sharps container when removing filled sharps containers from any area. D. Nursing Home Administrator or designee will perform weekly audit x4 weeks and monthly x 2 of shower rooms to ensure sharps containers are present and secured. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		12/13/22

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F 690	Continued From page 7 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to provide the appropriate care and services to prevent potential injury to a resident with an NJ EX Order. 264b1 NJ EX Order. 264b1) by not securing the NJ EX O properly to the securement device (plastic device used to secure the NJ EX Or to prevent the NJ EX Order. 26 from being pulled). The deficient practice was observed for 1 of 3 residents (Resident #1) investigated for NJ EX Order. 264b1 and was evidenced by the following:	F 690	It is the intent of this facility to ensure appropriate care and services are in place for NJ EX Order. 264b1 . A. Resident 1 securement device was secured correctly upon identification. Resident was discharged from facility. B. Current residents have the potential to be affected by this practice. Residents with NJ EX Order. 264b1 were audited to ensure securement devices were applied properly.	

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F 690	Continued From page 8 On 10/24/2022 at 10:26 AM, the surveyor obtained permission from Resident #1 to observe the NJ EX Order. 264b1 device applied to the NJ EX Order. 264b1. At this time, the surveyor observed that the tube was not secured properly and could move freely within the securement device. On 10/25/2022 at 11:18 AM, the surveyor obtained permission from Resident #1 to observe the NJ EX Order. 264b1 securement device again. At this time, the surveyor observed that a new securement device was applied to Resident #1's NJ EX Order. 264b1. The surveyor further observed that the securement device tab was not secured in place, allowing the NJ EX Order. 264b1 to move freely. On 10/25/2022 at 11:27 AM, during an interview with the surveyor, the Unit Manager Registered Nurse #1 stated, "No" when asked if the securement device was secured correctly in both observations. She further stated, "I'll fix it now. I don't want it to pull on him." On 10/31/2022 at 1:01 PM, during an interview with the surveyor, the Director of Nursing stated, "Yes" when asked if the NJ EX Order. 264b1 should be secured in a securement device. A review of Resident #1's Admission Minimum Data Set (a tool used for assessments) dated NJ EX Order. 264b1 revealed Resident #1 had an NJ EX Order. 264b1 because of a diagnosis of NJ EX Order. 264b1). A review of the NJ EX Order. 264b1 securement kit package revealed a diagram showing the NJ EX Order. 264b1 is supposed to be secured using flexible tabs on the	F 690	C. Staff Development Coordinator or designee will re-educate licensed nurses on the correct method of how a securement device should be applied. D. Director of Nursing or designee will perform weekly audit x4 weeks and monthly x2 of residents with urinary catheters to ensure their securement device is applied correctly. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

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F 690	Continued From page 9 securement device. A review of the policy titled, "NJ EX Order. 264b1 NJ EX Order. 264b1) care and management" with a revised date of November 19, 2021 revealed under the heading Implementation: "Make sure that the NJ EX Order. 264b1 is secured properly." N.J.A.C 8:39-27.1(a)	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their dialysis schedule for 1 of 2 residents (Resident #38) reviewed for dialysis. This deficient practice was evidenced by the following: On 10/24/2022 at 9:41 AM, Resident #38 was observed lying in bed. Resident #38 said he/she goes to NJ EX Order. 264b1, and NJ EX Order. 264b1 in the AM. A review of the Electronic Medical Record revealed Resident #38 was admitted to the facility	F 698	It is the intent of this facility to ensure residents who received NJ EX Order. 264 receive services with professional standard of practice. A. Resident 38 medication was adjusted around dialysis times on NJ EX Order. 26 days. B. Current residents have the potential to be affected by this practice. Current NJ EX Order. 264 residents' medication times were audited to ensure medications are coordinated around NJ EX Order. 26 chair times. C. Staff Development Coordinator will re-educate licensed nurses to ensure medications are coordinated around Dialysis chair times and transportation.	12/13/22

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F 698	Continued From page 10 with diagnoses including but not limited to, [redacted] and [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care, dated [redacted] revealed a Brief Interview for Mental Status score of [redacted] indicating Resident #38 has [redacted]. The MDS further revealed Resident #38 received [redacted] while a resident at the facility. A review of the Clinical Physicians Orders revealed a physician order for [redacted], per physician order: [redacted] Chair time for 5AM. A further review of the physician's order revealed the following orders. [redacted] Tablet (medication used for [redacted] MG (milligram) Give [redacted] mg by mouth every [redacted] hours for [redacted]). A review of the Medication Administration Record (MAR) dated [redacted] showed the physician order for [redacted] mg by mouth every 8 hours for [redacted]. There were nurses' initials and a check mark to indicate the medication was given at 6:00 AM on the following dates: [redacted], and [redacted] All the above dates are resident scheduled [redacted] days. A review of the [redacted] MARs dated [redacted] showed the physician order for [redacted] mg by mouth every 8 hours for [redacted]. There were nurses' initials and a check mark to indicate the medication was given at 6:00 AM on the following dates: [redacted]	F 698	D. Director of Nursing of designee will audit dialysis residents' weekly x 4 weeks and monthly x 2 to ensure medication orders are coordinated around dialysis chair time and transportation. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

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F 698	Continued From page 11	F 698		

NJ EX Order. 264b1 [redacted]. All the above dates are Resident # 38's scheduled [redacted] days.

A review of the Progress Notes (PN) dated NJ EX Order. 264b1 indicated resident #38 refused (1) [redacted] treatment on [redacted] and attended all other scheduled [redacted] days.

During an interview with the surveyor on [redacted] at 9:25 AM, Resident #38 said he/she leaves at 5 AM daily and returns by lunch.

During an interview with the surveyor on [redacted] at 11:33 AM, the Unit Manager Registered Nurse #2 (UM/RN #2) said the resident leaves for [redacted] between 4:00 AM-5:00 AM.

During an interview with the surveyor on [redacted] at 1:12 PM, the UM/RN #2 said I came up here to the [redacted] floor in early [redacted] and I readjusted the resident's medication times when I saw it was a problem. I adjusted the medication times appropriately based on his/her [redacted] schedule. Resident #38 returns from [redacted] sometimes at 10 AM maybe 11 AM. Today was 12:30 PM. UM/RN #2 went on to say Resident #38's [redacted] should be given at 5:00 AM. UM/RN #2 confirmed the [redacted] was signed as administered at 6:00 AM on the MARS. UM/RN #2 went on to say that the expectation is "medications are timed around the [redacted] schedule."

During an interview with the surveyor on 10/31/2022 at 1:19 PM, the facility Director of Nursing said, "We audit the chair time and time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING _____ B. WING _____	11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WEST DEPTFORD)	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 12 return from [redacted] and adjust medications around that time." She went on to say that the nurses know the process and it wasn't communicated to me that the resident wasn't getting back by 9 AM. The facility was unable to provide a policy regarding the scheduling of medications and a resident [redacted] schedule. NJAC 8:39-27.1(a)	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		12/13/22

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F 755	Continued From page 13 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to supervise the administration of medication for 1 of 31 sampled residents, (Resident #34). This deficient practice was evidenced by the following: Upon entering Resident #34's room on 10/24/2022 at 9:18 AM, the surveyor, in the presence of another surveyor, observed an NJ EX Order. 264b1 sitting on the bedside table. There was no nurse observed in the room. The surveyor questioned Resident #34 if he/she keeps the medications at their bedside. Resident #34 said, "No, the nurse brought them and leaves them." Resident #34 said, "Most nurses leave the NJ EX Order. 264b1 spray. The nurse watched me take my pills and I do these (motioning to the NJ EX Order. 264b1) and then they pick them up." On 10/24/2022 at 9:20 AM, a nurse entered the room and went to assist a roommate and then stopped and picked up the NJ EX Order. 264b1 spray on Resident #34's bedside table. At that time during an interview with the surveyor, Licensed Practical Nurse (LPN #1) said "I made a mistake. I meant to grab them NJ EX Order. 264b1 spray)." LPN #1 said she left them at the bedside at 8:28 AM when she administered the oral meds	F 755	It is the intent of this facility to provide pharmaceutical services and administering of all drugs to meet the needs of each resident. A. LPN#1 was provided re- education to monitor the use of an NJ EX Order. 264b1 spray. B. Current residents have the potential to be affected by this practice. C. Staff development coordinator will re-educate licensed nurses to monitor the administration of NJ EX Order. 264b1 sprays. D. Director of Nursing or designee will perform random audits weekly x 4 weeks, monthly x 2 to ensure licensed nurse monitors the administration of inhalers and nasal sprays. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

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F 755	Continued From page 14	F 755		

(medications).

According to the Admission Record Report, Resident #34 was admitted with diagnosis of NJ EX Order. 264b1

A review of the most recent Minimum Data Set dated NJ EX Order. 264b1, an assessment tool used to facilitate care, revealed a Brief Interview for Mental Status (BIMS score of) NJ EX Order indicating Resident #34 was NJ EX Order. 264b1.

A review of the current Clinical Physicians Orders revealed an order for NJ EX Order. 264b1 (medication used to treat ongoing NJ EX Order. 264b1 orally every NJ EX hours for NJ EX Order. 264b1 after use. The physician's order also revealed an order for NJ EX Order. 2NJ EX Orde application in NJ EX. CNJ EX Order. 264b1 times per day for NJ EX Order. 264

A review of the Clinical Physicians Orders did not include an order for Resident #34 to self-administer medications.

During a follow-up interview with LPN #1 on 10/24/2022 at 12:40 PM, LPN #1 said no we are not supposed to leave medications at the bedside and confirmed the medications were the NJ EX Order. 2 NJ EX Order. 2 and NJ EX Order. 264b1

During an interview with the surveyor on 10/27/2022 at 10:00 AM, the Director of Nursing (DON) stated, "We typically don't put medications at the bedside unless the patient is capable of self-administering medications and then they are locked in a bag, and they keep them in their

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F 755	Continued From page 15 drawer." The physician also evaluates if the patient can self-administer. The surveyor asked the DON if that would include an [redacted] and [redacted] spray. The DON went on to say, "Yes, that would include an inhaler if the resident says I can do it myself." The DON also explained, "When she (LPN #1) came to me and said I forgot the medications and I meant to take them after Resident #34 was done. Resident #34 is able to take his/her own [redacted] and I forgot it." The DON then stated to the surveyor, "That would not be considered self-administering and typically we don't leave it ([redacted]) on the bedside table." A review of a facility policy titled General Dose Preparation and Medication Administration with revised date of 08/2018, revealed the following under procedure section 3: dose preparation Nursing Center should not leave medications or chemicals unattended. A review of a facility policy titled Storage and expiration dating of drugs, biologicals, syringes And Needles revealed the following under procedure section 2.: The nursing center that all drugs and biologicals, including treatment items, are securely stored in locked cabinet/cart or locked medication room....	F 755		
F 761 SS=D	NJAC 8:3927.1(a) 29.2(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	F 761		12/13/22

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F 761	Continued From page 16 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 §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 record review, it was determined that the facility failed to detect and remove opened expired medication from active inventory in 1 of 2 medication storage areas reviewed. This deficient practice was evidenced by the following: On 10/27/22 09:13 AM the surveyors reviewed the [redacted] floor medication storage room and observed a used vial of NJ EX Order. 264b1 [redacted]) in the opened manufacturer's box. The surveyor observed the box dated [redacted] in blue pen. The vial and the box reflected to discard opened product after 30 days.	F 761	It is the intent of this facility to label drugs and biologicals in accordance with currently accepted professional principals. A. [redacted] solution was thrown away. B. Current residents have the potential to be affected by this practice. Medication storage areas were audited to ensure any expired [redacted] solution was discarded. C. Staff Development Coordinator will re-educate licensed nurses to discard [redacted] solution after 30 days of opening.	

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F 761	Continued From page 17 During an interview with the surveyor on 10/27/2022 at 9:13 AM, the Licensed Practical Nurse #2 stated the [redacted] solution should have been discarded on the 16th or 17th of October. During an interview with the surveyor on on 10/27/22 at 09:28 AM, the Assistant Director of Nursing stated the [redacted] solution should have been discarded on 10/17/2022. During an interview with the surveyor on on 10/27/22 at 10:26 AM, the Director of Nursing stated the [redacted] solution should have been discarded within 30 days. On 10/31/22 11:24 AM the surveyor reviewed the facility policy for Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles dated 08/2018. According to the policy 3. The Nursing Center should ensure drugs and biologicals: Have not been retained longer than recommended by manufacturer or supplier guidelines. 4. Once any biological package is opened, the Nursing Center should follow manufacturer guidelines with respect to expiration dates for opened medications. Nursing Center staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.	F 761	D. Director of nursing or designee will perform audits weekly x 4, and monthly x 2 to ensure expired PPD solution is discarded. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	
F 812 SS=E	NJAC 8:39 - 29.1(e) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/13/22

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F 812	Continued From page 18 §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: FACILITY Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 10/31/2022 from 11:24 to 11:50 AM the surveyors, accompanied by the Food Service Director (FSD) observed the following in the kitchen: 1. The surveyors were in the kitchen to assess food temperatures prior to start of the lunch meal. The surveyor observed the cook behind the steam table. The cook proceeded to walk down to the end of the steam table and removed a pair of disposable gloves from a box. The cook was not	F 812	It is the intent of this facility to store, prepare, distribute and service food in accordance with professional standards for food services safety. A. 1:1 education provided to Dietary staff member regarding washing hands immediately prior to donning Gloves. No residents were affected by this practice. B. Current residents have the potential to be affected by this practice. C. Infection Preventionist re-educated Dietary staff on hand hygiene. D. Infection Preventionist or designee will perform random observation of dietary staff weekly x4 and monthly x2 to ensure proper hand hygiene is completed prior to	

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PROMEDICA SKILLED NURSING & REHAB (WEST DEPTFORD)	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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F 812	Continued From page 19 observed to perform hand washing prior to entering the steam table area. The cook proceeded to don the disposable gloves and grab the thermometer and alcohol wipes that were on the counter. Upon donning the gloves, the surveyor then stopped the cook and asked what the correct procedure was when donning a new pair of gloves. The FSD stated, "Hand washing is to be performed before putting on gloves or changing gloves." The cook then stated, "I washed my hands before putting on the gloves." The surveyor then explained to the cook and FSD that the surveyor did not observe the cook perform hand washing prior to donning gloves. The cook then proceeded to doff her gloves and perform handwashing at the designated handwashing sink according to facility policy. The surveyor reviewed the facility policy titled Glove Usage, Original Date: 11/2020. The policy revealed the following under the GUIDELINES heading: 4. "Hands are washed before putting on gloves and when changing into a fresh pair of gloves. See guidelines on hand washing in this manual." The surveyor reviewed the facility policy titled Hand Washing, Original Date: 11/2020. The policy revealed the following under the heading GUIDELINES: 1. The following list includes, but is not limited to, when hands are washed: "Before applying gloves" NJAC 8:39-17.2 (g)	F 812	donning gloves. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

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	060807	A. BUILDING: _____ B. WING _____	11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WEST DE	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shifts. The facility was deficient in CNA staffing for residents on 14 of 14-day shifts. This deficient practice was evidenced by the following: 1. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	It is the intent of this of this facility to provide minimum direct care staff to resident ratios. A. No residents were affected by this practice. B. Current residents have the potential of being affected by this practice. C. Nursing Home Administrator or designee will educate staffing coordinator to maintain minimum direct care staff to resident ratios. D. Nursing Home Administrator or designee will conduct random audits	12/13/22

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

Electronically Signed | 11/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/02/2022 to 10/08/2022 and 10/09/2022 to 10/15/2022 , the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, 1 direct care staff member to every 10 residents for the evening shift, and 1 direct care staff member to every 14 residents for the night shift are documented below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/02/22 had 11 CNAs for 117 residents on the day shift, required 15 CNAs.	S 560	weekly x4, and monthly x2 of daily staffing sheets to evaluate whether certified nursing aides to resident ratio is met. Ongoing recruitment efforts continue to hire and retain certified nursing assistants. Facility has an established an inhouse Nurse Aide Training and Competency Evaluation Program to recruit and train future certified nursing assistants. Incentives in place and enhanced for open shift pick ups, new hires, and referrals by employees. Results will be provided to the Quality Assessment and Assurance Committee monthly for review and action as appropriate.	

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S 560	Continued From page 2 -10/03/22 had 12 CNAs for 116 residents on the day shift, required 14 CNAs. -10/04/22 had 12 CNAs for 114 residents on the day shift, required 14 CNAs. -10/05/22 had 13 CNAs for 114 residents on the day shift, required 14 CNAs. -10/06/22 had 11 CNAs for 114 residents on the day shift, required 14 CNAs. -10/07/22 had 13 CNAs for 114 residents on the day shift, required 14 CNAs. -10/08/22 had 12 CNAs for 118 residents on the day shift, required 15 CNAs. -10/09/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -10/10/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -10/11/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -10/12/22 had 13 CNAs for 117 residents on the day shift, required 15 CNAs. -10/13/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs. -10/14/22 had 13 CNAs for 121 residents on the day shift, required 15 CNAs. -10/15/22 had 11 CNAs for 121 residents on the day shift, required 15 CNAs. During an interview with the surveyor on 10/26/22 at 12:24 PM the staffing coordinator stated that the staffing ratios are 8 residents to 1 CNA on the day shift, 10 residents to 1 CNA on the evening shift, and 14 residents to 1 CNA on the 11-7 shift. She stated that the facility is following the ratios "as best as we can but the staffing shortage is just insane." During an interview with the surveyor on 10/31/2022 at 9:35 AM, the Licensed Nursing	S 560		

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S 560	Continued From page 3 Home Administrator stated that she tries her best to meet the requirements.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060807 Y1	A. Building B. Wing Y2	12/14/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (WEST DEPTFORD)	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/13/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/1/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO